Independent Investigation

into the

Care and Treatment Provided to Mr. X

by the

Manchester Mental Health and Social Care NHS Trust

and

NHS Manchester

and the

Health Advocacy Resource Project

Commissioned by
NHS North West
Strategic Health Authority

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the death of Mr. W who was found killed on the 28 July 2008.

Mr. X received care and treatment for his mental health condition from the Manchester Mental Health and Social Care NHS Trust, NHS Manchester, and the Health Advocacy Resource Project. It is the care and treatment that Mr. X received from these organisations that is the subject of this Investigation.

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

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

We would like to thank the family of Mr. W who offered their full support to this process and who worked with the Independent Investigation Team. We acknowledge their distress and we are grateful for the openness and honesty with which they engaged with the Investigation. This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

1. Health service Guidance (94) 27

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

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

It is the sincere hope of the Independent Investigation Team that this inquiry process has addressed all of the issues that Mr. W's family have sought to have examined and explained.

The family of Mr. W wish to say the following:
"Mr. W was a true family man with a great sense of humour and heart of gold. He enjoyed the simple pleasures in life – fishing, watching Manchester United play, meals with the family. He was always around to help if anyone needed him and in that respect he was totally selfless.

His death has left a huge void in our lives and we will never forget him."

3. Incident Description and Consequences

The following account has been taken from the proceedings in the Crown Court at Manchester 10 June 2009.

Mr. X lived in one of five flats contained in a large converted Victorian semi-detached house in Manchester. At the time of the incident four out of the five flats were being renovated, and only Mr. X's flat was occupied.

Mr. W was employed by the Landlord of the house to install kitchens and do other odd jobs. On the morning of Monday of the 28 July 2008 Mr. W arrived at the house to work. In the mid morning a witness outside of the house heard someone shouting words similar to "*stop, please stop"*. At 10.27 and shortly afterwards at 10.33 two calls were made to the Police via the 999 emergency line. The caller identified himself as Mr. X and spoke in what appeared to be a controlled and calm manner. He stated to the Operator *"yeah, I've just killed somebody"* and gave the address. When questioned by the Operator he went on to say *"if the Police don't hurry up I'm going to kill somebody else"*.

Efforts to revive Mr. W by the emergency services were unsuccessful. Mr. W died from multiple stab wounds.

Mr. X was allowed to plead guilty due to diminished responsibility. He is currently detained in Frankland Prison serving a life sentence with a seven-year tariff.

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

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

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

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

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

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

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

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of health services in the future, incorporating what can be learnt from a robust analysis of the individual case.

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The Manchester Mental Health and Social Care NHS Trust, NHS Manchester, and the Health Advocacy Resource Project were consulted regarding the Terms of Reference and did not wish to make any additions. The family of Mr. W were also consulted. They made it clear to the Independent Investigation Team Chair that the events concerning the last three months of Mr. X's care and treatment were of particular interest to them. The Terms of Reference were as follows:

1. To examine:

- the care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the adequacy of risk assessments to support care planning and use of the care programme approach in practice;
- the exercise of professional judgement and clinical decision making;
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;
- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- the quality of the internal investigation and review conducted by the Trust.

2. To identify:

- learning points for improving systems and services;
- development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To Make:

- realistic recommendations for action to address the learning points to improve systems and services.

4. To report:

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

6. The Independent Investigation Team

Selection of the Investigation Team

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

Investigation Team Leader and Chair

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

Investigation Team Members

Ms. Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service. Nurse Member of the Team.
Dr. Susan O'Connor	Consultant Psychiatrist Member of the Team
Mr. Alan Watson	National Development Consultant, HASCAS Health and Social Care Advisory Service. Social Work Member of the Team
Mrs. Tina Coldham	National Development Consultant, HASCAS Health and Social Care Advisory Service. Service User Member of the Team

Support to the Investigation Team

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

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Investigation Methodology

On the 7 April 2010 NHS North West (the Strategic Health Authority) commissioned the HASCAS Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section six of this report. The investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. X and all witnesses to this Investigation.

Consent and Communications with Mr. X

During the course of this Investigation Mr. X has been detained at Frankland Prison. On the 15 June 2010 a letter was sent to him by NHS North West requesting his consent for the Independent Investigation Team to access his clinical records and a consent form was enclosed. Mr. X did not respond. On the 9 July a second letter requesting consent and another consent form was sent to Mr. X. Both of these letters set out the purpose of the Investigation and offered the opportunity of a face-to-face meeting so that any questions Mr. X had could be addressed directly.

Following this correspondence liaison was established with the Prison Mental Health Liaison Team. Mr. X was offered the opportunity to meet with a Senior Officer from NHS North West and the Independent Investigation Team Chair. On the 30 July 2010 this meeting took place at Frankland Prison. The Investigation process and *raison d'etre* were discussed with Mr. X and he gave his full consent for his clinical records to be both accessed and used. Issues regarding the future publication of the report were discussed with him. It was agreed that Mr. X would be able to participate in the Investigation, if he so wished, and that he would be provided with the opportunity to have a full feedback session regarding the completed report prior to publication.

Communications with the Victim's Family

On the 30 June 2010 an introductory meeting was held between the widow of Mr. W, his son and daughter, a Senior Officer from NHS North West and the Independent Investigation Team Chair. On this occasion the purpose and process of HSG (94) 27 was explained. The Terms of Reference were given to the family together with an invitation to consider any additional issues that they required to have addressed. The family were notified that the

witness interviews were scheduled to be held between the 13 and 16 of September. They were asked if they would like the opportunity to meet formally with the full Independent Investigation Team during this week.

On the 15 September 2010 the widow of Mr. W, together with his son and daughter, met formally with the Independent Investigation Team. During this meeting they voiced both their concerns about the care and treatment that Mr. X had received and also their frustration regarding the length of time it had taken to commission the Independent Investigation. A full transcription of this meeting was sent to the family.

Regular contact was maintained between the family of Mr. W, the Independent Investigation Team and NHS North West. This communication took the form of emails and telephone conversations.

A feedback meeting was held with the family on the 19 November 2010. On this occasion the key Investigation findings were shared with them in the presence of a Senior Officer from NHS North West and the Investigation Team Chair. An offer was made to the family for an additional meeting to take place prior to the publication of the report when they would have the opportunity to review the report in full.

Communications with the Family of Mr. X

A Senior Officer from NHS North West liaised directly with the mother of Mr. X. This Officer passed on a request from the Independent Investigation Team to make contact with them. During the Investigation, and at the time of writing this report, the mother of Mr. X was too distressed to make contact directly with the Team. However she wished the Team to have access to the statement that she made to the Manchester Coroner. This has been immensely helpful to the investigation process.

Communications with the Manchester Coroner

The Manchester Coroner will be holding an Inquest into the death of Mr. W on the completion of this Independent Investigation. A meeting was held between the Coroner, a Senior Officer from NHS North West, and the Independent Investigation Team Chair on the 30 July 2010. At this meeting timeframes were agreed, process was discussed and preliminary information was shared.

Communications with the Manchester Mental Health and Social Care NHS Trust

In June 2010 NHS North West wrote to the Manchester Mental Health and Social Care NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. X. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust.

On the 30 June 2010 a meeting was held with the identified Trust liaison person. The Investigation process was explained. An invitation was made for a workshop to take place to provide a briefing opportunity for all those who would be involved with the Investigation.

On the 29 July and the 2 September 2010 Trust workshops were held. NHS Manchester and the Health Advocacy Resource Project senior personnel and employees were also present. Each workshop attendee was given an information pack that described the HSG (94) 27 process, gave witness advice, and set out the draft Terms of Reference. The workshops provided each attendee with the opportunity to learn more about the forthcoming procedure and what would be expected of them.

Between the first meeting stage (June) and the formal witness interviews (September) the Independent Investigation Team Chair worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness would be accompanied by an appropriate support person when interviewed if they so wished.

On the 1 November 2010 a meeting was held between the Independent Investigation Team Chair and the Trust Top Team. The purpose of this meeting was to inform the Trust of the headline findings of the Investigation and to commence the factual accuracy stage of the process. On this occasion the Trust was invited to comment upon the recommendation section in the report and to contribute further after a period of reflection.

The draft report, and all relevant report clinical sections, was sent to the Trust and witnesses for factual accuracy checking on the 25 November 2010.

Communication with NHS Manchester (Primary Care Trust)

The Independent Investigation Team Chair made contact with NHS Manchester and a liaison person was identified. During the Investigation process both the Trust liaison person and the Primary Care Trust liaison person worked closely together to facilitate the workshop events and the witness interview week. This proved to be an effective way of working.

NHS Manchester provided GP clinical records and performance management data to the Investigation Team. The Primary Care Trust engaged fully with both the workshop and witness interview process.

On the 1 November 2010 a meeting was held between the Independent Investigation Team Chair, the Social Work Member of the Team and the Primary Care Trust. The purpose of this meeting was to share the headline findings of the Investigation. On this occasion NHS Manchester was invited to discuss the required recommendations for the report and to contribute to them after a period of reflection.

Communication with the Health Advocacy Resource Project (HARP)

The Health Advocacy Resource Project Chief Executive, senior personnel and employees attended the workshops and engaged fully with the interview and Investigation process. During the Investigation the Mental Health Trust provided a practical means of support and liaison between this agency and the Independent Investigation Team.

On the 15 November 2010 a meeting was held between the Independent Investigation Team Social Worker Member and the Health Advocacy Resource Project Chief Executive. The purpose of this meeting was to share the headline findings of the Investigation in order to commence the factual accuracy stage of the process.

The draft report, and all relevant report clinical sections, was sent to the Health Advocacy Resource Project and witnesses for factual accuracy checking on the 25 November 2010.

Completion of the Process

It was agreed that a formal workshop would be held with the Manchester Mental Health and Social Care NHS Trust, NHS Manchester and the Health Advocacy Resource Project directly prior to the publication of this report. The purpose of this workshop would be to focus on the lessons learned and the recommendations made.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

During the seven-year period that Mr. X received his care and treatment from Manchester-based services he was seen by a vast number of health and social care professionals. It would not have been either practical or useful to have interviewed them all. The Independent Investigation Team took the decision to interview each of the Responsible Medical Officers, Named Nurses and Care Coordinators that provided the principle aspects of Mr. X's care and treatment over this period and who were responsible for the formulation of his case management. The total number of witnesses interviewed by the Independent Investigation Team was 34. The witnesses who attended for interviews are set out below in table one.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
13 September 2010	NHS Manchester Associate Director of Commissioning NHS Manchester Assistant Director of Governance *** Mental Health Trust CEO Mental Health Trust Chief Operating Officer Mental Health Trust Interim Medical Director Mental Health Trust Associate Director of Governance Mental Health Trust Head of Nursing	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer

	*** HARP CEO HARP Service Manager *** Internal Investigation Member 1 Internal Investigation Member 2 Internal Investigation Member 3	
14 September 2010	Consultant Psychiatrist 1 *** Assertive Outreach Care Coordinator *** Assertive Outreach Team Manager *** Consultant Adult Psychotherapist *** General Practitioner *** Assertive Outreach Worker 1 Assertive Outreach Worker 2 Assertive Outreach Worker 3	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer
15 September 2010	Assertive Outreach Worker 4 *** Assertive Outreach Worker 5 Assertive Outreach Worker 6 *** The widow of Mr. W The Son of Mr. W The Daughter of Mr. W *** Assertive Outreach Worker 7 Assertive Outreach Worker 8	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker In attendance: Stenographer
16 September 2010	Assertive Outreach Consultant Psychiatrist *** Named Nurse 1 *** Consultant Psychiatrist 2 *** Community Psychiatric Nurse 1	Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Social Worker In attendance: Stenographer

	Community Psychiatric Nurse (not cited in report) *** Assertive Outreach Service Manager	

Salmon Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It

was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was made aware in advance of their interview the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

8 September 2010. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

13-16 September 2010. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose. On the 16 September, using the Terms of Reference and the timeline as guidance, the Team developed subject headings that required further examination.

Between the 16 September and the 11 October each Team Member prepared an analytical synopsis of identified subject headings in order to conduct an in-depth Root Cause Analysis process.

11 October 2010. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety Agency. This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the 11 October and being able to present written, referenced briefings at the meeting.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS North West throughout the process. Communications were maintained in-between meetings by email, letter and telephone.

Communications also took place with Ashworth High Security Hospital and Frankland Prison in the pursuit of clinical records and access to Mr. X respectively.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed throughout this process.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

During the course of this investigation 6,127 pages of clinical records have been read and some 4,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. X's Manchester Mental Health and Social Care NHS Trust records
2. Mr. X's HARP-based Assertive Outreach records
3. Mr. X's Ashworth Hospital forensic records
4. Mr. X's Manchester-based GP records
5. Mr. X's Frankland Prison-held records
6. The transcription of the Crown Court proceedings
7. The Manchester Mental Health and Social Care NHS Trust Internal Investigation Report and action plan
8. The Manchester Mental Health and Social Care NHS Trust Internal Investigation Archive
9. NHS Manchester Assertive Outreach Service review
10. The Boyington Review (2008)
11. NHS Manchester action plans
12. Secondary literature review of media documentation reporting the death of Mr. W
13. Independent Investigation Witness Transcriptions.
14. Manchester Mental Health and Social Care NHS Trust Care Programme Approach Policies, past and present
15. Manchester Mental Health and Social Care NHS Trust Clinical Risk Assessment and Management Policies, past and present
16. Manchester Mental Health and Social Care NHS Trust Crisis Resolution Home Treatment Policy
17. Health Advocacy Resource Project Assertive Outreach Operational Policies (2001-2008)
18. Manchester Mental Health and Social Care NHS Trust Assertive Outreach Policies (current)
19. Manchester Mental Health and Social Care NHS Trust Incident Reporting Policies

20. Manchester Mental Health and Social Care NHS Trust Clinical Supervision Policy

21. Manchester Mental Health and Social Care NHS Trust Being Open Policy

22. Health Advocacy Resource Project Clinical Supervision Policy and Procedure

23. Health Advocacy Resource Project Care Programme Approach and the Assessment and Management of Risk Policy

24. Manchester Mental Health and Social Care NHS Trust Operational Policies

25. Health Advocacy Resource Project Operational Policies

26. Healthcare Commission/Care Quality Commission Reports for Manchester Mental Health and Social Care NHS Trust services

27. 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

28. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

9. Profile of the Manchester Mental Health and Social Care NHS Trust Services (Past, Present and Transition)

The Manchester Mental Health and Social Care NHS Trust was established in 2002. At the time of writing this report it provided a comprehensive range of mental health and social care services and served a population of 484,900. The demography of the City of Manchester population is young and diverse, it is also growing rapidly. A particular challenge is that, in common with many other urban mental health trusts, there are areas of significant deprivation. At the time of writing this report the annual turnover was £97.1 million and the Trust employed 1,627 staff. The Trust seeks currently to improve the mental health and wellbeing of the City of Manchester through active partnership working with other statutory organisations and authorities, and with voluntary and third sector agencies.

2008 Trust Context

The Mental Health Trust experienced profound difficulties, prior to, and during 2008. The issues were as follows:

- lack of sustained leadership;
- lack of vision and strategic direction;
- poor reputation;
- fractured relationships with partners, staff and users and carers;
- poor identified performance.

The Boyington Review

In 2008 the Boyington review of Manchester Mental Health Services took place. This review was commissioned in April 2008 by NHS Manchester and Manchester City Council as it was acknowledged that "*the Mental Health System in Manchester has a troubled history and has generally performed poorly against national strategy benchmarks."*[2]

2 Manchester City Council Overview and Scrutiny mental Health Services Subgroup. 27 July 2009.

The report stated that whilst many improvements had been made (during 2007/2008) there were still many issues that needed to be addressed. The main issues identified in the report were as follows:

- "*the size and structure of the Manchester Mental Health and Social Care NHS Trust;*
- *the distribution of resources across the city;*
- *the investment of resources compared to the need;*
- *the interface between mental health services and the organisations directly supporting social inclusion, for example Job Centre Plus."*[3]

During the review a number of issues were identified that had been raised in previous reports concerning Manchester mental health service provision. These issues were stopping the progress of mental health services in the city.[4] They were:

- ***"Resources****: the way in which they were used, and matched with the needs of the population.*
- ***The lack of engagement with stakeholders****: this had been a real barrier to the progression of services.*
- ***Services:*** *instead of new services being put in place to replace older services, they had just been added onto the services which already existed.*
- ***Relationships, trust and confidence:*** *there had been too many changes in the Chief Executives and senior managers, for there to have been any solid relations or confidence in the Mental Health Trust.*
- ***Local Health Authority:*** *had not been monitoring the performance of the Mental Health Trust, and had left them to their own devices*."[5]

A total of 18 recommendations were identified that set out clearly the responsibilities of both commissioners and providers. The key recommendations were as follows:

3 http://www.manchesterusersnetwork.org.uk/?p=267.
4 http://www.manchesterusersnetwork.org.uk/?p=267
5 http://www.manchesterusersnetwork.org.uk/?p=267

- ***"Leadership and management:*** *the Chief Executive and senior managers should be appointed for a period of 3 – 5 years; key stakeholders should be involved with these appointments.*
- ***Resources:*** *the Mental Health Trust needs to make the most of the resources they have available before they ask for more money, the PCT or City Council needs to performance manage how these resources are used.*
- ***Engagement:*** *the Mental Health Trust needs to strengthen its levels of engagement with colleagues from the University of Manchester, the PCT / Local Authority and also needs to ensure that money is spent on effective user and carer engagement, and should consider putting a 'shadow council of governors' in place.*
- ***Relationships, trust and confidence:*** *the Mental Health Trust needs to improve their communications strategy for their own staff, and start on improving staff relations*."[6]

The Assertive Outreach Service in 2008

The implementation of the National Service Framework for Mental Health (1999) in Manchester had been delayed and took place at a rate which fell behind that of the rest of the country. One of the services advocated in the Framework was that of Assertive Outreach.

In 2007 the Assertive Outreach Service contract had been put out to tender by the Joint Commissioning Executive. The Health Advocacy Resource Project and the Mental Health Trust tendered as a partnership for the contract and were successful. The contract for the Service was to provide a caseload facility for 308 people across the City of Manchester. This Service was provided by three teams, North, Central and South.

Assertive Outreach Teams are intended to provide intensive support for the severely mentally ill service user who has proved difficult to engage with in more traditional services. Assertive Outreach Workers are encouraged to work with service users in their own homes, or any other place in the community that will encourage adherence to an ongoing care and treatment plan. The National Service Framework (1999) stated that:

"all mental health service users on the Care Programme Approach (CPA) should receive care which optimises engagement, prevents or anticipates crisis and reduces risk…There are

6 http://www.manchesterusersnetwork.org.uk/?p=267

a small number of people who are difficult to engage. They are very high users of services, and often suffer from a dual diagnosis of substance use and serious mental illness. A small proportion also have a history of offending. Services to provide assertive outreach and intensive input seven days a week are required to sustain engagement with services and to protect patient and public".[7]

In summary, the Assertive Outreach Service operated to a small service model with HARP as the main provider responsible for the day-to-day operational management of the service and the Mental Health Trust as a secondary agent. The Trust had a separate contract with NHS Manchester (the service commissioner) for input into this service. HARP managed the Assertive Outreach provision and the Trust employed several clinical staff who worked in the service. The Trust did not have the responsibility for any internal governance systems within the provision. There was a distinct lack of reporting structures and systems in place for the Mental Health Trust to highlight and then address any concerns as they arose.

2010 Trust Context

Following the Boyington Review a comprehensive action plan was developed. The Trust currently has in place:

- a strong and experienced leadership team;
- clear strategic direction;
- robust operational and governance systems;
- sound partnership arrangements;
- positive partnership working with both staff and service users;
- impending Foundation Trust authorisation.

The Assertive Outreach Team in 2010

At the time of writing this report the Assertive Outreach Service was managed by the Manchester Mental Health and Social Care NHS Trust following the contract being awarded to them in 2009, at this stage HARP became a sub-contracted partner to the Trust. This revised working arrangement has provided the benefit of dedicated clinical governance and professional leadership infrastructures being made available to the service. This arrangement

7 National Service Framework, DoH (1999)

also benefits the service by providing stringent performance and quality management monitoring systems as HARP reports to the Trust Board via its assurance framework.

10. Profile of the Health Advocacy Resource Project Services (Past, Present and Transition

The Health Advocacy Resource Project (HARP) is a local voluntary sector organisation providing services to people in Manchester. HARP is committed to improving the lives of people with mental health needs.

HARP Vision

"All people with mental health needs in Manchester live a life free from poverty and are able to contribute and flourish in society."[8]

HARP Aims

1. ***"****Promoting a positive approach to mental health.*

2. Putting individuals at the centre of service development, delivery and care planning.

3. Raising the voice and valuing the experience of service users.

4. Enabling people with mental health needs to improve their quality of life and fulfil their potential.

5. Empowering people with mental health needs to live successfully in their communities.

6. Challenging stereotypes and discrimination.

7. Developing and delivering innovative and proven practice in the mental health field in partnership with other agencies".[9]

HARP has been in existence since 1989, it currently employees 43 staff and also has 31 volunteers. The work of HARP is overseen by its Board of Trustees. Most of HARP's funding comes from statutory funders such as the Manchester Joint Commissioning Team and the Working Neighbourhood Fund[10].

Assertive Outreach Services 2001-2008

In 2001 HARP, in conjunction with Turning Point and the Manchester Mental Health Trust, provided a small Assertive Outreach Service to the Central part of Manchester. During this period the City of Manchester was served by three separate Primary Care Trusts, the North,

8 HARP http://www.harp-project.org/aboutus.php
9 HARP http://www.harp-project.org/aboutus.php
10 HARP http://www.harp-project.org/aboutus.php

Central and South. It was always the intention to expand the service to eventually provide a Manchester-wide provision.

In 2007 the Assertive Outreach Service was put out to tender to provide a Manchester-wide provision. The intention was to provide a service for 308 people, seven days a week, utilising three separate teams (North, Central and South) that would in effect increase the capacity by some 200%. At this stage HARP and the Mental Health Trust developed a joint tender.

In 2007 a contract was awarded for a city-wide service to both HARP and the Mental Health Trust. This contract was in operation at the time Mr. X received his care and treatment from the Assertive Outreach Service.

Assertive Outreach Services in 2010

At the time of writing this report the Manchester Assertive Outreach Service was provided by the Manchester Mental Health and Social Care NHS Trust in conjunction with HARP to provide a 365-days-a-year assertive outreach service for up to 308 Manchester residents. The service worked with people with severe and enduring mental health needs, a history of frequent or lengthy admissions to psychiatric wards, difficulty maintaining consenting engagement with services, and complex needs, including homelessness, substance misuse and offending.

The service operated to the recovery-focused model of assertive outreach, which was in part developed as a result of the culture and philosophy of the team. This incorporated the voluntary sector emphasis on social inclusion, engagement and rapport-building skills and the skilled interventions and specialist treatment available from the statutory sector.[11]

11 HARP http://www.harp-project.org/aboutus.php

11. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. X and on his care and treatment from mental health services. The following chronology is long due to the fact that it condenses over 6,000 pages of clinical records.

Background Information

Mr. X was born in Lancashire and moved to Manchester with his mother and stepfather at the age of ten. On reaching puberty Mr. X was reported as having "*lost confidence and could no longer cope*".[12] Mr. X was bullied at school by the other children however he managed to obtain six GCSEs although he did not choose to take A levels.

Clinical History with the Manchester Mental Health and Social Care NHS Trust

18 February 1991-19 September 1999. On the 19 February 1999 Mr. X attempted to overdose on paracetomol. No medical treatment was required. Following this incident he was referred to a Child Psychiatrist, it is uncertain whether or not Mr. X was taken onto the Psychiatrist's caseload at this point[13]. During this period Mr. X was also seen on several occasions by a Community Psychiatric Nurse (CPN A) at the request of his stepfather because Mr. X had been absenting himself from school for periods upwards of a month.

On the 25 April the CPN observed that Mr. X's mood had deteriorated to the point where there was evidence to believe that he was clinically depressed. There were also elements of paranoid delusion regarding his peers whom he thought ridiculed him for his appearance. The CPN thought it would be sensible to re-refer Mr. X to the Child and Family Service and also to the Child Psychiatrist that he had seen following his paracetomol overdose earlier the same

12 SM Case Notes Vol. 1 P.76
13 GP Records PP. 116-117

year. The CPN was particularly concerned because Mr. X appeared to be unpredictable and she was worried that he might try to kill himself.[14]

On the 19 September 1991 the Child Psychiatrist wrote to the GP to explain that he had seen Mr. X on several occasions and that his condition had improved. In conjunction with Mr. X's mother they had decided to "*call it a day*". Mr. X's mother had been told by the Psychiatrist that she could re-refer her son within the next six months directly to the Child and Family Services if his condition deteriorated again.[15]

20 September-11 October 1999. On the 20 September 1999 a GP at the Park Medical Practice referred Mr. X to the Community Psychiatric Nursing Services Acute Team because he was experiencing stress and anxiety. At this stage Mr. X admitted having recently visited Beachy Head to try and commit suicide.[16] On the 11 of October Mr. X cancelled his impending appointment with the Community Nursing Service. The Service wrote to the GP asking for advice as to how to proceed.[17]

31 January 2001. A referral was received by the Community Mental Health Team from the Primary Mental Health Team. The reason for the referral was that Mr. X required a psychiatric assessment because he was having "*strong suicidal ideation and violent fantasies"*. The referral also mentioned "*dissocial personality traits*". A risk screen conducted by the Primary Care Mental Health Team Social Worker stated that Mr. X should not be seen by a lone worker, either at his home or within the GP surgery, or at any team base. At this time it was recorded that Mr. X was receiving Venalfaxine 150mg daily.[18] Mr. X was reported as saying he was "*99% certain*" that he was going to kill himself.

Mr. X had been assessed as presenting a serious, although not imminent risk, regarding suicide and of being a serious, although not imminent risk, of harming others. The risk assessment mentioned that Mr. X had attempted suicide during the Christmas period when he had tried to cut his femoral artery. Mr. X mentioned that he went on holiday to find ways to kill himself, such as going to Beachy Head and United States of America shooting galleries.[19]

14 GP Records P. 114
15 GP Records P. 113
16 GP Records P. 103
17GP Records P. 108
18 SM Case notes Vol. 1 PP.172-177
19 GP Records PP. 99-103

14 May-29 August 2001. On the 14 May Mr. X was seen by a Consultant Psychiatrist (Consultant Psychiatrist A) in the presence of a colleague for safety reasons, due to Mr. X being reported as having had violent sexual fantasies. On this occasion it was noted that Mr. X had Schizoid/Schizotypal Personality Traits and that he also had an alcohol dependence accompanied by amphetamine abuse. The Consultant Psychiatrist did not feel threatened by Mr. X who described himself as shy and intelligent but as having no social skills. The Psychiatrist wrote to the GP suggesting that the Venalfaxine medication should be raised from 150mg a day to 225mg.[20]

On the 29 August Mr. X was seen again by the same Consultant Psychiatrist in an Outpatient Clinic. On this occasion Mr. did not report any feelings of anxiety or depression. He said he felt "*all right*" but that his amphetamine use remained a problem. A referral to the Community Drug Team was agreed.[21]

25 October 2001. Mr. X met with a Clinical Psychologist (Clinical Psychologist A) for Drug Team follow-up. It was noted that Mr. X expressed a negative view of psychology. He was observed as having "*very fixed ideas about his depression*". Mr. X said he was having amphetamine withdrawal and was drinking heavily. Mr. X said he was currently employed but that he hated his job. He also stated that he was incapable of killing himself. At this stage the Clinical Psychologist did not feel that Mr. X was willing to pursue therapy.[22]

4 December 2001-25 November 2002. On the 4 December Mr. X failed to attend an Outpatient appointment that had been arranged for him with a new Consultant Psychiatrist (Consultant Psychiatrist 1).[23] On the 14 December another appointment was sent to Mr. X for the 8 January 2002 for him to see Consultant Psychiatrist 1.[24]

It is not certain what happened to the planned appointment for the 8 January 2002, however Mr. X was seen by Consultant Psychiatrist 1 on the 11 February 2002. It was the view of the Psychiatrist that Mr. X tended to over intellectualise things and that primarily he needed to find a meaning to his life. He wrote a referral to Clinical Psychologist A as he felt Mr. X would benefit from Cognitive Behaviour Therapy. On the 15 February the Psychiatrist wrote

20 SM Case notes Vol. 1 PP. 166-168
21 SM Case notes Vol. 1 PP. 164-165
22 SM Case notes Vol. 1 PP. 132 &160-162
23 SM Case notes Vol. 1 P. 159
24 SM Case notes Vol. 1 P.158

to the GP to say that although Mr. X was potentially a risk to himself he was not suitable for assessment under the Mental Health Act (83) at that time. It was suggested that Mr. X be commenced on Fluoxetine 20 mg daily increasing it to 40 mg in six weeks time.[25]

On the 19 February the Clinical Psychologist wrote to the Consultant Psychiatrist to say that Mr. X would not benefit from psychology input at this stage as he continued to drink heavily and had little insight.[26]

On the 22 April Mr. X failed to attend his Outpatient appointment with Consultant Psychiatrist 1. Another appointment was made for him on 16 July[27]. On the 16 July once again Mr. X failed to attend his appointment. He was discharged from the caseload.[28]

On the 17 October the GP wrote to Consultant Psychiatrist 1 to request a follow-up appointment for the one that should have occurred on the 16 July. The GP also sought some advice regarding Mr. X's future management.[29] On the 31 October the Consultant wrote to the GP saying that he would give Mr. X another appointment but that he did not think there was anything his service could offer to him.[30] On the 25 November Mr. X failed to attend the appointment that had been made for him with Consultant Psychiatrist 1 who wrote to the GP to say that no more appointments would be offered at this stage.[31]

30 September-13 October 2003. On the 30 September Mr. X was referred to secondary mental health services by his GP due to depression. An assessment took place at his home by two Community Psychiatric Nurses. The previous non-attendance at Outpatient clinics was noted as was the fact that Mr. X had been prescribed Cipramil 20 mg daily but that he had "*self stopped*" three months previously.[32] The referral and assessment was discussed at the Community Mental Health Team (CMHT) meeting with Consultant Psychiatrist 1. It was felt that Mr. X could benefit from psychotherapy as he was now willing to engage with this treatment option. A letter was written to the GP stating that the CMHT would not take on the

25 SM Case notes Vol. 1 PP. 132 &153-157
26 SM Case notes Vol. 1 P. 154
27 SM Case notes Vol. 1 P. 154
28 SM Case notes Vol. 1 P. 151
29 SM Case notes Vol. 1 P. 150
30 SM Case notes Vol. 1 P. 149
31 SM Case notes Vol. 1 P. 148
32 SM Case notes Vol. 1 P. 146

referral as Mr. X did not meet their criteria but that it had been passed on to Gaskill House Psychotherapy Centre.[33]

26-29 January 2004. On the 24 January Mr. X was seen by a Consultant Psychotherapist. On this occasion Mr. X expressed suicidal ideation and stated that he had tried to overdose with 50 Ecstasy tablets a fortnight previously. Mr. X described constantly thinking about killing himself, however he admitted that it required a great deal of motivation and after an unsuccessful attempt he felt too exhausted to try and harm himself again for some time. Mr. X described himself as having no friends and as never having had a partner. He described a poor relationship with his parents. The Psychotherapist thought that Mr. X presented with a chronic risk of successful suicide which would be hard to predict. He wrote that he would want to see Mr. X in two weeks time. The issues noted were:

- suicidal preoccupation;
- loneliness and social isolation;
- concerns over medication;
- dissatisfaction with previous professional contacts.

On the 29 January the Psychotherapist wrote to the CMHT to brief them regarding his first meeting with Mr. X.[34]

6 February- 26 March 2004. Between the 6 and 7 of February Mr. X presented in crisis at Accident and Emergency. A passing motorist had reported seeing Mr. X standing on a motorway bridge with a rope around his neck. After a full medical and psychiatric assessment Mr. X was discharged and sent home. It was noted that he was known to Consultant Psychiatrist 1 and had a Schizotypal Personality Disorder. Mr. X agreed to have follow up and he was referred to the South Manchester Community Mental Health Team. The 'Minimum Psychiatric Assessment' noted previous extensive alcohol abuse *"one litre of vodka a day"* and that Mr. X was extremely anxious and had suicidal thoughts. Mr. X was recorded as expressing the view that *"he would willingly be sectioned right now"*.[35]

33 SM Case notes Vol. 1 P. 146
34 SM Case notes Vol. 1 PP. 143-145
35 SM Case notes Vol. 1 P. 117-118 & 130-139

On the 11 February Mr. X was seen at his second appointment with the Psychotherapist. During this session it was noted that Mr. X had felt suicidal the week before and that he had been advised to attend Accident and Emergency by a helpline of some kind. Mr. X did this only to be, in his own words, *"dismissed by the duty doctor"*. He then went to the motorway with a rope with the intention of hanging himself. He was taken back to the Accident and Emergency Department where Mr. X claimed that the doctor wanted to section him. Ultimately Mr. X claimed to have spoken to one of the Specialist Registrars who allowed him to go home with follow up from the Community Mental Health Team. The Psychotherapist wrote that Mr. X was exhibiting 'splitting behaviours' in that he was presenting some clinicians as 'good' and some as 'bad'. The Psychotherapist planned to see Mr. X again. [36]

On the 11 March Mr. X saw the Psychotherapist again. Mr. X said that he had been referred to the Brian Hore Unit where he could address his alcohol problems. Mr. X expressed his preference for some 1:1 work, but he was told that this would be *"problematic"*. Mr. X expressed some negative feelings about Consultant Psychiatrist 1. The Psychotherapist said that he would be putting Mr. X forward for a selection process for a therapy group.[37]

On the 26 March Mr. X was discussed at the CMHT meeting following the referral instigated by Mr. X's attendance at the Accident and Emergency Department on the 6 February. The team was aware that Mr. X was currently being assessed by the Psychotherapist and that a referral had already taken place to Brian Hore Unit to address his identified alcohol issues. Mr. X had been advised to approach MIND regarding a befriending scheme. In a letter written to the GP It was stated that the CMHT thought Mr. X would present with self harm again in the future but that they did not think they could offer Mr. X a service at the present time. The reason given for this was that the team did not want to encourage Mr. X to over intellectualise his problems. Psychotherapy was thought to be the most appropriate course for Mr. X who was thought to have a Personality Disorder and therefore did not meet their referral criteria.[38]

7 October-22 November 2004. Mr. X was seen by an Emergency Senior House Officer (who sought advice from an on call Consultant Psychiatrist) because he was feeling depressed following weaning himself off of his medication. It was decided to re-start Mr. X

36 SM Case notes Vol. 1 PP. 140-142
37 SM Case notes Vol. 1 PP. 114-116
38 SM Case notes Vol. 1 P. 117

on Fluoxetine 20 mg a day and to commence Olanzapine 5 mg at night.[39] The GP was advised to ensure follow up occurred with a Consultant Adult Psychiatrist.

The GP made a referral to the South Manchester CMHT on the 20 October requesting a Consultant Psychiatrist assessment for Mr. X. The GP wrote to explain the outcome of the assessment that had taken place on the 7 October.[40] Subsequently Consultant Psychiatrist 1 wrote to Mr. X on the 28 October offering him an appointment at the Outpatient Clinic on the 22 November.[41]

On the 22 November the Senior House Officer of Consultant Psychiatrist 1 saw Mr. X at the Outpatient Clinic. Mr. X said that he felt low following an Olanzapine overdose the previous week which he had not sought medical intervention for. It was noted that Mr. X had pale marks around his neck from a previous self-harm attempt. Mr. X said that his main problem was anxiety, he was however unwilling to remain compliant with the medication which had been prescribed on the 7 October. Mr. X was described as being pleasant and well kempt and the plan was to offer him another appointment at the Outpatient Clinic in six weeks time. There is no record of this follow up taking place.[42]

19 November 2004-26 September 2005. The Psychotherapist put Mr. X forward for membership of a programme called 'Fifteen' on the 19 November. 'Fifteen' was a therapeutic community.[43] On the 14 December the Psychotherapist wrote to Mr. X to say that the 'Fifteen' programme was due to commence its preparatory meetings in April 2005.[44]

The Psychotherapist saw Mr. X for a review and to discuss the referral to 'Fifteen'. Mr. X reported that he felt depressed although things were not as severe as they had been and that he was not troubled by thoughts of suicide. Mr. X said that the Olanzapine had proven to be helpful regarding his anxiety. He also reported that his relationship with his parents was good at the current time.[45]

39 SM Case notes Vol. 1 P.111
40 SM Case notes Vol. 1 PP.4-5
41 SM Case notes Vol. 1 P. 109
42 SM Case notes Vol. 1 PP.106-108
43 Internal Investigation Report
44 Internal Investigation Report
45 SM Case notes Vol. 1 P. 104

During April Mr. X underwent the screening process for 'Fifteen' and was accepted. Prior to the group commencing Mr. X attended a monthly preparation group for a period of six months between April and September 2005. [46]

26 September 2005. Mr. X presented at the Accident and Emergency Department at the Manchester Royal Infirmary, he had not been taking his medication for seven days as he had not renewed his prescription. He saw the Emergency GP who prescribed Fluoxetine, Diazepam and Lorazepam. Mr. X was also assessed by a nurse who recorded that he planned to kill himself in the *"easiest and most painless way possible"*. On this occasion it was decided that Mr. X was not detainable under the Mental Health Act (83). His risk was assessed as being medium to moderate (it was not recorded what this risk related to). Mr. X was described as having a Borderline Personality Disorder and of being aggressive. It was also noted that he lived alone, was labile in mood and socially isolated. Mr. X was referred to the Duty Psychiatrist prior to discharging him from the Accident and Emergency Department. The plan was for him to be discharged to his home with some medication and a follow up appointment with the GP.[47]

27 September 2005. A female member of the 'Fifteen' group alleged that Mr. X had been intimidating and threatening towards her. Mr. X had gone for a coffee with the female group member together with another service user from the programme. It became apparent to them that he had a length of rope in his bag which they 'confiscated' when he got up to go to the toilet. Mr. X became angry and said that he wanted to kill the female group member and expressed his hatred of her. The female group member had also received multiple telephone calls from Mr. X. As a consequence of his behaviour a report was made to the Police. Mr. X was cautioned under the Harassment Act. Subsequently the psychotherapy group felt that Mr. X was at an increased risk of committing suicide and contacted the Police to notify Mr. X as a vulnerable person. The GP was also notified of these events and the risk to Mr. X.[48]

3 October -2 November 2005. Mr. X presented at the Accident and Emergency Department requesting a psychiatric assessment. A Manchester Self-Harm Assessment Form was

46 Internal Investigation Report
47 NM Case notes Vol. 1 PP.63-65
48 Psychotherapy records PP. 11-12

completed. Whilst it was noted that Mr. X had tried to self-harm previously no other indicators were found to be remarkable and he was discharged to the care of his GP.[49]

The GP made a referral on the 4 October to the South Manchester CMHT due to Mr. X's depression and suicidal ideation. The medication prescribed previously for Mr. X did not appear to be effective and his mood was deteriorating. The GP queried whether Mr. X had a Personality Disorder and stated that Mr. X's Accident and Emergency attendance was increasing.[50] As a result of this request Consultant Psychiatrist 1 wrote to Mr. X offering him an outpatient appointment.[51] On the 2 November Consultant Psychiatrist 1 wrote to the GP to inform him that Mr. X had not made contact with the Outpatient Clinic to book his appointment and that there were no further plans to offer another at this stage.[52]

9 January 2006-3 February 2006. On the 24 October 2005 the full 'Fifteen' programme began. On the 9 January Mr. X discharged himself from the group. The 'Fifteen' group had challenged Mr. X about his drinking over the Christmas period. Mr. X did not agree with the challenge and stated that he found the group to be overly bureaucratic and not therapeutic.[53] Following this the Psychotherapist wrote to the GP explaining why Mr. X had taken his discharge from the group. This letter also recorded Mr. X's problematic attempts to form relationships with the other service users.[54]

12 June-27 June 2006. On the 12 June Mr. X took an overdose of Codeine and Brufen. He presented himself at the Accident and Emergency Department at Wythenshawe Hospital from where he was swiftly discharged.[55] On the 14 of June Mr. X was taken to the Accident and Emergency Hospital at Wythenshawe Hospital by his parents following an attempt to hang himself. Mr. X was subsequently admitted to the SAFIRE Unit (a short-term assessment facility) on the 15 June.

Once on the SAFIRE Unit no evidence of mental illness could be found. It was noted in the initial risk assessment made on the 15 June that Mr. X had previously assaulted his mother and smashed up his flat. The nursing record stated that Mr. X had reported that he had bought

49 GP records. PP. 60-61
50 SM Case notes. Vol.1 PP.7-8
51 SM Case notes. Vol.1. P.98
52 SM Case notes. Vol.1. P.97
53 SM Case notes. Vol.1. PP. 36 & 95-96. Psychotherapy Records PP. 163-164
54 GP Records PP. 54-55
55 SM Case notes Vol.1 P.89

two knives and that he had been practicing using them. The ward doctor recorded his impression that Mr. X was a high risk to both himself and to others. The plan was to treat him with caution and to confirm if Consultant Psychiatrist 1 remained the Responsible Medical Officer.[56]

On the 19 June Mr. X's mother visited the ward with two letters from Mr. X's neighbours. The first letter had been written by Mr. X asking his neighbours to keep their children away from him as he was beginning to hate them. The second letter was from a different set of neighbours stating that Mr. X's behaviour had been erratic and aggressive and that he had thrown plates and a mirror into their garden and at their visitors. Mr. X had gone to apologise the next day, but when the neighbours had refused to accept his apology Mr. X had refused to leave their garden.[57] On the 20 June the ward staff asked Mr. X's mother to visit his flat to have a look around and see if she could locate any knives. Later on the same day she visited the ward and showed the staff a picture of Mr. X's flat that she had taken on her mobile telephone. The flat was dirty, she had found approximately 60 cans of lager and vomit in the bathroom. The mother also found a large knife *"described as a knife like Rambo would have"* which she found alarming. The mother of Mr. X also reported that she had found a list of names and addresses of Mr. X's work colleagues by the knife and she expressed her concerns of what he might do. The plan to discharge Mr. X to the CMHT was discussed with his mother and she expressed the view that she would prefer an alternative if it was available. What this alternative could have been was not recorded. [58]

On 21 June the mother of Mr. X visited the ward again to say that she had found a total of two knives and that she had handed them both into the Police station. She approached the ward staff to discuss how best she could participate in Mr. X's future care. Later that day Mr. X was transferred to Grafton Ward in order to be aligned back with the South Manchester follow up services. He ought to have been transferred to Redwood Ward however the female service user from the 'Fifteen' group who had reported him to the Police was currently an inpatient there and it was thought best, in the interests of both patients, to keep them apart.[59]

56 NM Case notes. Vol.1. PP.22-23,31,76-77
57 NM Case notes. Vol.1. PP. 87,137-138
58 NM Case notes. Vol.1. PP. 89 &91
59 SM Case notes. Vol.1. P. 89

The following day Mr. X requested his discharge from Grafton Ward. The Senior House Officer (SHO) assessed his risk of harm to self and harm to others to be low. The diagnosis was depression with a psychotic element. Mr. X was discharged to his stepfather's home. On discharge his medication was Olanzapine 15 mg and Fluoxetine 40 mg daily. A referral was made to Consultant Psychiatrist 1 and a letter was sent to the GP. The ward staff planned to follow Mr. X up seven days after his discharge.[60] On the 27 June the Senior House Officer wrote to Consultant Psychiatrist 1 saying that Mr. X would prefer to be seen by a different doctor, the Senior House Officer asked if Consultant Psychiatrist 1 could use his discretion.[61]

30 June-11 September 2006. Mr. X was assessed by the South Manchester CMHT on the 30 June. He was not accepted onto their caseload as he did not meet the admitting criteria. Mr. X was advised regarding his medication and a request was made for him to be offered an Outpatient appointment. It was noted that Mr. X's relapse and admission had been due to the fact he had stopped taking his medication two months earlier. On this occasion Mr. X had no suicidal feelings but it was noted that he had some paranoid thoughts and delusional beliefs about his neighbours. Mr. X said that he would like to return to 'Fifteen'.[62]

On the 5 July Consultant Psychiatrist 1 wrote to Mr. X offering him an appointment at the Outpatient Clinic and requesting that he booked this within three weeks of receiving the letter.[63] Mr. X's GP wrote to Consultant Psychiatrist 1 asking for advice on the 26 July. Mr. X claimed to be hearing voices but the GP was reluctant to alter his medication. The GP wrote that Mr. X was a difficult patient to manage and he asked if the appointment set for September could be brought forward.[64] (Between June and November Consultant Psychiatrist 1 was on leave from the Trust).

On the 11 September the Specialist Registrar (SpR) to Consultant Psychiatrist 1 reviewed Mr. X as a new patient at Laureate House. On this day it was noted that Mr. X presented with multiple problems. Since his discharge in June Mr. X reported that his mental health had declined. He felt he was being mocked by his neighbours and that he had gone to live with his father to get away from them. At this review it was noted that Mr. X had been previously diagnosed as having a Schizoid Personality Disorder and Dysthymia. It was also noted that he

60 SM Case notes. Vol.1. P.90
61 SM Case notes. Vol.1. P. 88
62 Internal Investigation Report
63 SM Case notes. Vol.1.P. 80
64 SM Case notes. Vol.1.P.79

had made numerous previous self-harm attempts. The SpR did not identify any thought disorder although Mr. X described feelings of paranoia and reported second person derogatory auditory hallucinations. The diagnosis of Schizotypal Personality Disorder was given. It was recorded that Mr. X had a chronic long-term risk of suicide but that his immediate risk was low. A decision was made to reduce the Olanzapine down to 7.5 mg *nocte* (night) as it was making Mr. X tired. In the meantime the GP was asked to prescribe Quetiapine 100 mg in the morning, gradually increasing this to 100 mg BD (twice daily) and then 100 mg *mane* (morning) and 300 mg *nocte*. The plan was to follow Mr. X up in six weeks time.[65]

25 September -16 October 2006. On the 25 September Mr. X rejoined the 'Fifteen' group. During his first meeting he mentioned that he had bought a small knife for self-protection, he also mentioned feelings of paranoia. The therapy staff team recorded that this was probably an attempt by Mr. X to raise their anxiety about him. They decided to discuss it further following the next group.[66] At the next meeting on the 16 October Mr. X told the group he had bought a nine-inch hunting knife for his protection. The group discussed this. Following the group Mr. X took back a length of rope which had previously been confiscated from him by another group member as he said it offered him a means of *"ending his misery"*. The therapy staff discussed later whether or not Mr. X was deliberately attempting to raise the group's anxiety about him. The therapy staff discussed Mr. X's risk at length. It was decided to do nothing because Mr. X had talked about weapons before and that there was no evidence that he was experiencing any particular distress. Staff also wondered whether this was an attempt by Mr. X to get them to intervene with his GP on his behalf regarding the changes he wanted to make to his medication. Staff felt that if this was the case Mr. X should manage his issues on his own. [67]

21 October-24 October 2006. Mr. X was triaged in the Accident and Emergency Department at the South Manchester University Hospital on the 21 October. It was recorded that Mr. X *"wanted to self-harm. Hears and sees things he cannot explain"*. The assessing doctor felt that there was a high probability of Mr. X self-harming. He was referred to the On Call Psychiatrist. The Psychiatrist noted that Mr. X had tried to strangle himself with a piece of rope and that he was sweating and fearful, with pressure of speech. Mr. X was referred to

65 SM Case notes. Vol.1.PP. 75-77
66 Psychotherapy Records. P.167
67 Psychotherapy Records. PP. 168-169

the SAFIRE Unit and was admitted there later that same day. On his admission a Threshold Assessment Grid was filled in. It rated Mr. X as being:

- a severe risk of self-harm;
- a moderate risk of unintentional self-harm;
- no risk to others.

A mental state assessment described Mr. X as experiencing auditory hallucinations *"non-stop"*.[68]

On the 22 October Mr. X's mother was reported as being tearful and distraught. She said that Mr. X had spent thousands of pounds on hotels and eating out in order to get away from the place where he lived. She also claimed that her son was very hostile and always threatened to harm himself and that she could no longer tolerate his behaviour. Following his discharge from the Grafton Ward in June Mr. X had gone to live with his stepfather. Eventually the stepfather had to leave his own home due to Mr. X's chaotic behaviour. The stepfather had no choice but to live in Mr. X's flat which was in a dirty condition and had had the major services disconnected. Both places had been made a total mess by Mr. X. Mr. X's mother felt that she was no longer able to cope with her son's aggression and demands. Both the mother and her ex-husband had been supporting Mr. X financially and she no longer wanted her son to have unrestricted access to her *"for the time being"*. Mr. X's mental state assessment recorded that he had a cold manner and a flat expression. He was assessed as presenting a moderate risk of self-harm if allowed home and of presenting a low to moderate risk to others. It was recorded that Mr. X was experiencing auditory, visual and olfactory hallucinations. The mental state assessment also stated that there was *"some manipulation and control of the situation noted"*. [69]

The following day Mr. X tried to contact the Psychotherapist at 'Fifteen' to say that he had been admitted to the SAFIRE Unit. An assessment was conducted. It was written that there was no evidence to support the notion that Mr. X had auditory, visual or olfactory hallucinations. It was also noted that he had *"no delusions-some paranoid ideas about neighbours"*. Because Mr. X was not deemed to be acutely unwell he was not deemed suitable for admission. The plan was:

68 SM Case notes Vol, 1 PP.41-46
69 SM Case notes Vol.1 PP. 50&53

- a referral to Crisis Point;
- and if not accepted to be discharged to the care of Consultant Psychiatrist 1;
- refer to Psychology for Cognitive Behaviour Therapy and for assessment by the CMHT.

Unknown to the ward staff the mother of Mr. X contacted the Psychotherapist. She told him that Mr. X was making both her and his stepfather ill. She was anxious for Mr. X to receive regular help.[70]

31 October 2006. Mr. X was reviewed by Consultant Psychiatrist 1's Specialist Registrar. Mr. X was well kempt, he admitted to drinking four cans of lager a day and of not sleeping. He was described as being pleasant and appropriate with *"quasi-psychotic experiences probably in the context of his Schizotypal Personality Disorder"*. Mr. X was recommenced on Olanzepine 5 mg *nocte* and was asked to discontinue his Quetiapine slowly. The plan was to review Mr. X in two weeks time. If within this time no improvement had taken place Mr. X was to be referred to the Community Mental Health Team.[71]

11 November 2006-22 January 2007. Mr. X's employer, the Royal Mail Group, made contact with mental health services. The employer wished to access Mr. X's clinical records in readiness for a workplace occupational health assessment. A letter was written to the Specialist Registrar on the 11 November requesting for copies of the records to be sent.[72]

On the 13 November a care plan was developed by the Psychotherapist who had been identified as Mr. X's Care Coordinator. At this stage Mr. X was on standard level CPA. The care plan stated that the Psychotherapist would be able to support Mr. X with his social isolation, but would not be able to help in a crisis situation. The plan suggested Mr. X should manage a psychiatric crisis by going to the GP, Accident and Emergency, a Psychiatrist or the Samaritans. The date of the next review was set for 12 February 2007. Mr. X gave his consent for the CPA to be sent to his *"care network"* (in effect his GP). Consultant Psychiatrist 1's team was neither consulted nor communicated with.[73]

70 SM Case notes Vol.1 P. 68 and Psychotherapy Records P. 4
71 SM Case notes Vol.1 PP. 39-40
72 SM Case notes Vol.1 PP. 19-22
73 Psychotherapy Records P.5

19 December 2006. Consultant Psychiatrist 1's Specialist Registrar wrote to Mr. X's GP to say that he had missed a total of three appointments. This was described as being *"somewhat unusual for him"* the Registrar was concerned that Mr. X would develop *"a full blown psychotic illness"* given his previous paranoia and auditory hallucinations. The GP was asked to contact the Registrar if any concerns arose. The Registrar wrote that he intended to visit Mr. X at his home with one of the CMHT staff in January 2007.[74]

8 January-22 January 2007. On the 8 January Mr. X gave an account to the 'Fifteen' group of being admitted to hospital for a ten-day period over Christmas due to a potassium deficiency. Mr. X called for an ambulance but reported that he was so weak the police had to break into his flat. He reported that his step-father refused to visit him in hospital saying that he should *"get a life"*.[75] On the 22 January Mr. X was discharged from 'Fifteen' following admitting to some drinking breaches and failing to attend meetings. He was told that he could reapply to the programme following a three-month interval. The GP and Specialist Registrar were informed.[76]

13 February-14 May 2007. The Specialist Registrar reviewed Mr. X on the 13 February and thought that his mental state had deteriorated. Mr. X had missed several appointments since he had last been seen by the Registrar on the 31 October 2006. Mr. X felt that he was being persecuted in his neighbourhood and appeared to have experienced some psychotic symptoms. Mr. X was having difficulty in distinguishing between what was real and what was not; he was also experiencing panic attacks. Mr. X was described as being pleasant, well kempt and co-operative at the meeting. An outcome of the review was that the Registrar discussed the case with the CMHT and arranged for a Community Psychiatric Nurse to assess Mr. X in the near future. The next review date was set for 6 March.[77]

At the 6 March review Mr. X said that he continued to have feelings of persecution and was low in mood. However he appeared to be less anxious and showed some improvement of his mental state.[78] Following this review the Specialist Registrar wrote to the GP giving a diagnosis of *"Schizotypal Disorder, Dysthymia"*. The medication was recorded as being Fluoxetine 40 mg OD (once daily), Olanzapine 20 mg *nocte* and Propanolol 20mg BD (twice

74 SM Case notes Vol. 1 P.35
75 Psychotherapy Records. P188
76 SM Case notes. Vol. PP.32-33
77 SM Case notes. Vol. PP. 30-31
78 Internal Investigation Report

daily). The GP was advised to consider a short course of Zopiclone 7.5 mg to help with Mr. X's sleeping problems.[79] Another appointment had been set for Mr. X for the 27 March with the Specialist Registrar at the Outpatient Clinic. Mr. X missed the appointment set for the 27 March and he also missed the replacement appointment that had been set for the 1 May. The Specialist Registrar wrote to him asking him to make another appointment if he wished to be seen again. The GP was notified of the situation.[80]

28 May - 6 June 2007. On the 28 May Mr. X was admitted via Section 136 to a hospital in Eastbourne Sussex. He was admitted because he had suicidal thoughts and paranoid ideas about people following him. Mr. X told a Psychiatrist in Sussex that his trouble had begun when his neighbour's children had kicked his cat. This had led to problems with his neighbours in general. He claimed to have received threatening letters and to have had faeces and used condoms pushed through his letterbox. He was transferred back to Manchester Services on a medication regimen of Prozac 40 mg, Omeprazole 40 mgs and Diazepam 5 mg TDS.[81] Mr. X was transferred to Redwood Ward, North Locality and was then moved to the SAFIRE Unit for assessment. The ward staff contacted Mr. X's stepfather who asked them if they were aware of the past difficulties he had experienced with his son. They said they were not aware of any previous difficulties and Mr. X stated that he did not know why his father would not speak to him.[82]

The ward staff contacted the Sussex Police on the 4 June to ascertain more details of the events leading up Mr. X's admission in the south. The Police said that Mr. X had a knife in his possession and that he had shown them where he had hidden it. He told the Police he had it for his own protection.[83] On this same day the mother of Mr. X telephoned the ward to explain that she had had little contact with her son for many months. She had been aware of his hospital admission over Christmas and had seen him on a couple of occasions since Mother's Day. She was very upset and said that Mr. X had done some unforgivable things, that he refused to take responsibility for his actions and had tried to "*con*" her.[84] A risk assessment carried out on this day described Mr. X as being a high risk of suicide and a

79 SM Case notes. Vol. PP. 28-29
80 SM Case notes. Vol. PP. 26-27
81 NM Case notes Vol. 1 PP. 254-255
82 NM Case notes Vol. 1 P.180
83 NM Case notes Vol. 1 P. 191
84 NM Case notes Vol. 1 PP. 195-196

current low risk to others. However it was recognised that his risk to others could change if he suffered a psychotic relapse and purchased a knife.[85]

On the 6 June a discharge summary was prepared following a multidisciplinary team review. Mr. X had presented as being calm during the review, although he said that he still had paranoid thoughts and that he did not want to leave hospital. He said that if he was discharged he would buy a rope and hang himself. The plan was to:

- discharge to his home address;
- give Mr. X two days of medication;
- make an Outpatient appointment;
- make an appointment with the GP Surgery (8 June);
- contact the CMHT to ascertain whether Mr. X had been allocated a CPN;
- inform Mr. X's mother that he had been discharged.

A summary was written for Mr. X's GP. Mr. X was advised to re-refer to the 'Fifteen' group.[86] This discharge was planned without the input of Consultant Psychiatrist 1.

11 June-28 July 2007. The AMIGOS Trust electronic record system shows Mr. X to have been placed on enhanced CPA from the 14 June. Community Psychiatric Nurse 1 (CPN 1) was allocated his case.

On the 19 June Mr. X was admitted to Sentara Healthcare in the United States of America (USA). Mr. X had travelled to the USA (probably before the 11 June) where he had been admitted to hospital due to experiencing seizure-like symptoms at a shooting range. Mr. X had apparently tried to shoot himself on three occasions on the same range in quick succession but failed to do so by demonstrating some kind of seizure on each of the three occasions. Onlookers at the shooting range called 911 (the USA emergency services number). On examination at a general hospital facility no evidence could be found to suggest an epileptic fit had occurred. Following this episode Mr. X superficially scratched his wrists and showed an interest in jumping out of a window.[87]

85 NM Case notes Vol. 1 P. 208
86 SM Case notes Vol.1 PP.15-16
87 NM Case notes. Vol. 2 PP. 167-170

Meanwhile in England between the 20 and 25 June the Mental Health and Police Services were trying to locate Mr. X as they were worried about his apparent disappearance. In the end the Police decided to stand the investigation down as they had traced his credit card which was being used in New York USA. The New York Police Department and Homeland Security were informed by the British Police regarding their concerns for Mr. X. A trace was placed on Mr. X so that services in England would be notified when he tried to leave the USA.[88]

On the 26 June Mr. X was transferred to a psychiatric unit in the USA following the scratching of his wrists. He was given a diagnosis of Bipolar Disorder with severe psychotic features. However he was deemed fit to be discharged and this was done on the 5 July. It is not certain when Mr. X returned to the United Kingdom. During this period the hospital in the USA had contacted Mr. X's mother to say that he had injured his back (whilst falling around on the shooting range). Mr. X's mother notified CPN 1.[89]

28 July 2007. Mr. X presented at the Accident and Emergency Department of the Manchester Royal Infirmary. He was recorded as having suicidal ideation with no specific plans. He was also recorded as being paranoid. Mr. X claimed to have tried to hang himself as he got off of the aeroplane from the USA where Accident and Emergency staff assumed he had been on holiday. He was recorded as being very inconsistent and later retracted the claim that he had tried to hang himself. Mr. X was described as experiencing *"pseudo-auditory hallucinations"*. He was also described as being calm and maintaining good eye contact. Mr. X said he wanted to be in hospital. He was assessed as having a condition that would not respond to hospital treatment. The Mental Health Liaison Team took the view that Mr. X would not have been discharged from the American facility and allowed to travel back to England alone if his mental state had not been stable. He was discharged with planned follow up from the CMHT and Consultant Psychiatrist 1.[90]

29 July-17 August 2007. Between July and August Mr. X again went missing to both services and his family. On the 29 July Mr. X was admitted to the Newark Beth Israel Medical Centre in New Jersey USA. On travelling through Immigration Mr. X said that he had come to America to buy a pistol in order to shoot himself. On the 30 July Mr. X

88 AMIGOS PP. 32-34
89 AMIGOS P.36 NM Case notes Vol. 2 PP. 164-166
90 GP Records. P.46

underwent a psychiatric assessment. The Psychiatrist was uncertain as to what was wrong with Mr. X but decided to treat him with Clozaril and initiate Prozac on a *"one time dosage"*[91].

The Newark Beth Israel Hospital contacted Mr. X's mother on the 9 August to say that he had been admitted. Mr. X's mother notified the CMHT. On the 15 August the CMHT contacted the hospital in the USA. On this day Mr. X had been discharged and was being held in a detention centre where he was being observed on a one-to-one basis because he continued to threaten suicide and the American authorities did not want to take any risks with him. He was not thought to be actively mentally ill.[92]

17 August 2007- 31 January 2008. Mr. X returned to England on the 17 August. He was met at the airport by members of the CMHT and was admitted to the North Manchester Service under Section 2 of the Mental Health Act. The diagnosis from the American Team was *"Bipolar Affective Disorder mixed episode with psychotic features and poly substance misuse."*[93]

On admission Mr. X was placed on 15 Minute observations. However he settled very quickly and the next day the observations were reduced.[94] A risk assessment was conducted.

