NHS
East Midlands

An Independent Investigation into the Care and Treatment of a person using the services of Derbyshire Mental Health NHS Trust

Undertaken by the Health and Social Care Advisory Service

Ref 2007/13112

January 2010

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS East Midlands Strategic Health Authority pursuant to *HSG (94)27*[1]. This investigation was asked to examine a set of circumstances associated with the death of Ms. Halimah Ahmed and Mr. X who were found dead at the same address on the 27 November 2007[2]. The subsequent Coroner's Inquest held into the deaths of Ms. Ahmed and Mr. X on the 9 and 10 October 2008 ruled that Mr. X had unlawfully killed Ms. Ahmed followed by the act of taking of his own life[3].

Mr. X received care and treatment for his mental health condition from the Derbyshire Mental Health Services NHS Trust (the Trust). It is the care and treatment that Mr. X received from this organisation 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. Trust medical staff have been unflinchingly reflective of their practice and have engaged in this investigation process with rigour. 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 Senior Management Team has acted at all times in an exceptionally professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

We would like to thank the family of Ms. Halimah Ahmed who offered their full support to this process and who worked with the 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.

2. Condolences to the Family and Friends of Ms. Halimah Ahmed

The Independent Investigation Team would like to extend their condolences to the family and friends of Ms. Halimah Ahmed.

The parents of Ms. Ahmed wish to say the following:

Halimah Ahmed was a gifted young lady with aspirations and hopes to change the world for the better. Her compassion towards the helpless and needy was an example to us all and tragically and ironically and cruelly her final act of kindness lured her to the event that caused her untimely passing from this world.

Halimah was a precious gift to us, who we nurtured and loved for nineteen wonderful years. She brought into our lives her infectious laughter, her radiant smile and we miss her companionship dearly. Our family and our world have lost its most precious gift and every day is a battle to suppress and dull the pain in our hearts.

It is the wish of Ms. Ahmed's parents that her name is not anonymised in this report.

3. Condolences to the Family and Friends of Mr. X

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. X. Mr. X's relatives in the United Kingdom felt unable to take part in this review of his care and treatment.

4. Executive Summary

4.1. Incident Description and Consequences

The following account has been taken from the transcript of evidence heard at the Inquest into the deaths of Mr. X and Ms. Halimah Ahmed.

On the afternoon of the 26 November 2007 19 year old Ms. Ahmed rang her mother at 3.30 pm to inform her that she was going to visit friends from university. At this point it is assumed that Ms. Ahmed left the family home where she lived, in her car, to pursue the visit she planned to make.

A little later that same afternoon Ms. Ahmed's mother tried to call her on her mobile telephone and was diverted through to voicemail. When Ms. Ahmed missed the family meal that evening her parents grew increasingly concerned and at around 9.30pm Ms. Ahmed's father telephoned the police, but declined to report her missing at this stage as he hoped that she would return home. At around 11.30 pm, when she had still failed to return home, Ms. Ahmed's father telephoned the police again, this time to formally report her missing.

On the 26 November 2007 thirty-three year old Mr. X went to see his GP, on this occasion he was described by both his GP and his friends as being calm and relaxed. Following this appointment Mr. X went to a solicitor's firm in order to make a will. He was informed that his will would be finalised the following day.

At 4.30pm Mr. X met up with his brother outside of the shop that he (his brother) owned. Mr. X's brother stated to the Coroner that on this occasion Mr. X appeared to be 'normal' in his presentation, although he was a little tired and decided that he was going to go home.

Later on that afternoon at around 5.00 pm Mr. X telephoned a friend saying that he had a 'problem'. Mr. X went to this friend's house and was described by him as looking uncomfortable: his eyes were red and he was shaking. The friend was concerned because Mr. X was drinking and appeared to be swallowing tablets. Mr. X ran away out of the house and his friend telephoned the police because he was worried about Mr. X's wellbeing. Mr. X was not seen alive again.

The following day Mr. X's brother was unable to contact him via his mobile telephone as it appeared to be switched off. Mr. X's brother went to Mr. X's home. The front door was not locked and he entered the house. Mr. X was found dead hanging by the neck and a young woman was also found dead on the floor directly next to the body of Mr. X. Later that same day the young woman was identified as being Ms. Halimah Ahmed.