"Danger to others
Aggression and violence to others: ***yes in the past***
Arrested for violence: ***no***
Conviction for sexual offense: ***no***
Use of/obsession with weapons: ***yes in the past bought gun and knife***
Arson/fire setting: ***left blank***
Hostage taking: ***no***
Stalking/harassment: ***a note was made regarding information brought forward from counselling sessions***
Risk to children: ***no***

Self-harm
Actual self harm: ***yes past***
Suicidal ideation: ***yes***
Suicidal plans: ***yes***
Substance misuse: ***yes alcohol***
Family: ***no"***

91 NM Case notes Vol. 2 PP. 141-142
92 AMIGOS P. 52
93 SM Case notes Vol. 2 P.64
94 SM Case notes Vol. 2 PP. 11-122 & 106

Mr. X was considered to be potentially at risk from his neighbours. It was recorded that Mr. X said his neighbours thought he was a paedophile, he said they had broken his windows and followed him around. Mr. X described visual hallucinations in that walls and floors shivered around him. Mr. X was thought to be a low to moderate risk to others as his feelings and thoughts were non specific. In summary Mr. X's psychiatric symptoms were viewed in the light of his social situation. His capacity was thought to depend on the *"validity of his psychiatric symptoms"*. It was recognised that Mr. X had poor finances, housing, social and family relationships. Views about his psychiatric condition were uncertain at this stage. The management plan was for a formal admission. [95]

On the 5 September a ward round was held. A diagnosis was put forward of Personality Disorder. The ward Multidisciplinary Team recorded no concerns for Mr. X's safety.[96] On the 13 September Mr. X was found asleep in his bedroom with a kitchen knife on his pillow. When challenged about this Mr. X said he had thoughts of self-harm. However Mr. X appeared to be calm and settled. He was eating and sleeping well and interacting appropriately.[97] Around this time Mr. X decided that he would sell his flat and live in rented accommodation. He discussed this with his discharge planner.[98] An Occupational Therapy assessment that took place at this time stated that Mr. X was a high functioning individual who was *"clearly able to express and meet his own needs"*. No symptoms of mental illness were observed.[99]

A ward round was held on the 3 October when a disagreement regarding diagnosis took place. The Responsible Medical Officer suspected Schizophrenia, however the ward staff suspected strongly a Personality Disorder. The Care Coordinator, CPN 1, who was present noted that it was important for a clear diagnosis to be reached so that an appropriate discharge plan could be framed.[100]

The Occupational Therapist took Mr. X to his flat for a home assessment on the 10 October. The place was a mess. Mr. X felt that the flat was not habitable. The Occupational Therapist felt that it was simply a matter of removing empty milk cartons and lager cans. Mr. X

95 NM case notes Vol. 2 P.150
96 AMIGOS P.59
97 NM Case notes Vol. 2 P.20
98 NM Case notes Vol. 2 PP.23
99 NM Case notes Vol 2 PP. 57-59
100 AMIGOS P.72

requested that the mental health services employ a 'clean up team' but this was refused. He was advised to look up a cleaner in the *Yellow Pages.* It was noted that the furniture and carpets were in very good condition and that the mess was superficial only. Mr. X was told that the condition of his flat would not be a reason to delay his discharge.[101]

On the 15 October Mr. X was transferred to Bronte Ward South Manchester Service. He was discharged with a diagnosis of Schizoaffective Disorder. At the time of his admission Mr. X was an informal patient. The admitting doctor did not have access to Mr. X's clinical records and had to depend upon a handover from nursing staff. Mr. X had been returned back to the care of Consultant Psychiatrist 1. The admitting doctor recorded that Mr. X had been admitted seven times over a fifteen-month period and that he had accrued a range of diagnoses which included Schizophrenia, Schizotypal Personality Disorder, Personality Disorder, Bipolar Depression, Depression and Poly Substance Misuse. It was noted that Mr. X was receiving both anti-depressant and anti-psychotic medication. Mr. X did not present with any paranoid delusions or thought insertion. No active thoughts of self harm could be detected. Mr. X was not happy about being transferred to the South Manchester Service.[102]

A risk assessment was conducted on the 17 October by the Senior House Officer. Mr. X was not assessed as presenting with any current risk. On the same day the Named Nurse undertook a risk assessment. This assessment did describe Mr. X as presenting with current levels of risk to both himself and to others. Regardless of this Mr. X was granted up to one hour of unescorted leave each day for a period of one week.[103]

A ward round was held on the 22 October, Consultant Psychiatrist 1 was in attendance. Mr. X's medications were listed as being:
Quetiapine 100mg
Perphenazine 4mg BD
Orphenadrine (dose not noted)
Tryptophan 1g TDS
Zyban 150 mg BD
Escutalopram 10 mg OD
Zopralone 7-5 mg OD

101 NM Case notes Vol. 2 P.60
102 SM Case notes Vol.2 PP. 23 & 58-63 & 68
103 SM Case notes Vol. 2 PP. 78-85 & AMIGOS P.86

Omeprazole 40 mg OD

Mr. X's previous risk behaviours were discussed in the context of his previously stated fantasies. The history of Mr. X having taken colleagues' telephone numbers and addresses and harassing a fellow patient was noted. Mr. X mentioned that he had experienced auditory hallucinations over the past eighteen months. It was agreed to stop the Zyban and Quetiapine and to also try to reduce the Tryptophan with a view to stopping it altogether. The aim was to commence Clozapine. Mr. X was reassured that there were no plans to discharge at this stage.[104]

Between the 26 and 27 of October Mr. X was reported as being missing from the ward. He was subsequently returned by the Police via Accident and Emergency. The Police said that he had been in possession of a knife. Mr. X said that he had it in his possession for self protection. It was felt that Mr. X was likely to abscond again and that he may be at risk of suicide. It was decided that he needed to be detained under the Mental Health Act.[105] On the 29 October Mr. X demanded the right to leave the ward but he was persuaded to stay until he was assessed. A Section 12 Approved Doctor had already made the first recommendation for a Section 3 to be applied. The Duty Social Worker was contacted for a further recommendation.[106] The next day Mr. X was placed on a Section 3 of the Mental Health Act. Mr. X's mother had been contacted as the next of kin. She was unwilling to be involved (although she raised no objection to the Section) and was too distressed to speak.[107] Very rapidly after the Section was placed on Mr. X he was described as being *"warm, pleasant and settled"*. Mr. X said that his voices had stopped.[108]

On the 8 November the Trust received a letter from Mr. X's solicitor in connection with an appeal against his detention. Mr. X was also requesting opportunity to have leave from the ward.[109] On the 12 November a ward round was held. Mr. X had been commenced on Clozapine two days previously. He was described as being pleasant and affable, interacting

104 SM Case notes Vol.2 PP. 106-107
105 SM Case notes Vol. 2 P.143
106 SM Case notes Vol. 2. PP. 146-149
107 SM Case notes Vol. 2 PP 155 & 565
108 SM Case notes Vol. 2 PP 165-166
109 SM Case notes Vol.2 P. 294

well with his peers and expressing no delusional thoughts. Mr. X was given up to two hours of escorted leave. A Section 17 form was completed to this effect.[110]

A ward round was held on the 26 November, Consultant Psychiatrist 1 was in attendance. During this period Mr. X's risk profile had not changed to any great extent. It was felt that Mr. X was not ready to come off his Section. Mr. X on the other hand wished to come off the Section as he found it too restrictive because he was bored and wanted to go to the cinema. It was agreed that the Section would be reviewed once Mr. X had been fully titrated onto his Clozapine. Mr. X was given seven hours of unescorted leave to visit his flat. Mr. X refused to travel to his flat independently and demanded hospital transport which was provided to both take him and collect him.[111]

A Mental Health Act Managers Hearing was held on the 5 December as Mr. X had appealed against his Section. On this occasion it was noted that Mr. X had a diagnosis of Paranoid Schizophrenia 1CD10 Code S20.0. The report for the hearing was prepared by the Specialist Registrar of Consultant Psychiatrist 1. The medical recommendation was that Mr. X should remain on his Section due to the current high risk that he posed, in particular to himself. It was noted that Mr. X needed to be monitored for his Clozaril especially as he had been experiencing tachycardia (fast heartbeat) and low blood pressure. It was recommended by both the Doctor and the Social Worker that Mr. X remained on his Section. The Hospital Managers agreed to this.[112] Two days later Mr. X was found taking cocaine on the ward.

On the 9 December a follow up risk assessment was conducted. Mr. X was described as being pleasant toward both patients and staff. He was not expressing ideas about harming himself or other people. Mr. X expressed the view that he ought to be discharged and his Section was no longer warranted, however he stated that he wished to continue his treatment.[113]

Mr. X had requested a Mental Health Act Tribunal to appeal against his Section. He was becoming anxious about the event and was upset that his mother was refusing to become involved. The Tribunal was held on the 13 December. On this occasion Mr. X told the Tribunal that he was happy to comply with his treatment and medication but that the Section

110 SM Case notes Vol. 2 PP. 204-205
111 SM Case notes Vol. 2 P. 264 & AMIGOS PP. 196-197
112 SM Case notes Vol. 2 PP. 546-548
113 SM Case notes Vol. 2 PP. 29-30

served no purpose. The medical report recommended that the Section be upheld. The Tribunal rescinded Mr. X's Section stating that it would terminate on the 20 December. This was discussed in the ward round that followed. It was noted that Mr. X was subdued following the decision; he became very worried that he would be discharged once he became an Informal patient.[114]

In the run up to the end of Mr. X's period on Section a risk assessment was undertaken. No psychotic symptoms were observed and Mr. X was not thought to be a risk to either himself or to others. On the 20 December Mr. X's Section was terminated. He was described as feeling frightened about being discharged. At this stage his family did not want to resume their relationship with him, they had contacted the ward asking for Mr. X to stop contacting them. Mr. X had not enjoyed overnight leave to his flat because he felt lonely.[115]

On the 4 January 2008 it was noted during a risk assessment that Mr. X was *"sabotaging his medical treatment"*. He had spent most of the Christmas period in bed on the ward. He claimed to have heard voices when he went on overnight leave and was assessed as being a medium risk to both himself and to others. A comprehensive discharge plan was developed.[116]

On the 10 January Mr. X was given a seven-day period of leave to his flat. The plan was for a CPA assessment to take place and for Mr. X to be visited by his Care Coordinator (CPN 2).[117] Mr. X returned back to the ward after three days saying that he was not well and that he had heard people talking about him. It was noted that he did not appear to be anxious or worried, he just did not want to go back home.[118] On the 20 January Mr. X took an overnight period of leave as he had arranged for estate agents to visit his flat the following morning.[119] On the 21 January a risk assessment took place. This assessment recorded Mr. X was a medium risk to both himself and to others, it was noted that Mr. X did not want to be discharged. At ward round on the same day it was feared that Mr. X was becoming institutionalised. It was agreed that his mental state would continue to be monitored weekly

114 SM Case notes Vol. 3. PP. 82-83 &245 & AMIGOS Records P. 237
115 SM Case notes Vol. 3. PP. 107-109
116 SM Case notes Vol. 3 PP. 153-155 & AMIGOS P. 297
117 SM Case notes Vol. 3. P. 182
118 SM Case notes Vol. 3. P. 186
119 AMIGOS P. 331

and that he would be granted another seven-day period of leave during which time the Care Coordinator, CPN 2, would visit him.

A ward round was held on the 31 January, Mr. X failed to attend. The Named Nurse stated that Mr. X was trying to sabotage his discharge. He had been trying to make himself homeless and was refusing to cooperate with the Clozaril Monitoring Clinic. He had also refused to have his mental state assessed. There had been signs during the previous week that Mr. X was failing to engage, he had not allowed either CPN 2 or the Occupational Therapist access to visit him at his home. Mr. X was discharged in his absence. Following the ward round Mr. X returned to the ward. He was angry to learn that he had been discharged and he refused to take his TTO (medication to take home) medication with him. At the point of Mr. X's discharge he stopped taking his Clozapine.[120]

On the 1 February the Crisis Resolution Team tried to visit Mr. X at his home to give him his medication. He was not in. On the 4 February a seven-day follow up visit was made to Mr. X's home, but he was not there. CPN 2 telephoned Mr. X to arrange an appointment to make a visit to his home on the 11 February. Mr. X explained that he had moved and apologised for missing his previous appointments.[121]

18 February 2008. An unusual event occurred. Several months after Mr. X had been discharged from the North Manchester Inpatient Unit a letter was written by the Staff Grade Doctor to Mr. X's GP. This letter stated that there had been a disagreement between the Consultant Psychiatrist and the rest of the clinical team regarding the diagnosis of Mr. X. The Consultant had diagnosed Mr. X as having a Schizoaffective Disorder. The rest of the team maintained that Mr. X was not mentally ill and that he had fabricated his symptoms for both psychological and material gain. The clinical team viewed Mr. X's presentation as being *"flamboyant, histrionic and insincere"*. Nursing staff had felt that all of Mr. X's behaviour had been goal orientated and they had been manipulated. At no time did they feel that Mr. X presented with any symptoms of mental illness. The Staff grade believed that Mr. X was fabricating his illness and actively pursuing hospitalisation.[122]

120 SM Case notes Vol.3 PP. 42,46, 234, 237 & Vol 4 P. 19
121 AMIGOS Records PP. 368-369
122 NM case notes Vol. 2 PP. 149-152

18 February-3 April 2008. CPN 2 was able to make a home visit. He was concerned because Mr. X appeared to be very paranoid and had been staying in hotels in Blackpool in order to get away from Manchester thus avoiding people he knew. CPN 2 arranged for Mr. X to see Consultant Psychiatrist 1 that afternoon. Mr. X went to the appointment carrying a knife which he showed to the Consultant. Consultant Psychiatrist 1 arranged for an inpatient admission to Bronte Ward.[123]Bronte Ward staff were informed and sent someone to remove the knife and collect Mr. X prior to his admission. A Police Officer who happened to be on Bronte Ward at the time questioned Mr. X on his arrival there. Mr. X was arrested and taken to the Police Station, he was subsequently bailed and returned to the Ward. On admission Mr. X was found to be well kempt although it appeared that he had lost weight. Mr. X was described as being tense, agitated, tearful, and distressed on occasion. He had stopped taking his Clozaril and thought that people were calling him a paedophile, he was worried that these people would break into his flat. Mr. X presented as depressed with suicidal ideation. He had no thought disorder but did have some delusional ideas, whilst his insight was described as limited he was accepting of treatment.[124]

Following his admission a risk assessment was conducted. Under 'Risk to Others' it was noted that Mr. X was obsessed with weapons and had threatened previously to harm people. It was written that he felt the need to protect himself from others and slept with a knife. Under 'Risk of Harm to Self' Mr. X's previous history was considered. Mr. X had claimed to have taken a "*massive overdose of Ecstasy*" at the end of January. Mr. X said he had not reported this overdose as he had expected to die. Mr. X was assessed as being a high risk of future suicide and self harm. Mr. X was described as having a high risk of relapse due to medication non-compliance and disengagement from services. He was recorded as saying *"I welcome Consultant Psychiatrist 1's decision to admit me"*. The summary stated that Mr. X had a paranoid psychotic illness exacerbated by non-compliance and stress.[125]

On the 21 February Mr. X was recommenced on Clozaril. This was almost immediately changed to Clopixol (a depot) due to compliance issues. Mr. X expressed a preference for being on a depot.[126] Mr. X struggled to stay on the ward. On the 25 February he asked for leave and was granted unescorted leave for a period of one hour. Shortly after returning to

123 SM Case notes Vol. 4 P.19
124 SM Case note Vol. 4 P.19 &GP Records P.34
125 SM Case notes Vol.4 PP. 17-30
126 GP records P.30

the ward Mr. X said he had taken an overdose of 72 Cuprofen tablets which he claimed to have purchased by visiting three separate pharmacies. Mr. X said that he taken the tablets over a period of an hour after returning to the ward. Ward staff could find evidence for only 12 tablets having been taken. His physical examinations and blood tests were returned as being normal.[127]

A ward round took place on the 28 February. Due to *New Ways of Working*, a national initiative, services were realigned and the Inpatient Consultant became the new Responsible Medical Officer for Mr. X (Consultant Psychiatrist 2). It was noted at ward round that Mr. X had no psychotic symptoms although he was expressing some paranoid ideas. A referral was made to the South Manchester Assertive Outreach Team and it was agreed that this team would be represented at the next ward round in order to plan for Mr. X's discharge. Mr. X's depot was increased to 200 mg and his oral medication was discontinued.[128]

A ward round took place on the 6 March. Mr. X said that he could not sleep at night and requested Diazepam; the nursing staff challenged the veracity of this as Mr. X appeared to sleep well. A clinical assessment also took place on this day when it was noted that Mr. X was now suitable for psychological input as he was willing to engage. Mr. X was observed to have fixed delusional ideas about people believing him to be a paedophile. Mr. X also claimed to be experiencing auditory hallucinations.[129] On the 10 March a fellow patient broke down Mr. X's bedroom door. Following this event he wanted to spend time off the ward as he felt he would be better off at home. Mr. X was assessed by Consultant Psychiatrist 2 and a period of leave was granted provided he agreed to return to the ward within a few days.[130]

On the 13 March a ward round was held. Representation from the South Manchester Assertive Outreach Team failed to attend. Mr. X reported that his leave had gone well.[131] He was given another week of leave. It was agreed that the South Manchester Assertive Outreach Team (AOT) would be invited to a discharge meeting the following week. Ward staff were to contact the AOT to arrange for them to visit Mr. X whilst he was on leave.[132] Following the ward round on the 16 March care plans were prepared for Mr. X. They cited his previous

127 GP records P.30 & SM Case notes Vol.4 PP.99-100
128 SM Case notes Vol. 4 PP. 110-115
129 SM Case notes Vol. 4 P. 135
130 SM Case notes Vol. 4 PP. 142-143
131 SM Case notes Vol. 4 P.145
132 SM Case notes Vol. 4 P. 146

history with weapon possession. The plan was to maintain both his safety and that of others whilst he was on the ward.

On the 16 March two members of the South Manchester Assertive Outreach South Team came onto the ward to review the transfer form and to work with Mr. X's named nurse.

On the 20 March a ward round was held. The AOT attended. Mr. X was reported as being well when he was seen. The agreed plan was that Mr. X would be given another week of leave and that the AOT would visit him at his home. The discharge was planned for the 3 April. This in effect was a delayed transfer, the plan had been to discharge Mr. X at an earlier date but it was felt that the AOT needed to get to know him better based on the fact that they had failed to attend earlier meetings as planned.[133]

Mr. X was seen on the ward by the AOT on the 27 March, they had been unable to make contact with Mr. X prior to this date at his home as had been previously arranged. It was reported that Mr. X had not been sleeping well and was self medicating with between two or three cans of lager a day. Mr. X was assessed as retaining some residual paranoid ideas. The plan was for the AOT to continue to visit Mr. X at his home. At this time his depot was increased to 400 mg weekly. He was also prescribed Zopiclone. Mr. X's discharge was planned for the following week.[134] The AOT made a visit to Mr. X's flat on the 30 March. The flat was described as being clean and tidy.[135]

A ward round was held on the 3 April. Mr. X was still reported as being paranoid but he felt that the voices might be a product of his imagination. The AOT were to take over the administration of Mr. X's medication after his discharge and the South Manchester Assertive Outreach Consultant Psychiatrist was to follow him up in Outpatients two weeks from the time of his discharge. Initially the AOT were to see Mr. X on a fortnightly basis, he was also to receive psychology input from the AOT. A CPA was conducted by both members of the ward staff and the AOT, unfortunately no paperwork appears to exist for this review.[136] Following the ward round Mr. X was discharged from Bronte Ward. A comprehensive

133 SM Case notes Vol. 4 PP. 151-1554 &AMIGOS P.461
134 AMIGOS P. 476
135 AMIGOS P.476
136 SM Case notes Vol. 4 PP. 167-169

medical discharge summary was sent to the GP.[137] This ended Mr. X's time with the Manchester Mental Health and Social Care NHS Trust.

Clinical History with the South Manchester Assertive Outreach Service

On the 6 April AOT Workers 4 and 5 tried to visit Mr. X at his flat. He was not in, an appointment card was left.[138]

Mr. X telephoned the AOT on the 9 April to say that he did not feel well and that he needed another appointment. He also asked for his depot medication to be rescheduled (which was due on this day). AOT Worker 7 made an appointment for Mr. X to be seen on the 10 April.[139] Mr. X's seven-day follow up meeting was due to be held on Bronte Ward on this day, he did not attend. The ward staff managed to contact Mr. X on his mobile to find out how to proceed. Mr. X told them he was well and the AOT were due to meet with him the following day with his depot.[140]

On the 10 April Mr. X telephoned the AOT to say that he was not feeling well and to ask for his appointment to be rescheduled. AOT Worker 7 wrote that Mr. X would be discussed at the daily handover meeting and that a new appointment would be made.[141]

An admission/discharge summary was prepared for the GP on the 11 April. The summary outlined the events following Mr. X's admission and the plan to be followed on his discharge.[142]

On the 12 April Mr. X telephoned the AOT to say that he was still too ill for his appointment to go ahead and asked them not to attend his home. It was agreed that the AOT would call later that day to remake the appointment. The AOT made several calls but Mr. X did not answer any of them. The AOT decided to visit Mr. X the next day.[143]

137 GP Records P.31
138 AMIGOS P.494
139 AMIGOS P.495
140 AMIGOS P.496
141 AMIGOS P.497
142 SM Case Notes Vol. 4. PP. 173-175
143 AMIGOS PP.498-499

Two days later on the 14 April the AOT Care Coordinator and the AOT Manager attempted to visit Mr. X at his flat in order to give him his depot. He was not in and could not be contacted on the telephone.[144] A visit was also made the following day, Mr. X was not in.[145]

On the 16 April the AOT Care Coordinator visited Mr. X's flat, he was not in. The AOT Manager made a visit on the 17 April, Mr. X was not in.

On the 20 April the AOT Care Coordinator and AOT Worker 3 successfully made face-to-face contact with Mr. X at his flat. The flat was reported to be well kempt. It was noted that Mr. X's depot was overdue, unfortunately neither AOT Worker making the visit that day was qualified to administer it, Mr. X was told that someone would visit as soon as possible to do this. Mr. X said he was not well and requested two visits a week until he had "*settled down*".[146]

On the 23 April the AOT Manager (a Registered Nurse) telephoned Mr. X to say she was going to visit him to give him his depot. Mr. X had his telephone switched off. A message was left asking him to contact the AOT.[147]

Mr. X telephoned the AOT on the 24 April to arrange a visit for the 27 April which was a Sunday. Mr. X was described as being warm and engaging in manner.[148] On the 27 April the AOT Manager successfully visited Mr. X at his home and gave him his depot which was 20 days overdue.[149] It was recorded that Mr. X was aware that he was due to meet with the AOT Consultant Psychiatrist on the 1 May. It would appear from the records that this appointment with the Psychiatrist did not take place.

On the 6 May Mr. X telephoned the AOT to say that he wanted to cancel his visit scheduled for that day.[150] On the 7 May the AOT Care Coordinator and Team Manager successfully visited Mr. X at his flat. He refused his depot medication. Mr. X described himself as vulnerable and keen to see the AOT Consultant Psychiatrist at the Outpatient Clinic.[151]

144 AMIGOS P.500
145 AMIGOS P.501
146 AMIGOS P. 504
147 AMIGOS P. 505
148 AMIGOS P.507
149 AMIGOS P.508 & AOT Notes File P.44
150 AOT Notes File P. 4
151 AMIGOS P.509 & AOT Notes File P. 44

As Mr. X had requested additional support the AOT tried to contact him on three occasions prior to the planned visit they had made with him for the 10 May. Mr. X did not pick up the telephone and the visit was not successful as Mr. X did not answer his door.[152] On the 11 May another attempt was made to contact Mr. X via telephone, once again he did not pick up and a message was left for him to contact the AOT.[153]

On the 12 May Mr. X telephoned the AOT. He said he had not been able to answer his door at the weekend because he had been asleep. He requested another visit.[154]

On the 16 May Mr. X telephoned the AOT to ask for some assistance with his benefits. The AOT agreed to help him.[155] Mr. X telephoned the AOT four days later to rearrange his appointment with them for later that week.[156] On the 23 May the AOT Manager visited Mr. X at his home and despite arranging the appointment with him the previous day he was not in.[157]

On the 27 May Mr. X telephoned the AOT to ask if his appointment scheduled for later that day could be cancelled. Mr. X was told that this would be fine and another appointment was made for the 29 May.[158] There was no record made to say what, if anything, occurred on the 29 May.

Two members of the AOT tried to visit Mr. X on the 30 May. They had not visited Mr. X before and were uncertain of the flat number. It also appeared that the doorbell for Mr. X did not work. They rang a couple of buzzers and tried to telephone Mr. X with no success.[159] AOT Worker 7 spoke to Mr. X on the telephone on the 3 June. Mr. X said that he would be happy to see someone if they could help him with his benefits as this was his priority. An appointment was made for the 12 June so that issues regarding Mr. X's benefits could be explored.[160]

152 AMIGOS P.510
153 AMIGOS P. 511
154 AMIGOS P.512
155 AMIGOS 513
156 AMIGOS P.514
157 AMIGOS P.515
158 AMIGOS P.516
159 AMIGOS P.517
160 AMIGOS P.518

On the 5 June a Community Psychiatric Nurse form the AOT attempted to visit Mr. X but he was not in.[161] On the 10 June a home visit was successfully made. Mr. X reported that he had developed a crack cocaine habit since his discharge. He claimed to have lost at least two stones in weight and said that he planned to avoid psychiatrists. On this occasion no mention was made by either the AOT Workers or Mr. X regarding his depot medication which was severely overdue.[162]

On the 12 June a visit was made to Mr. X's home. He was not in.[163] A telephone call was made to Mr. X on the 19 June and it was arranged for a visit to be made the following day. There was no record made to ascertain whether this visit took place or not.[164] A member of the AOT telephoned Mr. X on the 24 June to say a visit was due to take place in fifteen minutes time. Someone answered the call and said that Mr. X was in Trafford. Another appointment was arranged for the 26 June.[165]

On the 28 and 30 June visits were made to Mr. X's flat. On the first occasion he was not in. On the second occasion he refused to come to the door, but when telephoned said he was fine and asked for another appointment to be made.[166] On the 17 July another visit was attempted. Mr. X was not in. When telephoned Mr. X said he was fine and that he had sold his flat.[167]

On the 22 July direct contact was made by the AOT Care Coordinator and AOT Worker 3. Mr. X told the AOT Workers that he had sold his flat and used the money to pay off his debts and to buy heroin and cocaine. Mr. X also said that he had tried to commit suicide that weekend by injecting three bags of heroin into his groin. Mr. X agreed to see the AOT Consultant Psychiatrist the following day. He said he felt groggy and would be happy to see the AOT two or three times a week. Mr. X said he was fearful of attack and was carrying a knife for protection. It is unclear whether or not Mr. X showed the knife to the AOT as this was not recorded in the clinical records. However it was later reported in Court that a knife had been shown to them.[168]

161 AMIGOS P. 519
162 AMIGOS P.520
163 AMIGOS P.522
164 AMIGOS P.524
165 AMIGOS P. 525
166 AMIGOS PP. 528- 529
167 AMIGOS P.530
168 AMIGOS P.531

The next day Mr. X telephoned the AOT he spoke to the AOT Care Coordinator and said he was too ill to attend the Outpatient clinic. Mr. X said he had caught a bug. The Care Coordinator agreed to telephone Mr. X daily in order to check on his progress.[169] On the 27 July a visit was made to Mr. X's home but he was not in.[170] On the 28 July at an AOT meeting it was agreed that a further Outpatient appointment should be made and a visit arranged for the next day unless Mr. X wanted one before.[171]

Following the AOT meeting on the 28 July they were notified that Mr. X had been arrested and charged with homicide.[172]

169 AMIGOS P.532
170 AMIGOS P.533
171 AMIGOS P.535
172 AMIGOS P.534

12. Timeline and Identification of the Critical Thematic Issues

Root Cause Analysis (RCA) Second Stage

12.1. Timeline

The Independent Investigation Team formulated a timeline and a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

12.2. Critical Issues Arising from the Timeline

On examining the timeline, care pathway and chronology the Independent Investigation Team identified four critical thematic issues that rose directly from analysing the care and treatment that Mr. X received from the Manchester Mental Health and Social Care NHS Trust and the Manchester Assertive Outreach Service. These critical thematic issues are set out below.

1. **Diagnosis and Management of the Case.** There was both confusion and disagreement over a period of seven years in reaching a diagnosis for Mr. X. This confusion and disagreement ensured that an appropriately formatted care and treatment plan was never put into place for Mr. X and managed over time. The failure to ensure an agreed diagnosis and treatment strategy was made more problematic due to the Personality Disorder(s) that Mr. X probably had and the behaviours that he displayed.
2. **Risk and Psychiatric History.** Due to the chaotic nature of Mr. X's presentation, Trust-wide organisational change and poor professional communication processes, the risk presented by the patient, both to himself and to others, was never understood fully in the context of his full psychiatric history.
3. **Continuity of Care.** Mr. X was seen by a total of nine Manchester-based services, two South of England-based services and two United States of America-based services over a seven-year period. The speed and frequency that he oscillated between these services meant there was a lack of continuity of care.

4. **Lack of Timely Intervention.** Mr. X was a difficult person to manage clinically. However on frequent occasions he would present in such a way that urgent and sure-footed management was required nonetheless. The resources retained by clinical teams to intervene were not always used in a timely manner in order to ensure the safety of both Mr. X and others. This was exacerbated by CMHT Operational Policy prior to October 2006 effectively disbarring people with Personality Disorders from accessing their services. A specialist Personality Disorder service had been developed by the Trust in 2005 in the form of a therapeutic community to which Mr. X attended, however it was not constructed to provide suitable levels of care coordination or the robust clinical management frameworks that Mr. X required.

The critical thematic issues listed above are incorporated under the relevant headings listed directly below. They are examined in detail under these headings in Section 14 of this report.

12.3. Critical Issues Arising from the Review of other Data

The Independent Investigation Team found other critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the key headings of the Independent Investigation Terms of Reference.

12.3.1. Manchester Mental Health and Social Care NHS Trust. January 2001 - 3 April 2008

1. **Diagnosis.** There was a high degree of confusion, disagreement and uncertainty regarding Mr. X's diagnosis over a seven-year period. This became a particular issue throughout 2007 and the legacy of diagnostic uncertainty continued through into 2008. The effect of this was to prevent a robust management plan for Mr. X being developed that had any degree of sustainability over time. If Mr. X had been reviewed against extant Personality Disorder criteria a robust treatment plan could have been formulated and a referral to a specialist service considered. There would however have been no guarantee that Mr. X would have complied with or accepted such an approach. Mr. X did access two periods of therapeutic community-based treatment which is a recognised evidence-based approach for people with Personality Disorder. However Mr. X did not remain in treatment for any length of time and this service did not offer the degree of management and support that his particular circumstances required.

2. **Medication and Treatment.** Mr. X received a range of medication including antipsychotics and antidepressants. Prior to the diagnosis of schizophrenia Mr. X received antipsychotic medication. Antidepressants were used to deal with Mr. X's lowered mood. It was unclear whether the effects of these medications on Mr. X's mental state were monitored carefully. Mr. X received two periods of therapeutic community-based psychological treatment which is an evidence based approach for people with Personality Disorder. When the diagnosis was altered to one of Paranoid Schizophrenia Mr X received antipsychotics in appropriate doses. It was unclear whether these had an impact on either his symptomatology or behaviour. Treatment was not always tailored to any given diagnosis so antipsychotic and antidepressant medication was prescribed and psychotherapy was given, but it was unclear what set of problems they were expected to affect. This was exacerbated by Mr. X's sporadic compliance with medication and engagement with services. Both factors served to obfuscate his presentation and treatment needs.

3. **Clinical Management of the Case.** A hallmark of the care and treatment that Mr. X received from Manchester-based services was the lack of continuity of care. Mr. X was seen by nine separate Manchester-based services on a 'revolving door' cycle. Each service gave Mr. X a different diagnosis. Clinical assessment, when it did take place, did not lead to the formulation of a patient-centered care and treatment strategy.

4. **Mental Health Act (83 and 07).** For the majority of the time Mr. X received his care and treatment from Manchester-based services he would not have met the criteria for detention under the Act. When the Act was used it was implemented appropriately. It is a fact, that despite Mr. X presenting himself on many occasions to a variety of services, there is no evidence that Mr. X committed an act of self harm, aside from very superficial scratching of his wrists which required no clinical attention. However Section 117 aftercare was not applied appropriately to Mr. X. This could be seen as a missed opportunity when attempting to engage him with services and integrate him back into the community.

5. **Care Programme Approach (CPA).** Mr. X was on Standard CPA between 2001 and the summer of 2007. In effect CPA did not take place as no care coordination was made available. During this period Mr. X met many of the criteria for enhanced CPA,

had he been in receipt of this, his care and treatment would have been managed more effectively. However the admission criteria to the CMHT prior to October 2006 effectively excluded people with Personality Disorder from accessing the service, this meant Mr. X could not gain access to an enhanced level of CPA. Following the summer of 2007, when he was placed on enhanced CPA, Mr. X was passed between several services; this meant that no consistent care coordination could occur. Following Mr. X's transfer to Bronte Ward in the autumn of 2007 a period of stability ensued and Mr. X received effective CPA for the first time up until his discharge on the 3 April 2008.

6. **Risk Assessment.** The frequency and process of risk assessment as applied to Mr. X varied both over time and between services. A common feature of the risk assessments compiled for Mr. X was that they incorporated accurately neither past nor current known risks relating to his behaviour. In short they were incomplete, incorrect and failed to include much of the dialogue that occurred within teams when discussing Mr. X's case. Risk assessment did not inform care, treatment or management plans.

7. **Referral, Discharge and Handover Processes.** These processes were cited as being poor in the internal investigation report. The Independent Investigation would concur with this finding. The physical act of transferring Mr. X from service-to-service was often accomplished with no team-based handover, no clinical record transfer and no continuity of an overarching management plan. This was exacerbated in 2007/2008 by the Trust's adoption of *New Ways of Working.* However the Independent Investigation found that staff managing the discharge process on the 3 April 2008 did this well despite experiencing severe organisational disruption.

8. **Carer Assessment and Experience.** At no stage during the seven-year period that Mr. X received his care and treatment from the Mental Health Trust did his parents receive the offer of a carer assessment. It is clear from the analysis of this case that Mr. X's parents were left on more than one occasion in a position where they were exposed to significant risk of emotional, financial and physical abuse from their son. Trust personnel made no attempt to support Mr. X's parents in their role as carers.

This led in no small part to their ultimate decision to withdraw support from their son for their own safety and wellbeing.

9. **Service User Involvement in Care Planning and Treatment.** Uncertainty regarding Mr. X's diagnosis affected all major decisions regarding his care and treatment. CPA, and care planning generally, was under-developed which prevented a holistic and patient-centred management strategy to be formulated with Mr. X.

10. **Documentation and Professional Communication.** Throughout the period that Mr. X received his care and treatment from the Trust documentation and professional communication intended for *intra*-team purposes tended to be of an acceptable standard. Progress sheets and medical consultation records were maintained well. The documentation and professional communication that was not managed so effectively was that intended to facilitate long-term *inter*-team communication. CPA records and risk assessments were often incomplete or missing from the shared clinical record. It was evident that the kind of record that framed a long-term management strategy was not passed from team-to-team and that the CPA process often included only Mr. X and the person acting in the role of Care Coordinator. It remained unclear, even after extensive investigation, which team knew what and when. The clinical record was not integrated and the electronic universal record was primarily used as a progress recording sheet only.

11. **Clinical Supervision.** There was no evidence to suggest that supervision plans were being recorded in the case files. This should have been standard practice from 2005, especially for community teams. After 2006 the teams providing care and treatment for Mr. X experienced many changes leading to the disruption of all systems including supervision.

12. **Adherence to Local and National Policy and Procedure.** There is ample evidence to suggest that the Trust had fit for purpose policies and procedures in place based on national best policy expectation. Unfortunately clinical staff did not adhere to these policies. This is of particular note with regard to:
    - Carer Assessments;

- Discharge Planning
- Section 117 aftercare;
- CPA and Risk Assessment.

13. **Organisational Change and Professional Leadership.** Throughout 2007 and 2008 the Trust underwent a great deal of disruption and organisational change. Industrial action disrupted the care and treatment that Mr. X received throughout 2007 and *New Ways of Working* caused a distinct fracture in the continuity of his care during 2007/2008. During this period staff morale was low and professional leadership varied in effectiveness. This left the provision of services in a vulnerable and weakened position.

14. **Clinical Governance and Performance**. During the latter years that Mr. X received his care and treatment from the Mental Health Trust many problems were apparent with regard to both governance and performance. The Trust struggled to manage its activity, finances and service quality. There had been a lack of sustained leadership which had subsequently resulted in the formulation of limited strategic direction. This had led to poor relationships with strategic partners and with staff. This provided a backdrop against which difficulties within services could not be challenged and non-adherence to Trust policy and procedure could neither be detected nor managed.

12.3.2. Health Advocacy Resource Project (HARP) and Manchester Mental Health and Social Care NHS Trust Partnership. The Manchester Assertive Outreach Service. 3 April - 28 July 2008

1. **Liaison with Manchester Mental Health and Social Care NHS Trust and Transfer Process.** The South Manchester Assertive Outreach Team worked alongside the Mental Health Trust inpatient staff in the management of Mr. X for three weeks prior to his discharge from the 16 March until the 3 April 2008. Three joint meetings (ward rounds and a CPA meeting) were held between the Trust and South Manchester Assertive Outreach Team prior to the discharge taking place. Despite a high degree of organisational disruption this process was managed well.

2. **CPA, Care Coordination and Clinical Models of Care.** Aside from the allocation of a Care Coordinator the CPA process was entirely absent from the care and

treatment that Mr. X received from the South Manchester Assertive Outreach Team. Mr. X was on Enhanced CPA on his transfer to this service. The South Manchester Assertive Outreach Team did not adhere to its CPA policy and did not perform adequately against national CPA policy expectation. The clinical model that the South Manchester Assertive Outreach Team chose to adopt ran counter to the philosophy of CPA and as such provided no continuity of care and no formal framework for the care and treatment that it was expected to provide.

3. **Assessment of Risk and Forensic History.** No formal assessment of risk was undertaken during the four-month period that Mr. X was placed with the South Manchester Assertive Outreach Team. Mr. X presented with significant self-harm risk indicators which were not addressed in either an appropriate or timely manner. There was no written record to suggest that any potential risk Mr. X posed to either himself or to others had been discussed and evaluated within the Team. Assertive action should have been taken in the summer of 2008 to address the risk that Mr. X was presenting to himself. It must be understood that Mr. X was not presenting a significant risk of harm to others at this juncture. However had Mr. X been managed appropriately in the light of his presentation at this stage these actions may have, albeit inadvertently, created the circumstances in which his risk to others may also have been obviated.

4. **Management of the Case and Clinical Processes.** When Mr. X was discharged from Bronte Ward on the 3 April 2008 the plan included the following actions from the South Manchester Assertive Outreach Team**:**
    - the South Manchester Assertive Outreach Consultant Psychiatrist to follow up Mr. X within two weeks of transfer;
    - Mr. X was to receive psychological therapy input from the South Manchester Assertive Outreach Psychologist;
    - the South Manchester Assertive Outreach Team to be responsible for the administration of depot medication;
    - the South Manchester Assertive Outreach Team to provide a minimum of fortnightly follow-up to include CPA.

The South Manchester Assertive Outreach Team failed to accomplish the above planned actions in accordance with the discharge plan. On his discharge from Bronte Ward Mr. X had been placed in 'the red zone' by the South Manchester Assertive Outreach Team denoting the notion that he presented a significant risk and required priority assessment and management. When Mr. X refused to engage, refused his medication and began to present with strong indicators that he intended to harm himself no proactive assertive clinical management of the case was evident. No management plan was prepared and no timeframe set for urgent intervention.

5. **Use of the Mental Health Act.** There were two issues relating to the Mental Health Act that were identified by the Independent Investigation. First, Mr. X was still eligible for Section 117 aftercare when he was accepted onto the South Manchester Assertive Outreach Team caseload. His aftercare arrangements were never assessed or discussed. Second, in July it was evident that Mr. X was no longer on medication, was not engaging with services, claimed to have developed a serious drug habit, had claimed to have made a serious attempt on his life, was expressing paranoid ideas and had armed himself with a knife. At this point it would have been reasonable to expect a Mental Health Act assessment to have been considered. This was not forthcoming.

6. **Liaison with the Family of Mr. X.** No communication was made with the family of Mr. X. This was due to the pre-existing history of familial relationship breakdown.

7. **Documentation and use of Clinical Records.** The South Manchester Assertive Outreach Team used the AMIGOS electronic Mental Health Trust clinical record as its main recording method. Day-to-day contacts were logged on a regular basis utilising this system. However no CPA, Care Planning or Risk Assessment processes were either developed or recorded during the four-month period that Mr. X was with the team. The clinical record was found to be entirely blank apart from basic contact activity data.

8. **Supervision and Staff Competency.** Supervision arrangements were *ad hoc* with no formal arrangements in place for either clinical, management or caseload supervision. Clinical leadership within the team was at times both informal and uncertain. Important clinical decisions were often made by whoever happened to be in the office at the time because the people identified as being potential clinical leaders were often

unavailable or ambivalent about their role. The difficulties caused by the lack of supervision and professional leadership were exacerbated by the fact that internal governance systems were not sophisticated enough to detect issues relating to staff competency and the relatively new contract that had demanded a swift increase in accepting more complex and challenging patients onto the caseload.

9. **Adherence to Local and National Policy and Procedure.** The South Manchester Assertive Outreach Team appeared to have worked outside of both local and national best policy procedure. This was particularly evident when considering:
    - Section 117 aftercare;
    - CPA;
    - Risk Assessment;
    - documentation and record keeping.

10. **Clinical Governance and Performance.** Whilst there was a Joint Partnership Board that monitored the contract effective working relied on each partnership organisation retaining a fit for purpose internal governance system. Governance arrangements within HARP were not able to either identify or address the kind of clinical service issues as set out above. The governance framework was not sophisticated enough to enable clinical staff to raise concerns and have them acted upon. The South Manchester Assertive Outreach Service was under pressure to increase its activity and to take more complex and challenging service users onto its caseload. This added a greater pressure to a system that was already struggling to work within integrated city-wide services.

12.3.3. NHS Manchester

1. **NHS Manchester Commissioning and Performance Management Arrangements.** Commissioning and performance management arrangements for the South Manchester Assertive Outreach Service were weak. Service specifications were non specific with regard to quality and very little monitoring occurred. This ensured that weaknesses in the service were neither detected nor acted upon and corrected.

13. Further Exploration and Identification of Contributory Factors and Service Issues

Whilst examining the care and treatment that Mr. X received it became apparent that this particular case was both atypical and unusual. It was difficult to understand the relationship between Mr. X's mental disorder and any abnormality of mind he may have been experiencing at the time he killed Mr. W. An 'abnormality of mind' is not a formal psychiatric term. It is used however to denote a state of mind that serves to substantially impair or diminish a person's responsibility for their actions.

Mr. X presented in a complex and confusing manner and it was nearly one year following the death of Mr. W that a final assessment was completed and a diagnosis was reached. It was not clear, and still is not clear, to what extent the mental disorder Mr. X suffered from contributed to his decision to kill Mr. W. For this reason root cause analysis cannot be applied to the Investigation process in the manner normally expected. It would not be appropriate to assign contributory factors to either the acts or omissions of mental health services when it can never be certain how they could be linked to the third party behaviours of Mr. X.

This Investigation had to consider several basic dilemmas.

- A significant amount of what is now known to be certain about Mr. X was only made apparent one year after the incident occurred.
- Medical opinion regarding the nature of the 'abnormality of mind' Mr. X suffered from following the death of Mr. W was widely divergent and has left a legacy of uncertainty regarding the degree of diminished responsibility Mr. X experienced.
- It is an acknowledged fact that Personality Disorders are difficult to treat and successful clinical outcomes cannot be guaranteed as these are predominantly psychological approaches that require complete psychological engagement on behalf of the recipient. During the time Mr. X received his care and treatment from Manchester Mental Health Services national guidelines were still emergent and commissioning of specialist services embryonic.

In its simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'five whys' could look like this:

- Serious incident reported = serious injury to limb
- Immediate cause = wrong limb operated upon (ask why?)
- Wrong limb marked (ask why?)
- Notes had an error in them (ask why?)
- Clinical notes were temporary and incomplete (ask why?)
- Original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. X it would look like this:

- Mr. X killed Mr. W (ask why?)
- No consensus could be reached by a variety of independent clinical experts to determine Mr. X's state of mind at the time of the incident in order to understand why he killed Mr. W. No specific understanding of Mr. X's mental state could be reached, therefore no root cause could be attributed to the care and treatment he received and the death of Mr. W.

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. W. In order for causality to be attributed to a service it has to be shown that the service had complete control over the outcome of the events in question. There were three scenarios that the Independent Investigation Team considered as they worked through the root cause analysis process.

1. Mr. X suffered from a mental illness or disorder that went partially treated and managed and that this lack of treatment exacerbated his mental ill health and caused him to kill Mr. W. This scenario would indicate that a root cause could potentially be assigned to an act or omission on the part of mental health services.
2. Mr. X suffered from some kind of mental illness or disorder that went partially treated and managed but was of a nature that would not have responded to care and treatment, no matter how robust, beyond a very basic point. This scenario would not be able to assign a root cause to any specific act or omission that could have altered the course of events.

3. Mr. X was not suffering from a mental illness or disorder of the kind that would affect his capacity and he killed Mr. X for reasons independent of his mental illness or disorder. This scenario would provide a root cause that focused upon Mr. X and would not rest with mental health providers.

Based on the findings of the reports eventually prepared for the Crown Court scenarios two and three appear to be the most likely. It also has to be borne in mind that Mr. X also abused drugs and alcohol and did not always wish to engage with services, factors which in themselves can derail the best prepared care and treatment plan. When there is a significant degree of doubt it is not the role of an Independent Investigation Team to assign a root cause to an organisation when none can be identified with accuracy and confidence. The Independent Investigation Team concluded that the root cause ultimately rested with the independent third party actions of Mr. X.

The purpose of using root cause analysis is to seek out lessons that can be learned from the examination of a single case to try to establish how incidents of this kind can be prevented from occurring in the future. No Investigation Team should endeavour beyond a sensible limit to make connections where they cannot reasonably be made.

This Investigation has developed a detailed narrative which chronicles the events that occurred during Mr. X's time with Manchester-based services. It has assessed whether services worked in accordance with extant national and local best practice guidance and detailed where interventions could have been improved. However the findings in relation to both the clinical outcomes for Mr. X and the death of Mr. W have to be read with caution as it cannot be known for certain to what extent one set of circumstances (Mr X's clinical management) influenced the other (the death of Mr. W).

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms ‘key causal factor’, ‘influencing factor’ and ‘service issue’ are used in this section of the report. They are explained below.

Contributory factors can either be identified as either being ‘influencing’ or ‘causal’.

Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them. The term ‘causal factor’ is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage Mr. X effectively and that this as a consequence impacted directly upon the death of Mr. W.

Influencing Factors. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. X’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr. W need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

13.1. Manchester Mental Health and Social Care NHS Trust Findings

The findings set out under this sub-section analyse the care and treatment given to Mr. X by the Manchester Mental Health and Social Care Trust between January 2001 and the 3 April 2008.

Sections 13.1.1. and 13.1.2. address diagnostic, medication and treatment issues. These are key headings from the Terms of Reference and are addressed first in order to provide a context for the rest of the findings.

13.1.1. Diagnosis

13.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, mental state examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (tenth revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Throughout most of the time Mr. X received care and treatment from Manchester Mental Health Services he had a diagnosis of Personality Disorder. The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1992), defines a Personality Disorder as: *"a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption"*. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) is another internationally used classification system, often used in research. It defines a Personality Disorder as: *"an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment"*.[173]

Personality Disorders are broadly categorised into three groups. In the interests of clarity and to assist lay readers the Independent Investigation Team has used the Royal College of Psychiatry Advice Leaflet to explain what these three groups or clusters consist of.

- ***"Cluster A 'Suspicious' (set out in full as Mr. X was diagnosed principally within this cluster)***

  Paranoid

  - *suspicious*
  - *feel that other people are being nasty (even when this is not true);*
  - *sensitive to rejection*
  - *tend to hold grudges*

  Schizoid

173 *Personality Disorder no Longer a Diagnosis of Exclusion* DH P. 9

- *emotionally 'cold'*
- *does not like contact with other people*
- *have a rich fantasy world*

Schizotypal

- *eccentric behaviour*
- *odd ideas*
- *difficulties with thinking*
- *lack of emotion, or inappropriate emotional reactions*
- *can see or hear strange things*
- *related to schizophrenia*

- ***Cluster B 'Emotional and Impulsive'(set out in full for the areas in which Mr. X received a diagnosis)***

  Antisocial or Dissocial

  - *does not care about the feelings of others*
  - *easily frustrated*
  - *tends to be aggressive*
  - *commits crimes*
  - *finds it difficult to make intimate relationships*
  - *impulsive*
  - *does not feel guilty*
  - *does not learn from experience*

  Borderline

  - *impulsive*
  - *finds it hard to control emotions*
  - *feels bad about self*
  - *often self-harms*
  - *can feel paranoid and depressed*
  - *when stressed may hear noises or voices*

  This cluster also includes Histrionic and Narcissistic Personality Disorders

- ***Cluster C 'Anxious' (set out as headings only as Mr. X did not receive a diagnosis within this cluster)***

  Obsessive Compulsive

  Avoidant

Dependent"[174]

The diagnosis of Paranoid Schizophrenia was also given to Mr. X during the last five months of his care and treatment with the Mental Health Trust. The ICD 10 classification for Paranoid schizophrenia is set out *verbatim* below.

"This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent.

Examples of the most common paranoid symptoms are:

- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*
- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture."

13.1.1.2. Findings

Background Information

This Section forms essential background information to the rest of the report. It is essential to understand the degree of uncertainty and controversy that surrounded the diagnoses given to Mr. X over an eight-year period. This period commenced in January 2001 when he first

174 Personality Disorder Guidance Leaflet, Royal College of Psychiatry PP. 3-4

entered Manchester Mental Health Services and continued until his sentencing and disposal to Frankland Prison on the 9 June 2009, one year after the death of Mr. W.

Between January 2001 and 3 April 2008 Mr. X received a diverse variety of diagnoses. These included the following:

- **31 January 2001 Primary Care Mental Health Team.** Dissocial Personality Traits.
- **14 May 2001 Consultant Psychiatrist A.** Schizoid/Schizotypal Personality Traits accompanied by amphetamine abuse.
- **25 October 2001 Clinical Psychologist.** Amphetamine and alcohol abuse.
- **30 September 2002 GP.** Depression.
- **6-7 February 2004 Accident and Emergency.** Schizotypal Personality Disorder.
- **26 September 2005 Accident and Emergency.** Borderline Personality Disorder
- **22 June 2006 Grafton Ward.** Depression with a psychotic element and Schizoid Personality Disorder with a Dysthymic element.
- **21 October Accident and Emergency.** Psychotic Episode.
- **26 June 2007 United States of America.** Bipolar Disorder with severe psychotic features.
- **29 July 2007 United States of America.** Bipolar Affective Disorder with psychotic features accompanied by poly-substance misuse.
- **5 September 2007 North Manchester Inpatient Ward.** Personality Disorder.
- **3 October 2007 North Manchester Inpatient Ward.** Suspected: either Paranoid Schizophrenia or Schizoaffective Disorder.
- **Autumn 2007 North Manchester Inpatient Ward Staff.** Suspected: a fabricated mental illness for financial and psychological gain.
- **5 December 2007 Consultant Psychiatrist 1.** Paranoid Schizophrenia.
- **16 March 2008 transfer form.** Paranoid Schizophrenia/Personality Disorder.

Initially, in 2001, Mr. X was thought to have a Personality Disorder of the Schizoid or Schizotypal kind. This ‘formal’ diagnosis, with additional speculation about Dissocial and Borderline traits also being present, remained consistent until the autumn of 2007. It would appear that the notion of Mr. X fabricating his symptoms was also considered by some clinicians between the summer of 2006 and the winter of 2007.

In the autumn of 2007 the diagnosis of Paranoid Schizophrenia was given. At this stage three distinct clinical views were held regarding Mr. X and his diagnosis. They were:

- that Mr. X suffered from Paranoid Schizophrenia;
- that Mr. X had a Personality Disorder;
- that Mr. X was fabricating his symptoms for financial and psychological gain.

By October 2007 Paranoid Schizophrenia became the 'working diagnosis'. When witnesses were interviewed by the Independent Investigation Team it was apparent that there were differences of opinion about Mr. X's diagnosis during the autumn of 2007 when he was an inpatient with both the north and south service. Some nursing and medical staff thought he was fabricating his symptoms, and other nursing and medical staff thought he was suffering some kind of psychosis. However staff treated Mr. X's presenting symptoms in line with the agreed working diagnosis at that time.

Perceptions of Personality Disorder and Attitudes Taken Towards Mr. X

The diagnosis of Personality Disorder and the uncertainty and controversy that followed was found by the Independent Investigation Team to have had a negative impact on the care and treatment that Mr. X received over the years. It was evident from close examination of the clinical record that staff tended to write about Mr. X in a fairly critical manner. It would appear that no matter how he presented, the pre-existing diagnosis of Personality Disorder, served to minimise his level of risk in the eyes of those he met and also served to act as a barrier to his receiving an appropriate level of Care Coordination. This was exacerbated by CMHT referral criteria preventing people with Personality Disorder in Manchester from being accepted onto the caseload before October 2006.

Over recent years the clinical management of Personality Disorder has undergone a significant change. In January 2003 The National Institute for Mental Health (NIMHE) in England published *Personality Disorder: No Longer a Diagnosis of Exclusion.* This document served to remind mental health services that the 1999 National Service Framework had stated in Standards Four and Five that services needed to be developed for those with Personality Disorders. It also served to advise services how this should be achieved. The NIMHE document stated that *"as things stand today…in many services people with Personality Disorder are treated at the margins - through Accident and Emergency,*

inappropriate admissions to inpatient wards, on caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them."[175] On examination this would appear to have been the experience of Mr. X. Once the notion of Mr. X having a diagnosis of Paranoid Schizophrenia was entertained in December 2007 a step change occurred in the way his case was managed.

Court Assessments and Proceedings

Following the death of Mr. W the debate regarding Mr. X's diagnosis continued. On the 12 November 2008 Mr. X pleaded 'Not Guilty' to the murder of Mr. W even though he accepted responsibility for the killing. By the middle of December the Crown Court had been served with psychiatric reports prepared on behalf of the Defence and had also received reports from their own experts. Based on these psychiatric reports the Crown concluded that the medical evidence indicated that Mr. X was suffering from an abnormality of mind which substantially diminished his responsibility for the killing of Mr. W. The Crown therefore accepted Mr. X's plea to manslaughter on the 15 December 2008. The medical opinion offered at this stage on behalf of both the Defence and the Crown was that Mr. X had Paranoid Schizophrenia. It was decided at this stage to transfer Mr. X to Ashworth High Security Hospital so that a detailed report could be prepared on his psychiatric health prior to disposal and sentencing. On the 9 June 2009 this report was received by the Crown.[176]

The Consultant Psychiatrist who prepared the Ashworth pre-sentencing report reviewed the three previous psychiatric reports that had been submitted to the Crown. It was noted that none of the previous report authors had met Mr. X for more than one interview and that none of them had access to his complete previous clinical records. The Ashworth Psychiatrist focused his report on the two areas that the previous report authors had not had access to, namely the full psychiatric history of Mr. X, and an unrestricted six-month period of access to him in order to undertake a clinical assessment. During this assessment Mr. X also received an intense assessment by a clinical psychologist.

The Ashworth assessment concluded that:

- There had only ever been one objective piece of evidence to support the notion that Mr. X had symptoms that would indicate the presence of a psychotic illness. This was

175 *Personality Disorder: No Longer a Diagnosis of Exclusion.* NIMHE (2003) P. 5
176 Manchester Crown Court Proceedings. 9 June 2009

based on an observation made on 17 October 2007 during his third inpatient stay when it was recorded that Mr. X was responding to unseen stimulus. All other symptoms were self-reported and could not be verified by observation. Mr. X displayed no signs of psychosis during his six-month assessment period at Ashworth.

- *"the psychiatric services involved in Mr. X's care for the seven years prior to the index offence were extremely unclear and divided in their diagnostic categorisation of Mr. X. He is extremely complicated diagnostically and behaviourally difficult to manage, both as an inpatient and in the community."*[177]

- Mr. X was noted to have researched mental illness extensively and to be very familiar with the *British National Formulary* (a drug compendium). During his time at Ashworth he was described as friendly, chatty and settled. His self-reported symptoms matched the criteria for psychotic illness, his actual behaviour as observed by the clinical team did not.

- Following intensive assessment Mr. X was found to meet the criteria of:
    - Paranoid Personality Disorder;
    - Schizoid Personality Disorder;
    - Borderline Personality Disorder;
    - Narcissistic Personality Disorder;
    - Avoidant Personality Disorder (possible).

- The Ashworth clinical team were of the opinion that the mental health difficulties Mr. X had experienced, and continued to experience were better explained by a diagnosis of Personality Disorder rather than that of Paranoid Schizophrenia. The author of the Ashworth report made it clear, that whilst a fresh medical opinion would come too late to contribute to the debate as to whether or not Mr. X was suffering from an abnormality of mind at the time of the offence, it was the view of the Ashworth clinical team that the situation may not have been *"as clear as it may have appeared*

177 Ashworth Court Report. 8 June 2009 P. 27

> *to the three psychiatric report authors without the benefit of a six month inpatient admission and access to all of his psychiatric notes".* [178]

The Ashworth report author was uncertain whether or not Mr. X's Personality Disorders were treatable.[179] It was decided after careful reflection that no bed would be made available to Mr. X at Ashworth Hospital. The clinical view held was that Mr. X would continue to present a very significant risk of violence to members of the public. When assessed Mr. X scored 17 out of 24 on the HARE Psychopathy Checklist which indicated a close link to his personality traits and the associated risk of future harm to other people.

A second psychiatric report was prepared to assist the Court *"in matters regarding diagnosis and potential disposal".*[180] This report noted that Mr. X's *"desperate longing for institutional care can be a well recognised feature of Borderline Personality Disorder".* [181] This report also stated the notion that Mr. X's self-reported substance misuse may well have been greatly exaggerated in order to persuade services that he required inpatient care. The report made it quite clear that the author concluded Mr. X did *not* kill Mr. W as the result of any paranoid ideation or deluded belief system. Mr. X was calm, self possessed, and also within minutes of the offence decided that he may have been 'mistaken' in thinking that Mr. W had represented a threat to him. A person with a delusional set of beliefs usually possesses them in an unshakable way that is resistant to reasoning and evidence to the contrary. Delusional beliefs are usually held for long periods of time, sometimes for life. Mr. X was able to relinquish his within minutes of his arrest, this was cited as being so unusual as to be implausible.[182]

This view is reinforced by the fact that Mr. X had not received medication for psychotic symptoms for a period of three months prior to the incident, and neither did he receive it after the incident. However all psychotic symptoms appear to have vanished, if they had been present at all, within minutes of the incident occurring. This abrupt resolution of an acute and severe psychotic episode without medication is unlikely. It must be noted that the statements Mr. X gave were not always consistent, however Mr. X said in a statement he made to the police a few days following his arrest that he had not been able to afford any crack cocaine in

178 Ashworth Court Report. 8 June 2009 P. 37
179 Ashworth Court Report. 8 June 2009 P. 38
180 Medico-legal report 22 June 2009
181 Medico-legal report 22 June 2009 P. 48
182 Medico-legal report 22 June 2009 PP. 49-51

the ten days before the incident, so any link between his immediate substance misuse and the incident can also be called into question. Despite Mr. X stating that he was a regular heroin user there was no evidence to suggest he experienced any withdrawal symptoms following his arrest.[183]

On the transfer of Mr. X from Ashworth to the prison service on the 20 June 2009 the CPA meeting report stated that *"after six months assessment Mr. X should be returned back to prison because he does not appear to exhibit signs of mental illness despite three court reports by independent psychiatrists".*[184] It was decided that Mr. X did not require treatment in hospital for a mental health disorder.[185]

Management of the Diagnostic Issues within the Trust

During 2006 and 2007 the Independent Investigation Team found evidence within Mr. X's clinical record to suggest that significant difficulties existed in reaching a consensus regarding a diagnosis. These difficulties and differences of opinion were supported by the evidence some witnesses gave to the Investigation at interview. Whilst it is not unusual for a clinical team, or teams, to have differing views and theories regarding a patient it is both unusual and unprofessional for these disagreements to continue to the extent where a long-term care and treatment programme can be affected negatively.

In the case of Mr. X, even after a formal diagnosis of Paranoid Schizophrenia was given in December 2007, the clinical notes still continued to record evidence that this was not the diagnosis accepted by the entire team. Nowhere in the clinical record was there evidence to suggest that Mr. X was ever formally assessed against Personality Disorder criteria. This would have given clinical teams a better idea of what kind mental health difficulties Mr. X had. In the case of repeated diagnostic ambiguity and controversy it would be usual for a case conference to be held. This does not appear to have happened in the management of Mr. X and represents a missed opportunity to reach both a diagnostic and treatment consensus.

13.1.1.3. Conclusion

The teams caring for Mr. X over time found reaching a consensus regarding his diagnosis difficult. The resulting disagreements became overt on occasion and provided a real barrier to

183 Ashworth Records. Vol. 1 P.340
184 Ashworth Records Vol. 2 P. 208
185 Ashworth Records Vol, 3 P.5

managing Mr. X in a coherent manner. It is probable that Mr. X had several types of Personality Disorder with *possible* accompanying psychotic features at times that were exacerbated by his reported drug and alcohol misuse.

Mr. X was seen over a seven-year period but not regularly by any single medical clinician. Mr. X proved to be a challenging individual to work with. He was seen sporadically by different people and was not worked with in a consistent way. When Mr. X's mental state did not appear to be improving, rather than revisiting the clinical management strategy, medical clinicians altered the diagnosis and medication regimen. No clear criteria and observation processes appear to have been deployed when offering diagnoses, and no formulation was reached regarding the problems that were driving Mr. X's behaviour.

Whilst trying to avoid the use of hindsight it has to be noted that the initial diagnosis of Schizotypal Personality Disorder and Dissocial Personality Traits made in 2001, was probably correct when seen in the context of the in-depth six-month forensic psychiatric assessment that Mr. X received in Ashworth Hospital following the death of Mr. W. It is unfortunate that steps were not taken earlier with Mr. X to assess him thoroughly against the ICD10 criteria and to have taken the opportunities that his many inpatient stays afforded to consider his diagnosis more carefully. Had this occurred then a more robust management plan could have been formulated, against contemporaneous national guidance that would have informed the long-term approach required for this very challenging and complex individual.

It is the conclusion of the Independent Investigation Team that the failure to reach a consistent diagnosis, based on all the evidence available, ensured that Mr. X's condition was only ever partially managed. This diagnostic confusion worked in conjunction with Mr. X's chaotic and manipulative behaviour to confound all attempts to help him. There is a direct causal link between the conflicting diagnoses that Mr. X received over time and the ineffective management plan that he was subject to. After a seven-year period Mr. X was still an unknown quantity whose risk profile had never been assessed appropriately in the context of his mental state. Assumptions were made about Mr. X that were not based on fact. By not getting a 'firm hold' on Mr. X's diagnosis an ineffective care and treatment plan was implemented. This sole factor influenced negatively all aspects of the care and treatment that Mr. X was to receive from the Manchester-based services over time. Mr. X represented a

prime example of an individual who required a referral to a specialist Personality Disorder Service. At this point in time in Manchester the 'Fifteen' group was the only speciality service for Personality Disorder available, no other models for treatment had been accepted for funding.

However despite this fundamental flaw in the care and treatment that Mr. X received it is unlikely that any Trust-driven activity, no matter how well constructed, would necessarily have prevented the death of Mr. W. Expert forensic opinion from Ashworth Hospital, provided to the Crown Court for sentencing purposes, offered the view that Mr. X's particular condition was such that it possibly would not respond well to treatment. As a consequence Mr. X's place of disposal was ultimately Frankland Prison and not a high security special hospital. Mr. X has been assessed as being a dangerous individual who had a high degree of self determination and no objective third party evidence could be found to suggest that he had a long-term enduring mental illness or condition of a kind that could be assured of a successful response to treatment.

The learning in a case like this is significant. Personality disordered individuals cannot always be considered to have diminished responsibility for their actions. Often personality disordered people retain full responsibility for themselves and the decisions that they make. The clinical record needs to document the level of capacity such individuals retain and set out clearly the limitations that care and treatment can offer in each individual case.

Personality disordered people do not always accept the care and treatment that they are offered. However regardless of this people should be assessed and treated in accordance with best practice guidance. If this is done then it can be demonstrated that clinical teams have provided everything within their gift. Basically when complex individuals present themselves to a service, incite controversy and appear to be resistant to treatment, a structured series of assessments against evidence-based diagnostic criteria is essential in determining a sure-footed and coherent care and treatment response. Had this been done and the decisions regarding Mr. X's care and treatment been based on the best information available, then it could have been said that the best possible decisions were made at any one time. However decisions about Mr. X were not based on best evidence and both his case management and care and treatment were ineffective as a result. Whilst it cannot be said that any act or omission in this area by the Trust caused the death of Mr. W, it can be said that the Trust

failed to provide a clear diagnosis that was able to inform a consistent approach to both the management and treatment of Mr. X.

- ***Contributory Factor Number One (influencing). Failure to provide a consistent care and treatment plan based on sound diagnostic principles ensured that Mr. X was only ever partially managed and treated. He remained an unknown quantity who was never assessed appropriately through the lens of his psychiatric condition.***

13.1.2. Medication and Treatment

13.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice

to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a treatment order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and therefore a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia (restlessness) and dystonia (involuntary muscle movements) Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

13.1.2.2. Findings

Mr. X was under the care of Manchester mental health services from January 2001 until July 2008 when the death of Mr. W occurred. For the first six years he received a number of diagnoses including: Schizoid Personality Disorder, Schizotypal Disorder, Dysthymia, unspecified Personality Disorder, Bipolar Disorder, depressive illness and drug and alcohol

abuse. In the ten-month period prior to the offence there remained some diagnostic uncertainty and disagreement between different clinicians, however in October 2007 a diagnosis of Paranoid Schizophrenia was given by Consultant Psychiatrist 1.

It was apparent from examination of the clinical record that an agreed and consistent diagnosis was difficult to reach for Mr. X. However based on what was known at the time, and based on working diagnoses as they emerged, the Independent Investigation Team considered the treatment approaches made available to Mr. X between January 2001 and 28 July 2008.

Treatment Provided Between January 2001 and 3 April 2008

Between January 2001 and July 2007 the primary diagnosis provided for Mr. X was that of Personality Disorder, either of a Schizotypal or Emotionally Unstable type with an accompanying drug and alcohol abuse. In 2003 the Department of Health stated *"many clinicians are sceptical about the effectiveness of treatment interventionism for personality disorder, and hence often reluctant to accept people with a primary diagnosis of personality disorder for treatment. However, a range of treatment interventions are available for personality disorder, including psychological treatments and drug therapy, and there is a growing body of literature available on the efficacy of varying treatment approaches."*[186] Department of Health Guidance recommended that therapy and treatment processes for people with Personality Disorder should:

- be well structured;
- devote effort to achieving adherence;
- have a clear focus;
- be theoretically coherent to both therapist and patient;
- be relatively long term;
- be well integrated with other services available to the patient;
- involve a clear treatment alliance between therapist and patient.[187]

The 2003 Department of Health Guidance also included the suggestion that Community Mental Health Services should consider developing access to Specialist Personality Disorder

186 *Personality Disorder: No Longer a Diagnosis of Exclusion* DH P. 23
187 *Personality Disorder no Longer a Diagnosis of Exclusion* DH P. 23

Teams. Whilst this may not have been a realistic commissioning priority for most Trusts in 2003, the principles were that:

- services should be made available to people whose condition was causing them significant distress;
- personality disordered patients would need multidisciplinary input and a team approach.

The Department of Health Guidance placed an emphasis on the development of a therapeutic relationship within sound long-term management plans which should take into account the need for crisis and contingency plans agreed by both service users and carers alike.

In addition to the Department of Health Guidance the Royal College of Psychiatry has also offered guidance regarding the treatment of Personality Disorder. The Royal College Guidance lists the following factors as making the difficulties people have with Personality Disorders worsen. These are:

- misusing drugs and alcohol;
- having problems getting on with a partner or family;
- money problems;
- anxiety, depression and other mental health problems.

The Guidance advocates the following treatment:

- psychological and talking therapies, such as counselling, dynamic psychotherapy, cognitive behaviour therapy and treatment in a therapeutic community;
- antipsychotic drugs (usually at a low dose), these can reduce the suspiciousness often present in Borderline, Schizoid and Schizotypal Disorders;
- antidepressants: can help with mood and emotional difficulties;
- mood stabilisers: can reduce impulsiveness and aggression.

The Royal College points out in the Guidance that the evidence for the effectiveness of both medication and psychological therapies remains weak because:

- *"the interventions are usually quite complicated, so it is difficult to know which part (or parts) of the intervention are actually having an effect;*
- *the ways of measuring improvement is poor;*

- *the studies into interventions and treatments have mostly been quite short."*[188]

The principles of good quality of care for people with Personality Disorder are currently laid out in NICE Guidance (2009), and whilst this guidance was not available to the teams providing treatment to Mr. X between 2001 and 2008, it has not substantially changed from that previously issued by the Department of Health and the Royal College of Psychiatry, etc. It includes as specific points of good practice:

- access to services;
- comprehensive assessment;
- involving families or carers;
- developing an optimistic and trusting relationship;
- psychological treatments;
- treatment of co-morbidities;
- management of crises;
- limited use of medication for co-morbid conditions;
- risk assessment.

Mr. X had a complex presentation. However the principles of treatment outlined above were of an appropriate, and largely contemporaneous, nature to have been applied to the care and treatment of Mr. X. The care and treatment Mr. X received is considered against them below.

Approach when Treating Mr. X for a Personality Disorder

Access to Services

Prior to October 2006 the Community Mental Health Team Operational Policy did not allow for people with Personality Disorders to be accepted onto the caseload. This single factor prevented Mr. X's case from being effectively managed over time. Mr. X was able to access other services but his contact was frequent, short-lived and often chaotic. There was little consistency in who saw him where and when. This may have been in part because he was not sure what treatment he was prepared to engage with. However the service response to this was also somewhat inconsistent. Consequently Mr. X drifted in and out of services in a way that prevented a full assessment being carried out or a trusting relationship with a mental health practitioner being developed. Although Consultant Psychiatrist 1's Outpatient Clinic had regular contact with Mr. X between 2001 and 2007 it would appear that no single

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medical clinician was able to provide consistent contact (for a number of service related reasons) prior to him being admitted onto Bronte Ward in the autumn of 2007.

On examination of the care and treatment timeline it is evident that Mr. X was referred to, and between, services a minimum of 28 times over a seven-year period. This is discussed in detail in Section 13.1.7. below. Whilst he was able to access services Mr. X was not in receipt of any meaningful CPA until the summer of 2007. This had the effect of creating a 'revolving door' sequence of events. Each referral often took Mr. X back to 'square one'. Had Mr. X been accepted onto a community mental health team caseload prior to the summer of 2007 it is possible that he would have been offered a higher level of consistency and a more structured level of access to services as and when he required them.

Following the summer of 2007 Mr. X was placed on enhanced level CPA. This ensured that from this date Mr. X was able to access the services he required in a planned and proactive manner due to the input of a care coordinator who worked as part of multidisciplinary team.

Comprehensive Assessment

Despite being seen frequently Mr. X received neither a comprehensive nor holistic assessment that was informed by a good grasp of all the information available. This was compounded by poor communication within the service across different teams. One of the main difficulties with assessment was that Mr. X did not receive a multidisciplinary approach until the summer of 2007 when he was admitted to inpatient units for a period of six months and had been allocated to a care coordinator. Over time Mr. X was seen by individual practitioners who offered assessments from a uni-professional point of view. Mr. X presented with a wide range of psychiatric, psychological and social needs. In the absence of robust care coordination and a multidisciplinary team approach Mr. X was never treated in the full context of his needs.

Involving Families or Carers

This was limited. This meant that Mr. X was not understood in the context of his family relationships which were fraught. It also meant that the family did not receive the support that they needed and this contributed to their eventual disengagement from Mr. X. In addition important and relevant information that they had was not made available to the teams

providing care and treatment to Mr. X. The nature of this information would have informed both the assessment and treatment process.

Developing an Optimistic and Trusting Relationship

The only time this became possible was during Mr. X's time with the 'Fifteen' group. This group was a therapeutic community and was commissioned in 2005 as a partial response to the need for a specialist Personality Disorder service. Unfortunately this treatment episode was not long lasting as Mr. X found it difficult to engage within a group dynamic. Mr. X was not on enhanced level CPA at this time and had no consistent care coordination. This meant there was no other opportunity for him to develop a consistent and trusting relationship. This was clearly an area of difficulty for him and to some extent he may have both wanted and feared such a relationship. It therefore required a skilled practitioner prepared to persevere and work consistently with an individual like Mr. X.

Psychological Treatments

Between 2005 and 2007 Mr. X was offered and received an appropriate psychological treatment in line with National Guidance with the 'Fifteen' group. It took a long time for this to be organised and become available. However once the therapy had begun it became apparent that the 'Fifteen' group approach was something that served to increase Mr. X's anxiety and feelings of social isolation. Ultimately he left the group programme on two occasions. Mr. X was also referred for Cognitive Behaviour Therapy many times over the years. Mr. X was recorded as saying that he would have preferred this one-to-one approach.[189] However he was told a one-to-one approach would be *"problematic"* and he did not receive this kind of intervention until the Spring of 2008 when he was Bronte Ward.

Treatment of Co-morbidities

Mr. X did receive treatment for depression and was offered treatment approaches for alcohol and substance misuse, however he was not motivated to change his behaviour. The fact that he did not have a consistent relationship with a mental health practitioner meant his motivation with respect to his treatment programme could not be strengthened.

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Management of Crisis Situations

Between 2001 and 2007 Mr. X had a number of crises involving self-harming behaviour. He received help from a number of different sources but these crises did not lead to an appropriate level of re- assessment and a review of the care plan until the summer of 2007. In the absence of a coherent CPA Mr. X did not have a crisis management plan developed with him. When in crisis Mr. X self-presented at Accident and Emergency departments and this meant that he was not necessarily seen by a person who knew him in the context of his psychiatric history. Prior to the summer of 2007 the only recorded crisis plan in the clinical notes was developed by the Consultant Adult Psychotherapist on the 13 November 2006. This plan simply stated that when in crisis Mr. X should go to Accident and Emergency, his GP or the Samaritans. It did not proactively support Mr. X and offered suggestions for interventions only once a crisis had been reached.[190] At no stage was a proactive therapeutic plan developed that aimed to prevent Mr. X from reaching a point of crisis in the first place.

From the summer of 2007, once Mr. X was placed on enhanced level CPA, crisis management plans were developed. At the point of his discharge from Bronte Ward on the 3 April 2008 an appropriate and proactive plan had been put into place.

Medication

Mr. X received antidepressants for low mood and antipsychotics to manage some of his anxiety symptoms and paranoid ideas. The doses were appropriate and prescribed in accordance with national guidelines for the treatment of Personality Disorder. Importantly medication was appropriately not seen as the main treatment. However there were two significant issues regarding medication.

First, Mr. X was routinely non compliant with his medication. In the absence of robust care coordination the ongoing monitoring of his medication regimen could not take place. In the absence of an enduring therapeutic relationship education, encouragement and support regarding medication issues could also not take place.

Second, no regular monitoring occurred to assess whether the medication was having any positive effect on Mr. X's mental state.

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Risk Assessment

Risk assessments were carried out but often these were conducted with insufficient information because data relevant to the formulation of a risk profile was not always shared between teams in a timely manner. In addition risk assessments were not based on a full understanding of Mr. X's personality and the psychological drivers of his behaviour because no one had established a sufficiently consistent relationship with him to achieve this. This subject is examined in detail in Section 13.1.6. below.

Approach when Treating Mr. X for Paranoid Schizophrenia (between December 2007 and 3 April 2008)

The change in diagnosis appears to have been made for three reasons:

- an escalation in Mr. X's self harming and rather chaotic help-seeking behaviour e.g. two visits to the USA;
- a decline in his social functioning i.e. loss of employment, his accommodation being very untidy;
- self reported psychotic symptomatology.

The principles of treatment for Schizophrenia are similar to those for Personality Disorder.

Access to Services

Mr. X had access to appropriate service provision throughout this period. During this time Mr. X was proactively managed and care coordinated. This ensured that he was appropriately signposted to both the interventions and the services that he needed in a timely and effective manner.

Assessment

In the summer of 2007 Mr. X was admitted to inpatient services and once detained under the Mental Health Act there was plenty of opportunity to undertake a full assessment of his mental state. Despite the continuing debate regarding his psychiatric condition a change in diagnosis was made, his treatment reviewed, and the effect of medication was monitored.

Care Coordinator 2 was able to work with Mr. X prior to his discharge on the 31 January 2008 and a comprehensive and holistic assessment was undertaken which led to a relevant and well-communicated care plan. There is ample evidence in the clinical record to illustrate

that the assessment process was multidisciplinary and entirely appropriate for Mr. X at that time.

Involving Families or Carers

By this stage the family no longer wanted any active engagement with Mr. X.

Effective Evidence-Based Treatments

Mr. X was given antipsychotic medication in adequate doses and this was monitored against improvements in his mental state. The only possible issue would be the choice of Clozapine that was prescribed in the autumn of 2007. This drug required careful monitoring and Mr. X had a long history of chaotic engagement with services making it unlikely that effective monitoring would be achieved. It was also apparent on his discharge from inpatient services on the 31 January that Mr. X had no intention of complying with his medication.

Mr. X was offered psychological treatment during his inpatient stay between the 18 February and 3 April 2008. This treatment appeared to be going well and was something that Mr. X was recorded as having found useful.[191]

Treatment of Co-morbidities

Between December 2007 and the 3 April 2008 there were two occasions when staff were aware that Mr. X was still abusing substances whilst on the ward. It was also apparent on his admission on the 18 February 2008 that Mr. X was low in mood and suffering from anxiety. These issues were treated appropriately with both medication and psychological therapy inputs.

Continuity of Care

The continuity of care that Mr. X received in the last few months of his treatment with the Mental Health Trust was variable. Whilst he was being cared for in a consistent manner by the Trust services were subject to change. *New Ways of Working* arrangements led to a change being made to his Consultant Psychiatrist provision (from Consultant Psychiatrist 1 to Consultant Psychiatrist 2). Care Coordinator 2 went on a prolonged period of leave and then retired, and Mr. X was transferred on his discharge from Bronte Ward from the Community Mental Health Team to the Assertive Outreach Team. This necessitated him being transferred to the care of yet another Consultant Psychiatrist, the third over a period of four months. As

191 AMIGOS Record P. 520

has been stated above, Mr. X had difficulties in forming relationships, this lack of continuity would have presented difficulties for him. The lack of continuity came at a bad time for Mr. X as he was facing discharge from the inpatient service, a situation that he always found difficult.

Engagement with Service

Mr. X's engagement was variable between December 2007 and 3 April 2008. He did however always appear to be relatively content during his inpatient stays. As soon as he was discharged on the 31 January 2008 (against his wishes) Mr. X actively disengaged with the service, possibly in an attempt to provoke services into readmitting him. He cancelled several appointments and discontinued his medication. This led to a rapid readmission on the 18 February 2008 during which Mr. X appeared to work reasonably well with the clinical team, the exception to this being, as usual, when discharge planning commenced.

Risk Assessment

Between December 2007 and 3 April 2008 risk assessments were conducted and care plans developed. It was evident that not all knowledge of Mr. X's past risk behaviour travelled through time with him. However a reasonably accurate risk assessment was developed and planned against during this period.

3 April 2008 Discharge Plan

Mr. X was discharged to the Assertive Outreach South Manchester Team on the 3 April 2008. The plan formulated at the time was appropriate and comprehensive. The plan was for:

- the South Manchester Assertive Outreach Team to meet with Mr. X every two weeks;
- the South Manchester Assertive Outreach Team were to take over the administration of depot medication (weekly);
- the South Manchester Assertive Outreach Team Consultant Psychiatrist to follow Mr. X up within two weeks of his discharge;
- the South Manchester Assertive Outreach Psychologist to provide therapy and intervention.[192]

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At the time Mr. X left the Trust a robust care and treatment plan had been constructed and Mr. X transferred to the South Manchester Assertive Outreach Service which should have been able to provide a structured framework for service delivery.

14.1.2.3. Conclusion

As has been noted previously, the diagnosis for Mr. X was uncertain and changed over time. Medication and treatment were not always tailored to his diagnosis. Antipsychotics, antidepressants and psychological therapy approaches were tried but it was sometimes unclear, particularly during 2006 and 2007, what set of problems they were expected to affect.

Nonetheless, on the whole, the treatment given to Mr. X throughout his time with the Mental Health Trust was clinically appropriate for whichever diagnosis he held at any one time. However the key weakness with the approach taken when reviewed in the context of contemporaneous guidelines was the framework within which treatment was delivered. All contemporaneous guidelines for both Personality Disorder and Paranoid Schizophrenia stressed the importance of care and treatment being provided within robust and coherent frameworks. People with these disorders are notoriously difficult to assess, engage and monitor, therefore treatment needs to be provided in a stable clinical environment that offsets the chaos often created by the service user. Treatment should have followed comprehensive assessment and should have been delivered by a multidisciplinary team combined with dedicated care coordination. It is regrettable that Mr. X could not have been accepted onto a CMHT caseload at an earlier date. As a result Mr. X received a disorganised approach that could not sustain over time the long-term resource commitment and management strategy that was required in order to ensure effective treatment delivery. Had Mr. X been in receipt of a more coherent treatment programme it remains uncertain as to what the long term outcome could have been. The Royal College of Psychiatry acknowledges the difficulties of achieving positive clinical outcomes when providing care and treatment to people with Personality Disorders. However, had Mr. X received his treatment within a more structured framework it is possible that he would have responded in a more positive manner and that his distressing and worrying symptomology could have been addressed more appropriately.

Mental Health Trusts are required to deliver health care within a nationally recognised evidence base. In the case of Mr. X to a large extent this was achieved, however treatment

cannot be provided in a vacuum, it has to be delivered in a structured manner in order to be truly effective. This structure was not provided within a clinical case management process and this is discussed further in sub-section 13.1.3. directly below.

At the point of discharge on the 3 April 2008 the Trust had arranged for appropriate medication, psychological therapy support, and medical and community follow-up by the South Manchester Assertive Outreach Team. This approach was appropriate for Mr. X in that it covered the key treatment requirements for a psychotic illness and also provided a treatment programme that was appropriate for a Personality Disorder. The plan on discharge was the most comprehensive and structured that had been developed for Mr. X to-date. At this juncture there was no reason to believe that it would not be able to provide a robust long-term treatment and management strategy. However the care and treatment plan was new and relatively untested and was being handed over to a team that did not know Mr. X and who had yet to build up a relationship with him.

- ***Contributory Factor Number Two (influencing). The failure to provide treatment within a coherent management plan and multidisciplinary framework led to a fragmented delivery that could neither monitor effectiveness nor ensure the best clinical outcome possible. Whilst Mr. X was discharged with an appropriate care and treatment plan in the 3 April 2008, it was untried and untested and transferred to a team that had yet to build up a relationship with Mr. X.***

13.1.3. Management of the Clinical Care and Treatment of Mr. X

This section serves as an introduction to the remaining key headings from the Investigation Terms of Reference. These key headings are addressed separately in sub-sections 13.1.4. - 13.1.14 directly below.

13.1.3.1. Context

The delivery of patient care and treatment in secondary mental health services is usually provided within a team context. People with mental health problems often require a high degree of case management in order to ensure that effective liaison between agencies takes place and that long-term treatment strategies are effective. In order to achieve this several frameworks exist, in the case of Mr. X the following were of particular relevance:

- the Care Programme Approach that provides for a care coordinator to be appointed to each person receiving care and treatment (this is examined in section 13.1.5. below).
- The Responsible Medical Officer (pre 2007 this was a doctor) or Responsible Clinician (post 2007 this can be a registered doctor, nurse, social worker, psychologist or occupational therapist), that provides for a professional lead to be appointed who takes responsibility for the management of a patient's care whilst they are detained under the Mental Health Act or subject to a supervised Community Treatment Order.
- Section 117 aftercare arrangements that ensure a person who has been detained under certain Sections of the Mental Health Act is integrated back into the community with a comprehensive and fully resourced care and treatment package.

People with mental health problems can transition between services on a frequent basis. Continuity of care and robust management is essential in order to ensure that professional communication occurs in a timely manner. This is essential in providing a safe and effective level of intervention.

On the 17 October 2007 the Department of Health Published *New Ways of Working.* This document advocated a change to traditional working practice. Historically the Psychiatrist was seen as the senior professional leader of any clinical team. *New Ways of Working* set out a revised model of management. This revised model promoted the concept of the 'democratisation of power'. This model suggested a change in the focus of key roles within teams. For example, a team manager would provide management, team leadership and service coordination. In addition professional leads were to be appointed on a patient-by-patient basis according to the individual needs of the person requiring the care and treatment. The professional lead role would no longer be allocated to a Psychiatrist as a default position as had been done previously. The purpose of introducing *New Ways of Working* was to provide a patient-centered ethos that provided a more bespoke model of care and treatment.

In Manchester *New Ways of Working* became operational in December 2007. As part of the new working arrangements in some parts of the organisation Consultant Psychiatrists were allocated to either inpatient or community-based teams. This meant that patients would be allocated a different Consultant Psychiatrist each time they transitioned from one service to another, rather than remaining on the caseload of a single medical practitioner. This

represented a large-scale level of organisational change within the Trust and to the experience of individual users of service.

13.1.3.2. Findings

Services Involved

Between January 2001 and July 2008 Mr. X was seen by 12 different NHS services in Manchester, one service in Sussex and two in the United States of America. These are set out below:

- GP Surgery (throughout the seven-year period);
- South Manchester Outpatient Clinic (throughout the seven year period);
- South Manchester CMHT (2003-2007 referral and assessment, 2007-March 2008 care and treatment);
- Clinical Psychology Services (2001-2002 referral and assessment, and 2008 treatment);
- Psychotherapy Services (2004-2007 treatment);
- Accident and Emergency Department Manchester Royal Infirmary (sporadic);
- Accident and Emergency Department South Manchester University Hospital NHS Trust (sporadic);
- The Psychiatric Liaison Team (sporadic);
- Sussex Mental Health Services (summer 2007);
- North Manchester Inpatient Services (2006 and 2007);
- South Manchester Inpatient Services (2006, 2007 and 2008);
- Sentara Healthcare, USA (summer 2007);
- Newark Beth Israel Medical Centre, USA (summer 2007;
- Crisis and Home Management Team (2008);
- South Manchester Assertive Outreach Team (2008).

From the bullet points listed above it can be ascertained that Mr. X was seen by a multitude of different healthcare services. Often he was seen by several different services at the same time, either as a planned sequence of interventions or as an unplanned series of crisis interventions. This pattern is not necessarily unusual when working with a person with either a Personality Disorder or a severe and enduring mental illness such as Paranoid Schizophrenia. However a presentation like this does require a consistent and robust

approach to case management and care coordination. If this does not occur then changes to diagnostic formulations, levels of risk, and changes to care and treatment needs cannot be communicated effectively. In the case of Mr. X there were several periods of time when separate services appeared to be operating as independent 'silos'. On these occasions communication and information sharing were sporadic.

Communication and Liaison

Up until the summer of 2007 when Mr. X was admitted to inpatient services for a prolonged period of time, most of the referral and liaison activity took place in response to a series of crisis or unplanned interventions. This was usually instigated by either the GP or the two Manchester Accident and Emergency departments. Between 2001 and the summer of 2007 Mr. X was seen on a sporadic basis by the Outpatient Clinic and between 2004 and 2007 by the Consultant Psychotherapist for psychotherapy work. In the summer of 2006 Mr. X had an inpatient admission. It is evident from examining the clinical records that no single person was coordinating the clinical pathway of Mr. X during this five-year period. Mr. X appears to have been the chief instigating factor in his own care and treatment as he self-presented on a constant basis ensuring that he got picked up by a variety of services. It is clear both from examination of the clinical records and from Investigation interviews with the witnesses that no single service knew everything of relevance about Mr. X at the same time. This lack of timely communication and liaison meant that clinical decisions were taken often without all of the facts being present.

Between January 2001 and August 2007 Mr. X was placed on standard level CPA (please see section 13.1.5 below). On the 26 September 2005 the Care Coordinator was listed as being Consultant Psychiatrist 1. On the 13 November 2006 the Consultant Psychotherapist was listed as being the Care Coordinator. It would appear that the electronic system flagged these individuals up as being Care Coordinators without them being aware that this had occurred. Not surprisingly the CPA documentation for this period is almost entirely absent, and what little exists does not fulfil the requirements of a Care Programme Approach process. The most problematic issue regarding CPA during this period was that the management of Mr. X's care was not achieved. The Care Coordinators did not act as a communication and care and treatment liaison focus as they were not aware that they had been placed in this role. As a result Mr. X ricocheted from one service to another without his accumulative psychiatrist history and risk profile being passed on with him as he moved around.

Mr. X was not accepted onto the CMHT caseload until the summer of 2007 when he was placed on Enhanced CPA. Had he been accepted onto the caseload and been in receipt of a coherent CPA process prior to this time many of the issues described above could have been circumnavigated and managed appropriately. Mr. X was referred to the CMHT a total of nine times between 2001 and the summer of 2007. It would appear that diagnostic ambiguity may have been a major factor in the decision not to accept the repeated referrals. It is a fact that prior to October 2006 due to extant Operational Policies a diagnosis of Personality Disorder would have meant that Mr. X did not meet the CMHT admission criteria and that this would have acted as a barrier to him receiving services.

Team Factors - Diagnosis and Management

Between 2001 and April 2008 diagnostic confusion and disagreement occurred. It is a fact that as a result a coherent and holistic care and treatment plan was never formulated for Mr. X. The clinical record provides a degree of insight into the situation. In July 2007 Mr. X was placed on Enhanced CPA. In the autumn of 2007 his Care Coordinator wrote that the confusion and controversy surrounding the diagnosis was preventing a discharge plan from being developed. Eventually in December 2007 a diagnosis of Paranoid Schizophrenia was specified by Consultant Psychiatrist 1 who was with the South Manchester Team. On the 18 February a Staff Grade Doctor with the North Manchester Locality Team wrote to the GP of Mr. X. This letter set out very clearly the disagreement regarding Mr. X's diagnosis that had in effect split the north clinical team in an irreconcilable manner in the autumn of 2007. The disagreement centred on whether or not Mr. X was a person who was fabricating his mental illness, or was suffering from Schizophrenia.

It is highly unusual for a clinical team to be split so contentiously. It is also highly unusual for a letter of this kind to be written and sent to a GP. The clinical record on the whole provided few explicit and unguarded examples of what clinicians actually thought of Mr. X and his diagnosis. Clinicians were, however, more forthcoming at interview when they met with the Independent Investigation Team. At interview it was quite clear that diagnostic uncertainty prevailed. Mr. X was a figure of controversy who aroused strong feelings within individuals and within teams. Rather than dealing with this highly unusual situation in a professional and united manner this issue was left unaddressed. This meant that each team Mr. X encountered treated him according to their own impression of him, in effect

disregarding the views of other services. Such an unusual situation should have led to a case conference at the very least in order to decide a long term management strategy for Mr. X.

Organisational Factors - Continuity of Care

In late 2007/early 2008 another issue arose with the management of Mr. X, that of continuity of care. Care Coordinator 1 was replaced by Care Coordinator 2 prior to his discharge on the 31 January 2008. New *Ways of Working* led to his medical lead being changed from Consultant Psychiatrist 1 to Consultant Psychiatrist 2. The decision to transfer Mr. X to the South Manchester Assertive Outreach Team on the 3 April 2008 instead of back to the South Manchester CMHT effectively severed all of his clinical continuity.

Diagnostic ambiguity was still present at the point of Mr. X's discharge to the South Manchester Assertive Outreach Team on the 3 April 2008. Care Coordinator 2 from the CMHT had only known Mr. X for a short period of time but had been able to get to know him reasonably well. Unfortunately this person had retired from the Trust and so was not available to provide a handover. Consultant Psychiatrist 2 had worked with Mr. X for a period of four months only having formally taken over from Consultant Psychiatrist 1 in December 2007. On the 3 April Mr. X's medical treatment was passed on to a third Psychiatrist who was a member of the South Manchester Assertive Outreach Team. The South Manchester Assertive Outreach Team base was not a considered a 'safe haven' and so could not accept a full set of Mr. X's previous clinical records. Whilst enough information had been forthcoming to formulate a sensible care and treatment plan it is probable that Mr. X's clinical management underwent significant disruption at this stage.

Task Factors - Clinical Process and Procedure

Every Mental Health Trust has to put into place a series of 'clinical safety nets' in order to ensure that care and treatment are delivered in a safe and effective manner. In the case of Mr. X these should have consisted of the following processes:

- Care Programme Approach;
- Risk Assessment;
- Carer assessments for relatives;
- Professional Communication;
- Discharge and Transfer;

- Section 117 aftercare.

The Independent Investigation Team found that the processes listed above were not implemented either appropriately or consistently between 2001 and 2008 by the clinical teams involved with Mr. X. Each of these processes will be examined in more detail in the sub-sections set out directly below.

Patient Factors

Mr. X accumulated many different diagnoses between 2001 and 2008, the two most dominant being Personality Disorder and Paranoid Schizophrenia. Regardless of which was correct Mr. X behaved in a flamboyant, histrionic, impulsive and unpredictable manner. Most of the clinical staff Mr. X encountered found it difficult to empathise with him and to build up a therapeutic relationship with him. Whilst some witnesses to the Independent Investigation were clear in their minds regarding a diagnosis for Mr. X, others stated that they were not certain what mental disorder, if any, Mr. X was suffering from. This affected negatively the approach that was taken.

Mr. X self-presented on frequent occasions with a bizarre mixture of suicidal ideation and delusional beliefs, at times he described psychotic symptoms. Over a prolonged period of time clinical staff found it difficult to match the reports Mr. X gave about his symptoms and the observed reality of his behaviour. A consistent feature over time was the disconnect between what Mr. X said, and what Mr. X actually did. It was this level of incongruent presentation that is consistent with someone who has a Personality Disorder, and should have been identified as such by the clinical teams caring for Mr. X over time.

Paradoxically whilst Mr. X constantly sought clinical intervention he also at times refused to engage with services. Because Mr. X was not observed to have any symptoms consistent with a mental illness clinical staff were content to let him go. Hence a constant pattern of self referral and self presentation occurred which led to a reactive intervention and an eventual self discharge or lack of engagement. This cycle of behaviour remained unbroken throughout the entire time Mr. X received his care and treatment from the Mental Health Trust. In the absence of an agreed diagnosis and robust care and treatment plan this was inevitable. It could be argued that in the absence of a discernable mental illness clinical teams were acting appropriately, however Mr. X was diagnosed as being Personality Disordered and during this

time he was clearly anxious and depressed and should have received more proactive help for his co-morbidities.

13.1.3.3. Conclusions

There is a limit to what mental health services can achieve when faced with a service user who is both chaotic and difficult to work with. However service users with chaotic and difficult behaviour require more than most a sure-footed and coherent management plan, even if that plan can never realise its full potential due to rejection on the part of the recipient.

Mr. X presented as a complex and challenging individual. It was evident to the Independent Investigation Team on close examination of this case that services responded to Mr. X in a mostly reactive manner. Mr. X was allowed to instigate clinical interventions and close them back down whenever he wanted to.

Diagnostic ambiguity, poor care coordination, non-adherence to policy, process and procedure and lack of continuity of care combined together over time to produce a set of circumstances that ensured Mr. X was not seen consistently in the light of his full psychiatric history and risk profile and was not managed effectively. At any one time the named Care Coordinators and Responsible Medical Officers should have fulfilled their responsibilities in a more proactive manner. They should have provided a structured and boundaried approach to the care of Mr. X that was discussed with, and agreed by, all of the agencies and services which had regular contact with him.

To what extent this paucity of a structured management approach contributed to the events of the 28 July 2008 is difficult to ascertain with any degree of certainty. The nature of Mr. X's mental health disorder was only verified as recently as 2009, a year after the death of Mr. W. However it can be stated that an unstructured management approach in combination with a challenging and chaotic service user is ill advised and when this occurs in the presence of either a complex range of Personality Disorders or a severe and enduring mental illness serious untoward incidents may inevitably occur. The Manchester Mental Health and Social Care NHS Trust ceased to be the lead provider of care and treatment to Mr. X four months prior to the death of Mr. W. Therefore a direct causal link between the activities of the Trust and the events of the 28 July cannot be made. However the approach taken by the Trust over time created a precedent with Mr. X whereby he engaged with mental health services on his

own terms only. At the point of discharge to the South Manchester Assertive Outreach Team Mr. X was transferred together with a legacy of ambiguity.

At the point of discharge on the 3 April 2008 the Trust had arranged for appropriate medication, psychological therapy support, and medical and community follow-up by the South Manchester Assertive Outreach Team. South Manchester Assertive Outreach Teams are skilled in reaching out to people who can be difficult to engage and who lead chaotic lifestyles, so this was entirely appropriate. This approach was also appropriate for Mr. X in that it covered the key treatment requirements for a psychotic illness and also provided a treatment programme that was appropriate for a Personality Disorder. The plan on discharge was the most comprehensive and structured plan that had been developed for Mr. X to-date. At this juncture there was no reason to believe that it would not be able to provide a robust long-term treatment and management strategy. However as has been mentioned above in sub-section 13.1.2. the plan was new and untested and was transferred to a team who had yet to build a relationship with Mr. X.

- ***Contributory Factor Number Three (influencing). The lack of a coordinated management approach to the care and treatment of Mr. X over time ensured that he was never seen in the full context of his psychiatric history and needs profile. Management was reactive and suffered from a lack of continuity and this contributed to Mr. X not receiving the coherent and consistent approach he required. Whilst this situation was retrieved in some measure by the 3 April 2008 Mr. X was transferred with a new and untried plan to a team that had yet to build up a relationship with him.***

13.1.4. Use of the Mental Health Act (83 & 07)

13.1.4.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes,

unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[193] Mr. X was subject to five Sections of the Act prior to the incident of the 28 July 2008. The Sections of the Act Mr. X was subject to are defined below.

Section 131 of the Mental Health Act (83 & 07) allows for people to be admitted into a psychiatric hospital on either a voluntary or informal basis, this means they can be treated without a compulsory detention order. Following the Bournewood findings in 2004 at the European Court of Human Rights a distinction was made between 'voluntary' and 'informal'. Voluntary patients are people who are judged to have full capacity to consent or refuse consent to treatment, this means that they have the right to refuse all treatment and to discharge themselves from hospital at any time they wish. An Informal patient is a person who is judged as not having the capacity to give consent. This means that whilst they may raise no objection to being admitted and receiving treatment additional measures have to be taken to ensure their continued risk is contained and that their human rights are safeguarded. The Manchester Mental Health and Social Care Trust *Rights Leaflet: Informal (Voluntary) patients* does not make the Bournewood differentiations explicit. Many mental health trusts in effect treat 'voluntary' and 'informal' patients in the same way. Therefore it is not clear whether Mr. X was judged as having capacity or not during his many admissions as either a voluntary or informal patient.

Section 136 of the Mental Health Act (83 & 07) allows for Police Officers to take a person who is in a public place and who appears to be suffering from a mental disorder and to be in need of immediate care and control to a place of safety. The Act defines a place of safety as a police station, hospital, care home or any other suitable place. The person can be held under

193 Mental Health Act Commission 12th Biennial Report. 2005-2007

this power for up to 72 hours in order that he/she can be assessed by mental health professionals.[194]

Section 2 of the Mental Health Act (83 & 07) allows for a 28-day period of compulsory detention in hospital for assessment purposes only. A patient has the right to appeal within 14 days of the section being ordered. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 3 of the Mental Health Act (83 & 07) is an admission for treatment order for a period of up to six months. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 117 of the Mental Health Act (83 & 07) provides free aftercare services to people who have been detained under Sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological therapy, crisis planning, accommodation, and help with managing money. The purpose of Section 117 is to prevent someone needing to go back to an inpatient unit. Services should ensure immediate needs are met and should also support people in gaining the skills they require to cope with life outside of hospital.

Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

13.1.4.2. Findings

Mr. X was detained under the Mental Health Act for the first time on the 28 May 2007. The Police admitted him under Section 136 of the Act to a hospital in Eastbourne Sussex. Mr. X had told Police Officers that he had a knife in his possession for his protection and that he

194 House of Lords Committee Briefing, Mental Health Alliance. www.mentalhealthalliance.org.uk

wished to kill himself. Mr. X was transferred from Sussex to Redwood Ward (North Manchester) and then on to the SAFIRE Unit. Mr. X was discharged on the 6 June as he was not thought to be suffering from a mental health problem.[195]

The second detention occurred on the 17 August 2007 when Mr. X returned from the United States of America. He was met at the airport and was admitted to the North Manchester inpatient service under Section 2 of the Act. The Section was allowed to lapse as the inpatient team had no immediate concerns about the level of risk he presented to either himself or to other people. Mr. X appeared content to be in hospital and was compliant with his treatment.[196]

The third detention took place following Mr. X's transfer from the North Manchester inpatient service to Bronte Ward in the South of the City. On the 27 and 28 October 2007 Mr. X went missing from the ward. He was subsequently returned by the Police who stated that he had been in possession of a hunting knife which Mr. X had claimed was for his own protection. Following this incident it was decided that Mr. X needed to be placed under Section 3 of the Act. This took place on the 30 October.[197]

Immediately following the section being applied Mr. X was observed to be calm and warm, pleasant and settled and expressing no suicidal ideas. He lodged an appeal against his detention on the 8 November. A Mental Health Act Managers meeting was held on the 5 December and it was decided that Mr. X should remain on his section. The medical recommendation was that Mr. X should remain on his section because he was still considered to be a high risk of harm to himself and that he required monitoring for his new Clozaril regimen. Mr. X appealed against this decision.[198]

On the 13 December a Mental Health Act Tribunal was held and it was decided to terminate the Section 3 Mr. X was subject to on the 20 December. The Tribunal understood that Mr. X had not been abusing his Section 17 leave, and was happy to both stay in hospital and comply with his medication. Basically they found that the Section 3 served no further purpose.[199]

195 SM Case notes Vol. PP. 15-16
196 NM Case notes Vol. 2 PP. 150 & 20
197 SM Case notes Vol. 2 PP.155&565
198 SM Case notes Vol. 2 PP. 546-548
199 SM Case notes Vol. 3 PP. 82-83 &245

Risk to Self

One of the underpinning tenets of the Mental Health Act is to provide a statutory level of intervention if a person is assessed to be a risk to their own health and safety. In order to understand the level of risk that Mr. X presented to himself between 2001 and July 2008 it is important to consider his history of self harm. During the seven-year period that Mr. X was in contact with Manchester-based mental health services he voluntarily presented himself on eleven separate occasions following self-reported acts of self harm. He was brought to the attention of services on two further occasions following dramatic acts that were reported by members of the public to the Emergency Services. There was, however, no evidence to suggest that Mr. X ever intentionally caused actual harm to himself on any of these occasions. No independent medical evidence could be found to support his repeated claims of having taken a drug overdose for example. Drug screens would be returned as negative and no medical intervention was ever required. The only time Mr. X caused harm to himself was during the incident on the shooting range in the United States of America when the act of Mr. X repeatedly throwing himself to the ground accidentally injured his neck.

Between January 2001 and 3 April 2008 (when he left the care of the CMHT and inpatient services) Mr. X was assessed on numerous occasions as being a chronic long-term risk to his own health and safety through acts of self harm. However on the occasions when Mr. X presented himself to services he appeared often to be both calm and rational. Mr. X was generally happy to accept medication and treatment and rarely met the threshold for an informal/voluntary inpatient admission. There was no justification for the use of compulsory detention under the Act other than on the occasions that it had been applied previously by the Trust in order to ensure the safety and wellbeing of Mr. X.

Risk to Others

Another underpinning tenet of the Mental Health Act is to provide a statutory level of intervention if a person is assessed to be a risk to the health and safety of others. There were eight separate recorded occasions when Mr. X was either found to, or was reported as having, a knife in his possession. On each of these occasions Mr. X claimed that the knives were for his own protection. On each of these occasions Mr. X either presented the knives to the authorities or made it evident where they could be found. In effect each reported knife ‘incident’ was disclosed by Mr. X in some way. It will never be known whether or not Mr. X was ever in possession of an undisclosed cache of weapons.

When Mr. X was risk assessed he was frequently cited as being a low to moderate risk to other people. On rare occasions he was deemed to be a high risk. When Mr. X was assessed as being a moderate to high risk to others he was usually either in a hospital setting or happy to be admitted into a hospital setting as an informal/voluntary patient. At no time did Mr. X ever contest a decision to admit him or seek his own discharge. On the contrary, Mr. X actively sought admission, and whilst he disliked being on a Section 3 of the Mental Health Act, he did not want to be discharged from hospital. There was no justification for the use of compulsory detention under the Act other than on the occasions that it had been applied previously by the Trust.

Section 117 Aftercare

On the 31 January 2008 Mr. X was discharged from Bronte Ward. Following Mr. X having previously been detained under Section 3 of the Mental Health Act he was eligible for Section 117 aftercare. The Independent Investigation Team could not detect, from a careful read through of the clinical records, of what the full aftercare arrangements comprised. A person who is eligible for Section 117 aftercare should be assessed in a holistic manner to determine ongoing medical *and* social care needs. Regardless of a person's financial situation these needs have to met and resourced fully by statutory services.

The Trust had put into place a range of clinical interventions as part of the discharge plan, but fell down on providing a comprehensive social care plan. Whilst it would appear that Mr. X was able to manage his own affairs in the spring of 2008 an offer of practical Section 117 aftercare support (help with accommodation, employment etc.) may have helped to engage Mr. X with community services following his discharge and may have helped to prevent his readmission on the 19 February 2008. Whilst referring Mr. X to the Assertive Outreach Service in April 2008 could be viewed as part of a Section 117 aftercare arrangement, in itself this did not comprise a totally adequate response that either adequately assessed the needs of Mr. X and/or secured funding for them.

13. 1.4.3. Conclusions

The use of the Mental Health Act does not feature as a major theme in the care and treatment of Mr. X. It must be remembered that an admission to an inpatient unit, either informally or under Section, should only take place if assessment, care and treatment are best provided in

such a setting. When a patient is compliant with care and treatment programmes and consents to an informal admission, as was the case with Mr. X, use of the Mental Health Act is generally not justified. It is the conclusion of the Independent Investigation Team that in the case of Mr. X the use of the Mental Health Act was used appropriately and in accordance with the legislation.

The Trust did not manage Section 117 aftercare in a comprehensive manner. Whilst this may have had no direct effect on the events of 28 July 2008, it represented a missed opportunity. It was a missed opportunity for two reasons. First, aftercare arrangements should be supportive of a recovery model that works actively with a person to equip them medically, socially and emotionally to cope with life outside of hospital. Mr. X could have benefitted from this kind of therapeutic intervention. It was noted, prior to his discharge, by the Named Nurse on Bronte ward that Mr. X was becoming institutionalised. Mr. X had been an inpatient in a highly structured environment for a period of six months. Section 117 aftercare arrangements are specifically designed to support people transitioning from one kind of clinical environment to another. Second, many patients will engage with services if they provide a means to attain accommodation, benefits and life skills. Whilst this is not the main *raison d'etre* of Section 117 it provides an additional therapeutic process for clinical teams to use when patients are reluctant to engage clinically.

- ***Service Issue Number One. Section 117 arrangements were not provided in accordance with either local or national best policy guidelines. This meant that the depth of support Mr. X required for his social care needs was not available to him.***

13.1.5. The Care Programme Approach

13.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[200]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to

200 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*[201].

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*[202]" (Building Bridges; DoH 1995). This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient;
  - to monitor that the agreed programme of care remains relevant; and
  - to take immediate action if it is not;

201 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

202 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Manchester Mental Health and Social Care NHS Trust CPA Policy

At the time Mr. X received his care and treatment from the Mental Health Trust a robust series of CPA policies were in place that were in keeping with national guidance. Policies stated that the Care Programme Approach applied to all people accepted by specialist mental health services. The main requirements of CPA were described as follows:

- *"an assessment of the service user's health and social care needs, including an assessment of any risks posed by them or to them;*
- *a multi-disciplinary care plan stating how the assessed needs are going to be met, including crisis and contingency plans;*
- *the appointment of a Care Coordinator to oversee the implementation of the care plan and to link the client to appropriate services;*
- *regular reviews to ensure the appropriateness of the care plan".*[203]

The criteria for a person to be accepted onto Enhanced CPA were as follows;

- *"multiple care needs, which could include housing, employment etc. requiring inter-agency co-ordination;*
- *contact with a number of agencies;*
- *likely to require more frequent and/or intensive interventions;*
- *have mental health problems co-existing with other problems such as substance abuse;*
- *at risk of harming themselves or others;*
- *likely to disengage with services;*
- *entitled to Section 117 aftercare;*

203 Manchester MHT Revised 2006 policy. Policy for 2007-2008. P. 4

- *people who are admitted to an in-patient facility, informally or under Section 2 of the Mental Health Act(although they may be discharged under the provisions of standard CPA)".*[204]

The criteria for a person to be accepted onto Standard CPA were as follows:

- *"people who are eligible to receive help from the Mental Health Services but do not meet the requirements for Enhanced CPA will be dealt with under the Standard CPA;*
- *if the user has eligible needs, but only requires the intervention of a single professional then Standard CPA applies. An appropriate worker will be allocated to offer a simple service and provide a simple care plan";*[205]

Trust Policies also outlined the importance of:

- *"one point of entry into services;*
- *one assessment of needs and risks;*
- *one care plan to include contingency and crisis care plans;*
- *the appointment of a lead officer, with the power to work across agencies, to allocate resources and develop the integrated CPA".*[206]

13.1.5.2. Findings

From the moment Mr. X was accepted into secondary care services in 2001 he was eligible for CPA. In order to understand the following sub-section the reader needs to be aware that up until October 2006 Manchester CMHTs were commissioned to provide services to people with 'enduring mental illness' only. This ensured that meeting the Trust CPA policy requirements for Enhanced Level CPA for individuals like Mr. X who did not have what could be described as an enduring mental illness was difficult. This in effect disbarred people like Mr. X from services and left the care approaches to clinicians limited.

First Episode

On the 31 January 2001 Mr. X was referred to the CMHT by Primary Care Services. The reason for the referral was for a psychiatric assessment because Mr. X had *"strong suicidal ideation and violent fantasies".* An assessment suggested that Mr. X should not be seen by a

204 Manchester MHT Revised 2006 policy. Policy for 2007-2008. PP.5-6
205 Manchester MHT Revised 2006 policy. Policy for 2007-2008. PP. 6 & 8
206 Manchester MHT Revised 2006 policy. Policy for 2007-2008. P.5

lone worker due to his risk profile.[207] Between 31 January and 25 November 2002 Mr. X was assessed, seen and treated by Consultant Psychiatrist A and Consultant Psychiatrist 1, he was also assessed by a Clinical Psychologist. Mr. X was initially diagnosed as having Schizoid/Schizotypal Personality Traits and an alcohol dependence accompanied by amphetamine abuse. He was described as presenting with a serious, although not imminent, risk of harm to both himself and to others.

Prior to Mr. X disengaging from services on the 25 November 2002 he was managed via a series of Outpatient appointments. No CPA documentation exists for this period, however by default Mr. X would have been on CPA and his Care Coordinator would have been whichever Consultant Psychiatrist was leading with his care and treatment. It was evident that between 2001 and 2002 psychiatrists in the Trust did not automatically view themselves as being eligible for the role of Care Coordinator.

At this stage Mr. X met two of the criteria that would have made him eligible for Enhanced CPA in that he was assessed as:

- presenting a serious risk of harm to himself and to others;
- having mental health problems that co-existed with alcohol and drug misuse.

30 September 2003- 26 March 2004

On the 30 September 2003 Mr. X was referred back to secondary care services by his GP. The reason for the referral was depression. It was noted that a lack of engagement had brought his previous contact with services to an end in November 2002 and that he had stopped taken his medication. At this stage Mr. X was referred on to Psychotherapy Services. Shortly after this, on the 13 October, Mr. X was re-referred back to the CMHT by his GP. Mr. X was referred on to Gaskill House so that his alcohol issues could be addressed.

On the 29 January 2004 the Adult Consultant Psychotherapist assessed Mr. X. On this occasion it was noted that he had recently tried to overdose, was feeling suicidal, lonely, and was not always taking his prescribed medication. The Psychotherapist provided a detailed assessment summary to the CMHT.[208]

207 SM Case notes. Vol. 1 PP.172-177
208 SM Case notes Vol.1 PP. 143-145

On the 6 February 2004 Mr. X presented in crisis at Accident and Emergency. A passing motorist had witnessed Mr. X standing on a motorway bridge with a rope around his neck. On this occasion Mr. X was discharged back home and was referred to the South Manchester CMHT. At this time it was noted that he was drinking a litre of vodka a day, was extremely anxious and had suicidal thoughts.[209]

Between the 6 February 2004 and the 11 March Mr. X was seen by the Consultant Psychotherapist. Mr. X updated the Psychotherapist as to what had been occurring regarding his recent suicide attempt. This information had not been passed on formally to the Psychotherapist via other clinical contacts.

On the 26 March 2004 Mr. X was discussed at the CMHT allocation meeting. It was noted that he was currently being assessed by Psychotherapy Services and that a referral had been made with regards to his alcohol intake. The CMHT acknowledged that Mr. X would present with self harm again in the future and that this would necessitate further assessment, however it was decided that the CMHT could not offer any service to Mr. X at that time. At this stage the CMHT thought intervention would be counter productive and would encourage Mr. X to over intellectualise his problems. He was thought to be suffering from a Personality Disorder. At this stage Mr. X met several of the criteria that would have made him eligible for Enhanced CPA in that he had:

- made two reported suicide attempts;
- an identified high risk of future self harm;
- a significant drinking problem;
- been seen by/referred to two other services, psychotherapy and alcohol services;
- a history of not engaging with services;
- a history of not being compliant with his medication;
- required frequent intervention;
- significant social problems with isolation and loneliness.

At this stage Mr. X was not receiving any kind of CPA. It would appear that this presumptive diagnosis of Personality Disorder acted as a barrier to his being able to access CMHT

209 SM Case notes Vol.1 PP. 117-118

services. However Mr. X had been referred to the CMHT twice in rapid succession during this period and this should have instigated a more thorough assessment process.

7 October 2004 - 15 June 2006

On the 20 October 2004 a referral was made to the CMHT by Mr. X's GP. On the 7 October Mr. X had been seen by Emergency Psychiatric Services who made the recommendation that Mr. X needed to be referred to an adult psychiatrist. Subsequently Consultant Psychiatrist 1 wrote to Mr. X on the 28 October offering him an appointment.

Mr. X was reviewed by the Senior House Officer of Consultant Psychiatrist 1 on the 22 November 2004[210]. The review was shared with the GP in the form of a letter but it does not appear to have been shared with Psychotherapy Services. On this occasion Mr. X claimed to be drinking eight cans of strong lager each day. He was pale, anxious and had marks around his neck suggestive of a previous hanging attempt (the origin of the marks around his neck do not appear to have been explored with Mr. X in the review). Mr. X stated he was reluctant to comply with his medication.[211]

During this period Mr. X was being assessed by Psychotherapy Services. He was referred for the psychotherapy group 'Fifteen' (a therapeutic community style intervention). Between April and September 2005 Mr. X attended a monthly preparatory group in readiness for the group commencement in October.

On the 26 September 2005 Mr. X presented at Accident and Emergency. At this time Mr. X stated that he planned to kill himself *"in the easiest and most painless way possible"*. It was noted that Mr. X had a Borderline Personality Disorder that he was aggressive, lived alone, was labile in mood and socially isolated. It was also noted that Mr. X had not taken his medication for ten days.[212] It is not clear what, if any, action occurred at this stage.

During this period Mr. X continued to attend 'Fifteen'. On the 27 September 2005 events led to Mr. X being cautioned by the Police under the Harassment Act. He had threatened to kill a

210 AMIGOS Records P.12
211 SM Case notes. Vol. 1 PP.106-107
212 NM Case notes Vol. 1 P.63

female group member and had been harassing her with multiple telephone calls. The GP was notified of these events.[213]

On the 4 October 2005, following Mr. X presenting at Accident and Emergency the previous day, the GP made another referral to the CMHT. The reason for the referral was Mr. X feeling depressed and having suicidal ideation. The GP was concerned that Mr. X's mental state was deteriorating and that his attendance at Accident and Emergency was increasing. As a response to this Consultant Psychiatrist 1 wrote to Mr. X offering him an appointment at the Outpatient Clinic. Mr. X did not respond.

Between the 9 January 2006 and 12 June 2006 Mr. X was not seen by secondary care services as he had resigned from the 'Fifteen' group and had not attended follow up at the Outpatient Clinic.

It is evident that between 7 October 2004 and 15 June 2006 Mr. X was not in receipt of CPA. It is not exactly clear what the 22 November 2004 review consisted of. During this period Mr. X was involved with:

- General Practice;
- Accident and Emergency Services;
- Outpatient Clinic;
- Psychotherapy;
- Police Service.

At this stage Mr. X met most of the criteria that would have made him eligible for Enhanced CPA in that he was assessed as:

- being suicidal;
- having an identified high risk of future self harm;
- having a significant drinking problem;
- having been in contact with numerous services;
- not engaging with services;
- not being compliant with his medication;
- having significant social problems with isolation and loneliness.

213 Psychotherapy Records PP. 11-12

15 June 2006 - 14 June 2007

On the 15 June 2006 Mr. X was admitted to the SAFIRE Unit following a two self-reported incidents, an overdose of Codeine and Brufen on the 12 June and an attempted hanging on the 14 June. Following his discharge back into the community on the 22 June Mr. X was referred to Consultant Psychiatrist 1 and back to the 'Fifteen' group. On the 30 June Mr. X was assessed by the South Manchester CMHT. The decision was made not to take Mr. X onto the caseload at this stage. Instead the CMHT made a request for an Outpatient appointment. On the 7 July the CMHT wrote to Mr. X's GP to say that his psychotic relapse had probably occurred because he had stopped taking his medication.[214]

On the 11 September 2006 Mr. X was seen as a new patient by the Specialist Registrar of Consultant Psychiatrist 1 at the Outpatient Clinic. On the 25 September 2006 Mr. X rejoined the 'Fifteen' group. On the 16 October Mr. X mentioned in the group that he had bought a nine inch hunting knife for his protection. This was not communicated to any other clinical service.[215]

On the 21 October 2006 following a presentation at Accident and Emergency Mr. X was admitted to the SAFIRE Unit. It was felt at the time of his admission that Mr. X presented with a high risk of self harm and appeared to be having a psychotic episode. Mr. X was discharged back into the community on the 23 October. Mr. X was to be referred to Crisis Point, and if he was refused by them back to the care of Consultant Psychiatrist 1. Mr. X was also to be referred for Cognitive Behaviour Therapy and for assessment by the CMHT.[216] In effect the outcome was that Mr. X was referred back to 'Fifteen' and to the Outpatient Clinic.

After a period of confusion the Consultant Psychotherapist took over the role of Care Coordinator, Mr. X was on Standard CPA. How this occurred is not recorded, however the clinical record indicates that it was an unexpected turn of events for the Psychotherapy Team.[217] On the 13 November 2006 a CPA care plan was developed. The plan stated that the Care Coordinator would be able to assist Mr. X with his feelings of isolation, but would not be able to assist him in a crisis. In a crisis Mr. X was advised to go to his GP, the Accident and Emergency Department, a psychiatrist or the Samaritans. This care plan was sent to Mr.

214 SM Case notes Vol.1 PP.81-85
215 Psychotherapy records PP. 168-169
216 SM Case notes Vol.1 PP. 50 & 57
217 Psychotherapy Records P. 3

X's *"care network"* which was in effect his GP. It was not sent to Consultant Psychiatrist 1.[218]

Mr. X failed to attend the Outpatient Clinic. The Specialist Registrar of Consultant Psychiatrist 1 wrote to the GP regarding his concerns that Mr. X's mental health was deteriorating and stated that he would visit Mr. X at his home in the New Year with a member of the CMHT. The Care Coordinator was not informed of the situation.

In January 2007 Mr. X was discharged from 'Fifteen'. It is uncertain what long-term effect this had on his CPA arrangements. On the 13 February and the 14 March 2007 Mr. X was seen at the Outpatient Clinic by the Specialist Registrar of Consultant Psychiatrist 1. Whilst letters were sent on a regular basis to the GP there was no indication to suggest that any information was sent on to the Care Coordinator.

On the 28 May 2007 Mr. X was admitted via Section 136 to a hospital in Eastbourne and was transferred to Redwood Ward in North Manchester. Mr. X had been in possession of a knife and was admitted because he had paranoid ideas about people and suicidal thoughts. On the 6 of June 2007 he was discharged back into the community. The AMIGOS record shows Mr. X to have been placed on Enhanced CPA from the 14 June 2007.[219]

It was evident to the Independent Investigation Team that throughout a significant part of this period Mr. X was not in receipt of any CPA and did not have a Care Coordinator. When Mr. X did have a Care Coordinator no actual care coordination took place between the services who were involved in providing his care and treatment. It is also evident that the Psychotherapist did not feel best placed to support Mr. X with many aspects of the care plan other than those that related to psychotherapy approaches. Once again, throughout this period whilst Mr. X was either in receipt of no CPA, or Standard level CPA, he was in fact probably eligible for an Enhanced CPA approach.

14 June 2007 - 3 April 2008

Directly following being placed on Enhanced CPA Mr. X went to the United States of America where he was hospitalised on two occasions. On his return to England he was

218 Psychotherapy Records P. 5
219 Internal Investigation Report

admitted to the North Manchester Inpatient service on the 17 August 2007. On his admission Mr. X was detained under Section 2 of the Mental Health Act. He was placed on Section 3 of the Mental Health Act on the 30 October 2007.