Dr. Robert Hunter Her Majesty's Coroner for Derby and South Derbyshire found that Mr. X 'had taken his own life by ingesting a quantity of Paracetamol and Aspirin and had hung himself...and died as a result of the hanging' and that Ms. Halimah Ahmed had been unlawfully killed by Mr. X.

At the time of Mr. X's death he had been in receipt of community-based mental health services from the Derbyshire Mental Health Service NHS Trust. He had received his care and treatment from this organisation for a period of some fifteen weeks. His diagnosis had been determined as depression with symptoms of Post Traumatic Stress Disorder. Mr. X was 33 years old at the time of his death and was member of the Kurdish Iraqi community in Derby.

4.2. Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS East Midlands (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27.

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.

4.3. Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS East Midlands. The Derbyshire Mental Health Services NHS Trust, NHS Derby City Primary Care Trust and the family of Ms. Halimah Ahmed were consulted with regard to the content of the Terms of

Reference and their requested amendments were duly made. NHS Derby City Primary Care Trust did not wish to make any amendments.

Terms of Reference for the Independent Investigation into the Care and Treatment of X under HSG (94) 27

Undertake a systematic review of the care and treatment provided to Mr. X by Derbyshire Mental Health Services NHS Trust, in conjunction with other provider bodies, to identify whether there were any aspects of care and management that could have altered or prevented the events of 26/27 November 2007.

The Investigation Team is asked to pay particular attention to the following:

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

- to identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to Mr. X;

- to identify whether the risk assessments of Mr. X were timely, appropriate, contained the necessary plans to manage the risk identified and were actioned and communicated appropriately;

- to examine the adequacy of the assessment, care plans, intervention, monitoring and review, to ensure that these addressed the needs of Mr. X. This will include standards of documentation and access to comprehensive records;

- to examine The Mental Health Act (83) assessment process including the role and provision of Approved Social Workers and their interface with other teams;

- to consider any issues arising regarding cultural and diversity sensitivities, and consider whether they were appropriately handled. This to include language and communication issues;

- to consider the competency and experience of the clinical team that delivered care and treatment to Mr. X;

- to determine the quality and content of all written clinical documentation concerning Mr. X.

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

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

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

Approach

This investigation will be classified as a Type A Investigation. This will mean that a full and Independent Investigation will be conducted regarding all aspects of Mr. X's care and treatment. The Investigation will be conducted in private and will culminate in a report fit for publication by the East Midlands Strategic Health Authority.

The Investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations.
As is usual practice, should the reviewers identify a serious cause for concern during the course of the investigation likely to compromise public safety, this should be notified to the SHA and the Trust immediately.

It is expected the final report will include recommendations to inform the appropriate commissioning of the service by Derbyshire County PCT Commissioning PCT as the lead commissioner of mental health services.

4.4. The Investigation Team

Investigation Team Leader and Chair

Dr. Androulla Johnstone Chief Executive, Health and Social Care

	Advisory Service, Nurse Panel Member

Investigation Team Members

Professor John Hall	Director of Research at the Health and Social Care Advisory Service and Professor of Psychology at Oxford Brookes University. Psychologist Member of the Team
Dr. Rizkar Amin	Consultant Psychiatrist Member of the Team
Mr. Alan Watson	Social Work Member of the Team
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Panel

Mrs. Janet Sayers	Solicitor, Kennedys
Dr. Tim Saunders	GP Advisor to the Investigation

4.5. Findings and Conclusions

Key Causal Factors

The Independent Investigation Team found no direct causal factors which connected the care and treatment Mr. X received and the events of the 26/27 November 2007.

Contributory Factors

The following factors were identified as contributing to the fact that at best Mr. X's condition remained partially treated. The Independent Investigation Team found ten factors that contributed to the less than effective care and treatment package that Mr. X received.

Contributory Factor Number One. Mr. X did not receive a diagnosis based on formally recognised assessment criteria directly following his referral to mental health specialist services.

Contributory Factor Number Two. Mr. X did not receive a coherent care and treatment plan.

Contributory factor Number Three. Mr. X did not receive an appropriate care and treatment package for his presumed diagnosis of Post Traumatic Stress Disorder (PTSD). As a result Mr. X may have been placed at significant risk of deterioration and harm.

Contributory Factor Number Four. Mr. X was not risk assessed in a comprehensive and timely manner. The eventual risk assessment was not communicated effectively and did not result in the development of a robust care and treatment plan which was formulated as part of a multidisciplinary team action.

Contributory Factor Number Five. Mr. X did not receive a comprehensive and holistic Care Programme Approach (CPA). The notion of Mr. X's presumed diagnosis of PTSD was formulated to the detriment of all other diagnoses and approaches. As a result Mr. X did not receive the care, support and treatment that he needed.

Contributory Factor Number Six. The services that were offered to Mr. X did not take his cultural needs and requirements into account. This contributed to the provision of an approach which was not sensitive to his needs and which may have led to his difficulties in engaging with the services that were offered to him.

Contributory Factor Number Seven. Clinical practice within the Trust did not adhere to internal policies and procedures.

Contributory Factor Number Eight. Failure to adhere to Trust local policy and national guidance compromised the quality of care that Mr. X received.

Contributory Factor Number Nine. Inappropriate clinical supervision contributed to the incomplete CPA that Mr. X received.

Contributory Factor Number Ten. Mr. X's case was not subject to coherent clinical case management; as a result his condition was at best partially treated. This contributed to Mr. X's continued distress and inability to manage his affairs.

Service Issues

The Independent Investigation Team found three Service Issues.

Service Issue Number One. The Trust was unable to provide an Approved Social Worker (ASW) to undertake a Mental Health Act (83) assessment in a timely manner.

Service Issue Number Two. Some of Mr. X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry could leave both healthcare professionals and the Trust vulnerable.

Service Issue Number Three. The CPN drove Mr. X around in her car prior to having conducted a full risk assessment and without the required insurance for her car.

Conclusions

Although Mr. X had a previous conviction for assault he was not considered to have been dangerous by the criminal justice system, he had been in receipt of a punishment order only and not a supervision order which would normally have been the case had he been considered a risk to the safety of others. Throughout his time with secondary care mental health services Mr. X was not considered to be a risk to others as a result of his psychiatric diagnosis. It was noted that he was often angry and that he had concerns about being able to control his temper however it was never established that this was a direct result of any treatable psychiatric condition. The Consultant Psychiatrist recorded that Mr. X was not psychotic and was not suffering from any delusional thought processes. It is not possible for this Independent Investigation to find any definitive causal link between the death of Ms. Halimah Ahmed and Mr. X's psychiatric condition, whether this had been appropriately treated or not. The nature of the relationship between Mr. X and Ms. Halimah Ahmed has never been established and it is therefore not possible to know what may have taken place between them. The Coroner ruled that in his view Mr. X's mental state did not contribute to the death of Ms. Halimah Ahmed and therefore declined to provide a verdict of manslaughter and ruled that she was unlawfully killed by him. It is a fact that people kill other people. In this case the Independent Investigation Team was not able to understand exactly what led to Ms. Halimah Ahmed's death. It is possible that Mr. X's mental state contributed to him losing control of his temper, it is also possible that Mr. X's actions had absolutely nothing to do with his mental state. This cannot be known or proved and therefore no causal link can be made.

Mr. X was considered to be at high risk of harming himself by secondary care mental health services. Mr. X's social situation grew steadily worse throughout the summer and autumn of 2007. It is certain that Mr. X presented as being depressed and possibly had PTSD. It cannot be known what the final trigger was for Mr. X to end his own life, it is not possible to say whether or not Mr. X would have killed himself had Ms. Halimah Ahmed not also met her death, but it is likely that this was the final factor. It cannot be known to what extent Mr. X's mental illness contributed to the tragic events of the 26/27 November 2007. Neither can it be known now to what extent Mr. X's social stressors contributed to them. However it is certain that Mr. X was an individual whose life was falling apart in such a way that he was ill equipped to deal with it. It has to remain conjecture as to whether or not mental health services could have altered the outcome of the events of the 26/27 November 2007 as there are many facts that remain unknown about the lives of Mr. X and Ms. Halimah Ahmed. However it can be said that Mr. X's condition was partially treated at best and that he did not always receive care and treatment from Derbyshire Mental Health Services Trust in accordance with either local policy or national guidance.

4.6. Recommendations

The Trust has made significant improvements and developed significant innovations following the events of the 26/27 November 2007. The following recommendations take this into consideration, a full rationale can be found in section 19 of this report.