On the 20 December 2007 Mr. X's Section 3 was terminated. On this day a comprehensive CPA was prepared by Care Coordinator 2, a comprehensive Discharge Plan was also prepared in conjunction with Mr. X and the ward-based Named Nurse. This represented the first full CPA that Mr. X ever received during his time with Manchester-based services.[220]

On the 10 January 2008 Mr. X was granted a one-week period of leave so that he could have another CPA assessment in his own home. On the 24 January the CPA documentation was completed by Care Coordinator 2 at Laureate House the site of the Outpatient Clinic. It was noted on the CPA documentation that Mr. X was eligible for Section 117 aftercare, although some potential areas of need were listed, actions were not explicitly stated. This CPA built upon the earlier plan developed on the 20 December 2007. It assessed Mr. X in the light of some (not all) of his previous risk, his history of non-engagement and substance misuse.[221]

Following Mr. X's discharge on the 31 January 2008 he proved difficult to engage with. However the Care Coordinator persevered and eventually managed to meet Mr. X at his home on the 18 February. It became immediately evident to the Care Coordinator that Mr. X was not well. An appointment was arranged for Mr. X to meet with Consultant Psychiatrist 1 later that afternoon. This rapid intervention led to Mr. X being admitted to Bronte Ward on the 19 February.[222] This provides an excellent example of how proactive care coordination can be utilised to manage crisis intervention in an orderly and supportive manner. Shortly after this event Care Coordinator 2 left the service.

During this admission to Bronte Ward it was decided to transfer Mr. X to the South Manchester Assertive Outreach Service on his discharge. During this period it was decided that the CPA process should be taken over by the South Manchester Assertive Outreach Team whilst working in tandem with the ward staff.

220 AMIGOS Records PP. 255-261
221 AMIGOS Records PP.347-350
222 SM Case notes Vol.4 PP. 4,19,34

Mr. X was given several periods of leave prior to his planned discharge on the 3 April. He proved elusive and difficult for the South Manchester Assertive Outreach Team to engage with. A discharge CPA was due to be held on the 27 March 2008. A meeting with Mr. X did take place, but it does not appear to have constituted a CPA. This CPA review, if that is what it was, did not appear to have been recorded on AMIGOS or in any of the other clinical files. The South Manchester Assertive Outreach Team did however have copies of the CPA care plans that had been previously prepared by Care Coordinator 2 in January 2008 which still provided an accurate indication of what Mr. X's future care, treatment and management needs were.[223]

The Role of the Care Coordinator

Between January 2001 and 14 June 2007 Mr. X in effect did not receive any kind of CPA which ran counter to both Trust policy and procedure and National guidance. Between these dates the clinicians who perhaps could have acted as the Care Coordinator had either not been made aware of their responsibilities, or did not know what was expected of them.

Following the decision to place Mr. X on Enhanced CPA on the 14 June 2007 Mr. X's chaotic presentation and eventual inpatient admission meant that the active role of Care Coordinator was subsumed into the workings of the inpatient Multidisciplinary Team whilst a period of mental state assessment and treatment occurred.

The value of effective Care Coordination was evident between December 2007 and February 2008 when Mr. X received the beginnings of a comprehensive CPA under the guidance of an experienced Care Coordinator. Unfortunately this person retired from the Trust during Mr. X's second admission at the end of February 2008. However a sound basis for CPA working had been laid.

13.1.5.3. Conclusions

On paper it would appear to be a relatively 'open and shut' case to have placed Mr. X on Enhanced CPA at a relatively early stage during his time with Manchester-based services. Mr. X met sufficient criteria to be accepted. The CMHT refused to accept Mr. X onto their caseload due to the referral criteria excluding individuals with Personality Disorder. By

223 Assertive Outreach Notes PP. 7-10. AMIGOS Records

refusing to accept Mr. X he was in effect barred from receiving effective CPA management for a period of at least five years. Community-based teams are the main vehicle by which Enhanced level CPA is delivered, if a person is not accepted onto the caseload then they are usually not deemed to require such a high level of care coordination and do not receive it.

The clinical record does not chart accurately the ambivalence that was probably felt about Mr. X by the health and social care staff that he met. Historically across the country it has not been uncommon for mental health community-based teams to reject people for treatment if they carry a diagnosis of Personality Disorder. However research has established, and national guidance expects, that mental health services *can* and *should* provide help to people with Personality Disorders.[224]

Mr. X was receiving care and treatment from the Outpatient Clinic and from Psychotherapy Services therefore he had been accepted by secondary care mental health services. This meant he should have been receiving robust CPA management. His presentation did not change over time and his problems did not go away. Whether Mr. X had a Personality Disorder or a psychotic illness he should have been treated appropriately according to his presentation and national guidelines. It was evident during this period that Mr. X also suffered from a depressive illness and a substance misuse problem, this alone should have merited a more proactive response.

Prior to his inpatient admission in 2006 issues around the debate regarding the veracity of his symptoms had not been recorded in the clinical record so it would not have been unreasonable to have expected Mr. X to have been taken at face value before this time. In the light of Mr. X's known risk it would have been better practice to have accepted him onto the CMHT caseload and then, if it was felt he was not benefitting from this approach, to have discharged him following a full period of assessment that would have been able to articulate fully the clinical rationale for doing so.

Whilst Mr. X did receive appropriate CPA between December 2007 and March 2008 this represents a relatively short interval of time over the course of his history with the Mental Health Trust. In summary Mr. X met the criteria for Enhanced CPA for the majority of the

224 Rcpsych.ac.uk/…/pd.aspx

time he was receiving care and treatment from the Trust. Robust care coordination was essential in the management of this complex and challenging case. Mr. X did not receive this and as a result his behaviour escalated over time to the point where he had to be detained under the Mental Health Act. Patient factors, team factors and process factors combined together to ensure Mr. X was not managed appropriately. Whether Mr. X received robust CPA or not he may well have gone on to commit acts of violence. However the Mental Health Trust did not discharge its duty of care appropriately over time and did not ensure that this essential 'safety net of care' was in place. This made a contribution to the poor management of Mr. X over time and ensured that his mental disorder was only ever partially managed.

- ***Contributory Factor Number Four (influencing). The Mental Health Trust did not discharge its duty of care appropriately with regards to CPA and did not ensure that this essential 'safety net of care' was in place for most of the time that Mr. X was receiving services from them. This made a contribution to the poor management of Mr. X over time and ensured that his mental disorder was only ever partially managed.***

13.1.6. Risk Assessment

13.1.6.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their

health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users' past and current clinical presentation to allow an informed professional opinion about assisting the service users' recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that '*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[225].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

225 Best Practice in Managing Risk; DoH; 2007

Manchester Mental Health and Social Care NHS Trust Policy

During the period that Mr. X received his care and treatment from the Trust robust risk policies were in place. These policies very sensibly made the connection between risk management processes and other Trust policies and procedures such as the:

- Care Programme Approach;
- Mental Health Act procedures;
- Medicines Management;
- Child Protection Policy;
- Vulnerable Adults Policy;
- Incident Reporting Policy.

The Policies stated that it was the responsibility of the clinicians making the first contact with the service user to commence the risk assessment process. The Care Coordinator, RMO or Named Nurse should continue the process and that all clinicians working with the service user should keep risk profiles updated as required.

The policies also stated that risk assessment should be conducted on the following occasions:

- at the beginning of each major episode of care;
- when a person presents in an emergency situation where there are no previous notes available;
- every time a mental state examination is carried out;
- as clinically required, e.g. at CPA reviews and ward rounds;
- prior to discharge;
- prior to leave and return from leave;
- after a Serious Untoward Incident or period of seclusion;
- updated as clinically required.

The Trust established that there were two main approaches to risk assessment. The formulation approach and the measurement approach. The formulation approach was described as *"the application of clinical knowledge in predicting risks, identifying cues and using expert interviewing and care planning to bring together a formulation of risk that deals with the origins, development, maintenance and recent changes in risk level."* [226] The

226 Trust Clinical Risk Management and Assessment Policy and Procedure. Nov. 2007. P.9

measurement approach was described as being a method that provides an objective measurement tool in order to facilitate an accurate prediction of the likelihood of a risk event occurring. The Trust policies advocated the two approaches being combined together in order to effectively assess and manage risk.

13.1.6.2. Findings

Events History

The first recorded risk assessment that Mr. X received was formulated by the Primary Care Mental Health Team Social Worker who referred him to secondary mental health services in January 2001. Mr. X was described as having *"strong suicidal ideation and violent fantasies. Dissocial Personality Traits."*[227] The risks identified stated that Mr. X presented a serious, although not immediate, risk of both self harm and of harming others. He was identified as being at serious risk of deterioration and of having both *previously* attempted suicide and of having *current* plans of committing future acts of self harm. The recommendation on referral was that Mr. X presented with a risk of such a significant nature that he should not be seen by a lone worker. In effect Mr. X's risk profile, presentation and diagnosis changed very little over time from this original assessment.

The Independent Investigation Team found that clinicians conducted risk assessments on a regular basis very much in line with policy expectations with regard to timeliness. Assessments tended to follow a formulation method when developed by medical clinicians and a measurement tool method when developed by other health and social care professionals. This ensured that assessments occurred as part of the routine patient care process and also as a response to changes in Mr. X's presentation and mental state. The consistent risks that Mr. X presented with were those relating to potential harm to himself and potential harm to others.

Self Harm

There were 13 separate recorded incidents of Mr. X attempting either suicide or self-harm. They are as follows:

- 18 February 1991 paracetomol overdose (disclosed by mother);[228]

227 SM Case notes Vol. 1 PP.172-177
228 GP Records PP. 116-117

- Christmas 2000 attempt to cut femoral artery (disclosed during primary care assessment);[229]
- 29 January 2004 self-reported Ecstasy overdose (disclosed during psychotherapy session);[230]
- 6 February 2004 incident involving standing on a motorway bridge with a rope around neck (presentation at Accident and Emergency);[231]
- 22 November 2004 self-reported Olanzepine overdose (disclosed during an Outpatient Clinic);[232]
- 22 November 2004 presentation at Outpatient Clinic with marks around neck consistent with a hanging attempt (disclosed during an Outpatient Clinic);[233]
- 12 June 2006 self-reported overdose of Codeine and Brufen (presentation at Accident and Emergency);[234]
- 14 June self-reported attempted hanging (presentation at Accident and Emergency);[235]
- June 2007 shooting range incident in the United States of America;[236]
- June 2007 admission to a Psychiatric Unit in the United States of America following superficial scratching of wrists;[237]
- September 2001 on two occasions when an inpatient Mr. X superficially scratched his wrists;[238]
- 22 July 2008 self-reported attempt to commit suicide by injecting three bags of heroin into groin.[239]

Mr. X also appeared at Accident and Emergency Departments during this period on a *further five* occasions when he reporting feeling actively suicidal. It would appear from close examination of the clinical records that each of these events were communicated effectively between both primary, acute medical and secondary care services.

229 SM Case notes Vol.1 PP. 172-177
230 SM Case notes Vol.1 PP. 143-145
231 SM Case notes Vol. 1. PP. 117-118 & 140-142
232 SM Case notes Vol. 1 PP. 106-108
233 SM Case notes Vol. 1 PP. 106-108
234 SM Case notes Vol. 1 P. 89
235 SM Case notes Vol. 1 P. 89
236 NM Case notes Vol. 2. PP. 164-167. AMIGOS PP. 32-36
237 NM Case notes Vol. 2. PP. 164-167. AMIGOS PP. 32-36
238 NM Case notes. Vol. 2 PP. 26-27 & 30-31
239 AMIGOS P. 531

It is a fact that no medical evidence was found by the Independent Investigation Team to suggest that Mr. X had ever actually taken an overdose or made a serious attempt to cause actual physical harm to himself. There was only one reported occasion that Mr. X did cause harm to himself and that was when he accidentally injured his neck whilst throwing himself to the ground on the shooting range in America. What motivated Mr. X to present himself on a total of 18 occasions is uncertain. The clinical records would indicate that, amongst other things, he suffered from Depression and Dysthymia. It is possible that Mr. X needed help and support and may have exaggerated his problems in order to get the interventions that he felt he needed. However the Independent Investigation cannot rule out the possibility that Mr. X did in fact try to commit suicide on 13 occasions and felt that he was in danger of doing so the other five times he presented at Accident and Emergency Departments.

Whatever the true picture the issue of diagnostic ambiguity surfaces once again. Following each of the events listed above the clinical records usually appended a comment about Mr. X having a Personality Disorder. Each of the presentations resulted in a risk assessment taking place, and it was almost always universally decided that Mr. X was a long-term chronic risk of either suicide or serious self harm, even if it was sometimes noted that this may eventually be of an accidental nature. What never occurred was the development of a care plan that effectively addressed Mr. X's depression, alcohol and substance misuse, and loneliness. The risk assessments did not lead to a dynamic series of plans to try to help Mr. X overcome and manage his situation.

Interventions that were provided to manage Mr. X's risk of self harm did not prove to be effective. The psychotherapy 'Fifteen' group, which was intended to support Mr. X in effect appeared to increase his feelings of rejection and loneliness. Medication only appeared to have a limited effect, and intervention under the Mental Health Act which was utilised on three occasions cannot be seen as either an effective or proactive long-term treatment strategy. Over a period of five years the same approach was used repeatedly and it did not appear to have been effective, hence a 'revolving door' sequence of events was played out.

Potential Risk to Others

There were eight occasions whilst Mr. X was receiving care and treatment from the Mental Health Trust when Mr. X was reported to have knives in his possession which were intended for *"self protection"* purposes. These are as follows:

- 15 June 2006 (on admission to the SAFIRE Unit Mr. X disclosed he had two knives in his possession at his home. This was verified, these were large hunting knives);[240]
- 26 September 2006 Mr. X told the 'Fifteen' psychotherapy group that he had purchased a small knife for his protection;[241]
- 16 October 2006 Mr. X told the 'Fifteen' psychotherapy group that he had bought a nine-inch hunting knife for his protection;[242]
- 30 October 2006 Mr. X told a Psychotherapist that he carried a knife for protection;[243]
- 28 May 2007 Mr. X was admitted under Section 136 to a hospital in Eastbourne after showing Police Officers a knife;[244]
- 27 September 2007 whilst Mr. X was an inpatient with North Manchester Services he was found asleep with a kitchen knife on his pillow;[245]
- 27-28 October 2007 Mr. X went absent from Bronte ward and was returned by the Police via Accident and Emergency. The Police said he had a knife in his possession (he was subsequently placed under Section 3 of the Mental Health Act);[246]
- 18 February 2008 Mr. X was bailed by police for carrying a knife following an Outpatient Clinic appointment with Consultant Psychiatrist 1. This led to his being admitted to Bronte Ward the following day.[247]

There were also the following occasions when it was recorded that Mr. X had either caused harm or abuse, was threatening to cause harm or abuse, or was giving cause for concern in this area:

- 31 January 2001 Mr. X was described as having *"violent sexual fantasies"* during an assessment;[248]
- 26 September 2005 during a visit at an Accident and Emergency Department he was described as *"aggressive, living alone, labile and socially isolated"*.[249]
- 27 September 2005 a female member of the 'Fifteen' psychotherapy group had Mr. X cautioned under the Harassment Act by the Police. Mr. X had said that he wanted to kill her and had been sending her multiple nuisance telephone calls;[250]

240 NM Case notes Vol.1 PP 76-77
241 Psychotherapy Records P. 167
242 Psychotherapy Records PP. 168-169
243 SM case notes Vol. 1 PP.36-38
244 NM Case notes Vol. P. 191
245 NM Case notes Vol. 2 P. 20
246 SM Case notes Vol.2. P. 143
247 SM Case notes. Vol. 4 P. 19
248 SM Case notes Vol. 1 PP. 172-177
249 NM Case notes Vol.1 P.63

- 15 June 2006 on the SAFIRE Unit the admission risk assessment stated that Mr. X had previously assaulted his mother and smashed up his flat;[251]
- 19 June 2006 two letters were shown to the SAFIRE ward staff. The first indicating that Mr. X had threatened his neighbour's children. The second that Mr. X had thrown plates and a mirror into his neighbour's garden and had been abusive and aggressive towards them;[252]
- 20 June 2006 whilst an inpatient at the SAFIRE Unit Mr. X's mother reported that she had found 'stolen' information from the personnel files of Mr. X's colleagues at the Royal Mail. This information included their addresses. Hunting knives were placed with the documents. Mr. X had been previously recorded as saying he was going to *"make them pay"*.[253]
- 22 October 2006 Mr. X had been admitted to the SAFIRE Unit, his mother described him as being hostile and of having abused both her and his stepfather financially;[254]
- 17 October 2007 on transfer to Bronte Ward it was noted on the risk assessment that Mr. X had previously threatened and assaulted staff;[255]
- 16 November 2007 whilst on Bronte Ward a risk assessment stated that Mr. X said he intended to harm the person who *"started this if I see him [his neighbour]"*;[256]
- 24 December 2007 Mr. X sent upsetting and abusive texts to his mother and stepfather.[257]
- 19 February 2008 following admission to Bronte Ward the risk assessment described Mr. X as harbouring *"vengeance fantasies"* and of having made previous threats to *harm/kill others"*.[258]

Contrary to reports in the media and elsewhere following the death of Mr. W, mentions of Mr. X and gun use in the clinical records was restricted to his intentions of shooting himself with a pistol on a shooting range. There was never any mention of his purchasing a gun to harm other people.

250 Psychotherapy Records PP.11-12
251 NM Case notes Vol.1 PP. 22-23
252 NM Case notes Vol. 1 PP. 137-138
253 NM Case notes Vol. 1 PP. 89 & 91
254 SM Case notes. Vol. 1 PP. 50-53
255 AMIGOS P.86
256 SM Case notes Vol. 2 PP. 27-28
257 SM Case notes Vol. 3. PP.123
258 SM Case notes Vol. 4. PP. 17-30

As can be ascertained from the above bullet points Mr. X was recorded as having, or possibly having, a knife in his possession on eight separate occasions. He was recorded as having been aggressive and abusive, or as having plans to commit acts of violence on eleven separate occasions, three of which had merited Police intervention. The risk that Mr. X presented needed to be seen against the backdrop of his social isolation, paranoid ideas and delusional thinking about his neighbours having plans to hurt him. It also, most importantly of all, needed to be seen in the context of his diagnosis.

Mr. X had received from 2001 diagnoses of Schizotypal Personality Disorder (with possible Dissocial Personality Traits) and Borderline Personality Disorder. In latter years he also held a diagnosis of Paranoid Schizophrenia. Throughout the period that Mr. X received his care and treatment from the Mental Health Trust it was evident that he drank heavily and also had a substance abuse problem. In conjunction with his diagnoses and substance misuse Mr. X had been observed to be *"flamboyant, histrionic and insincere"*.[259] He had also acted consistently in an impulsive and unpredictable manner. This clinical presentation was complex and challenging, however all extant risk assessments served to chart his behaviour only. At no stage between 2001 and 2007 were any strategies (aside from detention under the Mental Health Act) ever formulated to monitor, manage and understand Mr. X.

Vulnerability Issues

The obvious aspects of Mr. X's risk profile have been listed above. Other aspects that were never appropriately considered by the clinical teams caring for Mr. X included:

- **Demographic profile.** Mr. X was under the age of 35, unemployed, male, socially isolated, financially constrained, and suffering form a mental illness/disorder. These aspects of Mr. X's profile increased his vulnerability to suicide. These factors were not considered when developing his risk profile;
- **Substance and alcohol misuse.** Mr. X routinely drank heavily and abused amphetamines, cocaine and heroin. His poly-substance misuse was cited as being a contributory factor to the presence of his possible psychotic symptoms. This factor was never appropriately addressed and his potential risk to other people was never considered in this context;

259 NM Case notes Vol.2 PP. 149-152

- **Abuse from others.** It is not possible to know whether any of Mr. X's delusional beliefs and paranoid ideas were rooted to a certain degree in reality. Mr. X held very consistent beliefs over a period of years regarding his neighbours and their behaviour and hatred towards him. The clinical records do not record a consistent endeavor to understand why Mr. X held such beliefs, whether there was any truth behind them and what coping strategies he could deploy.

Risk to Family

The risk to both the mother and stepfather of Mr. X was never assessed and managed appropriately. During the admission to the SAFIRE Unit on the 15 June 2006 issues came to light regarding family relationships that had not been recorded before. It was recorded on the initial risk assessment that Mr. X had previously assaulted his mother, this is not mentioned elsewhere.

Mr. X's mother was asked by the ward staff to search her son's flat for knives. This she did. She found two knives, one that she described as being *"a knife like Rambo would have"*. Under the knives she found a list of addresses and personal information about Mr. X's work colleagues. She expressed her concerns about what her son would do. She had also brought letters from Mr. X's neighbours onto the ward that explicitly pointed towards a serious level of aggression and inappropriate behaviour that Mr. X had been exhibiting towards them. When Mr. X's potential discharge was discussed with her she expressed a desire that an alternative to discharge was considered at that stage. On the 21 June Mr. X was transferred to Grafton Ward Central Manchester and on the 22 June Mr. X was discharged to his stepfather's home. No risk assessment was developed regarding the stepfather's safety and no carer assessment was offered. At this point there appears to have been a discontinuity between what the staff on the SAFIRE Unit *knew* and what the staff on Grafton Ward *did* regarding Mr. X's discharge.

On the 21 October 2006 Mr. X was admitted to the SAFIRE Unit once again. On this occasion his mother told the unit staff that following his previous discharge Mr. X had subjected both herself and his stepfather to a serious degree of both emotional and financial abuse. She and Mr. X's stepfather were so traumatised by his behaviour that she asked for him to not have unrestricted access to them for the time being. Mr. X's mother was worried that he was neglecting himself. She reported that he had reduced both his flat, and that of his

stepfather, to a squalid and filthy level. She asked for Mr. X to receive help and support on a regular basis. Mr. X was discharged two days later. Once again no carer assessment was considered and the concerns of Mr. X's mother were ignored.

From this time onwards the parents of Mr. X maintained their distance from him. Ward staff continued to make contact with them each time he was admitted as an inpatient or sectioned under the Mental Health Act. However in the absence of the support they felt both they, and Mr. X, needed they decided that they could not safely remain part of their son's life. It is not clear exactly what occurred between Mr. X and his parents. Ward staff recorded many conversations with his mother who summed it up by saying Mr. X had *"done unforgivable things"*. These concerns appear to have been recorded by staff 'in passing' and then ignored.

Safe Guarding Children

The safety of children does not feature largely in the examination of Mr. X's case. However there is a significant point of concern. During the June 2006 admission to the SAFIRE Unit the mother of Mr. X brought letters onto the ward that made explicit the fact that Mr. X was experiencing a serious breakdown in relations with his neighbours. When the mother of Mr. X went to visit his flat to search for knives she also obtained two letters concerning Mr. X's neighbours. The first letter was written by Mr. X, it is not certain whether it was ever sent as it was found in Mr. X's flat by his mother. Several months earlier Mr. X had written this letter saying *"please can you keep your children away from my house. I am aware of pretty much everything they have said and done over the past few months, and especially this week. Please keep them away from my home because I am beginning to hate them."*[260]

The second letter was given to Mr. X's mother to hand on to mental health services when she visited his flat. Following further issues with Mr. X a different set of neighbours had written a letter on the 18 June 2006 addressed *"to whom it may concern"*. The letter stated that Mr. X was "*erratic*" and "*aggressive*". The letter also cited an act of aggression and violence when Mr. X threw plates and a mirror into their garden at their friends.[261]

On the 28 May 2007, a year later, Mr. X told a Psychiatrist in Sussex that his troubles had begun when a neighbour's children had kicked his cat. He had told the children that if they

260 NM Case notes Vol. 1 P. 138
261 NM Case notes Vol. 1 P. 137

did it again he would kick them.[262] This information was ascertained by staff on the SAFIRE Unit following Mr. X's transfer from Eastbourne.

It is difficult to judge how significant these recorded events were. Both of these events were recorded by the same staff in the same North Manchester Unit and so there was a degree of continuity. Neither of these events were entered onto a risk assessment form in order to build up a picture of Mr. X's full risk profile. Insignificant as these events may have seemed to the ward staff, they were potentially of great relevance when seen in the light of everything else that was known about Mr. X at that time.

All Mental Health Trusts have to consider any issues relating to the safety and wellbeing of children. This was not done. Neither was any consideration given to an independent third-party account of Mr. X's relationship with his neighbours, something that had been at the centre of his paranoid beliefs and delusional thoughts for several years.

Risk Assessments and Management Plans - Process and Procedure

As has been mentioned above, risk assessments were conducted at appropriate intervals throughout the time Mr. X received his care and treatment from the Trust. However a risk assessment is more than the creation of log of potential concerns. It was quite evident that risk assessments were not always:

- completed fully;
- the result of inter-team communication exchange and discussion;
- an accurate historical compilation of both past and present risk behaviour and factors;
- completed as part of a multidisciplinary team process;
- part of a dynamic CPA, care and management planning process.

13.1.6.3. Conclusions

Task and Communication Factors

There are three main points to be made about risk management:

- risk assessments have to form part of a dynamic care, treatment and management process;
- risk assessments can only be effective if they are communicated in a timely manner to all clinicians working with the service user;

262 NM case notes Vol. 1 PP. 254-255

- as long as a risk management decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

In the case of Mr. X a log of events was documented. The log was not always accurate, complete or communicated appropriately between all of the services providing care and treatment for Mr. X over time. As a consequence of the absence of a CPA process it is a fact that no single team was in possession of all of the risk information held for Mr. X between 2001 and 2007. This ensured that a multifaceted understanding was never developed. The creation of a log of factors in itself does not constitute a risk assessment. Information was routinely entered onto risk assessment forms in a mechanistic fashion but this information did not advise an active management plan. Few management plans were ever developed which actually addressed the issues raised on the risk assessment forms, and those that were, were not based on the best evidence and information available.

Patient Factors

It is possible that clinical teams were lulled into a false sense of security in that Mr. X usually self presented if he thought about either harming himself or others. It is also possible that ambiguity about the veracity of his symptoms and his many diagnoses may have minimised clinicians' perception of the significance of Mr. X's risk profile. However, when the Independent Investigation Team overlaid all of the risk aspects one upon the other, it was evident that Mr. X had a risk profile that required a significantly higher degree of monitoring and management than he received. All of the information that was required to formulate a coherent management strategy was present 'in the system' and should have been both available to, and utilised by, the clinicians caring for Mr. X.

Understanding the complexity of Mr. X's presentation, the controversy surrounding his diagnosis and his risk profile it would not have been unreasonable for clinical teams to have referred him to either a forensic or specialist Personality Disorder service for advice on the development of a long-term risk management strategy. Had services done this then three options may have been considered. First, if it was felt Mr. X had a mental illness/disorder a suitable long-term care and treatment plan could have been constructed. Second, if it was thought that the risks Mr. X posed were not the product of his mental illness then the police could have been notified on an incident by incident basis every time clinical staff knew he

had a knife or was threatening harm to others. Third, a combination of the two approaches could have been worked through together if considered appropriate.

The failure to provide a legacy of robust risk assessment and CPA meant that the South Manchester Assertive Outreach Team inherited a degree of ambiguity regarding Mr. X on the 3 April 2008. It is difficult to make a direct causal link between the paucity of the Trust risk assessment processes and the events of the 28 July 2008 as Mr. X was transferred from their care to that of the South Manchester Assertive Outreach Team four months prior to the event. However the failure to care, treat and manage Mr. X in the light of his full risk profile ensured that his mental health problems were never adequately understood and managed. This potentially placed both him and other people at risk and effectively minimised the significance of Mr. X's risk profile on his transfer to a new service that sat within a totally different organisation.

- ***Contributory Factor Number Five (influencing). The failure to understand Mr. X in the light of his full risk profile ensured that his mental health problems were never adequately managed over time. This potentially placed both him and other people at risk and effectively minimised the significance of Mr. X's risk profile on his transfer between services.***

13.1.7. Referral, Transfer and Discharge

13.1.7.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been competed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

Trust Admission and Discharge Policy for Inpatient Care 2007

Throughout the period that Mr. X received his care and treatment from the Trust appropriate local policy guidance was in place. The policy information set out below comes from the policy that was in operation between 2007 and 2008 for inpatient services which addresses the most significant period concerning Mr. X being transferred between, and discharged from, services. Helpfully this policy set out the roles and functions of all of the key staff that formed part of the care and treatment continuum.

The role and responsibilities of the Named Nurse included the following:

- liaison with the Care Coordinator;
- filling in the admission check list;
- ensuring CPA plans were incorporated into the ward-based note;
- liaison with the Consultant Psychiatrist;
- liaison with carers;
- organisation of, and access to, the clinical record;
- recording of all significant meetings and reviews of the Multidisciplinary Team;
- discharge meeting coordination;
- on the occasion of a sudden, unplanned discharge to communicate and liaise with staff as appropriate, e.g. GP and Care Coordinator;
- following discharge to Fax notification of Discharge to CMHT Team Leaders.

The role and responsibilities of the Care Coordinator included the following:

- on admission of a patient to a ward to provide clinical information as soon as possible;
- as a probable referring agent, a risk assessment must be provided to the ward on the day of admission, documenting Mental State Examination, current presentation and the reason for admission;
- liaison with carers at the point of admission;
- provision of recent CPA;
- meetings with named nurse, service user, carers and other available members of the Multidisciplinary Team within five days of admission;
- proactive weekly liaison and communication with the ward, and the attendance at ward-based reviews at least monthly;

- liaison with any other agencies and services involved with the service user, e.g. residential care, supported accommodation;
- assistance in the identification of social care needs;
- preparation of the Discharge Care Plan;
- meeting with the Service User prior to discharge to help prepare the Discharge Care Plan and CPA and provide all necessary information regarding the pending discharge;
- agree arrangements for the seven-day discharge follow up.

The role and responsibilities of the Consultant Psychiatrist/Responsible Medical Officer included the following:

- discharging any relevant duties under the Mental Health Act;
- setting a discharge date on admission;
- reviewing medication, mood and mental state, risks and leave arrangements;
- in conjunction with the Multidisciplinary Team, developing a plan for admission and identifying criteria for discharge;
- consideration of provisional diagnosis.

The role and responsibilities of the Senior House Officer:

- assess the Service User prior to each admission;
- present new admissions to the Multidisciplinary Team to include history, mental state, risks etc.;
- record all clinical meeting discussions.

Section 117

There was no separate Section 117 Policy prior to 2008. It was incorporated into other relevant policies.

13.1.7.2. Findings

Referral

Between January 2001 and April 2008 Mr. X was referred to the CMHT on five occasions by the GP, on five occasions by inpatient services and on two occasions by Accident and Emergency Services. Mr. X was also referred to Psychology and Psychotherapy Services on five occasions, alcohol services on one occasion and had a total of five inpatient admissions to Psychiatric Units. Furthermore, as can be seen from examining the chronology, Mr. X self

referred to Accident and Emergency Services on a minimum of eight occasions and received two inpatient admissions whilst on holiday in the United States of America. From examination of Mr. X's clinical records a minimum of 28 separate referral processes can be detected over a seven-year period. It is entirely possible that more referrals took place that were not immediately apparent from the Independent Investigation Team's documentary analysis of the clinical record (this is discussed below in Section 13.1.10).

Whilst such a numerous set of referrals is not unique, it is an indication that something was not working well with Mr. X's case management. There are two main issues:

1. the referral process and procedure;

2. the care pathway.

Between 2001 and 2008 the referral process and procedure appears to have been conducted appropriately in that formal referral processes were in operation and communication between the people both making and receiving each referral was evident. However the main problem with each referral process was it was effectively made in a vacuum. Each referral process was primarily a reactive situation, resulting the majority of the time, from a crisis situation. The number of referrals from different agencies, in the absence of robust care coordination, ensured that each event was assessed as a 'stand alone event'. This, when coupled with diagnostic and treatment ambiguity, served to create a 'revolving door' situation.

The 'revolving door' situation could have been managed had robust care coordination been provided. As has already been ascertained, CPA did not occur in any meaningful way between 2001 and 2007. Since 1999 with the advent of the National Service Framework, and guidance issued by the National Institute for Clinical Excellence in 2003, explicit expectations were set regarding treatment options and patient care pathways. Whilst some of these were emerging during the period of time that Mr. X was receiving his care and treatment from the Trust the notion of the necessity of patients following a care pathway was an accepted part of the psychiatric canon. Mr. X's care and treatment did not appear to have followed a care pathway approach. This led directly to a reactive referral process which followed no appropriately formulated long-term management or treatment strategy.

Transfer

Mr. X was transferred between services on the following occasions:

- 21 June 2006 from the SAFIRE Unit to Grafton Ward;[263]
- 28 May 2007 from a hospital in Sussex to Redwood Ward, and then on the 31May from Redwood Ward to Grafton Ward;[264]
- 15 October 2007 from Redwood Ward, North Manchester, to Bronte Ward, South Manchester;[265]
- 3 April 2008 from Bronte Ward, (a Mental Health Trust service), to the South Manchester Assertive Outreach Service, (operationally managed by the Health Resource Advocacy Project).[266]

Inpatient admission usually provides the opportunity for assessment. In the case of Mr. X, in the context of his turbulent community-based experience, his inpatient admissions could have provided the basis for a planned pathway to be developed. However even on short admissions Mr. X was transferred between services, this prevented any continuity of care and fragmented the assessment and planning process.

Occasion One

On the 15 June Mr. X was admitted to the SAFIRE Unit following two self-reported self-harm attempts that had taken place within a two-day interval. On the 21 June Mr. X was transferred to Grafton Ward, and on the 22 June Mr. X was discharged at his own request. On admission to the SAFIRE Unit his assessed risk was considered to be high regarding both harm to himself and to others. During this inpatient episode important information was given to the staff of the SAFIRE Unit by Mr. X's mother and his neighbours. It had also been ascertained that Mr. X had two illegal knives in his possession. On transfer to Grafton Ward Mr. X's risk to both himself and to others was considered to be low and he was discharged. The question has to be, how could Mr. X's assessed risk go from being 'high' to 'low' over a period seven days when additional third party information would suggest that Mr. X's risk remained high? It is probable that the transfer process served to break the continuity of care. This meant that significant new information about Mr. X was not assimilated and the concerns of his family were not considered.

263 NM Case notes Vol. 1. PP.22-33, 76-77, 87-91, 137-138
264 NM Case notes Vol. 1. PP. 254-255, 261, 208, 180, 191
265 NM Case notes Vol. 2, & SM Case notes Vol. 2
266 SM case notes Vol. 4 & AMIGOS Records

Occasion Two

On the 28 May 2007 Mr. X was transferred via Section 136 from a hospital in Eastbourne Sussex to Redwood Ward in Manchester. On the 31 May Mr. X was transferred to the SAFIRE Unit. On the 6 June 2007 he was discharged back into the community. The clinical records show that it was not until Mr. X was transferred to the SAFIRE Unit that any collateral information was gathered from the Police in Sussex. On the 4 June the Police told staff that Mr. X had been in possession of a knife. The risk assessment on this day recorded Mr. X as being a high risk of suicide and a low risk to others. However it was noted that the low risk to others could change if he suffered a psychotic relapse and/or purchased another knife.[267] Mr. X stated that if he was discharged he would buy a rope and hang himself. He was discharged into the community and was referred to the CMHT who on this occasion accepted the referral and placed him on Enhanced CPA from the 14 June 2007.

Over a period of eight days, between the 28 May and the 6 June 2007, Mr. X was placed in three different inpatient units. The collation of information regarding Mr. X's mental state appeared to have been sporadic, the risk assessments and discharge plans contradictory, and the continuity of care very poor. Mr. X was handed over to a Care Coordinator who at the point of discharge had yet to confirm acceptance of the case.

Occasion Three

On the 17 August 2007 Mr. X was admitted onto Redwood Ward (North Manchester) under Section 2 of the Mental Health Act on his return from the United States of America. On the 15 October 2007 Mr. X was transferred to Bronte Ward (South Manchester). The rationale for the transfer was not made explicit in the clinical record and Mr. X was recorded as being unhappy about being moved to a different service.

This transfer represented a significant juncture and was not managed well. Significantly, Mr. X passed from the care of one Consultant Psychiatrist to another, back to Consultant Psychiatrist 1. On arrival at Bronte Ward Mr. X's clinical records were not available to the admitting doctor who had to 'make do' with a verbal handover from a member of the North Manchester Nursing Team. Mr. X was passed from a clinical team who had found reaching a consensus regarding his diagnosis impossible. It was uncertain from reading the clinical

267 NM Case notes Vol. 1 P. 208

records how much of this ambiguity and conflict was handed over to the South Manchester Team at the point of transfer. What was evident was that a very different management approach was adopted by the South Manchester Team and Mr. X subsequently received a radical change in diagnosis, from Personality Disorder to that of Paranoid Schizophrenia.

Occasion Four

The final transfer process that Mr. X experienced was between the Trust Inpatient Service on Bronte Ward to the South Manchester Assertive Outreach Service on the 3 April 2008. This will be addressed in the discharge section immediately below.

Discharge

Between January 2001 and April 2008 Mr. X was discharged from the Outpatient Clinic on three occasions, from the 'Fifteen' psychotherapy group on two occasions, from Accident and Emergency departments on eight occasions, and from Inpatient Services on five occasions.

Prior to his first inpatient admission in 2006, Outpatient and Psychotherapy services had discharged Mr. X back to the care of his GP when they either could not engage him, could not offer him a service, or when Mr. X breached service criteria (in the case of the 'Fifteen' psychotherapy group). Because Mr. X was not absorbed fully into secondary care services until 14 June 2007 each discharge placed his care effectively back 'at square one'.

Mr. X had the first of his five United Kingdom psychiatric admissions on the 15 June 2006. The first three admissions from this date all managed discharge arrangements in a similar way. Basically after a short period of assessment Mr. X was discharged back into the community with plans for either CMHT or Outpatient Clinic follow up that had not been confirmed or pre-planned.

On the first discharge of the 22 June 2006 Mr. X was discharged back to the Outpatient Clinic and to the care of Consultant Psychiatrist 1. On the 27 June the Grafton Ward Senior House Officer wrote to the Outpatient Clinic suggesting that Mr. X be followed up by them. A period of a week elapsed between discharging Mr. X and instigating the follow up process. This did not bear the hallmark of a well-planned process.[268]

268 SM Case notes Vol. 1 P. 88

On the second discharge of the 23 October 2006 it was recorded that Mr. X was not deemed to be acutely unwell and was not suitable for a long-term admission. The plan on discharge was to *"refer to Crisis Point and if not accepted to be discharged back to the Care of Consultant Psychiatrist 1"*. Mr. X was also to be referred for Cognitive Behaviour Therapy and for assessment by the CMHT.[269] The difficulty with this approach was that the discharge was not planned. Once again Mr. X had been admitted and then discharged back to a situation of uncertainty whilst it was ascertained whether the support services would accept him or not. In effect Mr. X was referred back to the Outpatient Clinic and the 'Fifteen' group.

On the third discharge of the 6 June 2007 the discharge plan was to:

- discharge to his home address;
- give a two day supply of medication;
- make an outpatient appointment;
- make an appointment with the GP surgery on the 8 June;
- attempt to contact CPN to ascertain whether Mr. X had been allocated a CPN service;
- inform Mr. X's mother regarding his discharge.[270]

On this occasion Mr. X had been admitted under Section 136 of the Mental Health Act. He had also been assessed as retaining a high degree of risk. Once again Mr. X was discharged with a very flimsy plan that had not been confirmed. This discharge did not meet any aspects of the Trust policy and procedure in place at the time.

Following Mr. X's return from the United States of America he was admitted under Section 2 of the Mental Health Act. From this point on the Trust followed more robust discharge procedures. The discharge that took place on the 31 January 2008 was conducted within the appropriate framework of the Trust discharge and CPA policies. This discharge took place following a six-month inpatient period of both assessment and treatment during which time Mr. X had been subject to detention under Section Three of the Mental Health Act.

The fifth and final discharge that Mr. X experienced whilst receiving care and treatment from the Trust occurred on the 3 April 2008. In preparation for this the decision was made on the 28 February to make a referral to the South Manchester Assertive Outreach Team, a service

269 SM Case notes Vol. 1 PP. 68 &72
270 SM Case notes Vol. 1 PP. 15-16

that had no previous knowledge of Mr. X. At this time the person who had been providing care coordination for Mr. X retired, and *New Ways of Working* had been implemented, this had the effect of changing Mr. X's medical lead from Consultant Psychiatrist 1 to Consultant Psychiatrist 2. Thus three distinct factors were brought together that impacted upon continuity of care at the same time as the planning of Mr. X's discharge, which in itself was a critical juncture.

The South Manchester Assertive Outreach Team was invited to a ward round due to be held on the 13 March in order for the discharge process to be commenced in accordance with Trust policy and procedure. The South Manchester Assertive Outreach Team did not attend this meeting. They were invited to the next ward round due to be held the following week, prior to this on the 16 March two members of the South Manchester Assertive Outreach Team visited the ward to commence the referral process. On the 20 March the South Manchester Assertive Outreach Team attended the ward round as planned. It was agreed that Mr. X would be given a one-week period of leave from the ward that would provide the South Manchester Assertive Outreach Team an opportunity to start working with him and to get to know him prior to his planned discharge on the 3 April. During the one-week period of leave the South Manchester Assertive Outreach Team was unable to make contact with Mr. X and no visit was made.

On the 27 March two members of the South Manchester Assertive Outreach Team were able to meet with Mr. X on the ward to which he had returned following the end of his period of leave. A ward round was held on the same day at which it was agreed that Mr. X would continue on leave to his flat and the South Manchester Assertive Outreach Team would continue to visit him at his home. On the 27 March the two members of the Team managed to visit Mr. X at his home which they described as being clean and tidy. On the 3 April another ward round was held to which members of the South Manchester Assertive Outreach Team attended. Mr. X was discharged with a plan that had been fully agreed and consulted upon. The plan was for:

- the South Manchester Assertive Outreach Team to meet with Mr. X every two weeks;
- the South Manchester Assertive Outreach Team to take over the administration of depot medication;

- the South Manchester Assertive Outreach Team Consultant Psychiatrist to follow Mr. X up within two weeks of his discharge;
- the South Manchester Assertive Outreach Psychologist to provide therapy and intervention.[271]

At the point of discharge a CPA review took place, for which no paperwork appears to exist. However a full discharge summary was sent to the GP and the South Manchester Assertive Outreach Team was given a full set of Mr. X's most recent risk and CPA documentation.

The Trust internal investigation into the care and treatment of Mr. X cited the failure of Consultant Psychiatrist 1 to provide a handover letter to the South Manchester Assertive Outreach Consultant Psychiatrist. It has to be noted at this juncture that Consultant Psychiatrist 1 was no longer the medical lead for Mr. X at this stage. It was clear from viewing the clinical records that the Senior House Officer for Consultant Psychiatrist 2 wrote a comprehensive discharge summary on the 11 April 2008 to the GP.

However whether a consultant to consultant letter was sent or not Mr. X was discharged from Bronte Ward. Whilst a letter would have been best practice it has to be remembered that by this stage *New Ways of Working* was in place which advocated placing communication responsibilities with a nominated clinical lead, this person no longer had to be the Consultant Psychiatrist. In the case of Mr. X ward-based and South Manchester Assertive Outreach Staff took on these roles and it could be argued that the responsibility to communicate with all other relevant team members rested with them. It is true that for a variety of reasons Mr. X's full psychiatric and risk history was not handed over to the South Manchester Assertive Outreach staff at this stage, but then this was not in the possession of Bronte Ward to give. As has been discussed above, and will be discussed further below, this was in part due to a great deal of information about Mr. X being scattered around many different services exacerbated by the lack of a service-wide integrated clinical record system. It is probable that the Independent Investigation has provided the first occasion where everything that was known about Mr. X has been brought together in the same place at the same time. This being said, the discharge on the 3 April was managed as well as it possibly could be in the face of both organisational change and incomplete available information.

271 AMIGOS P. 505

13.1.7.3. Conclusion

The practice discussed above sets out in more detail some of the issues raised in section 14.1.3. that addressed factors relating to the management of Mr. X's case. Referral processes tended to be operated within policy guidelines. The significance to an investigation of this kind in examining referral processes is that it provides a longitudinal picture of how Mr. X was worked with over time. It was apparent that Mr. X did not follow a pathway and appeared to be part of a 'revolving door' process that was not proactively managed.

Transfer processes were restricted to Mr. X's inpatient experience. It can be ascertained that the practice of transferring Mr. X during admissions of both short and long duration served to dislocate the continuity of care. This approach could not be described as patient-centered and exacerbated the themes of poor psychiatric history taking, poor cumulative risk assessment and poor management planning that run throughout this report.

Mr. X's first three discharges from inpatient care were not conducted to an acceptable standard when assessed against local Trust policy and procedure. These three occasions demonstrate the fact that Mr. X was not in receipt of an effective and proactive management process. Teams did not appear to work across the inpatient and community divide and this was to the detriment of patient care and left Mr. X in a vulnerable position.

The fourth and fifth discharges were managed well and entirely in keeping with both local and national best practice guidance.

Patient Factors

It is not certain to what extent patient factors contributed to the way in which Mr. X was managed. As has already been discussed, Mr. X was a figure of controversy within several of the teams that delivered his care and treatment. It is evident that the incongruity between Mr. X's self-reported symptoms and his observed behaviour possibly led many clinicians to minimise both his level of need and his level of risk. It was evident from conducting this investigation that Mr. X was challenging and complex in his presentation to services. This kind of presentation although difficult to manage is not unique. Presentations of this kind should indicate to clinicians that supplementary measures usually need to be taken in addition to those set out in policy and procedure in order to manage a person effectively. In the case of Mr. X, prior to January 2008, not even the basic policy guidelines were met regarding his

discharge from inpatient units. However, it would appear that once Mr. X received a diagnosis of Paranoid Schizophrenia in October 2007 a more focused approach was taken to his case, possibly because the ambiguity of his condition was to some extent addressed.

Organisational and Team Factors

It is evident that the Trust had appropriate policies and procedures in place. It is a fact that they were not always followed. 2006 and 2007 appeared to be the periods of time when teams were not working to policy guidance with regard to discharge procedures. It has been reported extensively in several documents in the public domain that Manchester Mental Health Services were underperforming for an interval encompassing several years. The Trust was dogged by industrial action and staff morale was low. Professional leadership and governance processes were not always effective during this period and this provides a reason, if not an excuse, for breaches in processes occurring and for them being neither detected nor corrected.

It is the conclusion of the Independent Investigation Team that Mr. X's referral history shows evidence of a 'revolving door' care pathway. Transfer practice and discharge procedures served to exacerbate the poor case management already made ineffective by other poorly executed processes such as CPA and risk assessment.

- ***Contributory Factor Number Six (influencing). The poor management of referral, transfer and discharge processes contributed to the poor management of Mr. X's care and treatment pathway between January 2001 and August 2007. This served to exacerbate the poor case management already made ineffective by other poorly executed processes such as CPA and risk assessment.***

13.1.8. Carer Assessment and Carer Experience

13.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at*

meeting their wishes'. In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that '*people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care*'. Also that it will '*deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed*'.

Carer involvement

The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- have their own written care plan which is given to them and implemented in discussion with them.

13.1.8.2. Findings

For much of Mr. X's adult life he lived independently in the community in his own accommodation. Mr. X did not live with either of his parents, who were divorced, apart from during a relatively short period of time in the summer of 2006 when he went to live with his stepfather. Mr. X's parents had intermittent contact with mental health services and did not present in a 'traditional carer role'.

The Account from Mr. X's Mother

The mother of Mr. X did not feel able to meet with the Independent Investigation Team, however she allowed a statement to be sent to us. The following account is taken from this statement. The mother of Mr. X admits that due to the stress of the situation she cannot remember all of the events necessarily in the correct time order.

Mr. X's mother described her son as having a normal and uneventful childhood. However when he reached the age of 14 years he began to become very withdrawn. At this time he took an overdose of Paracetomol which he self-reported to his mother who took him to the Accident and Emergency Department to have his stomach pumped. Following this event Mr. X was seen at a clinic by a Child Psychiatrist who eventually told his mother *"to take him home and be tougher on him"*. The overdose was an apparent reaction to the bullying Mr. X was subject to from a group of girls at his school. From this point Mr. X became very difficult to live with, his mother described it as *"walking on eggshells"*.

In his late teens, on leaving school, Mr. X began to make anonymous telephone calls to a girl that he worked with. Her boyfriend found out and threatened Mr. X, his mother tried to explain to him that making anonymous telephone calls *"wasn't good and that he was lucky the Police hadn't been called"*.

At the age of 18 years Mr. X went to work for the Royal Mail. From this time his behaviour grew more erratic. He would often state that he was depressed and wanted to kill himself. He found getting on with other people increasingly difficult to handle. He left the Royal Mail.

Shortly afterwards Mr. X rejoined the Royal Mail and was re-instated as a postman. In his early twenties, his mother reported, Mr. X went to the United States of America with the

intention of shooting himself on a pistol range. He returned unharmed and left home aged 22 years to live in a new house that he had purchased.

On moving to the new house Mr. X began to *"fixate and fret about things"*. The house very quickly became a mess and Mr. X did not look after himself and was regularly smoking cannabis. When his mother tried to visit him he would not open the door. Mr. X did not socialise and on the rare occasions when he did *"something would happen and he would be left feeling suicidal."*

In December 1999 Mr. X's parents sold their house and moved next door to him. At first Mr. X seemed to be relieved although he did not like his parents to visit his house, preferring to visit theirs instead. Around this time Mr. X became obsessed with Beachy Head, he was not looking after himself properly and his mother was worried he might try to commit suicide. During this period he had been assaulted whilst out on his postal route and he was convinced after this event that he saw his attacker *"all of the time"*. At around this time Mr. X started to carry *"Rambo style knives"* around with him. In 2000 Mr. X's mother separated from her husband which distressed Mr. X greatly. Both parents moved out of the house next door.

In the years that followed Mr. X's mother tried often to get support for her son by visiting her GP for advice. She was told that the General Practice could not help her as it would constitute a breach of patient confidentiality. During Mr. X's first admission to the SAFIRE Unit his mother attempted to explain her concerns to the ward staff in relation to how angry and aggressive Mr. X could become. She showed the ward staff two of the knives that she had discovered at his home but reported *"they told me off for doing so"*. During this admission Mr. X's mother *"never got to speak to the same person twice."* Mr. X's mother did not think that they had him on the ward long enough to get to understand him and that the ward staff were dismissive of her and did not believe what she had to tell them about her son. Both of Mr. X's parents found it difficult to find out what was wrong with him as they were told that the ward staff did not like *"pinning labels on people while they were still being assessed."*

Mr. X and his stepfather legally swopped their properties when he was discharged in the summer of 2006 following his first admission to the SAFIRE Unit. For a short period of time Mr. X's mood lifted but within weeks the flat was a mess and he refused to notify the credit card company, council tax office and utility companies that he had moved. In 2009, following

Mr. X being sent to Ashworth High Security Hospital after the killing of Mr. W, his stepfather stated to the Forensic Psychiatrist that he had been so frightened of his son at this time that he had slept with a piece of wood up against the door so that Mr. X could not enter his bedroom.[272]

In 2007 Mr. X was medically retired from the Post office. His mother began to feel afraid of him and was worried that he would either hurt her or someone else. Mr. X became more convinced that neighbours were *"laughing and talking about him"*. He kept a base ball bat at his house for his protection. His mother wanted to meet his Psychotherapist in order to discuss how best to deal with the situation but Mr. X would not let her.

Mr. X's mother described Mr. X as abusing a long list of illegal drugs over time. That he could not take care of himself and that he was not able to maintain any kind of social relationship. She endeavoured to provide as much support as she possibly could but Mr. X was often hostile and aggressive towards her.

Response to the Family by the Trust

It would appear from the clinical records and from the statement provided by Mr. X's mother that none of the clinical teams involved with Mr. X ever took the opportunity to gather collateral information about him from his family.

The clinical teams appeared to have developed set views about Mr. X, his diagnosis and his presentation. These views may have benefitted from both the experience and the insights of his parents. Mr. X's mother in her statement describes him as a young man who neglected himself, was frequently in tears and fearful, was frequently hostile and aggressive and whose experience of social failure constantly brought him to the brink of suicide. It is possible that had these views been taken into account Mr. X would have received a more patient-centered and proactive service.

The mother of Mr. X described her gradual withdrawal from her son's care and support due to the fact that she had become increasingly frightened of him and that the situation over the previous decade had left her feeling stressed and unwell. Mr. X was receiving CPA therefore

272 Ashworth Court report. 8 June 2009. P. 28

it would have been appropriate to have offered his parents a carer assessment in order to plan how best to maintain him in the community. The carer assessment would also have identified the levels of support the parents required in order to support their son.

13.1.8.3. Conclusions

It would appear that the ambivalence of some the clinical teams when working with Mr. X also extended to his parents. Both Personality Disorder and Paranoid Schizophrenia can be extremely difficult diagnoses for families to manage. In reality it did not matter which diagnosis was being formulated at any particular time. The parents of Mr. X needed to be listened to, to receive appropriate information, and to receive support. This did not occur and as a result family relationships were fractured. Whilst this has no direct bearing on the death of Mr. W this forms a significant area of learning for the Mental Health Trust to consider.

- ***Service Issue Number two. The parents of Mr. X were not offered the degree of advice and support they needed in order to support their son in the community. As a result relationships were fractured.***

13.1.9. Service User Involvement in Care Planning

13.1.9.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care"*. It also stated that it will *"deliver continuity of care for as long as this is needed*", *"offer choices which promote independence"* and *"be accessible so that help can be obtained when and where it is needed"*.

13.1.9.2. Findings

There was plenty of evidence in the clinical record to show that Mr. X received many different consultations with clinical staff over a period of seven years. However these consultations did not lead to continuity of care, proactive crisis and contingency support, and choice. It was evident that clinical staff found it difficult to empathise with Mr. X and felt that he over intellectualised his situation. Mr. X presented as an intelligent person who had obviously read-up on his diagnosis. He may also have read-up on other psychiatric diagnoses and attempted to interpret his own experiences against the information that he gleaned. This kind of behaviour is not uncommon and General Practitioners are frequently visited by patients who have researched their symptoms prior to a consultation. It would appear however, that this habit served to distance Mr. X from his care teams who found him to be self-absorbed.

The Independent Investigation Team found that entries in most of the clinical documentation over time tended to record information about Mr. X in a fairly negative way. Recorded observations often come across as being cold and critical. It is entirely possible that some clinicians found Mr. X difficult to like, unfortunately this is evident when reading Mr. X's psychiatric history. Without a doubt Mr. X presented in a complex and challenging way. It is not uncommon when working with people with mental illness to encounter behaviour that can exhaust clinical staff and lead to an overly judgemental approach. The fact that this happens is nothing to be surprised about. However clinicians are taught as a basic part of their professional training that this may occur and that it requires swift and objective management. Nothing should be allowed to interfere with the unconditional positive regard that service users should expect whilst receiving their care and treatment. This level of objectivity is sometimes extremely difficult for staff to attain. Circumstances like this are not unusual and require good solid multidisciplinary team working to manage the transference, counter transference and team splitting that can occur.

13.1.9.3. Conclusions

It is difficult to know to what extent the relationships that Mr. X had with his clinical teams affected the quality of his care and treatment. It is obvious from reading some of the clinical records and on interviewing witnesses that Mr. X was not universally liked and that this had an impact on how clinical staff perceived him.

Good practice would require that a situation like the one that existed in the management of Mr. X should have been professionally managed. It was evident from examining the clinical records and from talking to clinical witnesses that disagreements about Mr. X's diagnosis had led to divisions within teams and ultimately served to disadvantage Mr. X.

- ***Contributory Factor Number Seven (influencing). Clinical teams were unable to build up a therapeutic relationship with Mr. X over time. This impacted upon Mr. X's levels of engagement with services and also impacted upon his ability to access services when in crisis.***

13.1.10. Documentation and Professional Communication

13.1.10.1. Context

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.'[273]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[274]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[275]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

273 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P.121

274 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). P.144.

275 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

13.1.10.2. Findings

The standard of clinical record keeping in the case of Mr. X over time was found to be generally good. There were a few examples of unsigned and undated clinical entries but on the whole, considering the length of time over which the record was created, this was not found to be significant. There were also some examples of CPA and risk assessment forms that were not completed, however this would appear to have been an issue primarily stemming from the use of CPA and risk assessment *per se* rather than that of record keeping.

The issue here is not so much the quality of the clinical record but the purpose to which it was put. Over the years each team maintained an appropriate set of clinical information in accordance with Trust policy and procedure. However this information was not always shared in a timely manner and this lack of professional communication occurring across all of the clinical teams involved with Mr. X exacerbated the difficulties that were encountered in the management of his care and treatment. Communication processes were hindered by the lack of integrated clinical records and the relatively late (2007) adoption of an electronic clinical record system. It was evident from close examination of this case that no single team had in its possession a full set of clinical information about Mr. X at any one time. As has been discussed above in previous sections, this affected the quality and effectiveness of risk assessment and care planning. In the absence of robust care coordination it also made a significant contribution to the poor overall management of the care and treatment that Mr. X received.

13.1.10.3. Conclusions

Over the past seventeen years, following the Clunis Inquiry, the importance of robust record keeping and professional communication has been identified as a crucial protective factor in the effective and safe management of patients. Whilst Mr. X did not have a criminal history that required intensive interagency management he required frequent inputs from a multiple range of different services. In the absence of robust care coordination important information was at times retained by teams and this prevented the development of an accurate, comprehensive and timely assessment of Mr. X's condition and resulting care requirements. This contributed to the poor overall management of Mr. X's care and treatment package over time.

- ***Contributory Factor Number Eight (influencing). Poor professional communication hindered the development of an accurate, comprehensive and timely care and treatment plan. This had the effect of ensuring that Mr. X was not assessed within the full context of his psychiatric history and that the required planned interventions were not made.***

13.1.11. Clinical Supervision

13.1.11.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations [276] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:
'….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations'[277]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

13.1.11.2. Findings

The Care Quality Commission assessment for the Trust 2007/2008 identified that *"this organisation did not meet the standard of properly supervising clinical staff when caring for and treating patients."*[278] The Mental Health Trust could not provide evidence to demonstrate that:

276 Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses.
277 Nursing and Midwifery Council, Advice Sheet C. (2006)
278 http://2008ratings.cqc.org.uk

- *"all nursing staff had received clinical supervision;*
- *clinical supervision was monitored and reviewed;*
- *nurses could feedback their experiences of clinical supervision".*[279]

The Care Quality Commission found that the Trust could provide evidence during this period to show that supervision policy and procedure was in place for the supervisory arrangements of all professional groups delivering clinical care and treatment. The Trust was also able to provide evidence that some 132 approved clinical supervisors were available throughout the Trust to deliver clinical supervision. However whilst systems were in place to monitor the supervisory arrangements of doctors and occupational therapists, no evidence could be provided to support the view that a similar system was in place to assure that nursing staff were receiving supervision.

The Independent Investigation Team found that when interviewing clinical witnesses their recollection of supervision practice within the Trust was 'hazy' when related to the period that Mr. X was receiving his treatment and care. Few formal records appear to have been maintained; therefore it is not possible to understand how clinical supervision worked during this period.

13.1.11.3. Conclusion

Clinical supervision provides a formal opportunity for clinical staff to discuss all aspects of their clinical practice. Mr. X caused a degree of controversy within the clinical teams that provided his care and treatment. It is difficult to understand how exactly robust clinical supervision could have impacted upon his management plan. However it would be fair to say that clinical supervision provides an opportunity for clinicians to assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. The valuable safety net of clinical supervision appears to have been available to staff in a sporadic manner and was not able to provide the protection to service users that it was designed to afford. This absence of coherent clinical supervision was made more problematic by the failure to implement other safety frameworks such as the Care Programme Approach.

279 Inspection Guide 2007/2008 (Manchester) p.2

- ***Contributory Factor Number Nine (influencing). Clinical Supervision failed to provide the opportunity for the professional scrutiny of Mr. X's case. Whilst it is not the function of clinical supervision alone to ensure the safety and wellbeing of patients, it does provide an important part of assuring the patient pathway. In the absence of this process other safety frameworks which failed to work on Mr. X's behalf went unchallenged.***

13.1.12. Adherence to Local and National Policy and Procedure

13.1.12.1. Context

Evidence-based practice has been defined as "*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*"[280] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 13.1.14 below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

280 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing*, (2006) p. 328

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

13.1.12.2. Findings

Between 1999 and 2010 national policy and procedure guidance for mental health underwent an unprecedented period of change. Whilst policy and procedure evolved rapidly over time the Trust always had in operation a mostly appropriate collection of clinical policies and procedures. These policies met national policy guidance expectation regarding both their application and content and were available during the entire period of time that Mr. X received his care and treatment from the Trust.