Recommendation Number One. All Trust clinicians should use the formal ICD-10 criteria for making a diagnosis. All decisions and rationales for diagnostic decisions should be clearly recorded in full in the patient clinical record.

Recommendation Number Two. All care and treatment plans should follow NICE Guidance where applicable. If this is not possible or clinically indicated then a clear rationale should be provided within the patient clinical record.

Recommendation Number Three. Post Traumatic Stress Disorder assessment and treatment, and trauma focused therapy requirements should be ascertained by the Derbyshire City Primary Care Trust and appropriate commissioning arrangements should be put into place to ensure that specialist services are available to compliment the services currently provided by the Mental Health Trust.

Recommendation Number Four. The Trust should take all recent audit findings together with the results of the FACE Risk Profile review to reinforce its risk training programme and to revise their risk management policies and procedures as necessary.

Recommendation Number Five. The Trust should liaise with local community-based BME groups and networks in order to understand better the cultural sensitivities of the population that it serves. Using an outreach model the Trust should develop:

- culturally appropriate allocation criteria;
- systems to facilitate the transfer of service users to staff who can provide the most culturally acceptable 'fit' for them;
- appropriate anti-stigmatisation outreach programmes to key Black and Minority Ethnic (BME) stakeholders within the Derby City community.

Recommendation Number Six. The Trust should commission Phase Two of the Clinical Supervision audit as planned and the findings should be incorporated into any further required revisions of the policy.

Recommendation Number Seven. The Trust should audit the new clinical supervision policy within six months of the publication of this report to establish the effectiveness of new processes regarding caseload management. The necessary revisions to the policy should then be made in the light of the findings.

N.B. Since the time of the incident the Trust has conducted a full clinical supervision review. As a result a revised policy was developed which was ratified by the Trust Clinical Governance Committee on the 13 August 2009. To underpin this policy a full audit has been commissioned in order to analyse the quality and effectiveness of the Trust process (Phase One). The Trust also intends to analyse clinical supervision activity against clinical outcomes (Phase Two).

Recommendation Number Eight. That the Trust issues a clear policy statement with regard to the transportation of service users in health and social care worker's cars. This policy statement needs to cover:

- risk assessment;
- insurance;
- lone worker safety.

Recommendation Number Nine. The Trust Being Open Policy should be revised to incorporate a specific section which offers direct guidance to staff regarding the communication and support that should be offered to both victim and perpetrator families following a homicide committed by a mental health service user known to the service.

Since the time of the incident the Trust can demonstrate notable/best practice in the following areas:

- Care programme Approach;
- adherence to Trust policy and procedure;
- Case Management and Care Pathways.

The Independent Investigation Team does not consider recommendations to be necessary in these areas.

The Trust has responded to the requirements of Her Majesty's Coroner Rule 43 letter and has put into place rota systems that ensure Approved Mental Health Professionals (AMHPs) are available both within and outside of office hours. As a result no further recommendation is required.

The Trust minimum standards for record keeping were reviewed in January 2008. As a result all clinical areas have laminated standards clearly visible to all health and social care staff. A mandatory training day has been also been developed. The audit of the Trust Minimum Standards for Record Keeping is a component of the combined CPA/Records/risk audit programme. It is the view of the Independent Investigation Team that the Trust has both initiated and implemented sound performance management processes with regard to clinical records and that no recommendation is required.

5. Incident Description and Consequences

The following account has been taken from the transcript of evidence heard at the inquest into the deaths of Mr. X and Ms. Halimah Ahmed.

On the afternoon of the 26 November 2007 19 year old Ms. Ahmed rang her mother at 3.30 pm to inform her that she was going to visit friends from university. At this point it is assumed that Ms. Ahmed left the family home where she lived, in her car, to pursue the visit she planned to make[4].

A little later that same afternoon Ms. Ahmed's mother tried to call her on her mobile telephone and was diverted through to voicemail. When Ms. Ahmed missed the family meal that evening her parents grew increasingly concerned and at around 9.30pm Ms. Ahmed's father telephoned the police, but declined to report her missing at this stage as he hoped that she would return home. At around 11.30 pm, when she had still failed to return home, Ms. Ahmed's father telephoned the police again, this time to formally report her missing[5].

On the 26 November 2007 thirty-three year old Mr. X went to see his GP, on this occasion he was described by both his GP and his friends as being calm and relaxed. Following this appointment Mr. X went to a Solicitor's Firm in order to make a will. He was informed that his will would be finalised the following day[6].