As has already been discussed in the sections above, CPA, Risk and Discharge policies do not appear to have been followed by clinical staff. Other clinical processes that were not adhered to include those for Section 117 aftercare arrangements and those for clinical supervision assurance and delivery. Throughout the period that Mr. X was receiving his care and treatment from the Trust policies and procedures were made available freely to clinical staff and training and development were provided when necessary. However on examining the care pathway that Mr. X actually underwent it is apparent that it was significantly different to the one that he should have undergone in line with the national policy guidance that was in place during this time. Local policy guidance regarding CMHT referral criteria actively disadvantaged personality disordered people like Mr. X and prevented them from receiving Enhanced Level CPA, this was out of step with National guidance and other local inter-related policies. Significant departures from policy and procedure were found to have taken place between January 2001 and August 2007 in the following areas:

CPA

- criteria for being accepted onto Enhanced Level CPA were not followed;
- allocation of a care coordinator was not effectively made until the summer of 2007;
- care coordination of a rudimentary nature only occurred prior to the summer of 2007;
- CPA assessment, planning and review did not occur until December 2007;
- Section 117 aftercare arrangements were poor;

- interagency/service liaison did not occur appropriately in the absence of a care coordinator.

Risk Assessment

- service user involvement, disengagement and non compliance were not appropriately managed;
- multidisciplinary/service communication and working did not routinely occur;
- dynamic risk management care planning did not occur;
- discharge planning was rudimentary until December 2007.

Discharge

- care planning was absent or rudimentary until January 2008;
- confirmation of referral arrangements prior to discharge did not occur prior to January 2008;
- risk assessment did not translate into a meaningful care plan prior to January 2008;
- crisis and contingency planning did not occur until January 2008.

Between January 2001 and August 2007/Janaury 2008 the Independent Investigation Team found that individual clinicians did not fulfil their professional obligations satisfactorily regarding the implementation of clinical policy guidance. Clinical leaders and managers did not fulfil their professional obligations regarding the monitoring and supervision of the case.

Between August 2007 and 3 April 2008 Trust-based clinical teams did work in accordance to Trust policy and procedure and this is demonstrated by a substantial change in the assertive management of Mr. X's care and treatment.

13.1.12.3. Conclusions

It is uncertain why policy and procedure was not adhered to in the case of Mr. X. On occasion it was apparent that clinical teams were uncertain as to whether Mr. X had a mental illness or not. This may account for some of the non-adherence to Trust policy and procedure that occurred. Whether this was the case or not, Mr. X remained in receipt of secondary care mental health services, and all aspects of his care and treatment should have been carried out in strict accordance with Trust policy and procedure. This made a significant contribution to

the less than adequate care and treatment package that Mr. X received until he was finally placed on Enhanced Level CPA during the summer of 2007.

Clinical staff did not adhere to Trust policy and procedure and responsibility for this has to be placed at both individual and team management levels. From a corporate responsibility point of view the Trust had a well-documented history between 2005 and 2008 of managing poor systems and processes. During this period the Trust struggled to comply with statutory corporate-level expectations and responsibilities. How the Trust managed its Clinical Governance responsibilities will be examined in Sections 13.1.13 and 13.1.14. below.

- ***Contributory Factor Number Ten (influencing). The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical teams ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to the formulation of a coherent care and treatment plan. Mr. X was complex and challenging and required a systematic approach to his presenting problems against an evidence-based set of clinical standards.***

13.1.13. Organisational Change and Professional Leadership

13.1.13.1. Context

The Manchester Mental Health Trust has experienced many organisational changes since the time of its inception. These changes affected both the delivery of services and the continuity of professional leadership. During 2007 and 2008 staff morale was low and the Trust was subject to a series of industrial actions.

Professional Leadership

Prior to the summer of 2008 the Trust had been through a period where no sustained leadership had been in evidence at Board level. This meant that there was a lack of vision and strategic direction and this impacted upon every aspect of service delivery. Professional leadership suffered as a result and was found to be particularly weak by both the Boyington Review (June 2008) and the Care Quality Commission Report for the period 2007/2008. The Care Quality Commission is the independent regulator of health and social care in England.

New Ways of Working

In October 2007 *New Ways of Working for Everyone* was published. This document set out the national implementation guide for policy change that had been in development over a period of four years previously. The Department of Health stated that *New Ways of Working "promotes a model where distributed responsibility is shared amongst team members and no longer be delegated by a single professional such as the consultant"*.

The Department of Health also stated that *"this cultural shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs. More experienced staff will then support other staff to take on less complex or more routine work. All qualified staff will be able to extend the boundaries of what they do (i.e. non medical prescription) and there will be more chances for new roles such as support time and recovery workers (STR), primary care mental health workers and assistant practitioners to take their places within teams"*.[281]

The care and treatment received by Mr. X was impacted upon by *New Ways of Working for Everyone* between late December 2007 and February 2008 when the Trust reorganised services. As a consequence Mr. X was moved from the care of Consultant Psychiatrist 1 to the care of Consultant Psychiatrist 2.

13.1.13.2. Findings

Professional Leadership

In the years preceding, and leading up to the time Mr. X killed Mr. W, the Trust did not provide consistent professional leadership to the people on the front line delivering patient care. In the Care Quality Commission Review for 2007/2008 the Trust scored a 'Weak' with regards to meeting Core Standards. This score placed the Trust amongst the lowest performing Mental Health Trusts in the country. This review stated that the Trust failed to meet the required standards for clinical supervision and professional leadership.

The Boyington review was commissioned in April 2008. This review was commissioned against the backdrop of poorly performing mental health service delivery in the North West

281 http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_074106

Strategic Health Authority area. The main issues covered in the report for Manchester services were:

- the size and structure of Manchester Mental Health and Social Care NHS Trust;
- the distribution of resources across the city;
- the investment of resources compared to the need;
- the interface between mental health services and the organisations directly supporting social inclusion, for example Job Centre Plus.

The key areas of concern that were identified during the review for the Manchester mental health Trust were:

- the use of resources;
- the lack of engagement with stakeholders;
- the lack of coherent planning;
- relationships, trust and confidence being poor in that there had been too many changes in Chief Executives and Senior Managers;
- commissioning processes had not been effectively monitoring the performance of the Trust.

The review found that there had been a distinct lack of professional and managerial leadership. Senior Officers of the Trust had not stayed long enough to build up relationships both internally within the organisation, and externally with partners and stakeholders.

Internally there had been a breakdown of understanding between Trust senior managers and clinical staff due to the introduction of 'Change in Mind', a local consultation process for modernising mental health services in Manchester. Staff relations had become so poor that industrial action had been resorted to in order to resolve issues that had been allowed to escalate to such a pitch that traditional consultation and negotiation processes were no longer effective. During this period clinical staff endeavoured to maintain services, however these services were being delivered without the necessary levels of senior professional scrutiny and support that were required to provide an effective regulatory framework. Regulatory frameworks are required in order to ensure that policy and procedure are maintained and that clinical delivery is operated against best practice guidelines.

Externally the leadership from commissioners had failed to monitor the activities of the Trust which had effectively been allowed to manage its own affairs in a vacuum. Services went unmonitored and clinical processes went unchallenged.

New ways of Working

During the organisational turmoil that occurred between 2007 and 2008 *New Ways of Working for Everyone* was implemented. The implementation of such a process required a high degree of organisational change management, professional leadership and risk management. Unfortunately the Trust was in no position to provide the level of executive supervision that was required. During this period service users found themselves under the care and treatment of teams whose alignment had been altered. This meant that continuity of care was severely affected. A service change of this magnitude required a high degree of both management and risk assessment. In the case of Mr. X the implementation of *New Ways of Working for Everyone* effectively provided him with three different Lead Consultant Psychiatrists over a period of 12 weeks. This is probably a key factor that interfered with the traditional Consultant to Consultant handover that would normally have occurred at the point of transferring Mr. X from Bronte Ward to the South Manchester Assertive Outreach Service.

13.1.13.3. Conclusions

When the care and treatment that Mr. X received is reviewed within the context of the organisational chaos that existed and against the lack of professional leadership that was provided an additional level of insight is gained. Clinical staff continued to work hard, and this is to their credit. However two major factors arose that impacted upon the care and treatment that Mr. X received. First, policy and procedure was not adhered to. Second, continuity of care was fragmented. In the absence of robust professional leadership the safety nets underneath clinical care provision are often effectively removed. It would appear that neither clinical audit nor clinical supervision were able to ensure best practice policy adherence as the professional leadership structures were not there to enforce these processes. The implementation of *New Ways of Working* in some parts of the organisation was not effectively managed. This, when implemented at a time of weak professional leadership, exacerbated the situation where both safety and care and treatment processes were compromised.

- ***Contributory Factor Number Eleven (influencing). The compromised professional leadership provided between 2006 and 2008 created an environment where safety and care and treatment processes were severely compromised. This led to poor practice relating to Mr. X's care and treatment delivery going undetected and unresolved.***

13.1.14. Clinical Governance and Performance

13.1.14.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[282]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

During the time that Mr. X was receiving his care and treatment the Trust should also have been subject to robust performance monitoring and review from local statutory authorities charged with the commissioning of Manchester-based Mental Health Services.

[282] Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. W. The issues that have been set out below are those which have relevance to the care and treatment that Mr. X received.

13.1.14.2. Findings

Independent Performance Ratings

The Care Quality Commission Report for the period 2007/2008 rated the Trust quality of services as being 'Weak'. This placed the Trust within the bottom 3.6% of mental health services nationally with regards to quality performance. Areas in which the Trust was deemed to require improvement were identified as follows:

Core Standards:

- clinical supervision and professional leadership;
- public health partnerships;
- food provision;
- food needs;
- clean well designed clinical environment.

Community Services:

- availability of Out of Hours services;
- availability to service users of written care plans;
- service user involvement in care planning;
- choice of psychotropic medication;
- numbers of service users who had CPA reviews within the last 12 months;
- percentage of service users who knew who their care coordinator was.

Acute Inpatient Services:

- alternatives to admission to inpatient services;
- integrated care pathway for discharge processes;
- personalised care planning;
- safety for visitors and patients on wards.

These areas that required improvement as identified by the Care Quality Commission dovetail into the findings of this Investigation with regards to the care and treatment of Mr. X.

Local Commissioning and Performance Management Arrangements

The Boyington Review was commissioned against the backdrop of Manchester-based Mental Health Services performing poorly against national strategy and benchmarks over a period of several years. Basically this review made the finding that local commissioning and performance monitoring bodies had in effect left the Trust to its own devices. Services had not been monitored and had been allowed to develop in a haphazard fashion devoid of a coherent planning framework. Resources had not been allocated appropriately and investments had not been targeted towards services managing the areas of most need.

"Since the Care Trust's inception there have been debates and discussions about whether the resources available match the significant needs of the population. There have also been consistent challenges to the way in which resources are used and whether these represent best value for money. Most frequently raised of these is the issue of lengths of stay in acute beds within the Care Trust and the high utilisation of secure and other out of area services. Although some work has been undertaken in respect of length of stay this has still not been seen as an issue critical to the future success of the health economy. Additionally, across the health community little attention appears to have been focused on the fact that almost 27% of the economy's resources are deployed on secure and out of area placements for patients."[283]

Trust Internal Clinical Governance Management and Monitoring

Internal Trust clinical governance processes were affected by the lack of senior management continuity at Board level. Senior management team members were often on short-term contracts and this impacted upon the implementation of existing processes and structures. It also had an impact upon the dynamic monitoring of how well the system was delivering against the Trust's statutory responsibilities.

13.1.14.3. Conclusions

Clinical services cannot be operated successfully in a governance vacuum. For several years, up to and including the summer of 2008, Manchester-based Mental Health Services operated

283 Boyington Review PP. 9-10

poorly from both a commissioning and provider point of view. As a result of the Boyington Review a series of structured short-term (transactional) and long-term (transformational) approaches and recommendations were identified to improve the commissioning, planning and delivery of local Mental Health Services. At the time of writing this report these approaches and recommendations were in an advanced stage of implementation.

At the time Mr. X was receiving his care and treatment it was evident that clinical services were operating in less than ideal circumstances. Internal Trust policy and procedure processes failed. Audit, evidence-based policy guidelines, and clinical supervision did not provide the degree of internal regulation required that could assure the safety and effectiveness of clinical services. This was exacerbated by the lack of consistent and coherent professional leadership and senior trust management. External performance and monitoring arrangements were not able to support the Trust which was not operating within an integrated whole systems framework. In the light of the difficulties that were experienced it is to the credit of all the clinical staff involved with the care and treatment of Mr. X that service delivery was maintained throughout this difficult period. Mr. X was a chaotic and complex individual who received his care and treatment from a service that was also experiencing chaos and complexity.

- ***Contributory Factor Number Twelve (influencing). The absence of coherent internal and external governance arrangements led to chaotic service delivery which went unmonitored and uncorrected. This is the context in which Mr. X received his care and treatment and this will have contributed to the less than coherent service that was delivered to him.***

13.2. Health Advocacy Resource Project Findings

The following sections review the care and treatment given to Mr. X by the South Manchester Assertive Outreach Service which was operationally managed on a day-to-day basis by the Health Advocacy Resource Project. The ‘Context’ headings for each of the sections below, when similar to those already set out above, will not be replicated. The Chronology Chapter above should be used as supporting background information.

What is Assertive Outreach?

Manchester Assertive Outreach Service model has been in operation in the western world since the 1970s. This model provides a clear focus on those service users who require the most help from the mental health service delivery system. The model places an emphasis on home visits and places all care, treatment and rehabilitation activities in the context of each service user's own world.

In 1999 the Department of Health published the *National Service Framework for Mental Health.* In 2001 the *Mental Health Policy Implementation Guide* was published. This document provided clear guidance for mental health services across the country with regard to setting up new models of service delivery. Assertive Outreach Services formed a key part of the *National Service Framework.*

Assertive Outreach Services were intended for adults aged between 18 and 65 years of age with the following:

1. *"A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders associated with a high level of disability)*
2. *A history of high use of inpatient or intensive home-based care (for example, more than two admissions or more than six months of inpatient care in the past two years)*
3. *Difficulty in maintaining lasting and consenting contact with services*
4. *Multiple complex needs including a number of the following:*

- *History of violence or persistent offending*
- *Significant risk of persistent self harm or neglect*
- *Poor response to previous treatment*
- *Dual diagnosis of substance misuse and serious mental illness*
- *Detained under Mental Health Act (83) on at least one occasion in the past two years*
- *Unstable accommodation or homelessness."*[284]

Nationally, Assertive Outreach Services were intended to improve engagement with services, reduce hospital admission and improve the stability of the lives of service users and their families. The 'team approach' was advocated as being the model of choice for service delivery. This approach was intended to ensure continuity of care. Each team was to have a

284 *Mental Health Policy Guide* (2001) P. 26

caseload of no more than 90 service users and the ratio of service users to care coordinators was set at 12:1 ideally 10:1.

Configuration of the Manchester Assertive Outreach Service

At the time Mr. X was receiving his care and treatment the Assertive Outreach Service contract was delivered in partnership between the Health Advocacy Resource Project (HARP) and the Mental Health Trust. HARP was responsible for the operational management of the service.

The service comprised three multidisciplinary teams covering the north, south and central localities of Manchester. The contract required the service to provide 308 cases to be worked with at any one time across the three teams. Mr. X received his care and treatment from the south team. This team had a caseload capacity of 86, at the time of the incident the team was *not* working at full capacity. The staffing establishment had been constructed in line with the *Mental Health Policy Guide* (2001). The staffing establishment is set out in Table 2 below.

Table 2 South Manchester AOT Staff Establishment

Post	**Whole Time Equivalent**	**Clinical Caseload as Care Coordinator (maximum number)**
Team Manager	0.8	6
Community Mental Health Nurses (inc. 1 X senior post)	3.0	12 (each)
Social Inclusion Worker	2.0	N/A
Occupational Therapist	1.0	12
Social Workers (inc. 1 x senior post)	2.0	12 (each)
Clinical Psychologist	1.0	6
Consultant Psychiatrist	0.5	N/A
Staff grade Doctor	0.5	N/A
Housing and Welfare Rights Worker	0.5	N/A
Administrative Support	1.0	N/A

Background Information to Service Delivery between 3 April and the 27 July 2008

During the period that Mr. X received his care and treatment from the Assertive Outreach South Manchester Team the service was subject to a series of significant organisational

changes. In June 2007 a contract was awarded for the provision of a city-wide service. The contract was awarded to a partnership whereby HARP and the Manchester Mental Health and Social Care NHS Trust were to deliver Assertive Outreach Services together. HARP was issued with a detailed contract and service specification, however there was no specific contract and service level agreement between the Primary Care Trust and the Mental Health Trust as this was subsumed into the wider Trust contract provision. A Joint Management Board was set up that consisted of Commissioners, Senior Trust Managers, and HARP Senior Managers. This Board met monthly to discuss all aspects of service delivery.

Changes to the Assertive Outreach Service contract did not occur in isolation and formed part of a wider community service reconfiguration across Manchester. From June 2007 the Assertive Outreach South Manchester Team was comprised of staff drawn from the original HARP-led service and from the Mental Health Trust. The formation of the new team took place against the backdrop of industrial action. Many staff employees from the Trust had not chosen to join the Assertive Outreach Service and found the model of joint service delivery to be 'flawed'. Different employment terms and conditions existed and lines of accountability and supervision were found to be confusing. The service felt itself to be under pressure to build up its caseload and witnesses who met the Independent Investigation Team said that this led to service users being taken onto the caseload about whom they knew very little. The team base was not deemed to be a 'safe haven' for the storage of clinical information. This meant that service users' hard copy clinical records could not be made available to members of the team.

Witnesses giving evidence to this Investigation described services as being in a state of *"total chaos"* during 2008. South Manchester Assertive Outreach Team workers found the partnership arrangements difficult to understand and the clinical governance processes difficult to work with. Staff expressed a *"passion"* for delivering quality services to people suffering from mental health problems and felt that they were substantially challenged during 2008 in accomplishing this. This was the situation that existed when Mr. X was transferred to the Service.

13.2.1. Transfer and Referral Processes

13.2.1.1. Context

At the time Mr. X was referred to the South Manchester Assertive Outreach Service an Operational Service Policy was in place. This policy stated that service users would be accepted onto the caseload if they met the following criteria:

1. lived in the Manchester area;
2. were aged between 15-64 years;
3. had severe or enduring mental health needs associated with a high level of disability;
4. had a history of high-use inpatient care;
5. had a history of disengagement from services;
6. had a history of complex needs:
    - history of violence;
    - significant risk of self harm or neglect;
    - poor response to serious treatment;
    - dual diagnosis and serious mental illness;
    - detention under the Mental Health Act on at least one occasion over the past two years;
    - unstable accommodation or homelessness.

The referral pathway was set out as follows:

- referrals could be made from any source, including the service user;
- referrers should submit a completed Assertive Outreach Referral Form and copies of the most recent CPA, MANCAS (Manchester Care Assessment Schedule) and risk assessment;
- referrers who were not the Care Coordinator were expected to discuss the referral with the Care Coordinator;
- all referrals would be acknowledged by the Assertive Outreach Service within three working days;
- a decision regarding acceptance onto the caseload would usually be made within seven working days of receiving the referral at the team weekly allocation meeting.

13.2.1.2. Findings

Background Events

On the 19 February 2008 Mr. X was admitted to Bronte Ward following a rapid deterioration of his mental health. On the 28 February 2008 Bronte Ward staff made a referral to the South Manchester Assertive Outreach Service as part of a formal discharge planning process. An Assertive Outreach Service Referral Form was completed by Care Coordinator 2 and this was collected from the ward by two members of the South Manchester Assertive Outreach Team on the 16 March.[285] The next day Mr. X was discussed at the South Manchester Assertive Outreach Team allocation meeting when it was agreed to accept him onto the caseload.

On the 20 March 2008 a ward round was held to which a member of the South Manchester Assertive Outreach Team attended. During this ward round a joint short-term care and treatment plan for Mr. X was agreed between inpatient and Assertive Outreach Services. It was agreed that Mr. X would be granted a one-week period of leave from the ward during which time the South Manchester Assertive Outreach Team would visit him at his home in order to get to know him and be able to create a CPA for him. It was agreed to delay Mr. X's discharge until the 3 April 2008 in order to provide an appropriate interval of time for this to be achieved.[286]

On the 27 March 2008 another ward round was held to which a member of the South Manchester Assertive Outreach Team attended. It transpired that no one had been able to make contact with Mr. X during his one-week period of leave as he had switched off his telephone. It was agreed that Mr. X would be given another one-week period of leave and that the South Manchester Assertive Outreach Team would try once again to visit him at his home. Mr. X's progress was discussed at this ward round. It was reported that whilst Mr. X still had some paranoid ideas he was settled in both mood and mental state.[287]

On the 30 March 2008 two members of the South Manchester Assertive Outreach Team visited Mr. X at his home. On this occasion the flat was described as being clean and tidy and Mr. X appeared to be coping well.[288]

285 Assertive Outreach records PP. 54-60
286 SM Case Notes Vol. 4 PP. 151-154, AMIGOS P.461
287 AMIGOS P.471
288 AMIGOS P.476

On the 3 April 2008 a ward round was held at which a member of the South Manchester Assertive Outreach Team attended. Mr. X was reported to still have some paranoid ideas, but that he felt the voices he heard may have been the product of his imagination. It was agreed that Mr. X would be discharged to his home following the ward round. The plan was for South Manchester Assertive Outreach services to:

- take over the administration of the weekly depot medication;
- ensure the South Manchester Assertive Outreach Psychiatrist followed Mr. X up within a two week interval at the Outpatients Clinic;
- follow up Mr. X on a two weekly basis;
- ensure psychological therapy was made available.[289]

Prior to leaving the ward a CPA was developed by the South Manchester Assertive Outreach Team with Mr. X. No extant documentation exists to support this CPA.

Acceptance Criteria

It is clear from examination of the Operational Policy that Mr. X met the criteria for acceptance onto the South Manchester Assertive Outreach Caseload. At interview some witnesses told the Independent Investigation Team that had they known Mr. X had the possibility of having a Personality Disorder then he would not have been eligible to access the service. However, the Operational Policy does not mention any 'exclusion criteria' and at the time Mr. X was referred to the South Manchester Assertive Outreach Service he had a diagnosis of *"Paranoid Schizophrenia/Personality Disorder?"*

Documentation and Information Exchange

The hard copy clinical records held by the South Manchester Assertive Outreach Team show that the following information was provided by the Trust in accordance with Assertive Outreach Service policy expectation:

- a completed Assertive Outreach Referral Form;[290]
- a set of recent CPA documentation;[291]
- MANCAS documentation;[292]
- risk assessment and mental state examination.[293]

289 SM Case notes Vol, 4 PP. 167-169 AMIGOS P. 487
290 Assertive Outreach Records PP. 54-60
291 Assertive Outreach Records PP. 7-10
292 Assertive Outreach Records PP. 16-31

At interview witnesses stated that they felt that the South Manchester Assertive Outreach Team had been disadvantaged in that no letter was sent by a Consultant Psychiatrist to the South Manchester Assertive Outreach Psychiatrist at the time of Mr. X's discharge. No discharge letter appears to have been sent from one consultant to another when Mr. X transitioned between services. However it was clear from reading the South Manchester Assertive Outreach Team clinical records that the Consultant Psychiatrist letter to the GP on the occasion of Mr. X's admission in February 2008 had been forwarded to the South Manchester Assertive Outreach Team as part of the referral process, and that the Consultant Psychiatrist discharge letter to the GP had been placed on the AMIGOS system which was available to them. Consultant Psychiatrist 2 who had taken over the role of RMO had prepared a discharge summary form for the GP which was also forwarded to the South Manchester Assertive Outreach Team. It is evident from reading the hard copy information and the AMIGOS record that the South Manchester Assertive Outreach Team had a comprehensive, if not full, set of information about Mr. X at the point of transfer, adequate enough to support future working with a new patient.

Information exchange was facilitated greatly by the parallel management of Mr. X's case that occurred between the 16 March, when the South Manchester Assertive Outreach Team first attended the ward, and the 3 April 2008 when Mr. X was discharged. Members of the South Manchester Assertive Outreach Team met with ward staff on a total of four occasions to plan for Mr. X's discharge on the 3 April 2008.

13.2.1.3. Conclusions

It would appear from the evidence made available to the Independent Investigation Team that Mr. X's discharge on the 3 April 2008 was planned well. It is true that no consultant-to-consultant letter was prepared, however the South Manchester Assertive Outreach Team operated a 'team approach' model. This model did not follow a traditional 'medical professional lead' approach and ensured that "*in order to provide a holistic service, team members work across normal professional boundaries and operate out of role within clinical limitations. This is balanced by support for team members to maintain, develop and use their professional specialisms*".[294]

293 Assertive Outreach Records PP. 16-31
294 HARP AOT Operational Policy P. 6 (undated)

It was evident that inpatient services managed an effective period of handover to the South Manchester Assertive Outreach Team. This was made more remarkable given that Care Coordinator 2 had retired prior to Mr. X being discharged, and that the implementation of *New Ways of Working* had led to a change of Responsible Medical Officer. The Independent Investigation Team concludes that documentation was shared and developed in a manner that complied with both Trust and HARP policy expectation. This was consolidated by:

- four separate inter-agency meetings on the ward, three of which were ward rounds;
- an assessment visit to Mr. X's home on the 30 March 2008;
- a discharge CPA conducted by the South Manchester Assertive Outreach Team on the ward.

The Internal Investigation cited the failure to send a consultant-to-consultant letter as being a significant failure. Regrettable as it was the Independent Investigation Team concluded that too much significance was placed upon this omission. There was a multiplicity of other safeguards that worked well. Whilst no Care Coordinator-to-Care Coordinator handover took place due to the retirement of Care Coordinator 2 the ward staff, who knew Mr. X very well, and the South Manchester Assertive Outreach Team staff worked together appropriately in accordance with policy guidelines to manage the handover. Given the Assertive Outreach Team 'team approach' model it is difficult to see how this mission could have impacted negatively upon the care and treatment package that had been agreed for Mr. X.

As has already been discussed above, both Trust and Assertive Outreach Services were working during a period of significant change. It is to the credit of the teams involved that the discharge was managed in such a way to obviate the ongoing organisational disruption occurring around them. The Independent Investigation Team concluded that the discharge of Mr. X on the 3 April 2008 was planned in an appropriate and orderly manner.

13.2.2. CPA, Care Coordination and Clinical Models of Care

13.2.2.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[295]. Since its

295 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*[296].

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*[297]." (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and

296 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

297 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

  - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Health Advocacy Resource Project Policy

The Independent Investigation Team was not given a separate Care Programme Approach Policy for the Assertive Outreach Service that was in operation during the time that Mr. X received his care and treatment. However clear guidance was available to staff in the AOT Operational Policy that was active during this period. The policy stated that:

- Each service user should have a Care Coordinator who will ensure that the MANCAS needs assessment is completed at least annually, and that the CPA care plan and risk assessment is reviewed six-monthly. The Care Coordinator is to act as the first point of contact for service users and carers.
- Care Coordinators are to be matched according to service user preference, geographical location, and care and treatment needs.
- Care should be delivered by the multidisciplinary team as a whole with all team members working with all service users to ensure continuity of care.
- Team members are to provide continuity of care in the absence of the Care Coordinator.
- In order to provide a holistic approach team members are to work across normal professional boundaries, within clinical limitations.
- The 'team approach' is to be managed via weekly planning meetings and the daily handover when visit allocations are made.
- All team members are to have access to the AMIGOS case note reporting system. All visits are to be recorded onto AMIGOS on the same day a visit is made and all CPA and risk assessments are also to be recorded onto the system.[298]

298 HARP Operation Policy (undated) P. 6

13.2.2.2. Findings

Background Events

At the point of discharge on the 3 April 2008 the South Manchester Assertive Outreach Team had within their possession a full CPA that had been developed in January 2008, a detailed referral form and a full MANCAS assessment and risk profile. On the 3 April a discharge CPA was developed by a member of the South Manchester Assertive Outreach Team prior to Mr. X leaving Bronte Ward. At this time Mr. X was subject to Enhanced Level CPA.

CPA Process

On examination it was not clear what the discharge CPA on the 3 April 2008 consisted of because no documentation existed for this review, either in the South Manchester Assertive Outreach Team hardcopy file, the AMIGOS electronic record or in the GP notes. The AMIGOS record stated that a CPA was held on this day. It cannot be known what, if any, changes were made to Mr. X's care plan that differed from the previous CPA which had been conducted in January earlier the same year by the Mental Health Trust. It is difficult to understand how the discharge CPA review influenced the management of Mr. X's care and treatment if it was not recorded or communicated to Mr. X's care network.

At the time Mr. X was receiving his care and treatment from the South Manchester Assertive Outreach Team a 'team approach' model was used as advocated in national policy guidance. This meant that each team member was expected to work with each service user held on the caseload. The reason given for this was to ensure continuity of care. The utilisation of this model was intended to ensure that each service user could access at any time someone who knew their background history and current care and treatment plan. The Assertive Outreach Operational Policy stated that *"care would be delivered by the multidisciplinary team as a whole with all team members working with all service users to ensure continuity of care. Team members were to provide continuity of care in the absence of the Care Coordinator."* It would appear from a careful examination of the Operational Policy that the 'team approach' was not intended to replace Care Coordination, rather it was to ensure an effective multidisciplinary team support process to facilitate the provision of service to 'hard to reach' individuals.

In actual practice the 'team approach' model was not the most effective vehicle for the delivery of patient care that it was intended to be. Prior to discharge Mr. X was seen by four

different members of the South Manchester Assertive Outreach Team, they were the Assertive Outreach Team Manager, and Assertive Outreach Workers 2, 4 and 6 (as identified in the witness interview schedule in Table 1). Over the four-month period following his discharge Mr. X was seen by the Assertive Outreach Team Manager and a further three people who had not met him before, these comprised the Care Coordinator and Assertive Outreach Workers 3 and 7 (as identified in the witness interview schedule in Table 1). Mr. X was spoken to over the telephone by seven members of the team, four of whom he had never met. It has also to be noted that additional team members attempted unsuccessfully to visit him at his home. In total, from examination of the AMIGOS record, it would appear that 13 Assertive Outreach Team Workers (all 13 named in the clinical record) were involved in Mr. X's care and treatment during the four-month period that he was on the caseload. Prior to his discharge Mr. X was seen by Assertive Outreach personnel on four occasions, following his discharge he was seen on five occasions. In total seven different Assertive Outreach Team members met with Mr. X during this period. Whilst this model may have been advocated by the Service, it was possibly the worst kind of approach for Mr. X who found building up relationships with people extremely difficult.

The Independent Investigation Team found it difficult to track any kind of CPA process being activated following Mr. X's discharge from Bronte Ward. Between 3 April and the 27 July 2008 it became increasingly evident that Mr. X was:

- difficult to engage;
- refusing his medication;
- indulging in poly-substance misuse;
- had armed himself with a knife for his own protection;
- self-reporting a serious suicide attempt;
- stating that he felt ill and vulnerable.

There are two important points to deduce from the bullet points directly above. First, the plan that Mr. X was discharged with was not activated by the Care Coordinator. Second, Mr. X's changing presentation between 3 April and the 27 July 2008 did not lead to a re-evaluation of his care and treatment plan. Whether the South Manchester Assertive Outreach Service operated a 'team approach' model or not, it was evident that Mr. X received nothing that

could be recognised as CPA. Neither the 'team approach' model nor the CPA process ensured:

- the building of a therapeutic relationship with Mr. X;
- the implementation of his discharge plan;
- the administration of his weekly depot;
- a dynamic risk assessment process;
- an appropriate revision of his care and treatment plan in the light of his ongoing needs.

When witnesses were interviewed by the Independent Investigation Team it was evident that the notion of Care Coordination played a subordinate role to that of the 'team approach' model during the time that Mr. X received his care and treatment from the South Manchester Assertive Outreach Team. The 'team approach' was described as being a safe way to ensure continuity of care and this formed the basis of the Assertive Outreach clinical delivery model. CPA was not regarded as being the underpinning framework for service delivery, rather it was seen as being a process subordinate, albeit complimentary, to the clinical service delivery model being operated at the time.

In the case of Mr. X no documentation exists to chronicle the discussions that were held by the South Manchester Assertive Outreach Team regarding either the CPA process or the 'team approach' model. The extant documentation provides a day-to-day contact record sheet only. This record sheet did not provide any detail regarding the care and treatment plan that was being followed for Mr. X. Neither did the record feature any of the discussions that were held nor any of the planned interventions that resulted from the weekly team meeting and daily handover sessions.

It was evident from the examination of the clinical record that the five visits made to Mr. X did not constitute part of an ongoing assessment or care and treatment plan process. The visits appear to have been unproductive in that Mr. X only accepted his medication on one occasion, and none of the problems that he presented with were ever assessed in the light of either his psychiatric history or his current mental state. These visits appear to be simply that, visits, they cannot be described as therapeutic interventions. These occasions should have afforded the opportunity to develop a therapeutic relationship with Mr. X and to work with

the issues indentified in his current CPA plan. These visits should also have provided the means to implement the discharge plan and ensure that his ever-changing presentation was monitored and managed appropriately. This did not occur.

The Care Coordinator Role and Function

Mr. X was allocated a Care Coordinator following his discharge from Bronte Ward on the 3 April 2008. This individual was an experienced qualified Social Worker who had worked for several years with mental health service users. It is important to note that this individual was not involved in the four ward-based visits and ward round meetings that took place prior to Mr. X's discharge. Neither was this individual the person who visited Mr. X at his home on the 30 March and worked on the discharge CPA. It is not certain why Mr. X was allocated to this particular Care Coordinator.

The Internal Investigation found that the Care Coordinator was not a registered social worker at the time of the incident. All social workers were required to be registered with their awarding body from 2005, this individual did not. *"All qualified social workers should be registered. The title "social worker" has been protected by law in England since 1 April 2005. This law came from the Care Standards Act 2000 to ensure that only those who are properly qualified, registered and accountable for their work describe themselves as social workers."*[299] The fact that this individual was not registered was regrettable and demonstrated both a lack of professional judgement on the part of the practitioner and a lack of robust clinical governance systems within HARP. However, registered or not, it would appear that he was suitably qualified and experienced to be able to address Mr. X's care and treatment needs.

The Care Coordinator's name appeared in the clinical record for the first time on the 14 April when an unsuccessful attempt was made to visit Mr. X at his home. The Care Coordinator visited Mr. X on three occasions, once on the 20 April 2008, once on the 7 May, and once on the 22 July 2008. The following description of events sets out what occurred during the five home visits that were undertaken by the South Manchester Assertive Outreach Team.

299 General Social Care Council. http://www.gscc.org.uk/The+Social+Care+Register/

On the 20 April the Care Coordinator and Assertive Outreach Worker 3 visited Mr. X at his home. This was the first face-to-face meeting that had occurred since his discharge nearly three weeks earlier. The visit lasted for 45 minutes. The AMIGOS system recorded that the meeting focused on the concerns Mr. X had regarding his benefits. He was described as being warm and friendly with no psychotic features being present. It was noted that Mr. X's depot medication was overdue, (by two weeks) and that someone would come to administer it as soon as possible. No other concerns were recorded.[300]

On the 27 April the Assertive Outreach Team Manger visited Mr. X at his home and administered his depot medication. She was accompanied by Assertive Outreach Worker 6. By this stage Mr. X had missed three depot injections. The visit lasted 30 minutes. Mr. X appeared to be managing well. He mentioned that he had been drinking with friends and that he would like help from the team to re-establish contact with his family.[301]

On the 7 May the Care Coordinator visited Mr. X at his home with the Assertive Outreach Team Manager. On this occasion Mr. X refused his depot medication. No plan was recorded as to how this non-compliance with medication was to be managed and monitored. Mr. X expressed a desire to meet with the South Manchester Assertive Outreach Psychiatrist whom he had not yet met. Mr. X described feelings of vulnerability and said that he would like more intense support in the immediate short term. Mr. X also said that he had been using heroin. The session lasted 30 minutes.[302] No further face-to-face contacts were made with Mr. X for a period of one month following this visit. Mr. X was either not in when visits were made, or he telephoned to cancel appointments.

On the 10 June Assertive Outreach Team Worker 7 visited Mr. X at his home for 30 minutes. During this visit it was clear that Mr. X was presenting in a manner significantly different to that observed during earlier meetings. On this occasion Mr. X said that he had developed a crack cocaine habit. He also stated that he had lost two stones in weight and that he had stopped taking his antidepressants because he felt that crack was more effective. No specific plan was formulated as a result of this visit.[303]

300 AMIGOS Record P. 504
301 AMIGOS Records P. 508
302 AMIGOS Record P. 509
303 AMIGOS Record P. 520

On the 22 July Mr. X was visited by the Care Coordinator and Assertive Outreach Team Worker 3. On this occasion it was noted that Mr. X was very low in mood and that he could not maintain eye contact. Mr. X apologised for not maintaining contact but explained this was because he was heavily abusing drugs *"using eight rocks of crack cocaine and one/two bags of heroin daily"*. Mr. X reported that he *"could not carry on anymore"* and that he had injected three bags of heroin into his groin at the weekend in an attempt to commit suicide. The suicide attempt had been unsuccessful but he said that it had left him feeling *"nauseous and groggy"*. Mr. X expressed some paranoid ideas and also stated that he had a knife in his possession for his protection (at interview with the Independent Investigation Team and during the criminal justice proceedings it was evident that Mr. X showed the Care Coordinator a knife). During this visit it was agreed that Mr. X would meet the South Manchester Assertive Outreach Psychiatrist in the Outpatient Clinic the following day and that his support from the team would be increased with visits at his home occurring two or three times a week.[304]

It is not easy to understand the rationale for what happened next. Mr. X telephoned on the 23 July to say he felt too unwell with a *"bug"* to visit the Outpatient Clinic. It is recorded on the AMIGOS record that an unsuccessful attempt was made to visit Mr. X on the 27 July at 10.05am at his home. No further attempts to contact Mr. X were made. No attempts were made to undertake a risk assessment, and no appropriate plans were developed to address Mr. X's rapidly changing presentation.

13.2.2.3. Conclusions

The Independent Investigation Team concluded that Mr. X was not in receipt of any kind of systematic clinical service delivery framework that could be recognised as meeting the requirements of the Care Programme Approach. As a result this service failed in its duty of care to Mr. X. However, the controversy regarding Mr. X's diagnosis will always beg the question, 'could anything practically have been done differently by Assertive Outreach Services to have prevented the killing of Mr. W?' The answer after careful examination of his forensic record which was created after the incident is 'probably not'. A person with a complex series of Personality Disorders cannot be managed or treated with any predictable measure of success. The fact Mr. X was no longer receiving his antipsychotic medication is

304 AMIGOS P. 531

possibly not as relevant as it would at first appear to be as in all probability Mr. X was not suffering from any degree of psychosis.

However this would be using the benefit of hindsight. At the time Mr. X was receiving his care and treatment from the South Manchester Assertive Outreach Service he had the formal diagnosis of Paranoid Schizophrenia. He was in receipt of secondary care mental health services and was subject to Enhanced Level CPA. Mr. X should have been in receipt of a comprehensive Care Programme Approach. When the care and treatment Mr. X received is examined in the context of this diagnosis it is clear that neither local nor national policy expectation were met.

The Care Coordinator did not provide the level of Care Coordination required. Whilst this individual should take responsibility for the lack of assessment, and care and treatment planning that occurred, it has to be recognised that he was working within a dysfunctional system. The issue of this individual's registration with the General Social Care Council is an important one in that he was breaking the law and acting in both an unacceptable and unprofessional manner. However this person's qualifications and experience were never in doubt and the fact he was not registered did not in itself make a direct contribution to the poor care that Mr. X received.

The Independent Investigation Team understands that the 'team approach' model is advocated by national policy. The model itself is not in question here, however the HARP interpretation and delivery of the model is. The failure to provide a comprehensive CPA was probably exacerbated by the 'team approach' model operated by the South Manchester Assertive Outreach Service. This model appeared to actively prevent the very continuity of care that it was intended to deliver. Mr. X had inputs, or attempted inputs, from 14 different individuals during a four-month period. As no records exist documenting team discussions it is impossible to understand how the 'team approach' model worked with CPA to ensure a safe patient-centred delivery of service. On the evidence presented to the Independent Investigation Team the conclusion has to be that the clinical service model as operated by the South Manchester Assertive Outreach Team between 20 March and the 28 July 2008 did not provide a fit for purpose service able to deliver the *"cornerstone of the Government's mental*

health policy".[305] This made a direct contribution to the circumstances whereby Mr. X was not sufficiently assessed, monitored or managed. These circumstances provided the conditions in which a serious untoward incident was more likely to occur. Whilst the death of Mr. W could not have been predicted on the 22 July 2008 the clinical team had within its gift the opportunity to intervene in a timely manner as other teams working with Mr. X had done before. The risk that Mr. X presented to himself should have instigated an assessment under the Mental Health Act and the possession of an illegal knife should have instigated the input of the Police Service. The Independent Investigation Team speculated that had these actions been initiated by either the Care Coordinator, or the multidisciplinary team working within the 'team approach', it is possible that the actual events leading to Mr. W's death may have been avoided. In the absence of any care coordination, regardless of the model of provision, no assertive actions were taken in a timely manner and the situation went unmanaged.

- ***Contributory Factor Number One (influencing). The failure to provide a fit for purpose Care Programme Approach contributed to the circumstances in which a serious untoward incident was more likely to occur. The lack of Care Coordination ensured that this vital safety net of care did not exist and Mr. X was not appropriately assessed, monitored or managed.***

13.2.3. Risk Assessment

13.2.3.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective

305 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that '*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[306].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical

306 Best Practice in Managing Risk; DoH; 2007

presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Health Advocacy Resource Project Risk Assessment Policy

During the period that Mr. X was receiving his care and treatment from the South Manchester Assertive Outreach Team the Mental Health Trust risk policy was used by the service.

The Assertive Outreach Service was operating an embryonic 'Risk Zoning' system at the time Mr. X was receiving his care and treatment. Risk zoning systems have been used in the United Kingdom for several years in mental health community care contexts. Basically a coding of red, amber and green is associated with specific criteria agreed by all disciplines in the team. The change of a code leads to a rapid change in risk management. An agreed clinical and non-clinical action plan leads to a whole team response. The limitation of use is dependent on the size of the caseload and the number of clinical staff attending a daily clinical briefing.[307] Zoning is a method of prioritising essential resources and of targeting them towards service users presenting with the highest levels of risk.

13.2.3.2. Findings

Organisational Factors

The HARP Operational Policy in use during 2008 advocated the use of MANCAS and the Trust risk assessment toolkit. MANCAS and Trust risk assessment documentation was not utilised by the South Manchester Assertive Outreach Team when working with Mr. X despite this usage being part of the 2007 contract specification. Any risk assessment discussions pertaining to Mr. X were not recorded and there was no evidence brought forward to this Investigation to suggest that Mr. X's risk was systematically discussed, identified and mitigated against utilising an accepted format or process.

307 http://www.emeraldinsight.com

Since approximately June 2008 the Assertive Outreach Service used a zoning system. There was no mention in any of the extant policy guidance for 2008 to explain how this system worked or was expected to be implemented. Neither was there any mention within Mr. X's clinical record of him being in any particular risk assessment related zone. The internal investigation report detailed how the system probably worked at the time. Service users were classified as follows:

- **Red.** Intensive support and input required
- **Amber.** Medium support and input required
- **Green.** Well engaged and in recovery. Low support required.

Both the Internal and Independent Investigation Teams were told that service users placed in the 'Red' zone were discussed daily during the handover meeting. Both Investigation Teams were told that Mr. X was placed in the 'Red' zone throughout his time with the South Manchester Assertive Outreach Service. The management of this system and the discussions that took place were recorded onto an electronic 'Smart Board'. The difficulty with this system was that nothing was entered into the permanent patient record and the electronic 'Smart Board' was overwritten every morning.

There was *no* written risk assessment documentation made available to the Independent Investigation Team. The word 'risk' does not appear in any of the clinical records developed for Mr. X between 3 April and 28 July 2008. Information was recorded about Mr. X's presentation and changing condition but there is no written evidence to suggest this information was ever considered in the context of the risk that Mr. X may have presented to either himself or to other people.

One of the difficulties in examining the care and treatment that Mr. X received from the South Manchester Assertive Outreach Service is that very little of the discussion purported to have taken place was ever written down. It was obvious that Mr. X did not have the required risk assessment conducted on his admission into the Service as set out in the risk assessment policy. It would appear that it was for this reason that workers visited Mr. X at his home in pairs between 3 April - 28 July 2008. This may also have been the reason why Mr. X was placed into the 'Red' zone. When witnesses were interviewed by the Independent

Investigation Team it became apparent that individuals offered a series of contradictory reasons why Mr. X had been placed in the 'Red' zone.

The first reason offered was that his risk history suggested that this would be good practice until the team got to know him better. The second reason offered was that in the absence of a risk history Mr. X was an unknown quantity and that he was placed in the 'Red' zone until a thorough assessment was conducted. Various other suggestions were offered to this Investigation, however it became apparent that no one could really remember why Mr. X was placed in the 'Red' zone. Neither could the witnesses explain why the visits made had not provided the opportunity to conduct a risk assessment and develop a management plan. It would appear that Mr. X remained in the 'Red' zone and continued to be visited by two Assertive Outreach Workers during his time on the caseload. It could be assumed that Mr. X was discussed daily and that members of the team were alerted to his requirements for intensive support, but that the understanding of this level of activity has been lost over time because it was not recorded. On the other hand it could also be assumed that Mr. X remained in the 'Red' zone by default due to inefficient clinical processes and that the team never got around to assessing his risk and the level of service required to ensure an appropriate level of intervention.

It has to be noted here that the South Manchester Assertive Outreach Team was in possession of a full CPA and risk assessment that had been completed by Care Coordinator 2 in January 2008. The team also had a full AMIGOS record that detailed most of Mr. X's known risk history from September 2005. The South Manchester Assertive Outreach Team had worked with Bronte Ward in the formulation of the AOT Referral Form which detailed many of Mr. X's risk indicators. At the point Mr. X came into the service a great deal of Mr. X's known risk history was available to the team had they taken the opportunity to read it, and his risk indicators should have been discussed fully at the allocation meeting when he entered the service. This information should have been sufficient to inform them of the relevance of Mr. X's changing presentation between 3 April and 28 July 2008, particularly in relation to his identified relapse risk factors which were non adherence with medication and disengagement from services.

Mr. X presented to the South Manchester Assertive Outreach Team with the following criteria that should have been identified in a risk assessment and that should also have been addressed via an active care and treatment plan.

- 27 April 2008. Home visit
    - Eating very little and had lost a great deal of weight
    - Drinking alcohol
    - Difficulties in engaging with AOT[308]
- 7 May 2008. Home visit
    - Eating very little and had lost a great deal of weight
    - Refusing medication (previously identified as a relapse indicator)
    - Poly substance misuse
    - Drinking alcohol
    - Difficulties in engaging with AOT[309]
- 10 June 2008. Home visit
    - Developed a crack cocaine /heroin habit
    - Financial difficulties
    - Non adherence to antidepressant medication
    - Non compliance with depot medication
    - Difficulties in engaging with AOT[310]
- 22 July 2008. Home visit
    - Non compliance with all medication
    - Difficulties in engaging with AOT
    - Possession of a knife for self protection
    - Substantial crack cocaine and heroin abuse
    - Report of serious suicide attempt
    - Violent argument with a friend involving a knife due to fact he owed money for his drug habit
    - Paranoid ideas about people
    - Feelings of wanting to kill himself and of vulnerability[311]

308 AMIGOS Record P. 508
309 AMIGOS Record P. 509
310 AMIGOS Record P. 520
311 AMIGOS record P. 531

On the 22 July 2008 Mr. X presented in a manner that did not lead the Care Coordinator to believe that he was a risk to other people. However it was evident from the way Mr. X was presenting that he may have been a significant risk to himself and also at significant risk from other people. At this stage Mr. X described a serious drug habit that had led him into debt with drug dealers. He described being threatened with a knife the previous weekend by a 'friend'. This 'friend' had apparently taken Mr. X at knife point to a cash point machine whereupon he had to give money to him.

The Care Coordinator made the decision to make an urgent appointment with the South Manchester Assertive Outreach Psychiatrist for the following day. This appointment did not take place at the request of Mr. X. No further contact was attempted with Mr. X aside from one telephone call (instigated by Mr. X) and a failed home visit made on the 27 July. This is extraordinary considering the recorded risk threshold that Mr. X had reached, by this stage it was evident that swift crisis management was required. The clinical record notes that the Care Coordinator decided to visit Mr. X two to three times a week, but it would appear that no attempt was made until seven days later. When interviewed by the Independent Investigation Team witnesses were asked if they had considered the possibility that Mr. X may have tried to commit suicide in the intervening period and that he may have been dead in his flat when they failed to make contact with him on the 27 July 2008. This thought had not occurred to any of the team.

The Independent Investigation Team concurs with the findings of the Internal Investigation. Had a risk assessment been formulated prior to the visit made on the 22 July 2008 then an agreed crisis and contingency plan would have been in place once Mr. X's risk threshold had reached a stage that required intervention. These plans should have detailed the range of options that were available to the Care Coordinator on the 22 July 2008. These options would have been:

- to take Mr. X directly to Accident and Emergency (to assess his physical condition following his self-reported overdose);
- to call out the GP (to assess his physical condition following his self-reported overdose);
- to arrange intensive input from the Crisis and Home Treatment Team;
- to negotiate a daily home visit from the AOT;

- to arrange an emergency visit from the AOT psychiatrist that day;
- to arrange an informal admission;
- to arrange an assessment under the Mental Health Act;
- to notify the police that Mr. X was carrying a knife;
- to support Mr. X in contacting the police with regards to the threats that had been made against him by his 'friend'.

It would appear that beyond a very rudimentary plan to make an appointment with the South Manchester Assertive Outreach Psychiatrist the following day nothing was done. In effect the team simply walked away.

13.2.3.3. Conclusion

It would appear that despite Mr. X's known levels of risk at the point of his transfer on the 3 April 2008 no rapid assessment of his risk was undertaken once he entered the Assertive Outreach Service. This went against the policy guidelines that were in operation at the time. It is possible that the discharge CPA addressed some of these issues, but no documentation exists for this review. Once Mr. X was on the South Manchester Assertive Outreach Caseload it would appear that a risk assessment process was never utilised and this meant that Mr. X's risk was not assessed, addressed or appropriately communicated in a dynamic manner.

The process of clinical risk assessment is intended to ensure the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service users' recovery. There can be no guarantees that all risk can be mitigated against. However the Department of Health Risk Management Guidelines state that as long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.[312]

In the case of Mr. X it is clear from the examination of his clinical record that his risk was never assessed in any meaningful sense whilst he was with the Assertive Outreach Service. Mr. X began to present with increasingly high levels of risk between the 27 April and the 27

312 Best Practice in Managing Risk; DoH; 2007

July 2008. This was not appropriately assessed, addressed or discussed. Clinical teams must be warned against being lulled into a false sense of security. Activity does not always equate to care and treatment. Whilst Mr. X was seen on five occasions and whilst some 25 attempts were made to contact him, this activity did not constitute the provision of care and treatment. It would appear that team workers passively recorded events and observations but never translated them into either significant actions or proactive plans. Decisions were not based on the presenting evidence and therefore cannot be judged to have been the best decisions that could have been made in the circumstances.

Once again the controversy surrounding Mr. X's diagnosis has to be raised. It would not have been possible to mitigate against all of the risks that Mr. X presented with. However he was in receipt of secondary mental health services, and as such, based on what the South Manchester Assertive Outreach Team knew at the time he should have been in receipt of robust services of which risk assessment and management forms a vital part.

Mr. X's risk was neither assessed, monitored nor managed. The care and treatment that he received fell far below that expected of an Assertive Outreach Service. Mr. X presented with a significant risk of harm to himself and an unquantified level of risk to others. It must be understood that Mr. X was not presenting a significant risk of harm to others at this juncture, only to himself. However had Mr. X been managed more appropriately in the light of his presentation at this stage these actions may have, albeit inadvertently, created the circumstances in which the risk to others may also have been obviated.

- ***Contributory Factor Number Two (influencing). The failure to follow a fit for purpose Risk Assessment process contributed to the circumstances in which a serious untoward incident was more likely to occur. The failure to act appropriately in the light of Mr. X's presentation on the 22 July 2008 left him at risk. Had this risk been appropriately addressed the circumstances leading up to Mr. W's death may also, albeit inadvertently, have been averted.***

13.2.4. Management of Clinical Processes

13.2.4.1. Context

The delivery of patient care and treatment in secondary mental health services is usually provided within a team context. People with mental health problems often require a high degree of case management in order to ensure that effective liaison between agencies and multidisciplinary team members takes place and that long-term treatment strategies are effective. In order to achieve this frameworks such as the Care Programme Approach and clinical policy guidance exist.

During the time that Mr. X was receiving his care and treatment from the South Manchester Assertive Outreach Service an Operational Policy was in place. This policy made provisions for the following:

- access criteria;
- referral pathway;
- staff composition;
- level of service provision;
- service governance arrangements;
- clinical assessment processes;
- care coordination and the 'team approach';
- age, culture and gender sensitive service;
- regular review processes;
- care and treatment interventions;
- the recovery focus;
- links with other services;
- step down processes;
- incident reporting;
- record keeping and confidentiality;
- service user involvement;
- recruitment training and supervision
- contract monitoring.

13.2.4.2. Findings

The 'team approach' model requires a high degree of management support, sound policy and procedure frameworks and robust professional leadership if it is to work effectively. From close examination of the care coordination and risk assessment processes it would appear that neither the Care Coordinator nor the multidisciplinary team were able to manage Mr. X effectively within the policy and procedure expectation in place at the time.

Implementation of the Discharge Plan

At the point of transfer to the South Manchester Assertive Outreach Service the discharge plan was for the Assertive Outreach Team to:

- take over the administration of the weekly depot medication;
- ensure the Assertive Outreach Psychiatrist followed Mr. X up within a two week interval at the Outpatient Clinic;
- follow up Mr. X on a two weekly basis;
- ensure psychological therapy was made available.

The Assertive Outreach Psychological Therapy Operational Policy current at the time Mr. X was receiving his care and treatment stated that:

- *"An important aspect of the AOS is the provision of high quality psychosocial interventions (PSI) to service users. In this context, PSI refers to cognitive behavioural therapy (CBT), family interventions (FI) and early warning signs monitoring (EWSM).*
- *NICE guidelines for schizophrenia recommend that all individuals with a diagnosis of schizophrenia should be offered a course of 10 sessions of CBT delivered over at least 6 months. In addition, The National Institute for Health and Clinical Excellence (NICE, 2002) recommend that families of people with schizophrenia should be offered a minimum of 10 sessions of Family Intervention over a 6-month period."* [313]

This excerpt demonstrates the fact that the Assertive Outreach Service was primed to provide psychological therapy and that it would have been expected good practice for them to offer it to someone with the diagnosis Mr. X carried at the time he entered the service.

313 AOS Psychological Therapy Operational Policy (undated) P. 3

It was apparent that Mr. X did not receive psychological therapy and neither did he see the South Manchester Assertive Outreach Psychiatrist. Mr. X's medication was administered on one occasion only and two weekly follow ups did not occur. Whilst it has to be acknowledged that Mr. X was a complex and challenging person to work with it does seem inexplicable that his discharge plan was not implemented and that no discussion was recorded in relation as to why this was the case and what was being done to ameliorate the situation. If a person has been referred to, and accepted by, an Assertive Outreach Service it will be because it has been determined that they require a coherent and long-term care and treatment strategy. It was not good practice to let the case management effectively 'grind to a halt'.

The internal investigation report explained that the appointments to see the South Manchester Assertive Outreach Psychiatrist were cancelled by Mr. X. Apart from the appointment arranged for the 22 July the Independent Investigation Team found little evidence to suggest that appointments had been made with the Psychiatrist and could not find the reasons apparently given by Mr. X for not attending them. As well as avoiding the Psychiatrist Mr. X declined his depot. There was no evidence either in the form of clinical records or witness testimonies to suggest that this issue was ever brought to the Psychiatrist's attention.

Other aspects of the discharge plan were to ensure that Mr. X received regular assessment and support. It was evident that this, in common with all other aspects of the discharge plan, did not occur.

Assessment and Interventions

At the point of transfer to the South Manchester Assertive Outreach Service the team had enough information to commence their work with Mr. X. The Operational Policy expectation was that all service users would receive an assessment that would focus upon their *"strengths, goals and aspirations"*.[314] The entire team was expected to become involved in the assessment process and to utilise the MANCAS and Mental Health Trust Risk Assessment Toolkit. The closest that Mr. X came to having an assessment conducted was on the 10 June 2008 when Assertive Outreach Worker 7 visited him at his home. On this occasion the visit lasted 30 minutes and Mr. X self-reported his ever-increasing substance misuse problems. The Assertive Outreach Worker took the opportunity to ask Mr. X what his

314 HARP Operational Policy P.5

goals were. On this occasion Mr. X was unable to state what they were. The plan was to *"review period with crack cocaine"*, to consider what would happen if he continued to take drugs and to focus Mr. X on what was the most happy period of his life.[315] This could not be said to have constituted an assessment and the plan did not address the issues that were of particular importance at the time, e.g. Mr. X's non-compliance with medication, his lack of engagement with services, his self neglect and self-reported increasing drug habit.

The Operational Policy stated that the Assertive Outreach Service prioritised interventions with newly referred service users. This was in order to build a therapeutic relationship and to understand how engagement issues should be managed in the future. This clearly was neither attempted nor achieved with Mr. X. The Operational Policy also stated: *"each service user will be seen a minimum of one hour a week. This will be increased if, for example, early warning signs are present; assistance is required with medication management; the service user is receiving a specific therapy or intervention; or if the service user is in crisis."*[316]

The reasons given to the Independent Investigation Team for the Assertive Outreach Team not complying with their policy guidance in relation to Mr. X was that he was difficult to engage. This is an entirely unsatisfactory response from an Assertive Outreach Team whose *raison d'etre* is to engage with difficult to engage patients.

The Service aimed to ensure:

"All service users are briefly reviewed at a daily handover meeting. This incorporates:

- *Handover of contacts in the previous 24 hours;*
- *Allocation of related tasks; discussion of changes in presentation, including changes in risk profile, with particular attention to service users whose early warning signs may be present;*
- *The attendance and contributions of a member of the medical team.*

All team members, including the consultant psychiatrist, attend a weekly review meeting. This incorporates:

- *Attention to service users whose early warning signs are present or who otherwise may be going into crisis.*

315 AMIGOS Record P.520
316 AOS Operational Policy (undated) P. 4

- *Whole team discussion of changes in treatment;*
- *Short to medium term action planning;*
- *Use of a case formulation approach to enable a more thorough exploration of the delivery of care and treatment to service users whose needs are particularly complex or where engagement is particularly problematic."*[317]

It was evident on close examination that clinical management processes in operation at the time were unable to ensure Mr. X received this level of input.

Multidisciplinary Working and Professional Leadership

The concept of the 'team approach' was explained to the Independent Investigation Team during interviews with witnesses. Witnesses were at pains to explain that whilst there were clinical leadership roles within the team the hierarchy was essentially a flattened one. It was interesting to note that during the interview process no consistent view emerged as to who the clinical leaders were. Witnesses described unsatisfactory procedures that were used to discuss clinical interventions and described a system of 'compromise' when team members could not agree one with the other.

One undisputed professional leader that was identified by each witness was the Assertive Outreach Team Consultant Psychiatrist. This individual was described as providing a very effective and supportive level of input. However the south team only had access to him for two and a half days a week. This meant that he was not always available for handovers and the team weekly review as the Consultant's precious time was used where possible with service users. This part time availability would not have been such a problem had the Service been able to recruit the 0.5 Staff Grade that should have formed part of the establishment. Unfortunately recruitment did not take place and the position was left unfilled. Another issue that impinged upon the Consultant's availability was that his office was based in an entirely different part of Manchester as the South Manchester Assertive Outreach Team base did not have enough room for him to be co-located with them. This meant that an important professional leader was physically absent from the team for a significant proportion of the time.

317 AOS Operational Policy (undated) P. 7

Professional Communication and Decision Making

It is clear that the South Manchester Assertive Outreach Consultant did not receive a handover letter from the inpatient Consultant Psychiatrist. It was also apparent from the interviews that were held with witnesses that no one from the South Manchester Assertive Outreach Team could remember having discussed Mr. X with their Consultant Psychiatrist. As conversations went routinely unrecorded it was difficult to understand whether any discussion ever took place or not. It would appear that everything the Consultant knew about Mr. X was *post hoc* to the incident.

Decisions about patients were made during team meetings and daily handovers. The daily handover provided the opportunity for the zoning meeting where high-risk patients were discussed. The Consultant Psychiatrist was only ever able to attend one of these meetings a week. Whilst it was expected that a Care Coordinator would take the lead with the people on their caseload this was not always possible. At this meeting visits would be allocated to members of the team who had spaces available in their diaries. Witnesses noted that allocations were not always given to the most suitable person as a result.

It was evident to the Independent Investigation Team that patients were discussed in a dynamic manner on a daily basis. However, as is common with a team of this nature, not everyone would be present at each meeting. In the absence of a written record being made many of the concerns and decisions discussed regarding Mr. X were not widely known throughout the team. Continuity was an important theme that was found when examining the care and treatment Mr. X received. There was poor continuity regarding team discussions and information flow, and poor continuity with regards to the workers that were allocated to him. Communication was fragmented and it was evident that the team did not build up an exact picture of how Mr. X was presenting during the four months that he was on their caseload.