At 4.30pm Mr. X met up with his brother outside of the shop that he (his brother) owned. Mr. X's brother stated to the Coroner that on this occasion Mr. X appeared to be 'normal' in his presentation, although he was a little tired and decided that he was going to go home[7].

Later on that afternoon at around 5.00 pm Mr. X telephoned a friend saying that he had a 'problem'. Mr. X went to this friend's house and was described by him as looking uncomfortable, his eyes were red and he was shaking. The friend was concerned because Mr. X was drinking and appeared to be swallowing tablets. Mr. X ran away out of the house and his friend telephoned the police because he was worried about Mr. X's wellbeing. Mr. X was not seen alive again[8].

The following day Mr. X's brother was unable to contact him via his mobile telephone as it appeared to be switched off. Mr. X's brother went to Mr. X's house. The front door was not

locked and he entered the house. Mr. X was found dead hanging by the neck and a young woman was also found dead on the floor directly next to the body of Mr. X[9]. Later that same day the young woman was identified as being Ms. Halimah Ahmed.

Dr. Robert Hunter Her Majesty's Coroner for Derby and South Derbyshire found that Mr. X 'had taken his own life by ingesting a quantity of Paracetamol and Aspirin and had hung himself...and died as a result of the hanging' and that Ms. Halimah Ahmed was unlawfully killed by Mr. X[10].

At the time of Mr. X's death he had been in receipt of community-based mental health services from the Derbyshire Mental Health Service NHS Trust. He had received his care and treatment from this organisation for a period of some fifteen weeks. His diagnosis had been determined as depression with symptoms of Post Traumatic Stress Disorder. Mr. X was 33 years old at the time of his death and was member of the Kurdish Iraqi community in Derby.

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

The Health and Social Care Advisory Service was commissioned by NHS East Midlands (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 minimize 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 would 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 fully investigated by an impartial and independent Investigation Team.

7. Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS East Midlands. The Derbyshire Mental Health Services NHS Trust, NHS Derby City Primary Care Trust and the family of Ms. Halimah Ahmed were consulted with regard to the content of the Terms of Reference and their requested additions were duly made. NHS Derby City Primary Care Trust did not wish to make any amendments.

Terms of Reference for the Independent Investigation into the Care and Treatment of X under HSG (94) 27

Undertake a systematic review of the care and treatment provided to Mr. X by Derbyshire Mental Health Services NHS Trust, in conjunction with other provider bodies, to identify whether there were any aspects of care and management that could have altered or prevented the events of 26/27 November 2007.

The Investigation Team is asked to pay particular attention to the following:

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

- to identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to Mr. X;

- to identify whether the risk assessments of Mr. X were timely, appropriate, contained the necessary plans to manage the risk identified and were actioned and communicated appropriately;

- to examine the adequacy of the assessment, care plans, intervention, monitoring and review to ensure that these addressed the needs of Mr. X. This will include standards of documentation and access to comprehensive records;

- to examine The Mental Health Act (83) assessment process including the role and provision of Approved Social Workers and their interface with other teams;

- to consider any issues arising regarding cultural and diversity sensitivities, and consider whether they were appropriately handled. This to include language and communication issues;

- to consider the competency and experience of the clinical team that delivered care and treatment to Mr. X;

- to determine the quality and content of all written clinical documentation concerning Mr. X.

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

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

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

Approach

This investigation will be classified as a Type A Investigation. This will mean that a full and Independent Investigation will be conducted regarding all aspects of Mr. X's care and treatment. The Investigation will be conducted in private and will culminate in a report fit for publication by the East Midlands Strategic Health Authority.

The Investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations.
As is usual practice, should the reviewers identify a serious cause for concern during the course of the investigation likely to compromise public safety, this should be notified to the SHA and the Trust immediately.

It is expected the final report will include recommendations to inform the appropriate commissioning of the service by Derbyshire County PCT as the lead commissioner of mental health services.

8. The Independent Investigation Team

This Investigation was undertaken by the following panel of healthcare professionals who are independent of the healthcare services provided by the Derbyshire Mental Health Services NHS Trust.

Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Also acting as the Nurse Member of the Team

Investigation Team Members

Professor John Hall	Director of Research at the Health and Social Care Advisory Service and Professor of Psychology at Oxford Brookes University. Psychologist Member of the Team
Dr. Rizkar Amin	Consultant Psychiatrist Member of the Team and cultural advisor
Mr. Alan Watson	Independent Consultant. Social Work Member of the Team
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Panel

Ms. Janet Sayers	Solicitor, Kennedys
Dr. Timothy Saunders	GP advice to the Team

9. Investigation Methodology

On the 27 October 2008 NHS East Midlands commissioned the Health and Social Care Advisory Service to conduct this Independent Investigation. Initially it was thought that this case would be treated as a Type C Investigation under HSG (94) 27. A Type C Investigation is one where a single investigator works with peer review support to examine the circumstances around the care and treatment that a service user receives.

On the 19 January after careful further consideration of the case it was decided by NHS East Midlands to upgrade the case to a Type A Investigation under HSG (94) 27. A Type A Investigation is a wide ranging investigation that requires the input from a full multidisciplinary team. The Terms of Reference for this Investigation were finalised on the 30 January 2009 and are set out above in section seven of this report. The Investigation Methodology is set out below.

Consent

Due to Mr. X's death his full clinical records were released directly to the Independent Investigation Team during January and February 2009 after discussion with NHS East Midlands, the Mental Health Trust, and the Primary Care Trust Caldicott Guardian. Derbyshire Mental Health Services NHS Trust also made the Trust Internal Investigation Report, archive and relevant Trust policies and procedures available to the Independent Investigation Team.

Communication with the Family of Ms. Halimah Ahmed

On the 26 January 2009 The Independent Investigation Chair met with the parents of Ms. Halimah Ahmed for the first time. The purpose of this meeting was to explain the Independent Investigation function and process. During this meeting the parents of Ms. Ahmed were invited to review the Investigation Terms of Reference in order to ensure that any of the family's outstanding questions could be addressed. At this meeting the parents of Ms. Ahmed were invited to formally meet the Independent Investigation Team and give evidence as part of the inquiry process.

On the 9 March 2009 the parents of Ms. Halimah Ahmed attended a formal meeting with the Independent Investigation Team.

On the 29 June 2009 the Independent Investigation Chair and representatives from NHS East Midlands met with Ms. Ahmed's father to give him a verbal briefing concerning the findings of the Investigation. At this meeting further clarification was given with regard to the final steps and stages of the process such as the publication of the Investigation Report.

Communication with the Family of Mr. X

On the 26 February 2009 a letter was sent to the brother of Mr. X who is resident in the United Kingdom. This letter was written in the appropriate Kurdish dialect as the Independent Investigation Team understood that Mr. X's brother did not speak, read or write English well.

On the 5 March 2009 the brother of Mr. X telephoned the Health and Social Care Advisory Service Office to state that he did not wish to be involved in the Independent Investigation.

Initial Communication with the Derbyshire Mental Health Services NHS Trust

On the 26 January 2009 a briefing meeting was held at the Derbyshire Mental Health Services NHS Trust Headquarters between the Independent Investigation Chair, the Trust CEO, the Trust Director of Nursing and the Trust Director of Corporate and Legal Affairs. The purpose of this meeting was to clarify the Independent Investigation process and to ensure that all witnesses to the Investigation were prepared fully in advance of their interviews.

It is the practice of the Health and Social Care Advisory Service to offer all Trusts subject to Independent Investigation a clinical witness workshop to provide clarity around the process. In this instance it was felt by the Trust that this would not be necessary owing to the small number of witnesses that would need to be called. HASCAS provided briefing packs to all witnesses and all witnesses were invited to speak with the Independent Investigation Chair if they had any questions or concerns. On the 9 March 2009 Trust witness interviews were held.

On the 4 June 2009 the Independent Investigation Chair and the Social Work Member of the Team met with the Derbyshire Mental Health Service NHS Trust CEO, Director of Nursing, Medical Director and Director of Corporate and Legal Affairs. The purpose of this meeting was to discuss the findings of the Independent Investigation Team. In the spirit of root cause analysis and in the interest of public safety the Trust was invited at this stage to work with

the Independent Investigation Team to develop recommendations and to commence the process of implementing remedial actions prior to the publication of the final report.