13.2.4.3. Conclusions

The Independent Investigation Team concluded that the management of the care and treatment Mr. X received was ineffective. Team systems and processes were under pressure as the caseload was being expanded and the team was having to take on patients with ever more complex needs. During this period lines of accountability were confused and many staff felt disenfranchised and cast adrift from the clinical governance structures that they had been previously used to. When interviewed several witnesses expressed the concern that they felt

during this period about the underpinning structure of the Assertive Outreach Service being unsafe leaving their practice vulnerable.

Care Coordination, whilst acknowledged by the team as being an important part of case management, in reality played a subordinate role to the 'team approach'. However the 'team approach' was not able to deliver the degree of continuity and case management required due to several factors. These factors consisted of organisational change, poorly understood systems and processes and poorly constructed governance frameworks. In effect the care and treatment Mr. X received was provided in the absence of any coherent clinical management of his case. This lack of management ensured that the team did not respond appropriately to the way Mr. X was presenting. It was evident that the team neither knew nor understood Mr. X. Had he been appropriately assessed psychiatrically and psychologically it may have been possible to determine that Mr. X was not suffering from Paranoid Schizophrenia. Had an effective period of assessment occurred it may have been possible that the team would have understood Mr. X in the light of his complex Personality Disorders. This should then have led to either an appropriate referral or a revision of his care and treatment plan. Whilst it is true that no service over time had managed to understand Mr. X and this ambiguity was passed on to the South Manchester Assertive Outreach Team, had they organised their resources appropriately and assessed and treated Mr. X in accordance to both the discharge plan and their own Operational Policy, a more appropriate approach to Mr. X could have been taken.

There are two main conclusions. First, based on what the South Manchester Assertive Outreach Team knew at the time, Mr. X did not receive an appropriate level of care and treatment for a person with a diagnosis of Paranoid Schizophrenia presenting in the manner that he did. Second, it is apparent that with the benefit of hindsight Mr. X did not suffer from Paranoid Schizophrenia. It was part of the duty of care of the South Manchester Assertive Outreach Team to assess Mr. X and to develop a dynamic care and treatment plan for him. Had this occurred it is a possibility that Mr. X would have reverted back to his original Personality Disorder diagnosis that would have led to a different management plan being constructed. At the time of the incident it was evident that Mr. X was presenting in a manner sufficient to raise grave concerns. No appropriate or timely interventions were made and this made a direct contribution to the failure to manage Mr. X appropriately and created the circumstances in which a serious untoward incident was more likely to occur.

- ***Contributory Factor Number Three (influencing). Mr. X's case went unmanaged. No appropriate assessments or timely interventions were made and this made a direct contribution to the failure to manage Mr. X appropriately and created the circumstances in which a serious untoward incident was more likely to occur.***

13.2.5. Use of the Mental Health Act

13.2.5.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007. The Act allows for the detention of individuals who may be considered to be a risk to either themselves or to other people.

At the time Mr. X was receiving his care and treatment from the Assertive Outreach South Manchester Team he was eligible for Section 117 aftercare.

Section 117 of the Mental Health Act provides free aftercare services to people who have been detained under Sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. The purpose of Section 117 is to prevent someone needing to go back to an inpatient unit. Services should ensure immediate needs are met and should also support people in gaining the skills they require to cope with life outside of hospital.

Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

13.2.5.2. Findings

On the 22 July 2008 Mr. X was presenting in such a manner that a hospital admission should have been considered alongside the other options discussed above in sub-section 13.2.3. It was evident that the Care Coordinator did not think this to be immediately required. It is probable that Mr. X would have accepted an informal admission had this been offered at this stage in line with his past behaviour. In all likelihood an assessment and detention under the Act would not have been required had an admission been considered necessary.

Mr. X was still eligible for Section 117 aftercare. It was evident between 3 April and the 28 July 2008 that no member of the South Manchester Assertive Outreach Team considered assessing Mr. X needs in the context of this eligibility.

13.2.5.3. Conclusions

There was no evidence to suggest that the Mental Health Act should have been utilised in the case of Mr. X on the 22 July 2008, although it should have been considered a part of an option appraisal at this stage.

The South Manchester Assertive Outreach Team did not manage Section 117 aftercare in accordance with either national expectation or local policy guidance. Whilst this may have had no direct effect on the events of 28 July 2008, it represented a missed opportunity. It was a missed opportunity for two reasons. First, aftercare arrangements should be supportive of a recovery model that works actively with a person to equip them medically, socially and emotionally to cope with life outside of hospital. Mr. X could have benefitted from this kind of therapeutic intervention. Second, many patients will engage with services if they provide a means to obtain accommodation, benefits and life skills. Whilst this is not the main *raison d'etre* of Section 117 it provides an additional therapeutic process for clinical teams to use when patients are reluctant to engage clinically.

- ***Contributory Factor Number Four (influencing). Use of the Mental Health Act was not considered as part of the care and treatment process offered to Mr. X. Section 117 aftercare was not adequately implemented, which could be seen as a missed opportunity when integrating Mr. X back into the community. Use of a Mental Health Act assessment was not considered as an approach once it appeared that the mental health of Mr. X was breaking down.***

13.2.6. Liaison with Carers

13.2.5.1. Context

The national context for this Section is the same as that for Section 13.1.8. above. The HARP Operational Policy current at the time Mr. X was receiving his treatment and care stated that where possible and with the Service user's consent the CPA process would be developed with them.

13.2.6.2. Findings

It is acknowledged by the Independent Investigation Team that by the time Mr. X entered the Assertive Outreach Service the relationships with his family had broken down to the extent where they were no longer part of his life and took no part in supporting him in the community.

On the 27 April 2008, during a home visit, members of the South Manchester Assertive Outreach Team were told that Mr. X would like them to support him in re-establishing contact with his family. Mr. X told the team members that he had resumed contact with his maternal grandfather and that his stepfather had helped him to move into his new flat but that there had been no contact with his family since.[318] There are two points to consider here.

First, at this stage Mr. X was already proving difficult to engage. Work with the family could have provided an opportunity for the team to establish some kind of relationship with Mr. X. It would also have been good practice to try and involve the family in trying to re-establish Mr. X living in the community. At the very least the family could have provided collateral information about Mr. X. Based on what *was* known to the South Manchester Assertive Outreach Team at the time this approach would not have been unreasonable.

Second, this desire for the South Manchester Assertive Outreach Team to contact his family could be seen as manipulative behaviour on the part of Mr. X who was well aware that his parents were trying to maintain some kind of distance from him (his stepfather had been in contact, his mother had not). The clinical record on AMIGOS (to which the Assertive Outreach team had access) documented a great deal of the history relating to the breakdown

318 AMIGOS Record. P. 508

of the family relationship and past issues detailing emotional and financial abuse. The fact Mr. X had established contact with his maternal grandfather should have raised a cause for concern within the team had they accessed Mr. X's clinical history appropriately. The team appeared not to have been aware of the situation. Based on what the Assertive Outreach Team *should* have known about Mr. X at the time this request from him should have led to his risk profile being assessed, particularly when Mr. X's substance misuse began to escalate and his financial situation began to worsen.

13.2.6.3. Conclusions

The relationship between Mr. X and his family had deteriorated at this stage and little could appropriately have been done to ameliorate this situation. However this presents an example that illustrates the fact that the South Manchester Assertive Outreach Team was not paying appropriate attention to Mr. X's clinical history. It was obvious that the team was under a great deal of pressure and relied heavily on the handover process from Bronte Ward. However the team did have access to the clinical record that detailed past family relationship problems. The team at this stage could have considered asking Mr. X's consent to contact his family. This could have provided the opportunity to find out more about why relationships had broken down and how to manage Mr. X's expectations. It may also have raised potential risk issues regarding the likelihood of Mr. X financially abusing his maternal grandfather if his financial situation deteriorated further caused by his increasing drug habit.

Whilst this issue cannot be said to have had any direct impact upon the death of Mr. W, the South Manchester Assertive Outreach Team was approached by Mr. X for help in this matter, help which does not appear to have become part of his CPA. Mr. X had a troubled history with his family and had emotionally and financially abused them in the past. He was in a situation where money was in short supply and he was getting into trouble with drug dealers. This fact raised his risk profile with regards to his family who had always felt vulnerable in relation to Mr. X, particularly from his financial demands.

This situation provides a significant example of how potential risks can exist without a team being made aware of them. Carer issues had been poorly managed by the Mental Health Trust and were largely absent from the risk profiles that they had developed for Mr. X. Whilst the South Manchester Assertive Outreach Team did not pick up upon this potentially significant

risk, this was in part due to its having been minimised by the previous teams caring for Mr. X.

13.2.7. Documentation and Use of Clinical Records

13.2.7.1. Context

'The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.
The Act... states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*
- *Not transferred to other countries without adequate protection*[319]*,*

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Act. All records should be archived in such a way that they can be retrieved and not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further treatment is considered necessary; or eight years after the patient's death if the patient died while still receiving treatment.

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

[319] Information Commissioner's Office Website 2009

The GMC states that:
'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off [320]*'*

Pullen and Loudon writing for the Royal College of Psychiatry state that:
'Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised. [321]*'*

13.2.7.2. Findings

There were two key issues regarding documentation and the use of clinical records identified by the Independent Investigation Team. First, Data Protection. Second, clinical record keeping.

Data Protection

Data Protection issues were identified by commissioners regarding the appropriateness of the Assertive Outreach South Manchester Team base to both receive and store hard-copy clinical records. No hard-copy patient records could be received and utilised by the Service in 2008. This situation was given as the reason why the team did not have access to a full set of Mr. X's clinical records which they felt was detrimental to the long-term care and treatment he received from their Service. The service was however able to access and utilise the Mental Health Trust AMIGOS electronic clinical recording system.

An anomaly that the Independent Investigation Team found difficult to understand was that the Assertive Outreach Team did in fact hold a hard copy file for Mr. X which contained an assorted of risk profiles and CPA care plans. This constituted a breach regarding the decision that the team base was not considered to be a 'safe haven' for documentation of this kind.

[320] http://www.medicalprotection.org/uk/factsheets/records

[321] Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) PP. 280-286

Clinical Record Keeping

Assertive Outreach Team workers used the AMIGOS electronic system to record clinical interventions on a day-today basis. The team also utilised an electronic spreadsheet system to record discussions and planned team activities. The Internal Investigation was able to examine the white board and spreadsheet systems, but by the time the Independent Investigation took place these systems were no longer in operation. The weakness of the clinical recording system was that the electronic spreadsheets were overwritten each day and no permanent record was either made or archived. This meant that the data would not have been available to any member of the team who had been absent from the meetings in which the temporary records had been generated.

The internal investigation team was told by witnesses that a case review for Mr. X had been held, and that an additional visit had been made to him at his home sometime between April and June 2008. However none of this activity was recorded and no witness that the Independent Investigation Team met could remember whether these events took place or not, and definitely could offer no view as to what might have been discussed.

The clinical record generated for Mr. X on AMIGOS between 3 April and the 28 July 2008 contained a basic record of contact only. Team discussions, risk assessments and care planning activities were entirely absent from the record. In the absence of any coherent explanation from witnesses the Independent Investigation Team had to conclude that these activities did not occur in any meaningful sense.

13.2.7.3. Conclusions

The poor standard of record management and record keeping constitutes a serious breach of duty of care on the part of commissioners, Assertive Outreach Management and individual Assertive Outreach Team Workers.

First, an Assertive Outreach Service should not have been allowed to operate from a team base that was not fit for purpose in that it was not considered to be an appropriate repository for clinical records.

Second, once it had been agreed that the team base was not a 'safe haven' it was a serious breach for the team to collect and store hard copy patient sensitive information as was the case with Mr. X.

Third, the standard of clinical record keeping fell below that to be expected from either health or social care professionals. This was exacerbated by the fact that the team did not have access to administrative support. The systems in operation, such as the electronic spreadsheet, were inappropriate and unsafe. The purpose of developing and maintaining a clinical record is to ensure that a longitudinal history is developed for each service user and that current information is recorded in such a manner as to aid clinical communication and decision making in order to ensure the wellbeing and safety of the patient. This did not occur in the case of Mr. X. The failure to maintain a basic minimum standard of record keeping that co-existed alongside poor case management processes and embryonic governance systems exacerbated the disorganised approach that was taken to the delivery of care and treatment to Mr. X. Poor record keeping made a direct contribution to the poor communication and follow up processes evident in the management of Mr. X.

- ***Contributory Factor Number Four (influencing). Inadequate record management processes and recording systems ensured that the planning and delivery of care and treatment to Mr. X did not form part of a dynamic assessment and intervention process that was communicated to, and understood by, all members of the Assertive Outreach South Manchester Team.***

13.2.8. Clinical Supervision and Staff Competency

13.2.8.1. Context

The external context for this section is the same as that for section 13.1.11. set out above. The HARP Supervision Policy stated that it recognised the need for three different kinds of supervision, operational, professional and personal. The policy did not require individuals to adhere to any particular model, but the expectation was that a supervision contract would be agreed formally between the supervisor and the supervisee for all types of supervision activity.

Operational (management) supervision was meant to operate on a six-weekly basis for all members of the team. The identified supervisor for operational supervision was the Assertive Outreach Team Manager. The purpose was to ensure discussion and management of the supervisee's caseload, other work related roles and duties, attendance, annual and other leave, training requirements, team goals and work performance

Professional supervision was meant to be conducted every four weeks by *"a suitably qualified and experienced person from a related working background."*[322] The aims were:

- *"To act as a means of quality assurance by ensuring safe and ethical practice and to ensure that the supervisee is acting in a professional manner and providing the best possible interventions to their clients.*
- *To allow both supervisee and supervisor the opportunity to discuss and evaluate interventions and explore alternatives where applicable.*
- *To provide an unthreatening environment for supervisees to develop their knowledge and expertise.*
- *To provide support to a supervisee in dealing with feelings or conflicts which may arise from their work with clients.*
- *To allow space for the identification of any personal conflicts which may arise within the team or any personal stressors and the effects these might be having when working with clients."*

Personal supervision was meant to be constituted once every two months and was intended to address any personal issues that arose relating to the work place.

13.2.8.2. Findings

Clinical Supervision

The Supervision Policy in place during the time that Mr. X was receiving his care and treatment was both appropriate and comprehensive. However difficulties arose in relation to its implementation. Due to the increased Assertive Outreach Team workload managers were pressured and supervision could not be provided against the expectations of the Supervision Policy.

322 AOS Supervision Policy (undated). P. 2

The Assertive Outreach Team Manager, very sensibly, delegated her operational supervision responsibilities out to other senior colleagues within the team in an attempt to alleviate the situation. There was a distinct lack of agreement between witnesses to this Investigation regarding the supervision processes that were in place. Clinical witness recollections varied distinctly from senior HARP manager recollections. Whatever the situation, the clinical witnesses to this Investigation described a supervision processes that did not support actively the South Manchester Assertive Outreach senior professional team who expressed many concerns regarding the effectiveness and safety of the Service.

Individual worker experience of supervision processes varied. Some witnesses described regular, formal supervision which was recorded. Other members of the team described supervision that did not occur in accordance with agreed policy and procedure. The Care Coordinator, for example, received a total of seven operational supervision sessions over the six and a half year period he was employed by HARP. During this time he received two clinical supervision sessions (which he arranged himself) and no specific caseload supervision or guidance.

Some members of the team who had been migrated over to the Assertive Outreach Service from the Mental Health Trust in 2007 maintained their professional supervision arrangements with people that they knew at the Trust, this was felt to be a good arrangement. However they described the operational supervision that was made available to them from HARP as being disjointed and subject to frequent cancellation.

Informal supervisory processes appeared to have been in operation and witnesses described how difficult issues could be discussed with other team members as situations arose. However these discussions were both unofficial and unrecorded and did not comprise part of a coherent approach to caseload management and safe service delivery.

Staff Competency

It was evident to the Independent Investigation Team that most of the staff employed by the Assertive Outreach South Manchester Service were appropriately qualified, experienced and skilled. When interviewed many witnesses expressed a high degree of frustration that they were not able to provide the level of care and treatment interventions that they would have liked due to the chaotic system that they found themselves working in.

The Internal Investigation Team identified the fact that the Care Coordinator was not registered with the General Social Care Council. This was a finding of fact. The Internal Investigation Team also raised concerns about the competency of this individual to practice. The Independent Investigation Team acknowledges that it was unacceptable for the Care Coordinator to practice as a Social Worker when he was not registered to do so. Nevertheless senior clinical witnesses to this Investigation described the Care Coordinator as being a highly skilled and well respected member of the team. It was evident that no mental state examination was carried out and that CPA and risk assessment processes were non-existent, and that once again this was unacceptable. However the Independent Investigation Team was not convinced this was evidence to indicate the Care Coordinator was not competent. The Assertive Outreach South Manchester Team was operating in a highly pressured and chaotic system. Sound governance processes such as best practice policy adherence, record keeping and supervision were failing to operate effectively. Individual practitioners were working within a flawed system.

13.2.8.3. Conclusions

It is the responsibility of every person involved in providing care and treatment to take part in clinical supervision activities to promote both safe practice and service delivery. It was evident that Assertive Outreach Team Workers pursued actively the opportunities made available to them.

It is also the responsibility of service providers to ensure that clinical supervision occurs and it is a specific core standard that every statutory health care provider service has to comply with in accordance with national Care Quality Commission guidance. This aspect of fitness for purpose did not appear to have been routinely considered or monitored by HARP, the Joint Partnership Board or the commissioning bodies. This ensured invidual team members who were working in a highly pressured service were practising without the basic safety nets of care beneath them that would normally have been expected.

On examination of the staff profiles of the people working in the Assertive Outreach South Manchester Service during 2008 it was evident that these individuals were appropriately qualified, experienced and skilled. When individuals of this calibre are found to be delivering unacceptable levels of service questions regarding the quality of the system that they working in have to be raised.

It was evident from the examination of Mr. X's case that governance processes within the Assertive Outreach South Manchester Team were not working well. This team was not working in isolation and was experiencing the wider chaos that existed throughout all Manchester-based mental health services at the time. Whilst each team worker maintained a responsibility to ensure their individual work met best practice standards, the system that they worked in did not enable this to happen.

- ***Contributory Factor Number Five (influencing). Supervision processes were ineffective in supporting Assertive Outreach Team Workers when delivering services. This meant that practitioners were working without professional regulatory processes in place during a time of great challenge and organisational change. This contributed to the less than effective care and treatment Mr. X received.***

13.2.9. Clinical Governance and Performance Management Arrangements (including adherence to local and national policy)

13.2.9.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[323]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

13.2.9.2. Findings

Clinical governance arrangements were not explicitly identified in the service specification for the Assertive Outreach Service tender process in January 2007. Whilst service delivery targets were made clear the Partnership (the Mental Health Trust and HARP) were not asked

[323] Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

to specify how clinical governance arrangements were intended to work to ensure safe and effective service delivery.

The clinical governance assurance process was not determined. However the service specification set out key processes that would require a robust clinical governance approach in order to be effective. These were:

- clinical assessment, review, care planning and intervention;
- record keeping;
- health and safety;
- training and supervision.

Following the Assertive Outreach Service tender being awarded to the Partnership in 2007 a Joint Management Board was created. This Board consisted of Commissioners, Senior Trust Managers, and HARP Senior Managers. This Board met monthly to discuss all aspects of service delivery and contract management.

The Board's chief role and function was to manage the contract. This monitoring focused upon the pre-set contractual targets however these were not deemed to be a sufficient basis upon which to regulate the service. One of the first things the Board had to agree upon was what exactly it was going to monitor and how this would be achieved. It was decided that information would be pulled from the AMIGOS system. However the Independent Investigation Team was told that there were problems with the AMIGOS system and that the information could not be collected and subsequently the contract was not able to be monitored against any specific data.

Several witnesses who gave evidence to this Investigation indicated that governance arrangements were poor and that the 'shared governance' processes brought into being by the Partnership were impossible to fathom. Complex caseloads that were rapidly increasing, new staff that required inducting into the team, and weak service infrastructures, all served to create additional pressure. Clinical governance was regarded as being an essential safety net, one which was not present. Some senior clinicians attempted to set up a Professional Practice Development Meeting to address the governance vacuum. However this meeting did not manage to capture senior management support and it was rendered ineffective. Senior

clinicians experienced a high degree of frustration as it became evident that the only effective vehicle that could support governance issues was the Joint Management Board. It was felt that raising governance shortfalls to this Board, which had a commissioner membership, would present the Assertive Outreach Service in a bad light and could be self defeating. This avenue was not explored for that reason. It was evident that many Assertive Outreach Team Workers were disillusioned as even the most simple processes, such as staff training and development, could not be managed successfully in the absence of a governance framework.

Policy and Procedure

Prior to the contract change in 2007 HARP had always developed its own suite of policies independently, utilising the Mental Health Trust risk and MANCAS assessment processes and documentation. Following the advent of the Joint Management Board all new or revised policies were taken to the Board for approval, pre-existing policies were not ratified or reviewed at this stage.

Clinical guidelines and service protocols were not available to staff working in the Assertive Outreach Service in 2008. For example no protocols existed for escalating cases or for instigating Mental Health Act assessments. Individual workers were expected to make their own judgement calls. In the absence of designated professional leaders some individuals found this difficult. Several witnesses to the Independent Investigation said that this was sometimes an issue as the team had to make a decision in the absence of a protocol or guideline, and on many occasions the team would not be able to reach a consensus view and then a ‘compromise’ would have to be reached. Clinical management by ‘compromise’ is not an evidence-based method of service delivery and should not have been in operation.

Registration of Professional Team Workers

At the time Mr. X was receiving his care and treatment from the Assertive Outreach Service there was no formal governance process to ensure that professional team workers maintained their registration. Senior managers described a process of holding the information ‘in their heads’. Not only was there no formal process, such as a database, for flagging up registration renewal dates, no system was deployed for physically checking a person’s registration status. A person’s word was regarded as being enough.

13.2.9.3. Conclusions

Very little can be said about the Assertive Outreach Service clinical governance system because it would appear that none actually existed in any meaningful way. It would also appear that whilst the Joint Management Board attempted to monitor the contract, albeit with varying degrees of success, it played no part in either assessing or monitoring clinical governance processes.

During the time that Mr. X was receiving his care and treatment with the Assertive Outreach South Team significant governance problems were in evidence. The Independent Investigation Team were informed by witnesses that training and development programmes were ineffective, clinical supervision failed to occur on a regular basis, and clinical protocols were not developed. It was also evident that no audit processes were in place to monitor policy and procedure compliance. In effect the team often practised in the absence of an evidence base and the clinical effectiveness and safety of the interventions the team implemented went unmonitored.

- ***Contributory Factor Number Six (influencing). The absence of a robust clinical governance system ensured that clinical practice was operated without an evidence-based regulatory framework. This created the circumstances in which a serious untoward incident was more likely to occur.***

13.3. NHS Manchester Commissioning Processes

13.3.1. Findings

Commissioning Issues Pertaining to the Trust

Commissioners were aware that Manchester-based services had struggled over a period of several years to deliver a mental health provision that was in step with the requirements of the 1999 *National Service Framework.* This led NHS Manchester and the Manchester City Council to commission the Boyington Review in 2008. This review found specific issues with regard to how the Manchester Mental Health and Social Care NHS Trust was performing in the context of the wider commissioning context:

- ***"Resources**: the way in which they were used, and matched with the needs of the population.*

- ***The lack of engagement with stakeholders****: this had been a real barrier to the progression of services.*
- ***Services:*** *instead of new services being put in place to replace older services, they had just been added onto the services which already existed.*
- ***Relationships, trust and confidence:*** *there had been too many changes in the Chief Executives and senior managers, for there to have been any solid relations or confidence in the Mental Health Trust.*
- ***Local Health Authority:*** *had not been monitoring the performance of the Mental Health Trust, and had left them to their own devices*."[324]

This review was taking place during the period of time that Mr. X was receiving his care and treatment from South Manchester Assertive Outreach Services.

Commissioning Issues Pertaining to the Health Advocacy Resource Project

HARP is, and was at the time of the death of Mr. W, a third sector organisation providing services on behalf of a statutory NHS organisation, NHS Manchester, the Primary Care Trust. In 2008 HARP provided the operational management lead for an Assertive Outreach Service which comprised three multidisciplinary teams covering the north, south and central localities of Manchester. The contract required the service to provide 308 cases to be worked with at any one time across the three teams.

Mr. X received his care and treatment from the south team. This team had a caseload capacity of 86. At the time of the incident the team was *not* working at full capacity. The staffing establishment had been constructed in line with the *Mental Health Policy Guide* (2001). As a consequence the service specification set out a clear contract monitoring and review section. However as has already been discussed above in sub-section 13.2.9, this review mechanism depended heavily upon the AMIGOS electronic clinical record system which for various reasons was unable to capture the data required for a robust level of performance management to occur.

A Joint Management Board was set up in 2007 to monitor the contract and this comprised Commissioners, Mental Health Trust Managers, the HARP Chief Executive and Service

324 http://www.manchesterusersnetwork.org.uk/?p=267

Manager, and the Assertive Outreach Team Managers. This Board met monthly. At this time there was a partnership arrangement between HARP and the Mental Health Trust to deliver Assertive Outreach Services. This partnership established an agreement on mutual responsibilities in the form of a protocol. There was a detailed contract specification between HARP and NHS Manchester. However there was no specific contract in place between NHS Manchester and the Trust which outlined a detailed service-level agreement.

13.3.2. Conclusions

It was evident to the Independent Investigation Team that commissioning processes were weak over a sustained period of time. This weakness had been identified by NHS Manchester and the Manchester City Council prior to the killing of Mr. W, and had led in part to the commissioning of the Boyington Review some six months before the incident.

In the case of the Manchester Mental Health and Social Care NHS Trust weaknesses in commissioning were identified as being specifically in relation to poor planning, resource prioritisation and performance monitoring.

In the case of the Assertive Outreach Service this weakness primarily lay in the performance management aspect of service contract monitoring, although it also has to be pointed out that the service specification did not set out clearly the expected level of infrastructure requirements that would be needed in order to deliver against the contract in a safe and effective manner. These infrastructure requirements would probably have been ‘taken as read’ with regard to the Mental Health Trust. However HARP was not a statutory service provider and did not have in place the clinical and corporate governance frameworks that would be expected normally when delivering a service usually provided by the statutory sector. The service specification did not focus upon:

- HARP internal clinical and corporate governance structures and processes (e.g. professional leadership, policy and procedure);
- internal capability and capacity to manage a large-scale service provision;
- internal quality assurance monitoring processes.

The situation on the 28 July 2008 was that Manchester-based mental health services were struggling to provide effective services. This long-term difficulty had been recognised by

commissioners and the Boyington Review had been commissioned to examine the system as a whole and to make recommendations in order to achieve better levels of service provision.

The Independent Investigation Team concludes that at the time Mr. W was killed clinical governance systems were not working effectively in either the Mental Health Trust or HARP. Poor clinical governance processes ensured that safe and effective clinical practice was neither achieved nor deficits detected and corrected. Contract monitoring processes failed to detect these deficits and performance management processes failed to detect the day-to-day difficulties that the Assertive Outreach Team was experiencing in achieving a level of service in keeping with the contract specification. As a result poor levels of performance were allowed to continue jeopardising the quality and safety of the care and treatment that was provided to service users.

- ***Contributory Factor Number One (Influencing). Commissioning arrangements were weak in that there was poor performance management of Manchester Mental Health Services. This made a contribution over time to commissioned services which followed unsafe practices and that went undetected and uncorrected.***

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

Root Cause Analysis

Mr. X presented in a challenging and complex manner over an eight-year period. This period commenced in January 2001, when he first came to the attention of Manchester Mental Health Services, and concluded in June 2009, one year after the death of Mr. W, when he was sentenced by Manchester Crown Court.

Between January 2001 and June 2009 Mr. X displayed abnormal illness behaviours accompanied at times by the fabrication of symptoms and the active pursuit of institutionalisation.[325] Mr. X's presentation led to both diagnostic ambiguity and controversy. This had a direct impact upon the effectiveness of the care and treatment plan that was formulated and implemented over time by Manchester Mental Health Services, and also served to confuse the Criminal Justice System until a systematic psychiatric assessment period was completed at Ashworth Hospital. It must be understood that whilst this report is broadly critical of the services Mr. X received, no direct causal link could be made by the Independent Investigation Team between the service that Manchester-based Mental Health Services provided and the death of Mr. W. Whilst this may appear to be contradictory this conclusion has been reached by the Independent Investigation Team for the following reasons:

- Mental Health Services when provided over a seven-year period do not always 'line themselves up' in an orderly sequence of events that can be proved to have a direct causal link between each other and a serious untoward incident.
- The nature of Mr. X's mental disorder has been identified by forensic psychiatric experts as having been of the kind that would not necessarily have responded to any kind of care and treatment programme, no matter how well constructed. The notion of Mr. X having a mental illness has been called into question as has the possibility that it played any part in his decision to kill Mr. W.
- It is an acknowledged fact that Personality Disorders are difficult to treat and successful clinical outcomes cannot be guaranteed. During the time Mr. X received his care and treatment from Manchester Mental Health Services national guidelines were still emergent and commissioning of specialist services embryonic.

325 Ashworth Court report 8 June 2008. P. 22

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. W. In order to assign a root cause to an organisation it has to be proven that it had complete control over the circumstances that ensued. There were three scenarios that the Independent Investigation Team considered as they worked through the root cause analysis process.

1. Mr. X suffered from a mental illness or disorder that went partially treated and managed and that this lack of treatment exacerbated his mental ill health and caused him to kill Mr. W. This scenario would indicate that a root cause could potentially be assigned to an act or omission on the part of mental health services.
2. Mr. X suffered from some kind of mental illness or disorder that went partially treated and managed but was of a nature that would not have responded to care and treatment, no matter how robust, beyond a very basic point. This scenario would not be able to assign a root cause to any specific act or omission that could have altered the course of events.
3. Mr. X was not suffering from a mental illness or disorder of the kind that would affect his capacity and he killed Mr. X for reasons independent of his mental illness or disorder. This scenario would provide a root cause that focused upon Mr. X and would not rest with mental health providers.

Based on the findings of the reports eventually prepared for the Crown Court scenarios two and three appear to be the most likely. When there is a significant degree of doubt it is not the role of an Independent Investigation Team to assign a root cause to an organisation when none can be identified with accuracy and confidence. The Independent Investigation Team concluded that the root cause ultimately rested with the independent third party actions of Mr. X.

It has to be noted here that whilst Mr. X was in the habit of carrying a knife for his own protection at no time prior to the event had he ever caused physical harm to anyone with a weapon or been arrested for assault. At the time of the incident, despite there having been no formalised risk assessment conducted, there was no evidence to suggest that an act of violence was foreseeable or that the killing of Mr. W was predictable. Preventability cannot be meaningfully discussed for the reasons already set out above.

This report has examined the care and treatment Mr. X received in a systematic and detailed manner in accordance with the Terms of Reference requirements. The detailed examination of the case, whilst not being able to make any direct causal links between the service delivered and the death of Mr. W, does provide a detailed case study that sets out the necessary learning for the organisation. The case of Mr. X was not managed well over time. This Investigation has highlighted service delivery problems that need to be understood by Manchester-based Mental Health Service providers and commissioners alike in order to ensure that practice is improved and service delivery made safer. The findings in this report are relevant to both the effectiveness and safety of current service delivery.

Findings

On examining the timeline, care pathway and chronology the Independent Investigation Team identified four critical thematic issues that rose directly from analysing the care and treatment that Mr. X received from the Manchester Mental Health and Social Care NHS Trust and the Health Advocacy Resource Project Assertive Outreach Service. These critical thematic issues are set out below together with the identified contributory factors present relating to the factors that made a contribution to the overall poor standard of care and treatment that Mr. X received.

1. **Diagnosis and Management of the Case.** There was both confusion and disagreement over a period of seven years in reaching a diagnosis for Mr. X. This confusion and disagreement ensured that an appropriately formulated care and treatment plan was never put into place for Mr. X and managed over time. The failure to ensure an agreed diagnosis and treatment strategy was made more problematic due to the Personality Disorder(s) that Mr. X probably had and the behaviours that he displayed.

2. **Risk and Psychiatric History.** Due to the chaotic nature of Mr. X's presentation, Trust-wide organisational change, and poor professional communication processes, the risk presented by the patient, both to himself and to others, was never understood fully in the context of his full psychiatric history.

3. **Continuity of Care.** Mr. X was seen by a total of nine Manchester-based services, two South of England-based services and two United States of America-based

services over a seven year period. The speed and frequency with which he oscillated between these services meant there was a lack of continuity of care.

4. **Lack of Timely Intervention.** Mr. X was a difficult person to manage clinically. However on frequent occasions he would present in such a way that urgent and sure-footed management was required nonetheless. The powers retained by clinical teams to intervene were not always used in a timely manner in order to ensure the safety of both Mr. X and others.

Manchester Mental Health and Social Care NHS Trust. January 2001 - 3 April 2008
The following findings were identified.

1. **Diagnosis.** There was a high degree of confusion, disagreement and uncertainty regarding Mr. X's diagnosis over a seven-year period. This became a particular issue throughout 2007 and the legacy of diagnostic uncertainty continued through into 2008. The effect of this was to prevent a robust management plan for Mr. X being developed that had any degree of sustainability over time. If Mr. X had been reviewed against extant Personality Disorder criteria a robust treatment plan could have been formulated and a referral to a specialist service considered. There would however have been no guarantee that Mr. X would have complied with or accepted such an approach. Mr. X did access two periods of therapeutic community-based treatment which is a recognised evidence-based approach for people with Personality Disorder. However Mr. X did not remain in treatment for any length of time and this service did not offer the degree of management and support that his particular circumstances required.

- ***Contributory Factor Number One (influencing). Failure to provide a consistent care and treatment plan based on sound diagnostic principles ensured that Mr. X was only ever partially managed and treated. He remained an unknown quantity who was never assessed appropriately through the lens of his psychiatric condition.***

2. **Medication and Treatment.** Mr. X received a range of medication including antipsychotics and antidepressants. Prior to the diagnosis of schizophrenia Mr. X received antipsychotic medication. Antidepressants were used to deal with Mr. X's lowered mood. It was unclear whether the effects of these medications on Mr. X's

mental state were monitored carefully. Mr. X received two periods of therapeutic community-based psychological treatment which is an evidence based approach for people with Personality Disorder. When the diagnosis was altered to one of Paranoid Schizophrenia Mr X received antipsychotics in appropriate doses. It was unclear whether these had an impact on either his symptomatology or behaviour. Treatment was not always tailored to any given diagnosis so antipsychotics and antidepressants were prescribed and psychotherapy was given, but it was unclear what set of problems they were expected to affect. This was exacerbated by Mr. X's sporadic compliance with medication and engagement with services. Both factors served to obfuscate his presentation and treatment needs.

- ***Contributory Factor Number Two (influencing). The failure to provide treatment within a coherent management plan and multidisciplinary framework led to a fragmented delivery that could neither monitor effectiveness nor ensure the best clinical outcome possible. Whilst Mr. X was discharged with an appropriate care and treatment plan on the 3 April 2008, it was untried and untested and transferred to a team that had yet to build up a relationship with Mr. X.***

3. **Clinical Management of the Case.** Lack of continuity was the hallmark of the care and treatment that Mr. X received from Manchester-based services. Mr. X was seen by nine separate Manchester-based services on a 'revolving door' cycle. Each service gave Mr. X a different diagnosis. Clinical assessment, when it did take place, did not lead to the formulation of a patient-centred care and treatment strategy.

- ***Contributory Factor Number Three (influencing). The lack of a coordinated management approach to the care and treatment of Mr. X over time ensured that he was never seen in the full context of his psychiatric history and needs profile. Management was reactive and suffered from a lack of continuity and this contributed to Mr. X not receiving the coherent and consistent approach he required. Whilst this situation was retrieved in some measure by the 3 April 2008 Mr. X was transferred with a new and untried plan to a team that had yet to build up a relationship with him.***

4. **Mental Health Act (83 and 07).** For the majority of the time Mr. X received his care and treatment from Manchester-based services he would not have met the criteria for detention under the Act. When the Act was used it was implemented appropriately. It is a fact, that despite Mr. X presenting himself on many occasions to a variety of services, there is no evidence that he ever actually committed an act of self harm, aside from very superficial scratching of his wrists which required no clinical attention. However Section 117 aftercare was not applied appropriately to Mr. X. This could be seen as a missed opportunity for engaging him with services and integrating him back into the community.

- ***Service Issue Number One. Section 117 arrangements were not provided in accordance with either local or national best policy guidelines. This meant that the depth of support Mr. X required for his social care was not available to him.***

5. **Care Programme Approach (CPA).** Mr. X was on Standard CPA between 2001 and the summer of 2007. In effect CPA did not take place as no care coordination was made available. During this period Mr. X met many of the criteria for enhanced CPA, had he been in receipt of this, his care and treatment would have been managed more effectively. However the admission criteria to the CMHT prior to October 2006 effectively excluded people with Personality Disorder from accessing the service, this meant Mr. X could not gain access to an enhanced level of CPA. Following the summer of 2007, when he was placed on enhanced CPA, Mr. X was passed between several services; this meant that no consistent care coordination could occur. Following Mr. X's transfer to Bronte Ward in the autumn of 2007 a period of stability ensued and Mr. X received effective CPA for the first time up until his discharge on the 3 April 2008.

- ***Contributory Factor Number Four (influencing). The Mental Health Trust did not discharge its duty of care appropriately with regards to CPA and did not ensure that this essential 'safety net of care' was in place for most of the time that Mr. X received his care and treatment from them. This made a contribution to the poor management of Mr. X over time and ensured that his mental disorder was only ever partially managed.***

6. **Risk Assessment.** The frequency and process of risk assessment as applied to Mr. X varied both over time and between services. A common feature of the risk assessments compiled for Mr. X was that they incorporated accurately neither the past nor current known risks relating to his behaviour. In short they were incomplete, incorrect and failed to include much of the dialogue that occurred within teams when discussing Mr. X's case. Risk assessments did not inform care, treatment or management plans.

- ***Contributory Factor Number Five (influencing). The failure to understand Mr. X in the light of his full risk profile ensured that his mental health problems were never adequately managed over time. This potentially placed both him and other people at risk and effectively minimised the significance of Mr. X's risk profile on his transfer between services.***

7. **Referral, Discharge and Handover Processes.** These processes were cited as being poor in the Internal Investigation report. The Independent Investigation would concur with this finding. The handover of Mr. X from service-to-service was often accomplished with no team-based discussion, no clinical record transfer and no continuity of an overarching management plan. This was exacerbated in 2007/2008 by the Trust's adoption of *New Ways of Working.* However the Independent Investigation found that staff managing the discharge process on the 3 April 2008 did this well despite experiencing severe organisational disruption at the time.

- ***Contributory Factor Number Six (influencing). The poor management of referral, transfer and discharge processes contributed to the poor management of Mr. X's care and treatment pathway between January 2001 and August 2007. This served to exacerbate the poor case management already made ineffective by other poorly executed processes such as CPA and risk assessment.***

8. **Carer Assessment and Experience.** At no stage during the seven-year period that Mr. X received his care and treatment from the Mental Health Trust did his parents receive the offer of a carer assessment. It is clear from the analysis of this case that Mr. X's parents were left on more than one occasion in a position where they were

exposed to significant risk of emotional, financial and physical abuse from their son. Trust personnel made no attempt to support Mr. X's parents in their role as carers. This led in no small part to their ultimate decision to withdraw from their son for their own safety and wellbeing.

- ***Service Issue Number two. The parents of Mr. X were not offered the degree of advice and support they needed in order to support their son in the community. As a result relationships were fractured.***

9. **Service User Involvement in Care Planning and Treatment.** Uncertainty regarding Mr. X's diagnosis affected all major decisions regarding his care and treatment. CPA, and care planning generally, was under-developed which prevented a holistic and patient-centered management strategy to be formulated with Mr. X.

- ***Contributory Factor Number Seven (influencing). Clinical teams were unable to build up a therapeutic relationship with Mr. X over time. This impacted upon Mr. X's levels of engagement with services and also impacted upon his ability to access services when in crisis.***

10. **Documentation and Professional Communication.** Throughout the period that Mr. X received his care and treatment from the Trust documentation and professional communication intended for *intra*-team purposes tended to be of an acceptable standard. Progress sheets and medical consultation records were maintained well. The documentation and professional communication that was not managed so effectively was that intended to facilitate long-term *inter*-team communication. CPA records and risk assessments were often incomplete or missing from the clinical record. It was evident that the kind of record that framed a long-term management strategy was not always passed from team-to-team and that the CPA process often included only Mr. X and the person acting in the role of Care Coordinator. It remains unclear, even after extensive investigation, which team knew what and when. The clinical record was not integrated and the AMIGOS electronic universal record was primarily used as a progress recording sheet only.

- ***Contributory Factor Number Eight (influencing). Poor professional communication hindered the development of an accurate, comprehensive and timely care and treatment plan. This had the effect of ensuring that Mr. X was not assessed within the full context of his psychiatric history and that the required interventions were not made.***

11. **Clinical Supervision.** There was no evidence to suggest that supervision plans were being recorded in the case files. This should have been standard practice from 2005, especially for community teams. After 2006 the teams providing care and treatment for Mr. X experienced many changes leading to the disruption of all systems including supervision.

- ***Contributory Factor Number Nine (influencing). Clinical Supervision failed to provide the opportunity for the professional scrutiny of Mr. X's case. Whilst it is not the function of clinical supervision alone to ensure the safety and wellbeing of patients, it does provide an important part of assuring the patient pathway. In the absence of this process other safety frameworks which failed to work on Mr. X's behalf went unchallenged.***

12. **Adherence to Local and National Policy and Procedure.** There is ample evidence to suggest that the Trust had fit for purpose policies and procedures in place based on national best policy expectation. Unfortunately clinical staff did not adhere to these policies. This is of particular note with regard to:
    - carer assessments;
    - discharge planning (prior to the summer of 2007);
    - Section 117 aftercare;
    - CPA and risk assessment.

- ***Contributory Factor Number Ten (influencing). The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical teams ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to the formulation of a coherent care and treatment plan. Mr. X was***

complex and challenging and required a systematic approach to his presenting problems against an evidence-based set of clinical standards.

13. **Organisational Change and Professional Leadership.** Throughout 2007 and 2008 the Trust underwent a great deal of disruption and organisational change. Industrial action disrupted the care and treatment that Mr. X received throughout 2007 and *New Ways of Working* caused a distinct fracture in the continuity of his care at the end of 2007 and beginning of 2008. During this period staff morale was low and professional leadership varied in effectiveness. This left the provision of services in a vulnerable and weakened position.

- ***Contributory Factor Number Eleven (influencing). The lack of professional leadership provided between 2007 and 2008 created an environment where safety and care and treatment processes were severely compromised. This led to poor practice relating to Mr. X's care and treatment delivery going undetected and unresolved.***

14. **Clinical Governance and Performance**. During the latter years that Mr. X received his care and treatment from the Mental Health Trust many problems were apparent with regard to both governance and performance. The Trust struggled to manage its activity, finances and service quality. There had been a lack of sustained leadership which had subsequently resulted in the formulation of limited strategic direction. This had led to poor relationships with strategic partners and with staff. This provided a backdrop against which difficulties within services could not be challenged and non-adherence to Trust policy and procedure could neither be detected nor managed.

- ***Contributory Factor Number Twelve (influencing). The absence of coherent internal and external governance arrangements led to chaotic service delivery which went unmonitored and uncorrected. This is the context in which Mr. X received his care and treatment and this will have contributed to the less than coherent service that was delivered to him.***

Health Advocacy Resource Project (HARP) and Manchester Mental Health and Social Care NHS Trust, Partnership. Manchester Assertive Outreach Service. 3 April - 28 July 2008

The following findings were identified

1. **Liaison with Manchester Mental Health and Social Care NHS Trust and Transfer Process.** The Assertive Outreach Team worked alongside the Mental Health Trust inpatient staff in the management of Mr. X for three weeks prior to his discharge from the 16 March until the 3 April 2008. Three joint meetings (ward rounds and a CPA meeting) were held between the Trust and Assertive Outreach Team prior to the discharge taking place. Despite a high degree of organisational disruption this process was managed well.

2. **CPA, Care Coordination and Clinical Models of Care.** Aside from the allocation of a Care Coordinator the CPA process was entirely absent from the care and treatment that Mr. X received from the South Manchester Assertive Outreach Team. Mr. X was on Enhanced CPA on his transfer to this service. The South Manchester Assertive Outreach Team did not adhere to its CPA policy and did not perform adequately against national CPA policy expectation. The clinical model that the Assertive Outreach Team chose to adopt ran counter to the philosophy of CPA and as such provided no continuity of care and no formal framework for the care and treatment that it was expected to provide.

- ***Contributory Factor Number One (Influencing). The failure to provide a fit for purpose Care Programme Approach contributed to the circumstances in which a serious untoward incident likely was more likely to occur. The lack of Care Coordination ensured that this vital safety net of care did not exist and Mr. X was not appropriately assessed, monitored or managed.***

3. **Assessment of Risk and Forensic History.** No formal assessment of risk was undertaken during the four-month period that Mr. X was placed with the South Manchester Assertive Outreach Team. Mr. X presented with significant self-harm risk indicators which were not addressed in either an appropriate or timely manner. There was no written record to suggest that any potential risk Mr. X posed to either himself or to others had been discussed and evaluated within the Team. Assertive action should have been taken in the summer of 2008 to address the risk that Mr. X was

presenting to himself. It must be understood that Mr. X was not presenting a significant risk of harm to others at this juncture. However had Mr. X been managed appropriately in the light of his presentation at this stage these actions may have, albeit inadvertently, created the circumstances in which his risk to others may also have been obviated.

- ***Contributory Factor Number Two (influencing). The failure to follow a fit for purpose Risk Assessment process contributed to the circumstances in which a serious untoward incident was more likely to occur. The failure to act appropriately in the light of Mr. X's presentation on the 22 July 2008 left him at risk. Had this risk been appropriately addressed the circumstances leading up to Mr. W's death may also, albeit inadvertently, have been averted.***

4. **Management of the Case and Clinical Processes.** When Mr. X was discharged from Bronte Ward on the 3 April 2008 the plan included the following actions from the South Manchester Assertive Outreach Team:
    - the South Manchester Assertive Outreach Consultant Psychiatrist to follow up Mr. X within two weeks of transfer;
    - Mr. X to receive psychological therapy input from the South Manchester Assertive Outreach Psychologist;
    - the South Manchester Assertive Outreach Team to be responsible for the administration of depot medication;
    - the South Manchester Assertive Outreach Team to provide a minimum of fortnightly follow-up to include CPA.

    The South Manchester Assertive Outreach Team failed to accomplish the above planned actions in accordance with the discharge plan. On his discharge from Bronte Ward Mr. X had been placed in 'the red zone' by the South Manchester Outreach Team denoting the notion that he presented a significant risk and required priority assessment and management. When Mr. X refused to engage, refused his medication and began to present with strong indicators that he intended to harm himself no proactive assertive clinical management of the case was evident. No management plan was prepared and no timeframe set for urgent intervention.

- ***Contributory Factor Number Three (influencing). Mr. X's case went unmanaged. No appropriate assessments or timely interventions were made and this made a direct contribution to the failure to manage Mr. X appropriately and created the circumstances in which a serious untoward incident was more likely to occur.***

5. **Use of the Mental Health Act.** There were two issues relating to the Mental Health Act identified by the Independent Investigation. First, Mr. X was still eligible for Section 117 aftercare when he was accepted onto the Assertive Outreach caseload. His aftercare arrangements were never assessed or discussed. Second, in July 2008 it was evident that Mr. X was no longer on medication, was not engaging with services, claimed to have developed a serious drug habit, had claimed to have made a serious attempt on his life, was expressing paranoid ideas and had armed himself with a knife. At this point it would have been reasonable to expect a Mental Health Act assessment to have been considered. This was not forthcoming.

- ***Contributory Factor Number Four (influencing). Use of the Mental Health Act was not considered as part of the care and treatment process offered to Mr. X. Section 117 aftercare was not adequately implemented, which could be seen as a missed opportunity when integrating Mr. X back into the community. Use of a Mental Health Act assessment was not considered as an approach once it appeared that the mental health of Mr. X was breaking down.***

6. **Liaison with the Family of Mr. X.** No communication was made with the family of Mr. X. This was due to the pre-existing history of familial relationship breakdown.

7. **Documentation and use of Clinical Records.** The South Manchester Assertive Outreach Team used the AMIGOS electronic Mental Health Trust clinical record as its main recording method. Day-to-day contacts were logged on a regular basis utilising this system. However no CPA, Care Planning or Risk Assessment processes were either developed or recorded during the four-month period that Mr. X was with the team. The clinical record was found to be entirely blank apart from basic contact activity data.

- ***Contributory Factor Number Five (influencing). Inadequate record management processes and recording systems ensured that the planning and delivery of care and treatment to Mr. X did not form part of a dynamic assessment and intervention process that was communicated to, and understood by, all members of the Assertive Outreach South Manchester Team.***

8. **Supervision and Staff Competency.** Supervision arrangements were *ad hoc* with no formal arrangements in place for either clinical, management or caseload supervision. Clinical leadership within the team was at times both informal and uncertain. Important clinical decisions were made often by whoever happened to be in the office at the time because the people identified as being potential clinical leaders were either unavailable or ambivalent about their role. The difficulties caused by the lack of supervision and professional leadership were exacerbated by the fact that internal governance systems were not sophisticated enough to detect issues relating to staff competency and the relatively new contract that had demanded a swift increase in accepting more complex and challenging patients onto the caseload.

9. ***Contributory Factor Number Six (influencing). Supervision processes were ineffective in supporting Assertive Outreach Team Workers when delivering services. This meant that practitioners were working without professional regulatory processes in place during a time of great challenge and organisational change. This contributed to the less than effective care and treatment Mr. X received.***

10. **Adherence to Local and National Policy and Procedure (contributory factor included in the clinical governance bullet below).** The South Manchester Assertive Outreach Team appeared to have worked outside of both local and national best policy procedure. This was particularly evident when considering:
    - Section 117 aftercare;
    - CPA;
    - risk assessment;
    - documentation and record keeping.

11. **Clinical Governance and Performance.** Whilst there was a Joint Partnership Board that monitored the contract effective working relied on each partnership organisation retaining a fit for purpose internal governance system. Governance arrangements within HARP were not able to either address or identify the kind of clinical service issues (as set out above). The governance framework was not sophisticated enough to enable clinical staff to raise concerns and have them acted upon. The Assertive Outreach Service was under pressure to increase its activity and to take more complex and challenging service users onto its caseload. This added a greater pressure to a system that was already struggling to work within integrated city-wide services.

- ***Contributory Factor Number Seven (influencing). The absence of a robust clinical governance system ensured that clinical practice was operated without an evidence-based regulatory framework. This created the circumstances in which a serious untoward incident was more likely to occur.***

NHS Manchester

1. **NHS Manchester Commissioning and Performance Management Arrangements.** Commissioning and performance management arrangements for the Assertive Outreach Service were weak. Service specifications were non specific with regards to quality and very little monitoring occurred. This ensured that weaknesses in the Service were neither detected nor acted upon and corrected.

- ***Contributory Factor Number One (Influencing). Commissioning arrangements were weak in that there was poor performance management of Manchester Mental Health Services. This made a contribution over time to commissioned services which followed unsafe practices and that went undetected and uncorrected.***

Conclusions

Mr. X was a young man who presented in a chaotic and challenging manner over a seven-year period to Manchester-based mental health services. His presentation was complex and this made providing him with a diagnosis difficult. Services sought to treat both his self-reported and observed symptoms as appropriately as they could. However the care and treatment provided to Mr. X often sat outside the clinical frameworks that should have been

in place to ensure a robust and coherent management of his case. This meant that on the occasions when Mr. X did receive a care and treatment regimen appropriate to his presentation it could not be sustained over time.

Between January 2001 and June 2009 Mr. X displayed abnormal illness behaviours accompanied on occasion by the fabrication of symptoms and the active pursuit of institutionalisation.[326] Mr. X's presentation led to both diagnostic ambiguity and controversy. This had a direct impact upon the effectiveness of the care and treatment plan that was formulated and implemented over time by Manchester mental health services, and also served to confuse the Criminal Justice System until a systematic psychiatric assessment period was completed one year after the death of Mr. W.

Whilst the content of this report is broadly critical of the services Mr. X received, it has been difficult to conclude that a direct causal link could be made between the service that Manchester-based Mental Health Services provided and the death of Mr. W. Whilst this may appear to be contradictory this conclusion has been reached by the Independent Investigation Team for the following reasons:

- Mental health services when provided over a seven-year period do not always 'line themselves up' in an orderly sequence of events that can be proved to have a direct causal link between each other and a serious untoward incident.
- The nature of Mr. X's mental illness/disorder has been identified by forensic psychiatric experts as having been of the kind that would not necessarily have responded positively to any kind of care and treatment programme, no matter how well constructed.
- It cannot be determined with any degree of certainty how the mental state of Mr. X impacted upon his decision to kill Mr. W. As this is the case then no causal link can be made with confidence between any act or omission by mental health services, the actions of Mr. X, and the death of Mr. W.

This report has examined the care and treatment Mr. X received in a systematic and detailed manner in accordance with the Terms of Reference requirements. The detailed examination of the case, whilst not being able to determine with confidence any direct causal links

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between the service delivered and the death of Mr. W, does provide a detailed case study that sets out necessary learning for Manchester-based Mental Health Services. The case of Mr. X was not managed well over time; this can be a common feature in the care and treatment of people with Personality Disorders. This Investigation has highlighted service delivery problems that need to be understood by Manchester-based Mental Health Service providers and commissioners alike in order to ensure that practice is improved and service delivery made safer in the future.

Commissioning

There are two main commissioning conclusions. First: mental health services have to be provided within a robust commissioning and performance management framework. Contract specification has to be clear and needs to address quality assurance as a key part of the service delivery process. In the case of Manchester mental health services this was not achieved. NHS Manchester was aware of the challenges local mental health services faced and prior to the time of Mr. W's death had begun a detailed review process (the Boyington Review). The review ultimately found that Manchester-based mental health services had not been planned strategically and had also not met the requirements of the National Service Framework for Mental Health (1999). Another finding was that services were provided without the benefit of either performance management or strong strategic leadership. The findings of the Boyington Review were also the findings of this Independent Investigation process.

Second: it was evident that Community Mental Health Team services commissioned by NHS Manchester up until October 2006 served to actively exclude people with a diagnosis of Personality Disorder from receiving key secondary care services. Whilst NHS Manchester had commissioned a therapeutic community service, the 'Fifteen' group, as the specialist provision for Personality Disorder, this service was effectively provided in a vacuum. The 'Fifteen' group made available a therapeutic community approach to care and treatment delivery however this 'one size fits all' approach to Personality Disorder was too broad to be an effective treatment model. Service users also required access to robust care coordination and a fully integrated mental health service provision that could respond in situations of crisis.

Personality Disorder

The narrative of events regarding the care and treatment that Mr X received reflects to a large extent the difficulties faced by people with Personality Disorders and the services providing care and treatment to them over the past decade. Since 1999 it has been an expectation that Personality Disorder should not be a diagnosis of exclusion. It is a fact that the specialist services for Personality Disorder care and treatment as recommended by the Department of Health in 2003 have still not been commissioned in a uniform manner across the country and that provision in the North West is currently poor. This leaves services, service users and their families in a difficult position. This means that other individuals presenting in a manner similar to Mr. X may possibly still receive their care and treatment in the same unsatisfactory manner in many parts of the country.

In the case of Mr. X service provision worked to actively exclude him from receiving a comprehensive secondary care service. Between 2001 and October 2006 Community Mental Health Services in Manchester were not commissioned to provide services to Personality Disordered people. The Care Programme Approach is an essential part of the delivery of care and treatment to people with either a mental illness or mental disorder. Because of the exclusion criteria in place Mr. X received poor quality CPA between January 2001 and June 2007. This situation continued until he was eventually placed on enhanced level CPA following an inpatient admission.

It is not always easy to work with individuals with a Personality Disorder. The very nature of a Personality Disorder may prevent individuals from engaging with services and the clinical effectiveness of any prescribed care and treatment approach cannot be guaranteed due to the difficulties inherent when working with the condition. It would appear that some Manchester-based mental health services retained a view that working with Personality Disordered people was ‘an ineffective use of clinical time’. This culture when coupled with commissioner-led referral criteria of exclusion created the situation where Mr. X was neither treated nor managed effectively. A more compassionate approach should have been taken to social isolation, substance misuse and depression issues which caused Mr. X significant distress. It would appear that Mr. X was viewed through the lens of his Personality Disorder only, as a result his case went largely unmanaged and he was continuously passed around mental health services in a reactive manner that did not address his needs.

Clinical Governance and Professional Practice

Adherence to best practice policy and procedure is essential when providing the basic building blocks of care. When care and treatment is provided outside of these frameworks then care and treatment can not be provided in an optimum manner and often the circumstances are created in which serious untoward instances are more likely to occur.

It was evident that Manchester mental health services failed the majority of the time to implement local and national best practice policy and procedure. This was of particular note with regard to the Care Programme Approach and risk assessment processes. As has already been stated elsewhere in this report the nature of Mr. X's mental disorder was such that it may not have responded well to any kind of care and treatment approach, no matter how well constructed. However, that being said, Mr. X was in receipt of secondary care mental health services and should have received a sound evidence-based approach to his care and treatment in keeping with both local and national best practice policy guidance.

The failure to achieve a consistently acceptable level of service was exacerbated by the absence of robust clinical governance processes and strong professional leadership. These essential safety nets of clinical care provision were severely impacted upon by organisational change and service instability. It is important to note how vulnerable the safe and effective delivery of services can become when regulatory processes cease to be effective. When Manchester mental health services were assessed through the lens of this single case it was evident that the system in which Mr. X's care and treatment was delivered was not able to guarantee a safe and effective evidence-based care pathway.

15. Manchester Mental Health Services Response to the Incident and Internal Investigation

The following section sets out the Manchester mental health services response to the events of 28 July 2008. It also sets out the view of the Independent Investigation Team with regards to how effective the Internal Investigation Panel was in conducting its work. The Independent Investigation Team acknowledges the fact that the Manchester Mental Health and Social Care NHS Trust has experienced few incidents of this kind before and that the requirement to manage an internal investigation of this nature was something that was largely outside of its experience. The following comments are intended to provide helpful feedback whilst offering a contextual background to assess the progress the Trust has made against the action plan developed from the findings of its own internal investigation.

15.1. The Trust Serious Untoward Incident Process

Following the incident it was agreed that the Manchester Mental Health and Social Care NHS Trust would lead the internal investigation process on behalf of all parties concerned. An investigation team was recruited to provide independence, rigor and stakeholder perspectives.

Shortly before the events of 28 July 2008 the National Patient Safety Agency issued a fresh set of guidance for the investigation of serious untoward incidents *Independent Investigation of Serious Patient Safety Incidents in Mental Health Services Good Practice Guidance (February 2008).* This guidance provided instruction for the management of both the internal and the independent investigation processes. The Trust made the decision to implement this guidance and it was used as a policy framework throughout the process.[327]

On reflection the Trust found this to be a sensible way forward and the Independent Investigation Team would concur with this thinking, especially as the Trust had not had to manage a situation such as this before.

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15.2. The Trust Internal Investigation

The Internal Investigation Panel comprised the following personnel:

- Chair/Lead Reviewer, External Management Consultant;
- Trust Consultant Psychiatrist, (& Interim Medical Director at the start of the review process);
- Principal Manager - Mental Health, Adult Social Care, Manchester City Council;
- Nurse Specialist in Dual Diagnosis & Teaching Fellow, MMHSCT & School of Nursing, Midwifery and Social Work- University of Manchester.

The Trust also invited a Team Manager and Clinical Nurse Specialist in Assertive Outreach and West Midlands Regional Coordinator for the National Forum of Assertive Outreach to act as a 'critical friend' to the process.

Due to the fact that the Trust had not managed an Internal Investigation of this kind before the decision was made at the outset to employ an external consultant to provide both the necessary experience and independence that was required. This individual chaired the Internal Investigation. Other members of the Investigation Panel were highly experienced clinicians with varying levels of experience of investigation processes.

The Terms of Reference

- *"To review the care and treatment of Mr. X, with particular focus on:*
    - *his overall history of contact with mental health services in Manchester;*
    - *the process of referral to, and acceptance by the Assertive Outreach Service (AOS), South Team;*
    - *the plan of care for Mr. X when under the AOS South Team;*
    - *the risks Mr. X presented and the plans to manage such risks when under the AOS South Team.*
- *To identify any process/procedural failures or causal factors which may have impacted on the incident with a particular focus on:*
    - *the partnership arrangements for the provision of assertive outreach services in Manchester.*

- *If necessary, to make appropriate recommendations for any part of the organisational system."*[328]

The review process, and subsequent report, was undertaken with an 'improvement philosophy' in mind.

Methodology

The Internal Investigation Panel undertook a documentary analysis at the inception of their work. These documents comprised:

- external secondary literature, such as National Patient Safety and Department of Health Guidance;
- Assertive Outreach Service commissioning and contract specification documentation;
- a full set of Mr. X's clinical records (the Panel also visited the AOS South Team offices to view the daily diary/smart board and associated spreadsheet that was used by the team at the time.

The Internal Investigation Panel had access to statements written in the days immediately following the incident from 12 members of the Assertive Outreach Team. The Panel interviewed 14 witnesses in total, four of whom formed part of the Mental Health Trust clinical team who delivered care and treatment to Mr. X prior to 3 April 2008, seven of whom were from the Assertive Outreach Service, and three of whom represented the commissioners of the service. Two further conversations were conducted over the telephone with Consultant Adult Psychologist 1 and the GP.

The report framework and root cause analysis process, on examination, appears to have been structured in an appropriate manner in keeping with national best policy guidance.

Key Findings

January 2001 -3 April 2008

The care and treatment that Mr. X received from the Mental Health Trust between January 2001 and 3 April 2008 was deemed to be *"of a standard to be expected"*.[329] The acknowledgement was made that Mr. X was a complex and challenging individual to work

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with. The main finding that was identified focused on the transfer and handover arrangements that took place between the inpatient service on Bronte Ward and the Assertive Outreach Team. This was felt to be weak.

Key examples of good practice were identified as follows:

- the assessments, plans and care delivery developed by the Outpatient Clinic seem to have been appropriate;
- the 'Fifteen' Group intervention appears to have been successful with beneficial results for Mr. X;
- Care Coordinator 2 made a speedy and well-judged intervention in February 2008 which led to his re-admission to Bronte Ward;
- the short but appropriate intervention that Mr. X received from Psychology Services during his last admission on Bronte Ward appeared to have shown the beginnings of good engagement.

Key points of learning for the Mental Health Trust were identified as follows:

- During Mr. X's inpatient episodes there was little evidence to suggest that the ward staff engaged in therapeutic activities with him;
- that the referral to the AOS should have been made by Care Coordinator 2 as opposed to the ward;
- that the split between community and inpatient RMO responsibility in February 2008 may have led to a fracture in clinical communication;
- that Consultant Psychiatrist 1 should have been involved in the discharge arrangements and that either Consultant Psychiatrist 1 or Consultant Psychiatrist 2 should have written to the Assertive Outreach Psychiatrist;

3 April - 27July 2008

The Internal Investigation Panel was of the "*opinion that overall the care and treatment provided to Mr. X during this period was of a standard below what might have been expected*".[330] The view of the Panel was that Mr. X was, when using the AOS Operational Policy criteria, an appropriate service user to be referred to and worked with by Assertive Outreach Services.

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Key examples of good practice were identified as follows:

- work was commenced to support Mr. X in the access of his Benefits;

Key points of learning for the Assertive Outreach Services were identified as follows:

- members of the AOS should have more proactively managed the transfer and handover process to ensure that they had all the information they required;
- needs assessment, risk assessment and care planning processes did not take place;
- face-to-face meetings were made on six occasions (the Independent Investigation Team found no evidence to support a sixth visit) and some 25 other attempts were made to contact Mr. X. However none of this activity actually lead to the kind of management plan expected from an Assertive Outreach Team;
- handovers were not managed well and this was exacerbated by poor record keeping;
- no plan was put into place with the Assertive Outreach Psychiatrist regarding Mr. X's medication non compliance;
- the visit made to Mr. X on the 22 July 2008 was not managed well and a significant error of judgement was made on this occasion. Mr. X should have received urgent intervention at this juncture;
- inadequate follow-up for Mr. X was provided in the week following the visit made on the 22 July 2008;
- pressure to reach caseload targets may have led to a less than appropriate approach being taken to the transfer and handover process for Mr. X;
- clinical record keeping processes were not safe and individual AOS Workers did not meet record keeping standards;
- supervision processes were confused and did not provide either effective or regular clinical, caseload or management supervision support to members of the AOS;
- the Care Coordinator, employed as a social worker, was not registered with the General Social Care Council;
- the AOS philosophy, management and supervision arrangements were not effective enough to ensure an appropriate level of care and treatment interventions to be made;
- the Care Coordinator did not have the core competencies required to fulfil his role;
- issues relating to the effectiveness of the 'Partnership Model' in delivering the assertive Outreach Service were identified in relation to commissioning and management frameworks;

- management arrangements were complex and lines of accountability were confusing;
- governance processes for the AOS were weak ensuring that policy and procedure were not adhered to and that key professional practices such as clinical supervision and record keeping fell below expected standards.

Internal Investigation Panel Analysis and Conclusions

"Mr. X was not straightforward to work with in any sense. The Panel were not of the view that staff ever approached the care and treatment of Mr. X in an unprofessional or inappropriate way. However whilst he seems to have been reasonably well managed for the majority of his time known to services the Panel are of the view that he was not robustly and assertively cared for in the months leading up to the death of Mr. W."[331]

The main points of concern to the Panel were:

- "*the quality of the referral and transfer of Mr. X's care from Bronte Ward to the AOS South Team;*
- *the overall processes by which crucial clinical information, particularly issues of risk, was shared and communicated between teams and individuals;*
- *the apparent lack of update assessments of need and risk, together with robust care and management plans when Mr. X was under the care of the AOS South Team;*
- *the apparent lack of proactive strategies within the AOS South Team when it became apparent that Mr. X was avoiding engagement and was non-compliant with medication;*
- *the decisions taken by the AOS Care Coordinator on the 22 July 2008;*
- *the amount of Consultant Psychiatry time available to the AOS South Team;*
- *the ability of the Joint Management Board and line managers within the AOS structure to effectively lead the service in a way that was supportive, challenging and safe."*[332]

Independent Investigation Team Feedback on the Internal Investigation Report Findings

It is the view of the Independent Investigation Team that the Internal Investigation findings were both insightful and relevant. The Internal Investigation took place in a timely manner

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(within 90 days[333]) that met national policy expectations, the findings of which were employed swiftly to ensure the necessary changes to services were made to ensure the future safety of both patients and the general public.

The Independent Investigation Team concurred with the findings of the Internal Investigation Panel with two exceptions. These differences of opinion in findings should not be regarded as unusual and should not give cause for concern. The function of an Independent Investigation is intended to be further reaching with a wider scope within the terms of reference. This, when coupled with the additional period of reflection that witnesses are afforded between one investigation and another, often leads to additional insights being offered to the Independent Investigation Team. It does *not* mean that the Internal Investigation Panel did not do their job well.

First, on close examination of the clinical records developed between January 2001 and August 2007, the Independent Investigation Team found several issues of concern relating to the Care Programme Approach, risk assessment, case management and professional communications relating to Mr. X's care and treatment. Diagnostic ambiguity and therapeutic engagement with Mr. X were also found to be areas of significance that were managed to the detriment of Mr. X's health and wellbeing. This led the Independent Investigation Team to conclude that the general standard of the care and treatment Mr. X received between January 2001 and 3 April 2008 fell below that to be expected.

Second, sometimes it is tempting to fasten upon small issues that could have been managed differently and superimpose upon them a significance that is not merited on closer inspection. Whilst the transfer and handover processes between the 20 March and the 3 April 2008 could have been managed better, policy expectation was met. For example, in the absence of a Care Coordinator being available to provide a handover, as was the case with Care Coordinator 2, Trust policy and procedure extant at the time stated that it was entirely appropriate for designated ward staff to carry out this role. In the case of Mr. X this was entirely appropriate as the Bronte Ward staff had known Mr. X for a period of some seven months. There was ample evidence to show that four meetings were held between ward-based staff and the Assertive Outreach Team prior to Mr. X being discharged. This provided sufficient

333 *Independent Investigation of Serious Patient safety Incidents in Mental Health Services Good Practice Guidance (February 2008).*P. 9

opportunity for all the necessary discussions to have taken place. Whilst the Independent Investigation Team acknowledges that a consultant-to-consultant letter would have facilitated the discharge and transfer process, letters were available on the AMIGOS system and the AOS was supposedly operating a 'team approach' model which should have more than made up for this deficiency had it been operated properly. It was the view of the Independent Investigation Team that the transfer and discharge processes were handled well.

It was noted that the Internal Investigation Panel did not explicitly assign either causal or contributory factors in relation to any act or omission on the part of Manchester mental health services and the death of Mr. W. The Internal Investigation Panel focused upon understanding where services fell short and what could have been done differently. In the light of the complexity of this particular case and the difficulties in assigning causality the Independent Investigation Team concluded that the Internal Investigation Panel was justified in taking this position.

15.3. Being Open

The Trust took proactive measures to communicate with the family of Mr. W as soon as the incident occurred. Once again the *Independent Investigation of Serious Patient safety Incidents in Mental Health Services Good Practice Guidance (February 2008)* was utilised. The decision was made by the Interim Medical Director and the Associate Director of Governance that a visit should be made to the family of Mr. W with immediate effect.

The Associate Director of Governance and the Interim Medical Director made this initial visit. On this occasion they listened to what the family had to say and endeavoured to explain the investigation process that was to ensue. The Trust maintained communication with the family and then on the completion of the Internal Investigation the Interim Medical Director and the Associate Director of Governance returned to visit them again to discuss the findings and the recommendations. The family of Mr. W told the Independent Investigation Team *"from our point of view, with regard to the dealings that we have had with Manchester Mental Health Trust, they have been quite good really. They have communicated well with us, they took on board our concerns when they were doing the internal review, and they were*

good at maintaining contact and sharing the findings with us… It could have been far worse for us if we had not had that." [334]

The Trust made attempts to contact the family of Mr. X but were not able to do so.

The Independent Investigation Team found that the Trust acted in an appropriate and timely manner to ensure that the family of Mr. W was both communicated with and supported.

15.4. Staff Support

At the time of the incident, and the internal investigation that ensued, Manchester mental health services experienced a period of a great change, challenge and disruption. The Trust had undergone a period of industrial action and leadership discontinuity, as a result staff morale was low. Shortly before the death of Mr. W the Manchester Assertive Outreach Service had been subject to significant contractual changes and staff reallocation which had also affected employee morale. Relationships with staff were fragile and individuals were feeling both stressed and unhappy. It is important to understand the pre-existing workforce context when examining how staff were supported following the incident.

Prior to the Internal Investigation

Following the incident staff were offered support in the production of witness statements and counselling services if they required them. It would appear that staff were prepared and supported in accordance with local and national best policy practice.

During and Following the Internal Investigation

The witness interviews were not recorded by a stenographer, but a contemporaneous record was made of each meeting. These records were made available to each witness and they were invited to make accuracy alterations. The Internal Investigation Panel felt that this gave witnesses a reasonable indication of what would be used in the report.

The Internal Investigation Panel gave a great deal of consideration to the feedback process that was employed. Witnesses were not given sight of any sections of the report in which

334 Witness Interview Transcription

they, or their service, were mentioned negatively prior to report being made public. The decision was made for the report to be disseminated to witnesses and service managers on the 14 November 2008. This was the first indication that witnesses had that the content of the report contained findings that were critical of both individuals and services. It was noted by the Internal Investigation Panel that this approach received a mixed response from those present. Some witnesses were observed to be happy with the method of dissemination, whilst others were noted to be in tears.

When interviewed it was evident that the Internal Investigation Panel had not undertaken a feedback session of this nature before and that they felt that the best course of action had been taken in the circumstances. This view was not shared by the witnesses involved who found the process to be critical, embarrassing and unsupportive. Two years later when interviewed by the Independent Investigation Team several witnesses cried at the memory of this event.

It is always difficult to provide critical feedback and it is always the task of an Investigation Team to ensure that this is done. It is the view of the Independent Investigation Team that the Trust considers a different approach in the future. This approach should include:

- providing a full stenography service for the interview process;
- a period for witness review and amendment of transcriptions following the interview;
- an opportunity for witnesses to see any report sections that may be critical of their practice, prior to the report being finalised and circulated, so that factual accuracy can be confirmed;
- individual witness/team feedback should be considered if findings are critical;
- continued support and counselling services to be made available if required;
- learning and dissemination events should focus on the learning and the required action plans. Care should be taken during these events not to allocate blame to individuals in a public forum.

15.5. Trust Internal Investigation Recommendations

The Internal Investigation Report set out recommendations that highlighted significant areas. The Trust, partners (HARP and commissioners) and local managers were expected to

"identify and take forward other issues from the report that are deemed appropriate".[335] The recommendations have been set out under the theme headings used by the Internal Investigation report.

15.5.1. Organisational - Partnership

"Recommendation Number One.

There should be a complete review of the Manchester Assertive Outreach Operational Policy with specific reference to:

- *the process of referral and transfer (including what information is expected and from where, e.g. joint visits, formal assessment etc.)*
- *record keeping requirements (including the use of AMIGOS as the primary clinical record and the function of CPA care plans);*
- *detailing minimum standards of clinical behaviour if staff become aware that risk factors are increasing or that new risks are emerging;*
- *caseload expectations (particularly the team managers);*
- *the stated philosophy of care;*
- *amending or removing any part of the policy that is not thought to be achievable (where this does not lead to failure to comply with national guidance or contractual obligations).*

Recommendation Number Two

That the strategic and operational management structures in place around AOS be examined with a view to ensuring that the teams can be managed and supported strongly. To include:

- *reviewing whether all qualified staff might be better employed by the Trust;*
- *reviewing the roles and responsibilities of the Service Manager, Team Manager and senior practitioners and deputies;*
- *specifically ensuring that Team Managers prioritise attendance at Board planning meetings and attend as many of the daily handovers as possible.*

Recommendation Number Three

That HARP develops robust processes and structures for the following:

- *ensuring the professional registration of appropriate staff;*

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- *staff appraisal and personal development;*
- *supervision (alongside the Trust).*

Recommendation Number Four

A review of the skills and abilities of all staff in AOS should be undertaken to ensure they are equipped to carry out the generic functions required in a team approach model. To include as a minimum for qualified staff:

- *ability to assess mental state;*
- *ability to develop early warning packages, which should include relapse signatures and relapse action plans;*
- *ability to carry out full assessment of risk, based on the Trust's risk assessment strategy; to formulate the assessment material into defensible risk management plans; and to be able to communicate any identified risk or exacerbation of risk to all appropriate parties.*

Recommendation Number Five

Provision of dedicated office space at each AOS base for Consultant and Staff Grade doctors and funding to be made available for dedicated medical secretarial time."[336]

15.5.2. Organisational - Trust

"Recommendation Number Six

The Trust should develop a policy on what is expected of staff when service users disclose (or it becomes otherwise apparent) that they are carrying what could be determined as a weapon.

Recommendation Number Seven

The Trust should review the AOS Consultant Psychiatrist job plan with a view to allowing more time to be spent with the team, with an emphasis on being available for the Board planning slot and regular 1:1 meetings with the AOS Team Manager".[337]

336 Internal Investigation Report PP. 31-32
337 Internal Investigation Report PP. 32-33

15.5.3. Policy/Procedure/Process

"Recommendation Number Eight

A review of the AOS South Team daily spreadsheet as a clinical decision record for the daily handover process to be conducted.

Recommendation Number Nine

Robust systems to be put in place in AOS South Team to ensure the availability and delivery of management and clinical supervision to all staff."[338]

15.5.4. Clinical Management

"Recommendation Number Ten

A review of the entire caseload of the AOS should take place to ensure needs assessments, risk assessment and care management plans are up to date and that clients who are clearly failing to engage are highlighted and being actively reviewed."[339]

15.5.5. Independent Investigation Team Feedback on the Internal Investigation Recommendation

It is the view of the Independent Investigation Team that the Internal Investigation recommendations were both appropriate and comprehensive. They fulfilled the purpose of the Investigation in ensuring that areas of significant concern were identified in a timely manner ensuring that immediate actions could be put into place to ensure the safety of service delivery.

15.6. Progress against the Trust Internal Investigation Action Plan

The Manchester Mental Health and Social Care NHS Trust and HARP have been successful in implementing fully the recommendations identified from the findings of their internal investigation process.

The subsequent action plan was taken forward by NHS Manchester. This was because the recommendations from the internal investigation process were made in relation to the

338 Internal Investigation Report P. 33
339 Internal Investigation Report P. 33

performance of the Assertive Outreach Service for which NHS Manchester held the commissioning and performance management accountability. Progress against the action plan is set out below in section 20 below (Recommendations).

16. NHS Manchester's Response to the Incident and Internal Investigation

The Manchester Mental Health and Social Care NHS Trust conducted an Internal Investigation into the care and treatment that Mr. X received from Manchester-based mental health services. However NHS Manchester, the commissioning body, decided to conduct its own review to consider the future required governance arrangements for the Assertive Outreach Service. This review was intended to provide a whole system evaluation of the partnership arrangement. It was the intention of NHS Manchester to put the findings of the two enquiry processes together in order to formulate a coherent long-term action plan in response to the death of Mr. W. The review was completed in October 2009.

16.1. Primary Care Trust Internal Investigation Process

16.1.1. Review Team

An external consultancy was employed to conduct the review. The team consisted of individuals from the Health Services Management Centre at the University of Birmingham who were appropriately experienced and qualified to conduct the work.

16.1.2. Terms of Reference

The review was intended to address three specific issues:

- *"whether or not a partnership arrangement such as that currently in place provides a sufficiently robust platform for safety and quality for AOS in the future (a question of principle);*
- *whether or not the current partnership between HARP and the Care Trust is, or can become in the future, best in class with regard to safety and quality (a question of practice); and*
- *if the current partnership between HARP and the Care Trust cannot secure best in class for safety and quality in the future, whether there are any specific recommendations to commissioners with regard to procuring future services (a question of procurement).*[340]

340 Safety and Quality: a review of the arrangements for the safe delivery of assertive outreach services in Manchester (2009) p. 2

16.1.3. Methodology

Three methods were employed.

- A range of documentation was examined.
- 25 semi-structured interviews took place with a range of stakeholders.
- Manchester Assertive Outreach Services were benchmarked against those of six other similar services.

Based upon the findings a report was written and recommendations were made.

16.1.4. Key Recommendations

Recommendations were made against three separate headings.

"Contract Specification

1. *Revise the current configuration of teams to achieve the Manchester target of 308 in line with safe levels of service, recommended in the national Department of Health Mental Health Policy Implementation Guide and revise the service specification in line with recommendations.*
2. *Ensure that the service specification is compliant with national policy guidance recommended levels of input to an AOS and medical staff are suitably accommodated within the team base and provided adequate medical support.*
3. *Identify clear outcomes related to 'fidelity' and establish these as part of the performance monitoring process. Limited, realistic and measurable performance indicators should be included. Processes and accountability data collection and reporting on an ongoing basis should be clearly established and actively monitored.*
4. *Make it a contractual requirement that the providers of service strive to reduce admission rates and provide regular performance data on, before, and after admission rates and lengths of stay for AOS clients. Ensure these are actively discussed in service reviews.*
5. *Require robust organisational governance arrangements between providers, that are effective for working in this kind of partnership; this document should be an addendum to the contract with commissioners.*
6. *Place lead agency status with the Care Trust which has the critical mass and resources to manage this more effectively.*

7. *Initiate three-way discussion on what being the lead agency would look like in practice. This should include clarifying in detail the different roles and responsibilities of the Care Trust and HARP, and being clear about service management and partnership governance; a revised agreement should be drawn up between the two providers to this effect.*
8. *Ensure the Manchester Assertive Outreach Service Manger overseeing the services in the three localities is a qualified, mental health practitioner with several years experience of managing mainstream, challenging mental health services. The capacity provided must be a whole time equivalent.*

The Partnership

1. *Assess that there are robust organisational governance arrangements in place between the providers and monitor this on an ongoing basis through active involvement in the Joint Management Board.*
2. *Ensure that the Care Trust demonstrates strategic, managerial and operational commitment to the partnership, role modelling from the top, collaborative working and embedding this in its management structure and community and community services across all locations. The Care Trust needs to provide coordinated leadership of key functions relating to Care Trust staff, policies and procedures adopted by the AOS.*
3. *Enable and ensure HARP develop sufficient capacity to work strategically and assertively in partnership with the Care Trust in order to deal with the complex management issues that come with the responsibility of working in this type of partnership and be able to psychologically contain the service and staff, when difficult events and serious untoward incidents take place, as they inevitably will from time to time.*
4. *Make certain that the Care Trust and HARP have agreed and implemented robust care planning and assessment, risk assessment, management and clinical governance procedures that are effective for working with this challenging client group; this should be monitored.*

Development

1. *Ensure the Care Trust initiates and provides proactive developmental support to embed the Change in Mind locality model, so that it functions more effectively. To this*

end NHS Manchester and the Care Trust should immediately draw up an organisational development action plan, and put in place an infrastructure to support the development of the localities. The implementation process should seek to engage staff from across the locality services, including partner providers in the voluntary sector, to improve care pathways and communication, coordinate criteria, referral and service protocols, develop collaborative working relationships and focus on outcome of service users."[341]

16.1.5. Actions Taken

A comprehensive action plan was developed as a result of the internal investigation process and the Safety and Quality Review report completed in October 2009. This action plan has been completed and key actions are set out in the recommendation section of this report below. In order to avoid duplication the actions taken to-date have been placed in the Independent Investigation recommendations section so that the reader can understand what progress has already been made against the internal investigation processes and what now needs to be considered in the light of the findings of this report. These actions are set out in more detail in the recommendation section below.

341 Safety and Quality Review October 2009.

17. Notable Practice

17.1. Manchester Mental Health and Social Care NHS Trust

The Manchester Mental Health and Social Care NHS Trust managed communication with the family of Mr. W well. In the experience of the Independent Investigation Team this is something that is rarely managed in an appropriate manner by NHS Trusts across the country.

The Trust established immediate contact with the family of Mr. W and maintained a consistent level of communication and support with them directly after the incident and throughout the internal investigation process. The family acknowledge that had the Trust not acted in the way that it did then things would have been significantly more difficult for them.

The Trust managed the case very simply and with a high degree of professionalism. They ensured that:

- communication was direct and timely;
- an apology was made with immediate effect;
- senior Trust personnel were deployed demonstrating a Board-level commitment to supporting the family;
- communication was sustained;
- the internal investigation report and recommendations were shared with the family in full.

The actions were of the Trust were simple and straightforward. It was evident that the needs of the family were the primary concern of the Trust. The Trust did not act defensively and as a result was able to provide the level of support required to Mr. W's family in a timely and effective manner.

17.2. Health Advocacy Resource Project

Current day Service Provision

The Health Advocacy Resource Project incorporates the voluntary sector emphasis on social inclusion, recovery, engagement and rapport-building skills along with skilled interventions and specialist treatment from the statutory sector and makes them available to service users from a single service. The service is very much based on the recovery model of assertive outreach.

HARP provides care and support to people with severe and enduring mental health needs who have previously experienced difficulties engaging with mainstream mental health services. The service aim is to help service users achieve greater mental and social stability in order for them to stay out of hospital and enjoy an improved quality of life. The service provides a holistic approach that supports clinical, accommodation, income, meaningful pursuits and activities needs. The Assertive Outreach Team comprises psychiatric, nursing, social work, social inclusion, specialist housing and welfare rights workers.

Across the HARP provision service users have the opportunity to engage in volunteer work. Some examples of this are:

- **Bite.** 'Bite's' aim is to develop a city-wide social enterprise engaging and benefitting adults over 15 with, or at risk of, developing mental health needs, in healthy local food activities in order to improve skill, confidence and overall health. Manchester has high levels of deprivation and mental illness. The 'Bite' partnership aims to tackle both these problems by making healthy food more accessible and providing valuable training, work-based learning and personal development opportunities for mental health service users.
- Current 'Bite' venues are managed by two partners (HARP and the Mental Health Trust). They are made up of community-based cafés located within day centres, hospitals, community gardens and allotments located across the city. Collectively the venues provide a large resource of facilities for growing, producing and cooking healthy food. The project also offers many different learning opportunities for service users and volunteers.

- HARP café aims to provide a safe and empowering environment for service users to learn a new range of skills. All volunteers are provided with on-going support with an emphasis being placed on building confidence and self esteem. Volunteers are encouraged to learn about all aspects of catering including basic food hygiene, health and safety, budgeting, nutrition, menu planning, cooking, food growing, customer service, invoicing and business skills.

One of HARP's core principles is that the people who use services should be involved as equal partners. There exists a strong commitment to involve service users in the planning and delivery of HARP services.

The Manchester Assertive Outreach Service is unique in that it employs two housing and welfare rights workers and six social inclusion workers within the professional health and social care team. This affords the provision of a truly holistic approach to a recovery model that supports service users in both realising their life-choice aspirations and in keeping well.

17.3. NHS Manchester

NHS Manchester took a proactive stance in managing the problems identified with the Assertive Outreach Service following the death of Mr. W. The PCT took a sustained lead in the review and the required modification of service delivery. This level of involvement is demonstrated by the following:

- a commissioning-led review of services;
- a strong commissioning responsibility in the management revisions to the new contract following the death of Mr. W;
- an external review led by clinicians and researchers;
- prompt action in relation to providing external interim management arrangements for the development of a new model of care, new governance arrangements, new systems and new management of clients;
- establishment of clear measurable outcomes, performance targets and quality metrics;
- development of new systems in relation to reporting and performance management.
- proactive engagement of advisors relative to the development of specific action plans in relation to incidents.

- gathering of evidence to assure the processes when developing new partnerships;
- reporting processes into appropriate Boards with clear reporting requirements.

Whilst it could be argued that NHS Manchester was only fulfilling its statutory obligations it has to be noted that the PCT acted swiftly to ensure the future safe provision of Assertive Outreach Services to the population of Manchester. In the experience of the Independent Investigation Team it is unusual to see such a rapid, whole-systems revision of services managed with the involvement of all stakeholders. This illustrates well the current level of commitment to the learning of lessons, the formulation of recommendations and their implementation within the health and social care economy of the City of Manchester.

18. Lessons Learned

Commissioning and Performance Management of Services

Mental health services should not be delivered in a vacuum. The safe delivery of care and treatment needs to be provided within a coherent commissioning and performance management structure. Contracts should be monitored rigorously against both service delivery specifications and quality assurance frameworks. Despite financial restrictions where possible, services should not be compromised by commissioning that does not adhere to the requirements of national policy guidance.

Personality Disorder

Personality Disorder treatment and management have been subject to emergent guidance over the past decade. Mr. X was a complex and challenging individual who was eventually diagnosed with five distinct Personality Disorders following his arrest for the killing of Mr. W. Mental Health Services often do not have either the specialist resources or the expertise to manage people with this kind of disorder. Mr. X received the diagnosis of Personality Disorder during his time with the Mental Health Trust. As well as having been diagnosed as having a Schizoid or Schizotypal Personality Disorder between 2001 and 2007, on two other occasions he was described as having Dissocial Personality Traits. Mr. X also carried a knife and had a risk profile that indicated that he was at times a significant risk to other people. At this juncture best practice would suggest that a forensic assessment should have been conducted. People with Dissocial Personality Disorders present an ongoing and serious risk to others. Mr. X should have received robust management and specialist assessment. It is a fact that Personality Disorder Services are still not freely available to service users across the country at the current time and this area of service provision is still significantly absent in the North West. The Department of Health and National Institute for Clinical Excellence expectations have still not been fully realised and this leaves mental health services unable to respond appropriately to service users with Personality Disorders and leaves both them and their families in a vulnerable situation. Clinicians working in general adult psychiatry contexts as well as meeting the NICE guidance for Personality Disorder should also always ensure:

- referrals to specialist Personality Disorder or forensic services take place where indicated;

- that robust multi-disciplinary management plans are both constructed and recorded;
- that any antisocial or dangerous criminal behaviour (e.g. the possession of weapons) is recorded and reported to the police;
- that the level of capacity and responsibility retained by a service user is both assessed and recorded in the clinical record on a regular basis.

Clinical Governance, Professional Leadership and Adherence to Policy and Procedure and Governance Systems

It is a fact that Independent Investigations of this kind conducted across the country often find the same findings regarding:

- poor CPA practice;
- poor risk assessment and management;
- poor levels of professional communication and record keeping;
- poor implementation of Section 117 aftercare arrangements.

Although it may seem repetitive for some readers to see similar findings set out in this report, it remains a fact that these findings represent a consistent national departure from safe practice and procedure. Many Trust clinical governance systems measure compliance with policy and procedure but do not measure the quality of that compliance. Governance systems should not be about Trusts demonstrating their fitness for purpose against national targets alone, they should be about ensuring the day-to-day assurance for the quality of direct patient care delivery.

An important lesson from this investigation is that when the basic building blocks of care are not provided within a coherent framework patient care is compromised. In the absence of robust clinical governance systems and sound professional leadership poor care delivery goes undetected and uncorrected creating the circumstances in which serious untoward incidents are more likely to occur.

Being Open and Family Support Following Homicides Perpetrated by Service Users

The death of Mr. W was a tragic event that has had devastating and far reaching consequences for his family. The Mental Health Trust acted in an appropriate and timely manner to communicate with and provide support to the family of Mr. W.

This timely action was taken with the interests of Mr. W's family as the first priority. Other Trusts when faced with this same situation should learn the lesson that avoidance and defensiveness should play no part in the management of families. Once a serious untoward incident of this kind has occurred the best interests of the families concerned must take precedence over any perceived self-interest operating within an NHS Trust. If this occurs then the distress to families is significantly reduced and this has to remain a major consideration for all NHS Trust Boards.

19. Recommendations

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

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

As the Assertive Outreach Service is now managed by the Manchester Mental Health and Social Care NHS Trust no separate recommendations have been framed for the Health Resource Advocacy Project.

19.1. Recommendations for Manchester Mental Health and Social Care NHS Trust

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

Manchester Mental Health and Social Care NHS Trust Perspective on Current Provision and Improvements Already Made

The Mental Health Trust context for 2010 is substantially different to the Trust context in 2008 when the homicide occurred. The key areas of change comprise;

- the establishment of a strong and experienced leadership team;
- a clear strategic direction;
- good robust operational and governance arrangements;
- the implementation of a robust and revised assurance framework;

- a new management structure based on care groups;
- stronger partnership arrangements; positive partnership working with both staff, service users and their carers;
- a growing reputation within the Trust for innovation and quality;
- impending Foundation Trust authorisation.

There has been a drive to improve the patient experience and a number of different initiatives are now in place that were absent two years ago. There is a user and carer strategy, revised governance arrangements, a range of engagements and partnership events that have taken place across the city; there is stronger leadership with the appointment of an Associate Director with specific responsibilities for service user and carer engagement.

The revised governance framework has been in place since April 2010. This framework has a Quality Board reporting directly to the Trust Board, and three specific committees supporting the work across the Trust; Patient Experience Committee; Clinical Governance Committee and Risk Committee; each of these are Chaired by an Executive Director and report directly to the Quality Board which is Chaired by a Non-Executive Director.

Manchester Mental Health and Social Care NHS Trust is now the full time provider of Assertive Outreach Services with HARP in support. The Assertive Outreach Services are now linked clearly into the Adult Mental Health Care Group structure, with clear management and accountability lines. There is now a full time Trust Manager who has oversight of the Assertive Outreach Service. With this brings the supporting governance and management environment necessary to provide quality care, with greater accountability and monitoring. To support this aim there are monthly partnership meetings between the Trust Chief Operating Officer and the Chief Executive of HARP, and regular operational level meetings involving the HARP Chief Executive.

One of the other major changes within the Trust is the establishment of higher profile effective clinical leadership. A range of new posts have been created to ensure that clinical leadership is prevalent throughout the organisation. In terms of medical leadership, there are now Associate Medical Directors reporting directly to the Trust Board Medical Director, and a range of Lead Consultants throughout the organisation. There is a Head of Nursing post; a

Head of Social Work post; and a Head of Occupational Therapy. All of these posts in terms of professional and clinical leadership are involved and engaged in the work of the Trust Management Board.

The action plans developed following the serious untoward incident by both the Mental Health Trust and the Primary Care Trust have been met in full. Comprehensive evidence files were made available to the Independent Investigation Team. The following recommendations have been set as a continuation of the Assertive Outreach Service and Mental Health Trust development programme and are intended to consolidate the work that has already taken place and to ensure that all mental health services are developed, monitored and performance managed in a robust manner in the future.

Recommendations

19.1.1. Theme: Clinical Management (CPA, Risk Assessment, Diagnosis and Treatment)

Recommendation 1

The Trust should ensure that the revised CPA Policy is implemented robustly throughout the organisation. The implementation should include the monitoring of:

- continual clinical review, particularly with regards to the role of the Care Coordinator;
- the personalisation of the care plan;
- work with carers and carer assessments;
- 117 aftercare planning (where appropriate);
- the transfer of care and the communication that happens between teams when the transfers have taken place.

Recommendation 2

The Trust should instigate quarterly review meetings to encompass the monitoring of care plans, which should:

- include a peer evaluation against agreed standards;
- ensure care planning, and the treatment and management of patients be informed and based on a comprehensive risk assessment.

Recommendation 3

The Trust should ensure that there is an appropriate level of adherence to policy and procedure through systematic audit processes. Where adherence is not happening, remedial action should be taken. The Trust will conduct clinical audits for CPA and risk assessment on the completion of the publication of this report that will:

- ensure clinical compliance across the entire service provision, e.g. completion of clinical records and maintenance of regular reviews;
- ensure the quality of the content of CPA and risk assessment documentation by conducting a randomised sampling across the Trust of 30 cases;
- revise existing policies and protocols if they are no longer fit for purpose;
- support the formulisation of training and development programmes for clinical staff to support appropriate practice.

Recommendation 4

The Trust should develop a clinical guideline that would trigger a clinical case conference when the formulation of a service user's needs are particularly complex or when there is clinical disagreement about how these needs should be met and managed. This guideline will:

- be developed in conjunction with Trust senior clinicians;
- be disseminated widely to all clinical teams;
- be monitored and reviewed in six month intervals for the first year of its implementation.

19.1.2. Theme: Assertive Outreach Services

Recommendation 5

The revised management arrangements for the Assertive Outreach Team should be reviewed to ensure they are working in line with the recommendations made by the Trust internal review. In order to ensure the success of the previous recommendation an audit should be conducted to evaluate progress made against:

- clinical record keeping practice;
- provision of adequate administration support;
- compliance with risk assessment and formulation and CPA expectation;
- implementation of the risk zoning system;
- amendments to the operational policy.

Recommendation 6

There should be a review of the model of care provided by the Assertive Outreach Team which should include a range of monitoring tools. This review should also examine the stated philosophy of care ensuring that clinical best practice issues are held in balance with those of the service user's wider social care needs.

19.1.3. Theme: Carer Assessment

Recommendation 7

Specific attention needs to be given to working with carers and listening to the voice of carers. The Trust needs to improve the mechanisms and prompts to practitioners in relation to carer involvement. The Trust needs to:

- review, and revise accordingly, its carer assessment practice;
- provide clear policy guidance as to the responsibilities of clinical staff relating to the development and maintenance of carer assessments;
- provide active dissemination of best practice expectation to all clinical and social care staff;
- incorporate carer assessment compliance into the Trust audit cycle.

19.1.4. Theme: Clinical Governance and Professional Leadership

Recommendation 8

The Trust has made significant alterations to its professional management and leadership structures. These arrangements should be reviewed in order to understand their effectiveness with particular regard to:

- clinical supervision practice, effectiveness and professional regulation;
- the implementation and development of professional leadership strategies;
- the integration of designated professional leaders within the Trust clinical governance system.

19.1.5. Theme: Internal Serious Untoward Incident Investigation

Recommendation 9

The Trust should ensure that any trends and patterns in relation to incidents, complaints or claims are examined for emerging themes and if there are performance issues, remedial action should be taken.

Recommendation 10

The Trust needs to consider how best to work with staff during future internal investigations. The following should be considered as basic best practice by providing:

- a full stenography service for the interview process;
- a period for witness review and amendment of transcriptions following an interview;
- an opportunity for witnesses to see any report sections that may be critical of their practice, prior to the report being finalised and circulated, so that factual accuracy can be confirmed;
- individual witness/team feedback should be considered if findings are critical;
- continued support and counselling services to be made available if required;
- learning and dissemination events that should focus on the learning and the required action plans. Care should be taken during these events not to allocate blame to individuals in a public forum.

Recommendation 11

The Trust should develop some good practice guidance on how to involve carers and relatives in investigations, based on the good practice that occurred in this case.

19.2. NHS Manchester (PCT)

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

NHS Manchester Perspective on Current Provision and Improvements Already Made

Commissioners have reviewed the critical issues arising from the Independent Investigation timeline and considered the four main areas contained within the report, those being:

- ***diagnosis and management of the case.***
- ***risk and psychiatric history.***
- ***continuity of care.***
- ***lack of timely intervention.***

The issues have been considered in relation to the provision of care from Manchester Mental Health & Social Care NHS Trust (MMHSCT) as the secondary care NHS mental health

provider and then in relation to HARP Assertive Outreach Service and their management of the case of Mr X. within the Assertive Outreach Service.

The PCT has previously considered a number of areas in formulating a response and recommendations for learning and these are key components for the future management of the Assertive Outreach Service.

In response to the incident in 2008, the PCT took a number of steps in order to provide robust comprehensive management of Assertive Outreach Services. This included a senior PCT manager taking responsibility for the lead commissioner role. There had been a number of commissioners involved and, following the incident, a review of governance arrangements, commissioning management arrangements, monitoring performance and the management of the contract were considered with new systems put in place.

Immediately following the incident an initial planning meeting took place with providers and commissioners which included a number of briefings to the PCT Board and the Joint Commissioning Executive. Following this it was decided that interim management arrangements would be put in place and Pennine Care NHS Foundation Trust was appointed and awarded a six month interim management contract. The Joint Management Board, which was led by providers and supported by commissioners, was disestablished and new governance arrangements were introduced. The new arrangements involved a lead commissioner for Assertive Outreach Contract Monitoring Meetings. In parallel to this a Homicide Action Plan Group was developed with a 12-month schedule of meetings put into place to monitor the Homicide Action Plan in support of the new arrangements.

Following completion and discontinuation of the commissioned service by Pennine Care NHS Foundation Trust, commissioners maintained involvement from a senior manager within Pennine Care to advise commissioners on embedded developments and their ongoing progress.

The Assertive Outreach Board was fully integrated into the main NHS contract meeting between the PCT and MMHSCT in the autumn of 2010, almost two years post-incident. A full evidence file of learning was completed and key elements were embedded into contracts across the Mental Health Commissioning Executive. It had been highlighted that some of the

performance management arrangements for the Assertive Outreach Service were weak and service specifications were non-specific. There was a very detailed service specification initially within the tender but it had not been adhered to. However, there is a newly refreshed service specification that is now contained within the three year NHS standard contract for the management of the service.

The action plans developed following the serious untoward incident by both the Mental Health Trust and the Primary Care Trust have been met in full. Comprehensive evidence files were made available to the Independent Investigation Team. The following recommendations have been set as a continuation of the Assertive Outreach Service and Mental Health Trust development programme and are intended to consolidate the work that has already taken place and to ensure that all mental health services are developed, monitored and performance managed in a robust manner in the future.

Recommendation 1

Quality indicators must be monitored closely and it must be ensured that they are delivered in relation to CPA, governance, supervision and the model of care. It is recommended that a tailor-made audit be completed with the Assertive Outreach Service to assess the service and the delivery of the outlined areas above. Quality indicators should also include care planning, care coordination and the delivery of safe, effective services and the recommendation is that the PCT monitor this within the Trust's audit processes.

Recommendation 2

In relation to risk management and risk assessment, the PCT will require assurances that all individuals have clear risk assessments and risk management plans in relation to Assertive Outreach and these are up-to-date and have appropriate reference to crisis management. The PCT will build this into performance management processes.

Recommendation 3

Clear performance targets and measurable outcomes need to be included in the monitoring and management of the Assertive Outreach Service. The PCT needs to address these within the routine monthly contract monitoring meetings and be provided with assurances that all performance targets are being met.

Recommendation 4

The PCT must receive assurances in relation to the clinical and managerial supervision of all staff and this must be tied in with a robust audit process and an assurance process to demonstrate that the evidence is in place and meets all the requirements of supervision.

Recommendation 5

The PCT must be given reassurances in relation to the use of the Mental Health Act (07), its appropriateness and in particular pay attention to evidence to monitor Section 117 aftercare to ensure that services are following individuals and that individuals are not left at risk when moving through services.

Recommendation 6

The PCT must be provided with assurances in relation to carer assessments and carer involvement and this will involve random audits in relation to carer assessments and family involvement, including user involvement in care planning and treatment.

Recommendation 7

In conjunction with the Mental Health Trust the PCT will consider the Assertive Outreach service delivery model and reassess this in relation to its compliance for policy implementation guidance and will consider this in relation to any transformation change programmes to ensure that the service adheres to national and local policies and procedures; the PCT need to provide evidence to support this recommendation.

Recommendation 8

The PCT will monitor the ongoing progress and implementation of all requirements and recommendations in relation to Assertive Outreach Services in their monthly monitoring meeting and report any issues to the Joint Commissioning Executive and the PCT Board where appropriate.

Recommendation 9

The PCT in collaboration with the Mental Health Trust should review the commissioning and provision of specialist services for people with Personality Disorder. This review should:

- consider the effectiveness of current Personality Disorder services against NICE and DH guidelines;

- consider the accessibility of current Personality Disorder services against NICE and DH guidelines;
- ensure that current Trust policy and practice neither excludes nor disadvantages individuals with Personality Disorders;
- that robust training and clinical guidelines are made available for all those working in general adult psychiatry contexts to support the clinical management of service users with Personality Disorders.

Glossary

Akathisia	Akathisia is a syndrome characterised by unpleasant sensations of 'inner' restlessness that manifests itself with an inability to sit still
Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders
Bipolar Disorder	The current term 'bipolar disorder' is of fairly recent origin and refers to the cycling between high (manic) and low (depressive) episodes (poles).
Borderline Personality Disorder	The main feature of borderline personality disorder (BPD) is a pervasive pattern of instability in interpersonal relationships, self-image and emotions. People with borderline personality disorder are also usually very impulsive
Brufen	Brufen is a non-steroidal anti-inflammatory drug (NSAID) used to relieve inflammation and pain
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes
Case Management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team
Cipramil	Cipramil is an antidepressant drug which is also prescribed for anxiety disorders.

Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies
Clopixol	This drug is used for the maintenance treatment of schizophrenia including agitation, psychomotor disturbances, hostility, suspiciousness, aggression and affective reactions. It is administered via an intramuscular injection
Clozaril	Clozaril (Clozapine): an antipsychotic drug used as a sedative and for treatment-resistant schizophrenia
Codeine	Codeine is in a group of drugs called narcotic pain medicines and is an opium derivative. Codeine is used to treat mild to moderately severe pain. Codeine may also be used for purposes not listed in this medication guide
Cuprofen Plus	Cuprofen is a range of ibuprofen based painkillers which also reduce inflammation, with standard, maximum strength and with codeine formulations (Cuprofen Plus)
Delusional Disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental disorder that is characterized by holding one or more non-bizarre delusions in the absence of any other significant psychopathology. Non-bizarre delusions are fixed beliefs that are certainly and definitely false, but that could possibly be plausible, for example, someone who thinks he or she is under police surveillance
Depot Injection	This is an intramuscular injection (an injection into the muscle) by which certain antipsychotic medication is administered, e.g. Clopixol
Diazepam	Diazepam is a benzodiazepine derivative drug. It is commonly used for treating anxiety and insomnia
DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up
Dysthymia	Dysthymia is a chronic long-lasting form of depression sharing many characteristic symptoms of major depressive disorder (in the form of the melancholic depression subtype). These symptoms tend to be less severe but do fluctuate in intensity
Ecstasy Tablets	MDMA or Ecstasy (3-4-methylenedioxymethampheta-

	mine), is a synthetic drug with amphetamine-like and hallucinogenic properties. It is classified as a stimulant
Electrocardiography (ECG)	Electrocardiography is a test that measures the electrical activity of the heart
Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support
Extrapyramidal	Extrapyramidal symptoms include extreme restlessness, involuntary movements, and uncontrollable speech
Fluoxetine	Trade name Prozac. It is an oral drug which is used to treat depression
Lorazepam	Lorazepam is a drug used for treating anxiety
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
Mental Health Act Managers Hearing	The 'Hospital Managers' are people from the community who act very much like school Governors and are non-Executive Directors of the hospital's Board of Directors. They act on behalf of the NHS Trust that runs the hospital. The managers have the power to discharge the patient (let the patient go) and a duty to refer certain cases to the Mental Health Review Tribunal. The Managers can also hold hearings at their own discretion for any reason
Mental Health Act Tribunal	Mental Health Tribunals are judicial bodies that are independent of government. Their function is to determine the cases of mental health patients who have been detained under the Mental Health Act and decide whether or not they should be discharged from hospital. Mental Health Tribunals are normally heard in private, and therefore there are no members of the press or media at the hearings. They usually take place either in the hospital where the patient is detained, or community unit, if applicable
MIND	MIND is a mental health charity. The charity provides many schemes for mental health service users in many locations across the country
Named Nurse	The ‘Named Nurse’ is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care

National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines
Olanzapine	A drug used for treating patients with schizophrenia and manic episodes associated with bipolar disorder
Omeprazole	A drug used to regulate stomach acid
Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts
Propranolol	Propranolol is a drug used for treating the physical symptoms of anxiety, such as a fast heart rates
Psychopathy	Was, until 1980, the term used for a personality disorder characterized by an abnormal lack of empathy combined with strongly amoral conduct but masked by an ability to appear outwardly normal. The publication of DSM-III changed the name of this mental disorder to Antisocial Personality Disorder. Despite being currently unused in diagnostic manuals, psychopathy and related terms such as psychopath are still widely used by mental health professionals and laymen alike
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place
Quetiapine	Quetiapine is a prescription drug used to help control symptoms of schizophrenia and bipolar disorder
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment

Schizophrenia	Schizophrenia is a mental disorder characterised by a disintegration of the process of thinking and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction
Schizoaffective Disorder	Schizoaffective disorder most commonly affects cognition and emotion. Auditory hallucinations, paranoia, bizarre delusions, or disorganised speech and thinking with significant social and occupational dysfunction are typical. The division into depressive and bipolar types is based on whether the individual has ever had a manic, hypomanic or mixed episode. Symptoms usually begin in early adulthood, which makes diagnosis prior to age 13 rare. Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder. There has been a controversy about whether schizoaffective disorder is a type of schizophrenia or a type of mood disorder. Today, most clinicians and researchers agree that it is primarily a form of schizophrenia
Schizoid/Schizotypal Personality Traits	Individuals with *schizoid personality* are characteristically detached from social relationships and show a restricted range of expressed emotions. Their social skills, as would be expected, are weak, and they do not typically express a need for attention or approval. They may be perceived by others as sombre and aloof, and often are referred to as "loners." *Schizotypal personalities* are characterised by odd forms of thought, perception and beliefs. They may have bizarre mannerisms, an eccentric appearance, and speech that is excessively elaborate and difficult to follow. However, these cognitive distortions and eccentricities are only considered to be a disorder when the behaviours become persistent and very disabling or distressing
Samaritans	Samaritans is a confidential emotional support service for anyone in the UK and Ireland. The service is available 24 hours a day for people who are experiencing feelings of distress or despair, including those which may lead to suicide
Section 2 Mental Health Act (83 & 07)	Section 2 of the Mental Health Act (83 & 07) allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days
Section 3 Mental Health Act	Section 3 of the Mental Health Act (83 & 07) is a

(83 & 07)	treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year. It is instituted in the same manner as Section 2, following an assessment by two doctors and an Approved Social Worker. Most treatments for mental disorder can be given under Section 3 treatment orders, including injections of psychotropic medication such antipsychotics. However, after three months of detention, either the person has to consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person's best interests
Section 12 Approved Doctors	A section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act
Section 17 Leave	Section 17 of the Mental Health Act (83 & 07) allows the responsible medical officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These can include a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO can require a patient to take medication while on section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of section 17 leave provided the original authority to detain remains in force. Section 17 leave is not required within the grounds of the hospital. (Code of Practice 20.1). However, the decision to allow the patient to leave the ward area should only be made at the formal multi-disciplinary review and/or following consultation with all involved in the patient's care and following a comprehensive risk assessment. It must be part of a plan and not a response to a patient's request, although the patient should be fully involved in the decision to grant leave
Section 117 Aftercare	Section 117 of the Mental Health Act (83 & 07) (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and local social services authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is

	a formal discharge meeting
Section 136	Police Officers have the power, under Section 136 of the Mental Health Act, to take a person who is in a public place and who appears to be suffering from a mental disorder and to be in need of immediate care or control to a place of safety. The Act defines this place as being a police station, hospital, care home or any other suitable place
Service User	The term of choice of individuals who receive mental health services when describing themselves
SHO (Senior House Officer)	A grade of junior doctor between House officer and Specialist registrar in the United Kingdom
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other
Trifluoperazine	An antipsychotic used for Schizophrenia, agitation and behavioural problems
TTOs	A prescription which is prepared for a patient to take out or away. Literally medication ‘to take out’
Venalfaxine	A drug prescribed for the treatment of depression with associated symptoms of anxiety

Appendix One

Timeline Mr. X

Date	Event
11 April 1976	Mr. X was born.
18 February 1991	Mr. X attempted to overdose on paracetomol. No treatment was required. He was referred to a Child Psychiatrist and a Community Psychiatric Nurse.
25 April 1991	Mr. X was seen by a Community Psychiatric Nurse (CPN) for the third time, on the request of his stepfather, because he had been absenting himself from school for upwards of a month. Mr. X's mood had deteriorated to the point where the CPN thought that he was clinically depressed. There were also elements of paranoid delusion regarding his peers whom he thought ridiculed him for his appearance. The CPN thought it was sensible to refer Mr. X back to the Child and Family Service Consultant Psychiatrist. This was done. The CPN was worried about Mr. X being unpredictable and was concerned that he may try to kill himself.
19 September 1991	The Consultant Psychiatrist wrote to the GP explaining that he had seen Mr. X for a number of sessions but that his condition had improved and that in conjunction with Mr. X's mother they had decided to *'call it a day'*. Mr. X's mother was told she could re-refer Mr. X to the centre within the next six months if things deteriorated again.
20 September 1999	A GP at the Park Medical Practice referred Mr. X to the Community Psychiatric Nursing Services Acute Team because he was experiencing stress and anxiety. Mr. X admitted having recently visited Beachy Head to try and commit suicide.
11 October 1999	Mr. X cancelled his appointment with the Community Psychiatric Nursing Service. The Service wrote to the GP who had made the referral asking for advice as to how to proceed.
31 January 2001	A referral form from the Primary Care Mental Health Team (a Mental Health Social Worker) was received by the Community Mental Health Team at Withington Hospital in Manchester. The reason for the referral was for a psychiatric assessment for Mr. X. Mr. X was described as having *'strong suicidal ideation and violent fantasies. Dissocial personality traits'*. A brief risk assessment suggested that Mr. X should not be seen at his home or within a GP surgery or the team base on his own with fewer than two staff. His medication was recorded as being Venalfaxine 150mg. Mr. X was *'99% Certain'* he was going to kill himself and disclosed that he had violent sexual fantasies. Mr. X was assessed as presenting a serious, although not immediate risk, regarding suicide and serious, but not imminent risk,

	of harming others. He was considered to be a serious risk of deterioration. The Primary Care worker had filled in a risk assessment which identified an overdose with paracetomol 1991, and an earlier attempt prior to Christmas 2000 when Mr. X had tried to cut his femoral artery. **The risk assessment also stated that Mr. X went on holiday to find ways to kill himself e.g. Beachy Head and USA Shooting Galleries.**
14 May 2001	Mr. X was seen by Consultant Psychiatrist A, for a psychiatric assessment following a referral by his GP. It was noted that Mr. X had Schizoid/Schizotypal Personality Traits and had an alcohol dependence accompanied by amphetamine abuse. Consultant Psychiatrist A initially assessed Mr. X in the presence of another doctor because he had expressed violent sexual fantasies in the past. However Mr. X was pleasant throughout the interview and the Psychiatrist did not feel intimidated or in danger. Mr. X described himself as shy, intelligent but with no social skills. He expressed a desire to have friends and said that he had never had a girlfriend, only liaisons with prostitutes. The Psychiatrist wrote to Mr. X's GP suggesting that the Efexor he was on should be raised from 150mg a day to 225mg.
29 August 2001	Mr. X was seen by Consultant Psychiatrist A, in an Outpatient Clinic. Mr. X stated that he felt *'all right'* but that his amphetamine use was still a problem. Mr. X did not present with any symptoms of depression, neither was there any evidence of anxiety. Mr. X denied any desire to self harm. Dr. Gonzalez suggested a referral to the Community Drug Team for help. Dr. Gonzalez suggested that Mr. X continued to take Efexor XL 225mg once a day (Venalfaxine)
25 October 2001	A Clinical Psychologist met with Mr. X following a referral from Consultant Psychiatrist A. It was noted that Mr. X expressed a negative view of psychology. Mr. X was described as *'having very fixed ideas about his depression'*. Mr. X was currently experiencing amphetamine withdrawal, he was also drinking heavily. Mr. X reported that he currently worked for the Royal Mail but that he hated his job. Mr. X also stated that he was incapable of successfully committing suicide, although the thought of death was very calming. He described both his parents as being alcoholics and that he was bullied a great deal as child. Mr. X expressed concerns that psychotherapy would involve *'brain washing'* and he did not want this to happen. The Clinical Psychologist felt that Mr. X was not willing to pursue therapy.
4 December 2001	Mr. X failed to attend an Outpatient appointment with Consultant Psychiatrist 1 to whom he had been referred, at Laureate House.
14 December 2001	An appointment was sent to Mr. X for the 8 January 2002 to see Consultant Psychiatrist 1.
15 February	Mr. X was seen by Consultant Psychiatrist 1. Mr. X presented with chronic suicidal thoughts. The Psychiatrist sent a referral

2002	back to the Clinical Psychologist as he felt Mr. X would benefit from Cognitive Behaviour Therapy. The Psychiatrist thought that Mr. X tended to over intellectualise things and that primarily he needed to find a meaning to his life. The Psychiatrist wrote to Mr. X's GP stating that although Mr. X was potentially a risk to himself he was not suitable for assessment under the Mental Health Act at the current time. The Psychiatrist suggested resuming him on Fluoxetine 20 mg daily increasing it to 40 mg in six weeks time.
19 February 2002	The Clinical Psychologist wrote to Consultant Psychiatrist 1 stating that she did not feel that Mr. X would benefit from psychological therapy as he continued to drink heavily and appeared to have little insight.
22 April 2002	Mr. X failed to attend his Outpatient appointment with Consultant Psychiatrist 1, another was made for him on the 16 July 2002.
23 April 2002	Mr. X attended A&E following an '*alleged*' assault by a resident whilst he was delivering mail. Mr. X received cuts and abrasions to his arm and face.
16 July 2002	Mr. X failed to attend his Outpatient appointment with Consultant Psychiatrist 1 who discharged him from follow up.
17 October 2002	Mr. X's GP wrote to request a follow up appointment as he missed his last one. Mr. X had stated that he had not received a letter detailing his appointment that should have occurred on the 16 July 2002. The GP sought a follow up appointment in order to obtain guidance regarding Mr. X's future management.
31 October 2002	Consultant Psychiatrist 1 wrote to Mr. X's GP stating that he would give Mr. X another appointment as a courtesy but that he did not think there was anything else his service could provide to him.
25 November 2002	Mr. X failed to attend the appointment with Consultant Psychiatrist 1 who wrote to Mr. X's GP stating that he would not be offering him any more appointments.
30 September 2003	Mr. X was referred to secondary mental health services by his GP. An assessment was conducted at his home by two Community Psychiatric Nurses. The reason given for the referral was Mr. X's depression. It was noted that Mr. X had not attended an appointment with Consultant Psychiatrist 1 on the 25 November 2002 because the patient had not received a letter setting out the details of the appointment. It was also noted that Mr. X had been prescribed Cipramil 20 mg but that he had *'self stopped'* three months previously.
8 October 2003	The referral was discussed at the CMHT team meeting with Consultant Psychiatrist 1. It was felt that Mr. X who had been seen several times in 2001 and 2002 could benefit from a psychotherapy referral as he was now willing to engage with this treatment option. A letter was sent to a Consultant Psychotherapist referring Mr. X to this service. A letter was written to Mr. X's GP stating that the CMHT would not take on the referral as they had passed it on to Gaskill House Psychotherapy Centre.
13 October 2003	Mr. X was re-referred to the South Manchester CMHT by his GP. He was referred on to Gaskill House as he was ready to address his alcohol issues.

29 January 2004	The Consultant Adult Psychotherapist who assessed Mr. X, wrote to the CMHT. Mr. X had been seen for a first assessment appointment on the 26 January 2004. On this occasion Mr. X had expressed suicidal ideation and stated that he had tried to overdose with fifty ecstasy tablets a fortnight previously. Mr. X described constantly thinking about killing himself, but it required a great deal of motivation and after an unsuccessful attempt he felt too exhausted for a while to consider doing any further harm to himself. Mr. X described himself as having no friends and as never having had a partner. His only sexual liaisons had been with prostitutes. Mr. X described a poor relationship with his parents. The Consultant Psychotherapist felt that Mr. X presented with a chronic risk of successful suicide which would be hard to predict. He wrote that he would want to see Mr. X again in two weeks time. The issues noted were: • Suicidal preoccupation • Loneliness and social isolation • Concerns over medication • Dissatisfaction with previous professional contacts
6/7 February 2004	Mr. X presented in crisis at Accident and Emergency. A passing motorist had reported seeing Mr. X with a rope around his neck standing on a motorway bridge. After a full assessment Mr. X was discharged and sent home. It was noted that Mr. X had been previously known to Consultant Psychiatrist 1 and had a Schizotypical Personality Disorder. Mr. X was agreeable to obtaining on-going help and he was referred to the South Manchester CMHT. The 'Minimum Psychiatric Assessment' noted previous extensive alcohol abuse *'one litre of vodka a day'*, that Mr. X was extremely anxious and had suicidal thoughts. Mr. X expressed the view that he would *'willingly be sectioned right now'*.
11 February 2004	Mr. X was seen by the Consultant Psychotherapist for a second psychotherapy session. He noted that Mr. X had felt suicidal the week before and had been advised by a helpline to attend Accident and Emergency. Mr. X did this only to be *'dismissed by the duty doctor'*. He then went to the motorway with a rope with the intention of hanging himself. He was taken back to the Accident and Emergency Department where the doctor wanted to section him. Ultimately he spoke to one of the Specialist Registrars who allowed him to go home and said that a visit from a Community Psychiatric Nurse would be arranged at his home. The Consultant Psychotherapist felt that Mr. X was presenting with splitting behaviour e.g. he presented the staff he encountered as unsatisfactory figures on the one hand and good figures on the other. He wrote in his letter to Mr. X's GP his intention of seeing him again and expressed his interest in hearing the outcome of the risk assessment that the GP's team intended on carrying out.