Witnesses Called by the Independent Investigation Team

Table One

Witnesses Interviewed by the Investigation Team

Date	Witnesses	Interviewers
9 March 2009	• Trust CEO • Trust Director of Nursing and Governance • GP 1 • Area Service Manager (Internal Investigation Panel) • Senior Nurse Advisor (Internal Investigation Panel) • Unit General Manager • Consultant Psychiatrist • Approved Social Worker 2 • The parents of Ms. Halimah Ahmed	Full Independent Investigation Team
18 March 2009	Mr. X's Probation Officer	Independent Investigation Team Chair and Social Work Team Member
6 May 2009	CMHT Manager	Independent Investigation Team Chair and Social Work Team Member

All witnesses to the Independent Investigation Team were provided with briefing packs. These packs contained the Investigation Terms of Reference, advice to witnesses, and a letter which detailed the Investigation process and what would be required of them. All witnesses were given a full list of the questions that would be asked of them in advance and were invited to attend their interviews in the presence of either their Union Representative or a work colleague for support. It was not possible to interview Mr. X's CPN/Care Coordinator as this individual had moved to New Zealand. The Independent Investigation Team sent letters to this individual's last known address but no received no reply. The NMC could not assist the Investigation in locating this individual.

Salmon compliant procedures were followed at all times. These are set out below at the end of this section.

Independent Investigation Team Meetings:

The full Independent Investigation Team met on a total of three occasions. Additional work was completed by the Team in a 'virtual' manner. This work included a full documentary analysis of the primary archive (clinical records and Trust data) and review of relevant secondary literature.

19 February 2009. First Team Meeting**:** this day consisted of a full briefing regarding the case and the Investigation process and reviewed the draft timeline.

9 March 2009. Clinical and managerial witness interviews were held

19 March 2009. Second Team Meeting: this day consisted of collating evidence and discussing findings. Root Cause Analysis took place on this day whereupon the data was considered in a systematic fashion as explained in the section directly below.

18 March 2009 the Independent Investigation Team Chair and the Social Work Member of the Team held briefing meetings with NHS Derby City Primary Care Trust and Derby City Council

Root Cause Analysis (RCA)

The ethos of RCA is to provide a robust model that focuses on 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 learned 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.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this causal factors or critical issues can be identified.

3. **Root Cause Identification.** The National Patient Safety Agency (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 avoids generalisations and seeks to use 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.

Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. This is 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 colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish 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

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory

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.

Anonymity

All clinical witness identities have been anonymised. There was only one Psychiatrist and one Community Psychiatric Nurse (CPN) (who was the nominated Care Coordinator) involved in the care and treatment of Mr. X. Throughout this report they are referred to as 'the Consultant' or the 'CPN, Care Coordinator, CPN/Care Coordinator' respectively. The title 'Mr. X' has been given to the individual whose care and treatment is the subject of this Investigation. All other individuals have been identified by their designation and an

identifying number as appropriate. For example social workers are referred to as SW1 and SW2, and the GP's are referred to as GP1 and GP2.

10. Information and Evidence Gathered (Documents)

During the course of this investigation some 4,000 pages of documentary evidence were gathered and considered. The following documents were actively used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. X's Derbyshire Mental Health Services NHS Trust records
2. Mr. X's GP records
3. The Trust Internal Investigation Report
4. The Trust Internal Investigation Archive
5. The Transcript of Evidence Heard at the Inquest into the Deaths of Mr. X and Ms. Halimah Ahmed
6. Mr. X's probation records
7. The Independent Investigation witness transcriptions
8. Trust policies and procedures in operation both in 2007, and where different, the present day:
   - Care Programme Approach Clinical Policy
   - Care Programme Approach – Managing Informal Service User's Non-Compliance
   - Being Open Policy 2008
   - Investigating, aggregating and Learning from Incidents, Complaints and Claims Policy
   - Minimum Standards for Clinical and Practice Records
   - Clinical Risk Management Standards
   - Policy on the Assessment and management of Clinical Risk
   - Protocol for the Assessment and Management of Risk in Mental Health and Learning Disability Practice: Us of the FACE risk Profile
   - Supervision Policy
   - CMHT Operational Policy
   - A guide to Witnesses Called to Give Evidence at Coroner's Court
9. Trust Board minutes and documentation
10. Trust Internal Investigation action plan and evidence set against the action plan
11. Healthcare Commission Reports
12. Memorandum of Understanding between the association of Chief Police Officers (ACPO) and the NHS Security Management Service

13. 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

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

11. Profile of the Trust Mental Health Services (Past, Present and Transition)

Introduction

The Derbyshire Mental Health Services NHS Trust was formed in 2002. The Trust boundaries are co-terminus with those of the Local Authority and the two Derbyshire-based Primary Care Trusts. The catchment area is primarily the county of Derbyshire.