11 March 2004	Mr. X was seen by the Consultant Psychotherapist in order to complete his assessment for psychotherapy. Mr. X told him that he had been referred to the Brian Hove Unit for work on his alcohol problem. Mr. X expressed a desire for some 1:1 work, but he was informed that this would be *'problematic'*. Mr. X expressed some negative feelings about Consultant Psychiatrist 1. The Consultant Psychotherapist said that Mr X would be put forward for selection for therapy. This thought of selection and possible rejection worried Mr. X.
26 March 2004	Mr. X was discussed at the CMHT allocation meeting. The CMHT were aware that Mr. X was currently being assessed by Psychotherapy Services. The CMHT was aware that Psychotherapy may necessitate a wait of several months and that a referral had already been made to the Brian Hore Unit for work on Mr. X's alcohol intake. Mr. X had been encouraged to approach MIND regarding a befriending scheme. It was felt that Mr. X would present with self harm again in the future and that he would require further assessment at his home. The CMHT did not think that they could offer Mr. X a service at this particular stage. They did not want to encourage further his over intellectualisation of his problems and felt that he was unlikely to be able to respond to medication. Psychotherapy was felt to be the most appropriate course for Mr. X who was thought to have a Personality Disorder.
7 October 2004	Mr. X was seen by a Senior House Officer (SHO) in Old Age Psychiatry (acting as an emergency duty SHO). Mr. X reported feeling depressed after weaning himself off of his prescribed Fluoxetine. It was noted that Mr. X had a long history of self harm and drug and alcohol misuse. On discussion with an Adult Consultant Psychiatrist, it was decided to recommence Mr. X on Fluoxetine 20 mg a day and also to start Olanzepine 5mg at night. It was also decided to refer Mr. X to an Adult Psychiatrist.
20 October 2004	A referral was made by Mr. X's GP to the South Manchester Community Mental Health Team for a Consultant Psychiatrist assessment. The referral stated that Mr. X had a Schizotypical Personality and depression. The referral mentioned that Mr. X had recently been seen by an on call psychiatrist where it had been noted his mood was low and that he was threatening self harm, on this occasion Mr. X had been prescribed Fluoxetine 20 mg and Olanzepine 5 mg.
28 October 2004	Subsequently Consultant Psychiatrist 1 wrote to Mr. X offering him an appointment at his Outpatient Clinic.
19 November 2004	The Consultant Psychotherapist put Mr. X forward for membership of a group programme called 'Fifteen'.
22 November 2004	Mr. X was reviewed in Consultant Psychiatrist 1's Outpatient clinic. Mr. X stated that he still felt low after taking an Olanzepine overdose the previous week (this had not been reported medically). Mr. X said that his main concern was his anxiety and that his heart beat too fast and he sweated in public. Because of these symptoms Mr. X chose to stay at home where possible. Mr. X said that he currently drank six-eight pints of lager every two to three days. He denied having hallucinations but said that

	he wanted to die all of the time. Mr. X presented as being pale with marks around his neck from a previous self-harm attempt. Mr. X expressed an unwillingness to be compliant with medication (Olanzepine 5 mg, Fluoxetine 40mg). Mr. X was described as pleasant and well kempt. AMIGOS shows Mr. X as being on standard CPA at this stage and that a review took place on this day.
14 December 2004	The Consultant Psychotherapist wrote to Mr. X advising him that the 'Fifteen' group programme was due to start in April 2005.
24 February 2005	The Consultant Psychotherapist saw Mr. X for a review and to discuss the referral to 'Fifteen'. Mr. X reported that he felt depressed although it was of a less severe nature than it had been and was not troubled by thoughts of suicide. Mr. X mentioned that he had been prescribed Olanzepine which he had found very helpful with his anxiety. Mr. X reported that his relationship with his parents was good at the current time.
April 2005	Mr. X underwent the screening process for 'Fifteen' and was accepted. He attended this group weekly from this time until September 2005.
26 September 2005	Mr. X presented at the Emergency department at Manchester Royal Infirmary and saw the Emergency GP who prescribed Fluoxetine, Diazepam and Lorazepam. Mr. X was assessed by a nurse who recorded that he planned to kill himself the '*easiest and most painless way possible'*. It was decided that he wasn't Sectionable, his risk was assessed as being medium to moderate (it did not state regarding what). Mr. X was described as having a borderline personality disorder and of being aggressive, living alone, labile and socially isolated. The plan was to refer to the '*duty psych prior to discharge'*. Mr. X had not been taking his medication for 10 days as he had not renewed his prescription. Consultant Psychiatrist 1 was noted as being Mr. X's Care Coordinator
27 September 2005	A female 'Fifteen' group member alleged that Mr. X was intimidating and threatening towards her. He had gone for coffee with this person together with another member of the Psychotherapy Group. Mr. X had a length of rope in his bag which one of the group members took from him. Mr. X discussed his hatred of the female group member and said that he wanted to kill her. The female group member had also received multiple telephone calls from Mr. X. The female group member made a report to the police. Mr. X was cautioned under the Harassment Act. The Psychotherapy Team felt there was an increased risk of Mr. X committing suicide and contacted the Police to notify Mr. X as being vulnerable. The psychotherapy notes stated that the GP was also notified of these events.
3 October 2005	Mr. X presented at A&E complaining of insomnia and requesting a psychiatric assessment. A 'Manchester Self-Harm' assessment form was completed. It was noted that Mr. X had previously tried to harm himself, however no other indicators were remarkable and Mr. X was discharged to the care of his GP.
4 October	A referral was made by Mr. X's GP to the South Manchester Community Mental Health Team due to Mr. X's depression and

2005	suicidal ideation. Mr. X had been seen at Accident and Emergency on the 3 October 2005. He also had started Fluoxetine 40mg and Lorazepam 1 mg twice daily but to little effect. Mr. X was not sleeping and his mood was deteriorating. Mr. X had been previously referred to psychology but was still awaiting the commencement of his treatment. The GP queried whether Mr. X had a Personality Disorder and stated that Mr. X's Accident and Emergency attendance was increasing.
6 October 2005	Consultant Psychiatrist 1 wrote to Mr. X offering him an Outpatient appointment.
17 October 2005	Mr. X received a letter stating that the 'Fifteen' programme was due to recommence on the 24 October and that Mr. X needed to attend the preparatory meeting on the 24 October 2005 if he was to attend the group. .
2 November 2005	Consultant Psychiatrist 1 wrote to Mr. X's GP to inform him that Mr. X had not contacted the Outpatient Clinic in order to make an appointment. There were no plans to send out an offer of any further appointments. The GP was asked to re-refer if concerns about Mr. X remained.
9 January 2006	After a two month membership Mr. X discharged himself from the 'Fifteen Group'. This was thought to be because he did not want the Group to challenge his drinking. The Group challenge came about because Mr. X stated he had drunk a bottle of port over Christmas which had made him sick. The Group felt this was unacceptable drinking, Mr. X said he had a stomach ulcer and therefore couldn't drink much anyway, and that a few drinks over Christmas did not constitute an alcohol breach. Mr. X stated that he didn't think the group was therapeutic and was overly bureaucratic. The day was a very negative experience for Mr. X who felt 'embattled'.
3 February 2006	The Consultant Psychotherapist wrote to Mr. X's GP regarding his self-discharge from 'Fifteen'. The letter recorded Mr. X's problematic attempts to form relationships with other patients, the difficulty he found being challenged about his alcohol abuse, his tendency to move between feeling hopeful and feeling alienated. This letter also detailed the fact that Mr. X had been reported to the police who had cautioned him under the Harassment Act following the incident with another patient.
12 June 2006	Mr. X took an overdose of Codeine and Brufen and went to the Accident and Emergency Department at Wythenshawe Hospital. He was discharged from the CLDU.
14 June 2006	Mr. X was taken to Accident and Emergency at Wythenshawe Hospital following an attempted hanging.
15 June 2006	Mr. X was admitted to the SAFIRE unit where no evidence of mental illness could be found. **It was noted on Mr. X's risk assessment that he had previously assaulted his mother and smashed up his flat.** The nursing record stated that Mr. X had purchased two knives and he was worried that he would use them, and that he had been practising using them. The Ward Doctor recorded his impression that Mr. X was a high risk at the present time to both himself and to others. The plan was to treat him with caution and to confirm that Consultant Psychiatrist 1 remained the RMO.
19 June 2006	The mother of Mr. X visited the ward with two letters from Mr. X's neighbours. The first letter was written by Mr. X asking his neighbours to keep their children away from him as he was beginning to hate them. The second letter was from his neighbour

	stating that his behaviour had been erratic and aggressive and that he had thrown plates and a mirror into their garden at their visitors and then come round the next day with a bunch of flowers, however when they refused to accept his apology Mr. X refused to leave their garden.
20 June 2006	The Consultant Psychotherapist discussed Mr. X's risks with ward staff, with special reference to a fellow service user (see directly below). The mother of Mr. X was asked to visit his flat and to have a look around to see if she could locate any knives and then to dispose of them. Later on that day the mother of Mr. X visited the ward and showed them a picture of his flat that she had taken on her mobile telephone. The flat was dirty, she also found approximately 60 cans of lager and vomit in the bathroom. **The mother found a large knife *'described as a knife like Rambo would have'* which she found alarming. The ward staff advised her to dispose of it at the local police station. The mother of Mr. X also described finding a list of names and addresses of Mr. X's work colleagues by the knife and she expressed her concerns of what he might do. The discharge plan to the CMHT was discussed with the mother, she said she would feel better if an alternative to discharge was available.**
21 June 2006	The mother of Mr. X visited the ward and expressed her concerns again about the finding of **two** knives that she handed in to the police station. The mother approached the ward staff to find out how she could participate in Mr. X's ongoing care. Mr. X was admitted to Grafton Ward having been transferred from the SAFIRE Unit at North Manchester General Hospital where he had been staying for the seven days previously. Mr. X should have been transferred to Redwood Ward, however the service user who had reported him to the police for harassment from the 'Fifteen' group was currently a patient on Redwood Ward and staff felt that in the interests of the safety of both patients they should be kept apart.
22 June 2006	Mr. X requested his discharge from Grafton Ward. The medical assessment by the SHO to the ward-based Consultant Psychiatrist considered Mr. X's risk of self harm, self neglect and harm to others to be low. The diagnosis was depression with a psychotic element. Mr. X was discharged to his father's house. Mr. X was discharged with a prescription of Olanzepine 15 mg and Fluoxetine 40 mg daily. A referral was made to Consultant Psychiatrist 1 for Outpatient follow up and a new referral was also made to 'Fifteen'. A letter was sent to Mr. X's GP. The ward staff planned to follow Mr. X's progress after seven days.
27 June 2006	The SHO wrote to Consultant Psychiatrist 1 explaining that he had briefly met Mr. X when he had been transferred from the SAFIRE Unit to Grafton Ward. The SHO had discussed the possibility of future Outpatient follow up with Mr. X. The SHO also explained that Mr. X had requested not to be seen by Consultant Psychiatrist 1 and he asked if Consultant Psychiatrist 1 could use his discretion.
30 June 2006	Mr. X was assessed by the South Manchester CMHT. He was not taken on by them at this stage. Mr. X was advised regarding

	compliance with his prescribed medication. A request was made for an Outpatient appointment. The plan was for Mr. X's GP was to monitor him.
5 July 2006	Consultant Psychiatrist 1 wrote to Mr. X offering him an appointment and requesting that he book one within three weeks of receiving the letter.
7 July 2006	On this day the community team wrote to Mr. X's GP. A community assessment had occurred on the 30 June 2006 following Mr. X's discharge from the SAFIRE Unit and subsequent two day admission to the Grafton Unit. It was noted that Mr. X thought that his psychotic relapse had occurred because he had stopped taking his medication two months before his admission because he was feeling better. It was noted that Mr. X had no suicidal thoughts but that he did have some paranoia. Mr. X wanted to return to a psychotherapy group and was referred to 'Fifteen'. It was noted that there were no first rank psychotic symptoms but that Mr. X had paranoia and delusional beliefs about his neighbours. During this assessment there was no evidence of Mr. X being low in mood. It was noted that Mr. X had no friends and felt that he couldn't relate to people.
26 July 2006	Mr. X's GP wrote to Consultant Psychiatrist 1 asking for advice. Mr. X was complaining of hearing voices but the GP was reluctant to change his medication stating that Mr. X could be a very difficult patient to manage and wondered whether the appointment booked for September could be brought forward. Mr. X was reluctant to take his Olanzepine as it made him feel lethargic.
11 September 2006	The Specialist Registrar (SpR) to Consultant Psychiatrist 1 reviewed Mr. X as a new patient at Laureate House (a letter was sent to the GP 19 September 2006). Mr. X presented with multiple problems. He had been admitted to the SAFIRE Unit in June 2006 following an overdose. Mr. X called the police and an ambulance and was taken to Accident and Emergency. He was discharged the following day, but returned with his parents stating that he could not cope, this led to his short admission to SAFIRE Unit. Since his discharge Mr. X felt that his mental state had deteriorated. He felt he was being mocked by his neighbours and he went to live with his father to get away from them. Mr. X reported poor concentration and poor appetite. He denied any current plans to commit suicide. Mr. X had been given a diagnosis of Schizoid Personality Disorder and Dysthmia. He also had a history of self harm and multiple overdoses. At this review Mr. X did not present with a thought disorder, although he reported feelings of paranoia. Mr. X also reported second person derogatory auditory hallucinations. The SpR recorded that Mr. X had a Dysthymic illness rather than recurrent depression. The diagnosis of **Schizotypal Personality Disorder** was given and it was noted that Mr. X had a

	chronic long term risk of suicide but that his immediate risk was low. Mr. X complained of tiredness and the SpR asked him to reduce the Olanzepine to 7.5.mg *nocte* and to stop after one week. In the meantime the GP was asked to prescribe Quetiapine 100mg in the morning, gradually increasing this to 100mg BD and then 100mg *mane* and 300mg *nocte*. The plan was to review Mr. X in six weeks time
25 September 2006	Mr. X rejoined the 'Fifteen' Group. During his first group meeting he mentioned that he had bought a small knife for self-protection, he also mentioned his feelings of paranoia. The therapy staff team felt that this was an attempt by Mr. X to raise their anxiety about him, they decided to discuss it following the next group meeting.
16 October 2006	Mr. X mentioned in a 'Fifteen' Group that he had bought a **nine inch hunting knife** with the intention of self-protection. The Group discussed this. Mr. X also took back a length of rope from a filing cabinet that had been previously taken from him by another group member, he said it offered him a means of *'ending his misery'*. The therapy staff team wondered whether Mr. X had deliberately tried to raise the group's anxiety in order to distance himself from having to talk about his feelings. The therapy staff team discussed Mr. X's risk at length. It was decided to do nothing because he had talked about weapons before and that there was no evidence of his being in any particular kind of distress. Staff felt that Mr. X was trying to get them to intervene with his GP to change his medication. Staff felt if this was the case Mr. X should do it on his own.
21 October 2006	Mr. X was triaged in the Accident and Emergency Department of South Manchester University Hospital NHS Trust. It was recorded that Mr. X *'wanted to self harm. Hears and sees things he cannot explain'*. It was noted that he had been admitted to SAFIRE recently and that he had a history of depression and self harm. The doctor assessing Mr. X felt that there was a *'high probability of self harm'*. Mr. X was referred to the On Call Psychiatrist who recorded that Mr. X had tried to strangle himself with a rope, that he was sweating, fearful with pressure of speech. It was recorded *'? psychotic episode'* it was also recorded that the patient was at risk of suicide. Mr. X was referred to SAFIRE. Mr. X went to SAFIRE at 18.15 hours. Mr. X had to return to Accident and Emergency to have his tongue sutured as he said he had bitten it whilst having a seizure. Mr. X was settled back on the unit at 22.50 hours and went to bed. A Threshold Assessment Grid was filled in. It rated Mr. X as being: • a severe risk of intentional self harm • a moderate risk of unintentional self harm • no risk to others

	A mental health assessment described Mr. X as experiencing auditory hallucinations '*non-stop'*.
22 October 2006	Mr. X stated that he had a duodenal ulcer and drank some milk to alleviate his symptoms. Mr. X's mother was tearful and distraught she claimed that he had spent thousands of pounds on hotels and eating out in order to get away from the place where he lived. **She also stated that he was very hostile and always threatened to harm himself and that she could no longer tolerate his behaviour.** Following Mr. X's discharge from Grafton ward in June he went to live with his stepfather, eventually the stepfather had to leave his own flat due to Mr. X's chaotic behaviour, to live in that of Mr. X. Mr. X had made a mess of both his stepfather's flat and his own home, his mother reported faeces on the floor and walls. His stepfather was living in Mr. X's flat but all essential services had been cut off as nothing had been paid for. The mother of Mr. X was no longer able to cope with his aggression. She and her ex-husband had been supporting Mr. X financially and she no longer wanted him to have unrestricted access to her for the time being. Mr. X's mental state assessment recorded that he said he had been depressed since he was fourteen. Mr. X was described as having a cold manner and a flat expression. Mr. X was assessed as presenting a high to moderate risk of self harm if allowed home and a low to moderate risk of physical harm to others. It was noted that Mr. X was experiencing auditory, visual and olfactory hallucinations. The mental state assessment also stated that there was '*some manipulation and control of the situation noted'*.
23 October 2006 12.30 pm	Mr. X tried to contact the Consultant Psychotherapist at 'Fifteen' to say that he had been admitted to the SAFIRE Unit. An assessment was conducted. It was recorded that there was no evidence that Mr. X had auditory, visual or olfactory hallucinations from which *'the patient claims he suffers'*. It was also recorded *'no delusions some paranoid ideas about neighbours.'* It was recorded in the clinical record that Mr. X was not deemed to be acutely unwell and was therefore not suitable for admission. The plan was: • a referral to Crisis Point • and if not accepted to be discharged to the Care of Consultant Psychiatrist 1, his RMO • refer to psychology for CBT and for assessment by the CMHT Mr. X's mother telephoned the Psychotherapy Service to say he had not attended 'Fifteen' that day because he had been admitted to the North Manchester Safire Unit over the weekend. She went on to say that he was making both his father and herself ill. Mr. X and his father had exchanged flats because Mr. X was worried about people persecuting him, Mr. X was also eager to not give his new address out, but his mother wanted the service to know it as they would not be able to contact him

	otherwise. The mother of Mr. X said he was not looking after himself properly and that his flat was dirty and the bathroom full of vomit. She was anxious for Mr. X to receive regular help.
30 October 2006	An Adult Psychotherapist with the 'Fifteen' Programme completed a review on Mr. X. (Mr. X had re-applied to join 'Fifteen' following his own discharge from the group on the 9 January 2006. Mr. X rejoined the programme on the 25 September 2006). Mr. X valued the group as a safe place to air his feelings and to establish a social network. Mr. X felt that his previous admission was triggered by his fears of having his flat petrol bombed by the children living in his area. Mr. X was still uncertain whether the threats were real or a figment of his imagination. Mr. X reported that since his crisis he had become estranged from his parents and that he felt distressed by their abandonment of him. Mr. X said that he **started to drink** in order to deal with his fears and anxiety. **Mr. X also stated that he carried a knife** to protect himself. Mr. X spoke to the group about his thoughts of **self harm and killing** himself, he said that he went to Accident and Emergency when these feelings were strong. During the 'Fifteen' Group sessions he reported that his neighbours thought wrongly that he was a threat to their children and that these children had posted dog excrement and used condoms through his letterbox.
31 October 2006	The SpR to Consultant Psychiatrist 1 reviewed Mr. X. Mr. X told him that he had been admitted to SAFIRE for four days following his attendance at Accident and Emergency with hallucinations. Mr. X thought that people were going to burn down his flat. Mr. X reported ongoing thoughts of committing suicide. Mr. X felt that his hallucinations had increased since he stopped Olanzepine and commenced Quetiapine. Mr. X was well kempt, admitted to drinking four cans of lager a day and of not sleeping. The SpR described him as pleasant and appropriate with '*quasi-psychotic experiences probably in the context of his Schizotypal Personality Disorder.*' Mr. X was recommenced on Olanzepine 5 mg *nocte* and was asked to slowly discontinue his Quetiapine. The SpR had arranged to see Mr. X in two weeks time and planned to refer him to the Community Mental Health Team if no improvement had taken place.
6 November 2006	At the 'Fifteen' Group Mr. X mentioned how distressed he was that his parents had abandoned him. He asked the staff to contact them on his behalf, they declined saying that the group was about empowering Mr. X to do it for himself.
11 November 2006	A request was made to the SpR by the Royal Mail Group (Mr. X's employer) to access Mr. X's clinical records for an occupational health assessment. Mr. X had given his written consent for this information to be shared.
13 November 2006	The Consultant Psychotherapist sent Mr. X a summary of his care plan. The Consultant Psychotherapist was acting as Mr. X's Care Coordinator and Mr. X was on standard CPA. The care plan stated that the Psychotherapist would be able to help him with his feelings of isolation, but would not be able to assist him in a crisis. The plan suggested managing a crisis by going to the GP, A&E, a Psychiatrist or the Samaritans. The date of the next CPA review was set for the 12 February 2007. Mr. X gave his consent for the CPA to be sent to his '*care network'* (in effect his GP)
24 November	The Royal Mail Group wrote once again to the SpR stating that they had written on the 11, and 17 of November for Mr. X's

2006	clinical records which had not been sent.
27 November 2006	Psychotherapy services wrote to the Staff nurse on Grafton Ward about Mr. X's progress with 'Fifteen'.
19 December 2006	The SpR wrote to Mr. X's GP. Mr. X had failed to attend his outpatient appointment on the 19 December and had also failed to attend two other consecutive appointments. This was stated as being *'somewhat unusual for him'*. The SpR was worried that Mr. X would develop *'a full blown psychotic illness'* given his previous paranoia and auditory hallucination. The GP was asked to notify the SpR of any concerns that he may have as soon as possible. The SpR also stated his intention to make a home visit with one of the community team members in January.
8 January 2007	Mr. X gave an account to the 'Fifteen' Group of being admitted to hospital for ten days over Christmas due to a potassium deficiency. He was so apparently weak that the police had to break into his flat in order to get him to the hospital. Mr. X called for the ambulance himself as *'he could hardly stand'*. He gave this as the reason for missing two groups. He said his father had refused to visit him in hospital telling him to *'get a life'*.
22 January 2007	Mr. X was discharged from 'Fifteen'. Mr. X had been absent from the Group two weeks prior to Christmas stating that he had been hospitalised with a potassium deficiency. On the 15 January Mr. X asked for his drinking to be considered under the procedure for minor breaches of the group rules and for this to be further examined without the ability to exempt himself from the examination process. Mr. X failed to attend the following week and thereby effectively discharged himself from the group due to the exemption clause. A post discharge meeting was offered to Mr. X. Mr. X was also given the opportunity to self refer to 'Fifteen' again after a three month interval. Letters to the SpR were sent on both the 31 January and 13 February 2007 by the Consultant Adult Psychotherapist, explaining the situation.
13 February 2007	The SpR reviewed Mr. X and felt that his mental state had deteriorated. Mr. X had missed several appointments since his appointment in October when he had last been seen. Mr. X reported that he had been unwell over Christmas with hypo-cholaemia. *'He had been eating very little and become constipated and he then commenced abusing Lactulose.'* Mr. X felt that he was being persecuted in his neighbourhood and appeared to have experienced some psychotic symptoms. Mr. X found it difficult to distinguish from events that were real and those which were not. Mr. X experienced panic attacks. Mr. X had been *'thrown out of 'Fifteen' for non-attendance'*. Mr. X felt little enjoyment, reduced appetite, negative thoughts about the future. Mr. X had been medically retired from the Post Office. However Mr. X presented at this meeting as pleasant, well kempt and co-operative. The SpR had discussed the case at a team meeting and had arranged for a CPN to assess Mr. X in the near future. The next review date had been set for the 6 March 2007.
6 March 2007	Mr. X was reviewed at an Outpatient Appointment. Mr. X continued to have feelings of persecution and was low in mood. However he also was less anxious and showed some improvement in his mental state.
14 March 2007	The SpR wrote to Mr. X's GP. The letter stated a diagnosis of ***'Schizotypal Disorder , Dysthmia'*** the medication was recorded as being *'Fluoxetine 40mg OD, Olanzepine 20 mg Nocte, Propranolol 20 mg BD'* Mr. X had reported that the Propranolol had

	helped him with his anxiety, but that he still could not separate out the difference between reality and his imagination. He was still complaining of feelings of persecution and thought that people were trying to petrol bomb his flat. He was no longer hearing voices, but although self caring *'felt too apathetic to commit suicide'*. The SpR felt that there had been some improvement in Mr. X's mental state and that at the current time he was not experiencing delusions or hallucinations. The SpR recommended a short course of Zopiclone 7.5mg (14 tablets maximum) to help with Mr. X's sleeping problems.
14 May 2007	The SpR wrote to Mr. X stating that he had missed his appointments due to have taken place on both the 27 March and the 1 May 2006. Mr. X was asked to make an appointment at outpatients if he wished to be seen again. Mr. X's GP was also notified by letter
23 May 2007	A CPA review took place (by Psychotherapy Services). The care plan was to provide support in social situations and to decrease isolation. The Consultant Psychotherapist was identified as the Care Coordinator. Mr. X was on standard CPA.
28 May 2007	Mr. X was admitted via section 136 to a hospital in Eastbourne Sussex. Mr. X was admitted because he had suicidal thoughts and had paranoid ideas about people following him. Mr. X told the Psychiatrist in Sussex that his trouble began in July 2006 with his neighbour's children when they kicked his cat. He told them that if they did it again he would kick them. He sent a note to the children's parents asking them to keep the children away from him. Mr. X stated that this was the worst thing he could have done as he started to get threatening letters from the children's parents. He also experienced having faeces pushed through his letterbox and a whispering campaign against him. He was discharged back to Manchester Services on Prozac 40 mg am Omeprazole 40 mg am Diazepam 5 mg TDS
31 May 2007	Mr. X was transferred to Redwood Ward, North locality and was then moved to the SAFIRE Unit. The ward staff contacted the father of Mr. X. He asked the ward if they were aware of the problems that he had experienced with his son in the past. The ward staff said that they were unaware. When confronted Mr. X said that he didn't know why his father did not want to speak to him.
4 June 2007	The ward staff contacted the Eastbourne Police to ascertain details of the events leading up to Mr. X's admission in the south. The police confirmed that Mr. X **had a knife** in his possession and that he had shown them where he had hidden it. Mr. X told them he had it in order to protect himself. The mother of Mr. X telephoned the ward. She explained that she had had little contact with him between Christmas and

	October. She was aware of his hospital admission during the Christmas period. Since Mother's Day she had seen him on a few occasions. She was upset and said that Mr. X had done some unforgivable things, that he refused to take responsibility for his actions and tried to '*con*' her. A risk assessment undertaken on this day described Mr. X as being a high risk of suicide and a current low risk to others, however this could change if he purchased a knife and suffered a psychotic relapse.
6 June 2007	On this date a discharge summary was prepared by a nurse on the SAFIRE Unit following a review by the Ward Doctor and Charge Nurse. Mr. X appeared to be calm throughout the review although he stated that he still had thoughts of a paranoid nature and that he did not want to leave hospital. Mr. X also stated that if he was discharged he would buy a rope and hang himself. The plan was to: • Discharge to his home address • Give a two day supply of medication • Make an outpatient appointment • Make an appointment with the GP surgery on the 8 June • Attempt to contact the CMT to ascertain whether Mr. X had been allocated a CPN service • Inform Mr. X's mother regarding his discharge A summary was also written for Mr. X's GP. This stated that Mr. X had been transferred from *'Kent, Surrey, initially to Redwood Ward 31 May 2007 and then to SAFIRE for a period of assessment'*. Approximately two weeks prior to his admission Mr. X had gone to London where he reported in to a police station saying that he recognised people from Manchester following him. He then went to Eastbourne and was subsequently admitted informally to hospital. Following admission to the SAFIRE Unit it was **not thought that he was suffering from a mental health problem** and he was discharged. He was advised to self-refer to the 'Fifteen' Group.
11 June 2007	The Police were to find evidence that Mr. X's credit card was used in New York on this day
14 June 2007	AMIGOS shows Mr. X as being on enhanced CPA from this date.
19 June 2007	Sentara Healthcare (United States of America). Mr. X had travelled to the United States of America (probably before the 11 June). Mr. X had been admitted to hospital due to experiencing seizure-like symptoms at a shooting range. Mr. X had tried to shoot himself on three occasions on the same range in quick succession but failed to do so by demonstrating some kind of seizure on each of the three occasions. Onlookers at the shooting range called 911. On examination and EEG no evidence could be found to suggest an epileptic fit had occurred. Mr. X superficially scratched his wrists and showed an interest in jumping out of a window whilst at the Sentara Healthcare

	facility.
20-25 June 2008	In the meantime in England mental health and police services tried to find Mr. X as they were worried about his apparent disappearance. In the end the police decided to stand the investigation down as they believed Mr. X was holidaying in the United States of America. NYPD and Homeland security were informed by the British Police regarding their concerns for Mr. X. A trace was placed on Mr. X so that services in England would be notified when he tried to leave the United States of America.
26 June 2007	Mr. X was admitted to a psychiatric unit in the United States of America following the scratching of his wrists. He was given a diagnosis of bipolar disorder with severe psychotic features. However it was felt that he was fit to be discharged and this was done on the 5 July 2007. The hospital in the United States of America contacted Mr. X's mother to say that he had injured his back. The mother of Mr. X notified his Care Coordinator in England.
5 July 2007	Mr. X was discharged from the American psychiatric facility. It is not certain when he returned back to the United Kingdom.
28 July 2007	Mr. X presented at Accident and Emergency at the Manchester Royal Infirmary. He was recorded as having suicidal ideation with no specific plans, he was also recorded as being paranoid. Mr. X claimed to have tried to hang himself as he got off of the plane from America, he was very inconsistent and later retracted the claim that he had tried to hang himself. He was described as experiencing '*pseudo-auditory hallucinations*'. Mr. X was described as being calm with good eye contact and maintaining the view that he wanted to be in hospital. **He was assessed as not having a condition that would respond to hospital treatment.** Mr. X's medication on discharge from the United States of America was Fluoxetine 40mg OD and Lorazepam 2mg PRN. The Mental Health Liaison Team took the view that Mr. X would not have been discharged from the American facility and allowed to travel back to the United Kingdom alone if his mental state had not been stable. He was discharged with CMHT follow up and an appointment with Consultant Psychiatrist 1 planned.
29 July 2007	Mr. X was admitted to the Newark Beth Israel Medical Centre in New Jersey, the United States of America. On travelling through immigration Mr. X told immigration the purpose for his visit to America was to buy a pistol in order to commit suicide. On the 30 July he underwent an assessment. The report that Mr. X gave to the admitting doctor was highly fabricated (his accounts did not match the information in his British held clinical records) unfortunately the America doctor was not to know this. It is evident that on this occasion the doctor was uncertain what was wrong with Mr. X. It was decided to treat him with Clozaril and to initiate Prozac on a 'one time dosage'.

July-August 2007	Mr. X went missing to both family and services again. During this period mental health services and the police sought to find him and maintained liaison with the family of Mr. X. On the 9 August the CMHT recorded (following a call from the mother of Mr. X) that he was once again in the United States though he appears to have been hospitalised as soon as tried to pass through immigration. He was discharged and transferred fairly rapidly to a detention centre to await his return to the United Kingdom.
15 August 2007	Consultant Psychiatrist 1 wrote to the GP stating that Mr. X had returned from the United States and that services had been informed of his arrival (referring to the events 28 July). Mr. X presented himself to the A&E at MRI the same day. He was not admitted during that assessment and disappeared. The CMHT had visited his flat but there was no sign of occupation. The plan was to contact his parent, and to inform police if he could not be located. It would appear from his letter that Consultant Psychiatrist 1 was not aware Mr. X's second visit to the United States was already taking place. On this day Mental Health Services (the CMHT) contacted the hospital to which Mr. X had been admitted. On this day he had been discharged from the hospital and was being held in a detention centre. He was being observed on a one-to-one simply because he threatened suicide and the American authorities didn't want to take any risks with him. He was not thought to be actively mentally ill.
17 August 2007	Mr. X returned to England and was met at the airport by staff from the CMHT. Mr. X was admitted under Section 2 of the Mental Health Act (83) to the North Manchester Service. Mr. X had been detained in America for two weeks. The diagnosis from the American team was **Bipolar Affective Disorder mixed episode with psychotic features and poly substance misuse.** On admission in Manchester he was placed in 15 minute observations. However he settled very quickly and the next day the observations were reduced. An 'Assessment Form Version 1' was completed. This constituted the development of a comprehensive risk assessment. **<u>Under danger to others it was recorded:</u>** Aggression and violence to others: **yes in the past** Arrested for violence: **no** Conviction for sexual offence: **no** Use of/obsession with weapons: **yes in the past bought gun and knife** Arson/fire setting: **left blank** Hostage taking: **no**

	Stalking/harassment: **a note was made regarding information brought forward from counselling sessions** Risk to children: **no** **<u>Self-harm</u>** Actual self harm: **yes past** Suicidal ideation: **yes** Suicidal plans: **yes** Substance misuse: **yes alcohol** Family: **no** Mr. X was considered to be potentially at risk from his neighbours. *He was thought to be at risk of relapse, however stressors and predictive relapse indicators were not identified, these were left blank on the form.* It was recorded that Mr. X said his neighbours thought he was a paedophile and had broken his windows and followed him around. He had apparently been to America to buy a gun, he also apparently went to a shooting range with the intention of killing himself, whereupon he passed out and was taken to hospital. Mr. X said he would not be able to kill himself with a razor as it would too painful. He also described visual hallucinations in that walls and floors shivered around him. Mr. X was thought to be a low to moderate risk to others as his thoughts and feelings were non specific. The suicide section of the form was left blank. In summary it was thought that Mr. X's psychiatric risk and symptoms were to be seen in the light of his social situation. He was described a being a risk to himself at all times. His capacity was thought to depend upon the validity of his psychiatric symptoms. The management plan was for a formal admission. It was recognised that he had poor finances, housing and social and family relationships. Views about Mr. X's psychiatric condition were still uncertain. **The plan was to keep Mr. X in hospital for the present time.**
5 September 2007	**A ward round was held on this day. A diagnosis was put forward of personality disorder. The ward MDT had no concerns for his safety.**
13 September 2007	Mr. X was found sleeping in his bed with a kitchen knife on his pillow. When challenged about this Mr. X said he had had thoughts of self-harm. However Mr. X appeared to be calm and settled during this period. He was sleeping well, eating well and

	interacting appropriately. The incident with the knife was discussed at a team meeting.
19 September 2007	Mr. X decided to sell his flat and to look for rented accommodation. This was discussed with his discharge planner.
24 September 2007	Mr. X approached a ward staff member to say he had cut his wrist, a small dressing was applied. Mr. X handed in the 'remainder *of the blades'* he had used to scratch his wrist.
26 September 2007	An Occupational Therapy assessment recorded that Mr. X consistently presented as a high functioning individual who was *'clearly able to express and meet his own needs'*. No signs or symptoms of mental illness were observed.
29 September 2007	Mr. X approached ward staff with superficial cuts to his wrist. He was facilitated to clean and dress the cuts himself.
3 October 2007	**A ward round was held on this day. The RMO suspected schizophrenia, the Staff Grade and the ward staff strongly suspected an anti-social personality disorder. The CPN who was present recorded the discussion that took place regarding the need for a clear diagnosis and subsequent discharge management plan.**
10 October 2007	The Occupational Therapist took Mr. X on a home visit. The flat was a mess. Mr. X felt that the flat was not habitable due to the mess, the Occupational Therapist stated that it simply needed a clean to remove the milk cartons and lager cans. Mr. X requested that mental health service find him a clean up team. He was advised to look through the yellow pages for a cleaner and that he needed to sort this out himself. The Occupational Therapist thought the flat was habitable and told Mr. X this would not prevent or delay his discharge.
15 October 2007	Mr. X was transferred from the North Manchester Redwood Ward, to the South Manchester Service Bronte Ward. He was discharged with a diagnosis of **schizoaffective disorder**. An admission checklist was completed. At the time of his transfer he was an **informal patient**. The admitting doctor did not have access to his previous medical records and had to depend on information from nursing staff. Consultant Psychiatrist 1 was listed as being Mr. X's Responsible Medical Officer. The admitting SHO recorded that Mr. X had four folders of previous clinical records (that were not present) and that Mr. X had listed seven admissions over the past fifteen months, two of which had been in the United States of America. The diagnoses that Mr. X accrued during this period ranged from **Schizophrenia to Schizotypical Personality Disorder, Bipolar Disorder to depression.** Mr. X was described as being on both anti-depressant and anti-psychotic medication. Mr. X presented with no paranoid delusions or thought insertion. No active thoughts of self harm were present. A comprehensive physical examination was undertaken. Mr. X was not happy about being transferred to the South Team.
17 October 2007	A Risk Assessment Follow Up Form Version 1 was completed by the SHO. Mr. X was not assessed as presenting any current risks. It was noted by the SHO that Mr. X had previously brought knives onto the NMGH. Mr. X stated that he felt his mood

	had dipped since being admitted to Bronte Ward. **Another** risk assessment was completed on the same day by a staff nurse. This risk assessment cited Mr. X's risk of harm to self and to others as being current. However it was agreed that Mr. X could take up to a one hour unescorted leave interval each day for a period of one week if he approached staff prior. It was also noted that Mr. X had a history of previously threatening and assaulting staff.
18 October 2007	Mr. X was described as pleasant but isolative. Mr. X asked for medication for his anxiety
22 October 2007	A ward round was held. Consultant Psychiatrist 1, a Staff Nurse and the SHO were present. Mr. X's medication was listed as being; Quetiapine 100mg Perphenazine 4mg BD Orphenadrine Tryptophan 1g tds Zyban 150 mg BD Escutalopram 10 mg OD Zopralone 7-5 mg OD Omeprazole 40 mg OD Previous risk behaviours were noted together with previous fantasies about violence. It was also recorded that Mr. X had kept the addresses of previous work colleagues and that there had been some previous mention of stalking. Mr. X had mentioned auditory hallucinations over the past eighteen months. It was agreed to stop the Zyban and Quetiapine and to also reduce the Tryptophan with a view to stopping it altogether. The aim was to commence Clozapine and Mr. X was given an information leaflet about this drug. Mr. X was reassured that there would be no plans for discharge at the present time.
23 October 2007	Mr. X was described as warm and pleasant but keeping a low profile.
27/28 October 2007	Mr. X was reported as being missing from the ward. He was subsequently returned by the police (via A&E) who stated that he had been in possession of a hunting knife which Mr. X claimed was for his own protection. It was felt that Mr. X was a high risk of absconding and that he may be a suicide risk. It was decided that he needed to be Sectioned under the Mental Health Act (83).

29 October 2007	Mr. X demanded the opportunity to leave the ward but was persuaded to stay until he had been assessed. The Section 3 application was commenced with the first medical recommendation. The Duty Social Worker was contacted for a further recommendation.
30 October 2007	Mr. X was placed on Section 3. The mother of Mr. X was contacted as the next of kin. She was unwilling to be involved and spoke of her distress. She offered the view that she felt Mr. X should be in hospital and that she would raise no objection to the Section. She became too distressed to speak.
31 October 2007	Mr. X was described as calm and expressing no suicidal ideas. He was also described as being warm, pleasant and settled.
2 November 2007	The risk assessment conducted on this day stated that '*since Mr. X has been placed on a Section the voices have stopped. His risk has lowered remarkably at present'*.
8 November 2007	The Trust received a letter from the solicitors of Mr. X in connection with an appeal against his Section 3. Mr. X wanted to have more leave from the ward.
12 November 2007	A ward round was held. Mr. X had been commenced on Clozapine on the 10 November 2007. Mr. X was described as being pleasant and affable, interacting well with his peers and expressing no delusional thoughts. Mr. X was put back onto general observations. Mr. X was to be given up to two hours of escorted leave. A Section 17 form was completed.
13 November 2007	A Risk Assessment Follow Up Form Version 1 was completed. Mr. X was recorded as being well kempt, relaxed and with good eye contact. Mr. X denied any thoughts of self harm or thoughts of harming others. There was no evidence of a thought disorder being present and Mr. X said he had heard no voices for two weeks. He was noted as having good insight. His risk assessment regarding thoughts of harming others remained the same as the previous assessment conducted on the 17 September, however his risk of self harm had been reduced. Mr. X denied any thoughts of harming either himself or other people.
16 November 2007	The Specialist Registrar noted that Mr. X had had escorted leave to Manchester and to his flat to collect some items and pay a bill. A Risk Assessment Follow Up Form Version 1 was completed. Mr. X was described as being well kempt, aware and able to maintain good eye contact. Mr. X was recorded as being depressed and suicidal and unhappy about being transferred to the South Manchester Service. Mr. X was described as being irritable and as having been described as having 'thought broadcasting' when in North Manchester. Mr. X felt that he was not mentally ill, but that he was being persecuted by various people who believed him to be

	a paedophile. The risk assessment recorded that Mr. X was intending harm to the person who *'started this if I see him [neighbour]'*. Mr. X was also assessed as actively planning harm to himself either through cutting, overdose or hanging. During this period Mr. X was started on Clozapine.
26 November 2007	A ward round was held on this day with Consultant Psychiatrist 1, the RMO present. It was felt that Mr. X was not ready to come off of his Section at the present time. Mr. X expressed his irritation at the slowness of the titration of Clozaril and stated he wanted to go back onto Clopixol. Mr. X said he wanted to come off of his Section as he found it too restrictive and that he was bored on the ward and would like to visit the cinema. The Section 3 was to be reviewed following the completion of the titration of the Clozapine. Mr. X was given seven hours of unescorted leave. However he refused to travel to his flat independently and demanded hospital transport to take him and collect him.
5 December 2007	On this day a Mental Health Act Managers hearing was held. It was noted that Mr. X had a diagnosis of **Paranoid Schizophrenia ICD10 Code S20.0.** The report was prepared by the SpR of Consultant Psychiatrist 1. The medical recommendation was that Mr. X should remain on his Section due to his current high risk, particularly to himself. It was recommended that Mr. X be monitored for his Clozaril especially as he had been experiencing tachycardia and low blood pressure. This medical report was seconded by the Social Worker who felt that Mr. X was still an active risk to himself. The Hospital Managers decision was to keep Mr. X on his Section 3.
7 December 2007	Mr. X was found taking cocaine on the ward. His urine tested positive.
9 December 2007	A follow up risk assessment was completed. Mr. X was described as being pleasant towards both staff and other patients. Mr. X was not expressing thoughts of harming himself or others. He wanted to continue with his treatment, his insight was thought to be *'moderate'*. Mr. X expressed the view that he should be discharged and that his Section under the Mental Health Act was no longer warranted.
	Observation during his time with South Manchester Mr. X reported few delusional thoughts and reported few hallucinations. He socialised well and appeared to be pleasant and relaxed most of the time. It was noted that at times he could appear depressed and low in mood.
12 December 2007	Mr. X was described as being preoccupied by his forthcoming tribunal. He was upset that his mother would not attend.
13 December 2007	**A ward round was held. A Mental Health Tribunal was held.** It was noted that Mr. X had won his tribunal and that his Section 3 was to terminate the following week. Mr. X had told the Tribunal that he was happy to comply with his treatment and

	medication and that the Section 3 served no purpose. The medical report suggested strongly that Mr. X needed to remain on his Section. Mr. X was reported to be subdued following the tribunal decision. Mr. X was advised by his solicitor (whom he had been using to liaise with his parents) not to make further contact with his parents. They had refused to attend the tribunal.
14 December 2007	Mr. X asked the ward staff to contact his parents. The ward staff were only able to access an answer machine.
17 December 2007	Mr. X was described as being worried about the plans to change his legal status to that of an informal patient as he worried he was going to be discharged. Mr. X was described as being relaxed and well and experiencing no hallucinations. The risk assessment completed on this day identified no current risks regarding Mr. X's risks to others or to himself. No psychotic symptoms were present although Mr. X still said he felt anxious.
18 December 2007	The stepfather of Mr. X was contacted by the ward and he agreed to work with both them and with Mr. X.
20 December 2007	A ward round took place. Mr. X's Section 3 lapsed and he became an informal patient from this point. Mr. X was reported as being frightened about his discharge. His family did not want to resume their relationship with him. He had not enjoyed his overnight leave because of the state his flat was in, he felt lonely.
24 December 2007	Mr. X had been trying to contact his family as he was hoping to spend Christmas with them. The family contacted the ward to ask this to stop and that they would like to be left alone to contact Mr. X when they were ready. Mr. X had been sending upsetting texts to his family.
27 December 2007	An OCAIRS occupational therapy assessment took place on Bronte Ward. Mr. X was assessed as requiring further occupational therapy inputs as he had difficulties in setting goals and appeared to have little motivation.
4 January 2008	A risk assessment was conducted. It was noted that Mr. X was '*sabotaging'* his medical treatment. Since Christmas he had spent a great deal of time in bed. Mr. X reported hearing voices whilst he had been home on leave. He was assessed as being a medium risk to himself and to others. A comprehensive short term discharge plan was developed.
10 January 2008	It was noted that Mr. X had taken overnight leave to his flat the previous week. Mr. X had been isolative since that time and had also refused help from the Occupational Therapist to clean his flat. The ward round plan was for Mr. X to have a one week period of leave, for a CPA to take place and for the Care Coordinator to visit Mr. X at this home.
14 January 2008	Mr. X returned early from his leave back to the ward saying that he was not well and that he heard people talking about him. He did not appear to be anxious or worried, but did not want to go back home.
17 January	Mr. X had mentioned that he thought his neighbours were planning to break his windows, Mr. X was not certain whether this

2008	was just his imagination. He spent the time after the ward round travelling around Manchester on public transport.
20 January 2008	Mr. X took overnight leave as he had arranged for the estate agents to visit his flat the following morning.
21 January 2008	A risk assessment was conducted. Mr. X was assessed as being at medium risk of suicide/self harm, medium risk of harm to others, and low risk of vulnerability/victimisation. It was clear that Mr. X did not want to be discharged home. However it was felt that Mr. X was becoming institutionalised. It was decided to continue with a weekly Mental State Assessment. The risk assessment did not detail all of the information about Mr. X's possession of knives, and so presented an incomplete picture. A ward round was held on this day. A one week leave period was granted. It was arranged that the Care Coordinator would visit Mr. X.
22 January 2008	Mr. X informed the ward staff that he was going to view some flats in Withington. The fact he could arrange this on his own was seen as an indicator that his mental state was sound. Staff had suspicions that he had brought drugs and alcohol onto the ward for the other patients. He agreed to be searched but nothing was found.
24 January 2008	Mr. X was given a one-week period home leave with plans for CMHT and occupational therapy visits to help prepare him for discharge. CPA documentation was completed. Mr. X was noted as being on enhanced CPA and eligible for section 117 aftercare. The clinical records state that Mr. X failed to keep any of the planned appointments during this period of leave. The date of the next CPA meeting was set as being 22 July 2008. Care Coordinator 2 conducted this CPA. Mr. X had cleaned up his flat and was in the process of selling it.
30 January 2008	Mr. X was on leave to his flat. He had been in touch with his stepfather whom he had contacted in order to get assistance in moving to a new flat. He did not want anyone to know his new address. It was noted that Mr. X's new address needed to be ascertained prior to his discharge.
31 January 2008	A ward round was held. It was noted by the named nurse on the ward that Mr. X was trying to sabotage his discharge. Mr. X had been trying to sell his flat in order to make himself homeless in order to hinder his discharge, he was refusing to cooperate with the Clozapine clinic and he refused to have a mental state examination conducted. There were signs that Mr. X was not engaging. Mr. X had not allowed access to either the CPN or the OT. The plan was for the discharge to be conducted in a graded fashion. Mr. X was discharged accordingly in his absence. Following his non attendance at the ward round and his discharge Mr. X returned to the ward. He was annoyed and refused to take his 'take home medication' with him.

	At the point of this discharge Mr. X stopped taking his Clozapine.
1 February 2008	The Crisis Resolution Team visited Mr. X's home to attempt to give him his medication but he was not in.
4 February 2008	A seven day discharge follow-up visit was made to Mr. X's home, he was not there.
6 February 2008	Care Coordinator 2 telephoned Mr. X to arrange an appointment to visit him at his home on the 11 February 2008. Mr. X explained that he had moved to a different flat and apologised for missing appointments.
18 February 2008	On this day the Staff Grade from the North Manchester Team wrote an admission/discharge summary to the GP of Mr. X. It is unclear why it was sent several months after Mr. X's discharge from their services. However this letter stated that the Staff Grade and the nursing staff disagreed with the diagnosis of the Consultant. The Consultant diagnosed Mr. X as having a Schizoaffective Disorder. The alternative view was that Mr. X was not mentally ill and was fabricating his symptoms for psychological and material gain. The staff viewed Mr. X's presentation as '*flamboyant, histrionic and insincere'*. Nursing staff felt that all of Mr. X's actions were goal orientated and that they were being manipulated. At no time did he present with any symptoms of mental illness. The Staff Grade doctor believed that Mr. X was fabricating his illness and actively pursuing hospitalisation. The letter also stated that Mr. X's mother no longer wanted anything more to do with her son due to his manipulation and threatening behaviour. It was clear Mr. X had received almost ever kind of diagnosis possible, with no agreement.
18 February 2008	A home visit was made by Care Coordinator 2, he was very concerned as Mr. X was very paranoid and had been travelling away from Manchester and staying in hotels in Blackpool to avoid people he knew. Care Coordinator 2 arranged for an appointment with Consultant Psychiatrist 1 that afternoon. Mr. X was brought to Accident and Emergency by the Police after he was bailed for carrying a knife when seen by his Consultant for an emergency appointment on the same day. Consultant Psychiatrist 1 recorded that Mr. X had stopped taking his Clozapine. Mr. X was becoming increasing paranoid and had been moving around the country in order to avoid people who thought he was a paedophile. Mr. X felt despondent and helpless and had suicidal thoughts. Consultant Psychiatrist 1 arranged for an inpatient admission. The mental state examination assessed Mr. X as being well kempt, although there was evidence Mr. X had lost weight. Mr. X was described as being tense and agitated and tearful and distressed on occasion. Mr. X appeared to be depressed with no formal thought disorder, although there was evidence of secondary delusional elaboration and suicidal ideation. Mr. X was cognitively intact, and whilst his insight was limited he was accepting of treatment.

19 February 2008	Mr. X was admitted informally to Bronte Ward following a referral from the accident and Emergency Department of the North Manchester General Hospital. His base Consultant was Consultant Psychiatrist 2, although at this stage the RMO was still Consultant Psychiatrist 1. It was noted that his Community Psychiatric Nurse and Care Coordinator was care Coordinator 2. A risk assessment was conducted. It was noted that: **Risk to others:** Whilst Mr. X had previously not been assessed as being a risk to others the form on this date bore a tick in the *'use of/obsessed with weapons'* box, and also in the *'threats to harm/kill others'* box. It was noted that Mr. X felt that he needed to protect himself from others and slept with a knife. **Risk of self harm** It was noted that Mr. X had been a previous risk to himself and was considered to be at present a risk to himself in that he had suicidal ideation and harboured suicidal plans. He had reported *'a massive overdose of ecstasy'* at the end of January. Mr. X did not report this overdose as he had expected to die. Mr. X was assessed as being a high risk of future suicide and self harm.. **Neglect** Mr. X was noted as having an open wound in his groin where he had tried to cut his femoral artery. (this was an old wound which was infected, he had had it for many years and it was not recent). Mr. X was also noted as having a high risk of relapse due to medication non-compliance and disengagement from services. Mr. X had been travelling around the country prior to this admission in an attempt to get rid of his voices. He was recorded saying '*I welcome Consultant Psychiatrist 1's decision to admit me'*. Mr. X described himself as a nervous wreck and wanting to kill himself. It was recorded that Mr. X constantly sensed threatening behaviour from others. Mr. X felt his neighbours would break into his home at night and harm him, because of this he reported sleeping with a knife under his pillow. It was noted that Mr. X had a history of substance misuse, and a current ecstasy habit. Under the heading of personality Mr. X was noted as having '*Aspergic Characteristics'*. It was also noted Mr. X lived on his own and had little contact with his family. It was also noted he harboured '*vengeance fantasies*'. **SUMMARY** It was recorded that Mr. X had a paranoid psychotic illness exacerbated by non-compliance and stress. He was thought to be a

	high suicide risk and a moderate risk to others if challenged.
During this admission	Mr. X wrote to the Clinical Director asking that his care be transferred from Consultant Psychiatrist 2 as he did not think she had dealt appropriately with his mental issues during his last admission. This request was declined.
21 February 2008	Mr. X was recommenced on Clozapine. This was almost immediately changed to depot Clopixol due to compliance issues. Mr. X had expressed a preference for being on Clopixol.
25 February 2008	Despite Mr. X being an informal patient he struggled to remain on the ward. He was given a one hour period of unescorted leave. Mr. X approached the ward staff to say that he had taken an overdose of 72 Cuprofen tablets Plus tablets. Mr. X described having visited three different pharmacies in order to accumulate the tablets which he claimed to have taken over a one hour period once he had returned to the ward. Ward staff could only find evidence for 12 tablets having been taken, his physical examinations and blood tests were returned as being normal.
27 February 2008	Consultant Psychiatrist 1 wrote to the GP of Mr. X outlining the events that had led to his current admission. This letter was written some 10 days following the events described.
28 February 2008	A ward round took place. No psychotic symptoms were noted by ward staff, although he did seem to be expressing paranoid ideas. His urine screen came back positive for opiates. A referral was made to the Assertive Outreach Service. It was agreed that they would attend the following ward round. Consultant Psychiatrist 2 became the RMO. Mr. X's depot was increased to 200 mg and oral medication was discontinued.
1 March 2008	Mr. X had to be spoken to in order to prevent him from interfering with other patient's treatment programmes. He had been advising them not to take their medication and to demand discharge.
6 March 2008	A ward round took place. Mr. X claimed not to be able to sleep at night requesting diazepam. The ward staff explained that Mr. X slept well every night, something he denied. Mr. X was assessed by a clinical psychologist regarding his suitability for psychological input. It was noted that Mr. X was willing to engage. It was also noted that he had fixed delusional ideas about people believing him to be a paedophile, that he was distressed and fearful, and that he was experiencing auditory hallucinations.
10 March 2008	A patient broke down Mr. X's bedroom door. Mr. X wanted to spend time off the ward as he was afraid and felt he would be better off in his own flat. Mr. X was assessed by the Consultant and a period of leave was agreed providing he returned to the ward on the following Thursday.
13 March 2008	A ward round was held. The Assertive Outreach did not attend. Mr. X had reported that his leave had gone well. Mr. X was given another one week period of leave. Assertive Outreach were to be invited to a discharge meeting the following week. Ward staff were to contact the AOT to arrange visits for Mr. X whilst he was on leave. **An incident document was to be completed**

	regarding DNA of teams (AOT) as this had caused a delayed discharge. Mr. X was seen by a Clinical Psychologist and it was agreed that he would commence Cognitive Behaviour Therapy. He was granted a one-week period of home leave.
16 March 2008	Care plans prepared for Mr. X cited his history with weapons and his current relapsed mental illness. The plan was to maintain both his safety and the safety of others whilst on the ward.
20 March 2008	Mr. X attended the Psychology Clinic. A ward round was also held on this day to which the Assertive Outreach Service attended. Mr. X was described as being well when seen. The agreed plan was that Mr. X would be granted another one- week period of leave, that Assertive Outreach would visit him at his home, and that his discharge was to be planned for the 3 April 2008. This is in effect was a delayed transfer which was requested so that the assertive outreach service could get to know Mr. X and create a discharge CPA for him.
27 March 2008	Mr. X was seen on the ward by the Assertive Outreach Team. They had not been able to contact Mr. X before whilst he had been on leave as he had his phone switched off. A ward round was also held on this day, the Assertive Outreach Team was present. It was recorded that Mr. X was settled in mood and mental state. It was also recorded that he was not sleeping well and was self medicating with 2-3 cans of lager daily. Mr. X was assessed as retaining some residual paranoid ideas. The plan was for the Assertive Outreach Team to continue visiting him at home. His depot was increased to 400mg, he was also prescribed Zopiclone. His discharge was planned for the following week.
30 March 2008	Assertive Outreach Visited Mr. X at his home together with the ward-based named nurse. The flat was reported as being clean and tidy.
3 April 2008	A ward round was held on this day. Mr. X was still reported as being paranoid but felt that the voices might be a product of his imagination. The AOT were to take over his depot administration and the AOT Psychiatrist was to pick him up in Outpatients. The AOT were to follow Mr. X up on a two weekly basis. Mr. X was discharged from Bronte Ward. Mr. X was due to receive a two weekly follow up from the Assertive Outreach Team. Input from psychology was arranged and a medical follow up was to be arranged two weeks following the discharge. Comprehensive discharge summary information was sent to the GP. Mr. X was due to see the inpatient psychologist on this day, but telephoned her to say that he would not be attending. He gave no reason for this, neither did he mention whether he was happy to be referred onto the Assertive Outreach Psychologist as previously planned. Mr. X confirmed that he was to be referred to the Psychologist with the Assertive Outreach Service.

	A Discharge CPA was conducted with a member of the AOT, Mr. X and staff from the ward. No full paperwork appears to exist.
6 April 2008	Two members of the AOT tried to visit Mr. X. He was not in and an appointment card was left.
9 April 2008	Mr. X contacted the Assertive Outreach Team to say he did not feel well and that he needed another appointment. A member of the AOT contacted Mr. X and made an appointment for the following day. Mr. X's depot was due on this day. Mr. X's seven day follow up meeting by Bronte Ward was due on this day. Mr. X did not attend, the ward contacted him on his mobile to find out how to proceed. Mr. X said he was well and the AOT were due to visit the following day with his depot.
10 April 2008	Mr. X called the Assertive Outreach Team to say that he wasn't feeling well and asked for his appointment and depot to be rescheduled. An AOT staff member wrote that Mr. X would be discussed at handover and a new appointment would be made.
11 April 2008	Consultant Psychiatrist 1's SHO wrote an admission/discharge summary to his GP. The summary outlined the events following Mr. X's admission and the plan to be followed on discharge.
12 April 2008	Mr. X telephoned the AOT saying he was still too ill for his appointment and to ask them not to attend. It was agreed that they would call to remake the appointment with him. Several calls were made to Mr. X but he answered none of them. It was decided to visit Mr. X at his home the following day.
14 April 2008	The AOT Care Coordinator and an AOT nurse team member visited Mr. X at home to administer his depot. He was not in. They were also unable to contact Mr. X by telephone.
15 April 2008	An AOT member visited Mr. X's home, but he was not there. This visit was made by a social worker who would not have been able to give Mr. X his depot which was now a week overdue.
16 April 2008	The AOT Care Coordinator visited Mr. X's home, but he was not in.
17 April 2008	An AOT nurse team member visited Mr. X's home, he was not in. It was recorded that his depot was now overdue.
20 April 2008	Mr. X was visited at his home by the Care Coordinator with an AOT colleague. The flat was well kempt. It was noted that the depot was overdue and that an appointment was needed to administer it. Mr. X was told someone would come around to do this as soon as possible. Mr. X requested two visits a week until he had settled down.
23 April 2008	An AOT nurse team member telephoned Mr. X to say she was going to visit him, he had his phone turned off. She left a message asking him to make contact at a convenient time.
24 April 2008	Mr. X telephoned the AOT to arrange an appointment on the 27 April 2008 which was a Sunday. Mr. X was described as being warm and engaging in manner.
27 April 2008	Mr. X received his depot injection from an AOT nurse team member. Mr. X was aware that he due to see the AOT Psychiatrist

	on the 1 May 2008.
6 May 2008	Mr. X telephoned the AOT to say that he would have to cancel his visit for that day.
7 May 2008	Mr. X declined his depot. An AOT nurse and the care Coordinator made the visit. There was no record made of any attempt by them to ensure that he took his depot. Mr. X described himself as feeling vulnerable and keen to see the AOT Psychiatrist at Outpatients.
10 May 2008	Mr. X had requested extra support from the AOT, they tried to call him three times prior to a scheduled visit. It was decided that the AOT would telephone again the following day.
11 May 2008	Mr. X was telephoned again. He did not pick up the phone and a message was left.
12 May 2008	Mr. X telephoned the assertive outreach to say he hadn't answered his door at the weekend because he had been asleep. He requested another visit.
16 May 2008	Mr. X telephoned the AOT to ask for some assistance with his benefits. The AOT agreed to help him.
20 May 2008	Mr. X telephoned to ask if his appointment could be rearranged and made later that week.
23 May 2008	An AOT nurse member visited Mr. X's home. Despite being called to arrange the appointment the previous day he was not in.
27 May 2008	Mr. X telephoned asking if he could cancel the appointment arranged for that day. Mr. X was told that this was fine and an appointment was made for the 29 May. There is no record to state what happened on the 29 May.
30 May 2008	Two members of the AOT tried to visit but they were unsure of the flat number. They rang a couple of buzzers and tried to telephone Mr. X with no success.
3 June 2008	An AOT team member spoke to Mr. X on the telephone. Mr. X said that he would be happy to see someone if they could sort out his benefits as this was his priority. An appointment was arranged for the 12 June 2008.
5 June 2008	A CPN from the AOT visited Mr. X but he was not in. Apparently this was a prearranged visit.
10 June 2008	**A home visit was successfully made.** Mr. X reported that he had developed a crack habit since his discharge. He claimed to have lost two stones in weight and that he planned to avoid psychiatrists. He would however accept support with benefits. No mention was recorded about the depot which was severely overdue.
12 June 2008	A visit was made to the home of Mr. X but he was not in.
19 June 2008	Telephone contact was made with Mr. X who felt he was owed £400 in benefits. A visit was planned for the next day.
24 June 2008	Mr. X was telephoned to say a member of the AOT was due to visit within the next 15 minutes. Someone answered the telephone to say that Mr. X was in Trafford. Another appointment was arranged for the 26 June.
26 June 2008	Mr. X left a message on the AOT answer machine to rearrange the appointment due on this day for another time.
28 June 2008	A visit was made to Mr. X's flat but he was not in. A message was left on Mr. X's answer machine.
30 June 2008	A visit was made to Mr. X's flat. He would not answer the door, but answered his mobile phone and asked for the appointment to be remade.

17 July	AOT tried to visit Mr. X, he was not in. When he was telephoned he said he did not want a visit. He said he was fine and that he had sold his flat.
22 July 2008	**Direct contact was made with Mr. X.** the AOT Care Coordinator and another team member made the visit. Mr. X said he had sold his house and had used the money to pay off debts and buy heroin and crack cocaine. Mr. X said he had tried to commit **suicide** that weekend by injecting three bags of heroin into his groin. He agreed to see the AOT Psychiatrist the following day. Mr. X said he was feeling groggy and would be happy to see the AOT 2-3 times a week. Mr. X said he was fearful of attack and was carrying a **knife** for protection.
23 July 2008	Mr. X said he felt too ill to attend his Outpatient appointment. Mr. X said he thought he had caught a bug. The care Coordinator agreed to phone him daily to check on his progress.
27 July 2008	A visit was made to Mr. X's home but he was not in.
28 July 2008	At the AOT meeting it was agreed that a further Outpatient appointment should be made and visit arranged for the next day unless Mr. X wanted one before. A call was made to AOT to say that Mr. X had been accused of Homicide.
18 May 2009	CPA meeting at Ashworth. After an extensive six month assessment the team treating Mr. X believed that he did not suffer from Schizophrenia, but from a complex cluster of personality disorders. Due to this they felt that a hospital order was not appropriate and recommended that he be returned to prison with the view to a reassessment in six months' time.

Diagram Showing Services Involved with Mr. X 2001-2008