The Trust serves a population of approximately 1 million within a geographical boundary that encompasses 1,000 square miles. The Trust employs 2,500 staff and operates within an annual budget of 95 million pounds each year.

The Trust is one of several providers of mental health services used by the people of Derbyshire. The trust focuses on services for those with severe and enduring mental health diagnoses. These supplement lower tier services such as those found in primary care and are themselves supplemented by more specialist services, such a forensic medium and low secure units.

The Trust's main commissioners are the Derbyshire County Primary Care Trusts (PCTs) and NHS Derby City. The Trust also holds contracts from other PCTs which reflects the specialist nature of some of its services, such as child and adolescent mental health services. The Trust provides the following:

- services for adults of working age (inpatient and community);
- forensic services (low secure and prison in-reach);
- services for older people (community only);
- memory services.

In addition the Trust provides the following services for Southern Derbyshire:

- inpatient service for older people;
- child and adolescent community services.

The Trust services are delivered through three business units which allow different approaches to be deployed according to the needs of the population and thus providing best value for commissioners.

Mr. X received his care and treatment from the Derby City Community Services. This service is comprised of three Community Mental Health Teams, an Assertive Outreach Team, an

early Intervention Team, a Social Inclusion Rehabilitation and Recovery Team (SIRRT), a Crisis Assessment and Home Treatment Team, and a Collaborative Care Team.

Target Population of the Derby City Community Mental Health Team 2007

In line with the *Mental Health Policy Implementation Guide: Community Mental Health Teams* (MHPIG) - DH, 2002, Community Mental Health Teams (CMHT's) within the County Confederation would normally have seen adults of working age. The Community Mental Health Team would endeavour to provide appropriate and fair access to services for all members of diverse communities and individuals with specific needs.

Locally, patients were transferred to the Older Adults Services at the age of 65 if there was evidence of an organic illness, but remained with the CMHT if the disorder was functional.

Certain referrals would be time limited and acute in nature, and would be referred back to Primary Care after a period of treatment. Others, however, would need ongoing Continuing Care, and may have remained within the CMHT for a longer period of time.

The *MHPIG* suggested that this latter group may include those who suffer with:

- Severe and persistent mental disorders, such as psychosis and schizophrenia.
- Longer-term disorders of lesser severity, but which are characterised by poor treatment adherence, requiring longer term follow up.
- Disorders where there is a risk of harm to self or others.
- Disorders requiring skilled or intensive treatments.
- Complex problems of management or engagement.
- Severe disorders of personality.

Who could refer?

- Primary Care – It was anticipated that this would be the predominant source of referrals for Community Mental Health services into Community Mental Health Teams via the clinical assessment service

- Forensic services
- Crisis and Home Treatment Teams / Mental Health Liaison Teams
- Social Services Departments
- Housing Department (within the agreed housing protocol)

- Homeless Hostels (where the person had no access to GP services, or was refusing to access GP services)
- Local Authorities, Health Authorities, Healthcare Trusts
- Social landlords where there were concerns about a person's mental state and they either had no access to a GP or they were refusing to access GP services
- Children's Services (particularly regarding requests for specialist assessments within the Core Assessment Framework of Children in Need and their families)
- Nearest relatives
- Carers
- Non-statutory mental health organisations
- Previously known service users (where it had been agreed at discharge planning that a crisis care plan should be developed which included self referral).

How were referrals made?

- Referrals were made via a Clinical Assessment Service (Multidisciplinary Team).
- Urgent referrals from GPs could be made via fax or telephone
- Routine referrals from GPs could be made via Choose and Book
- Referrals from any other source could be made via letter, fax or telephone.
- Where a referral was made from a non-statutory source, the referrer needed to be made aware that the GP would be informed of the referral and additional information re risk, history, medication etc would be sought from the relevant GP practice.
- Telephone referrals might have been made when there was a degree of urgency to the intervention required. This might have been when an Approved Social Worker was needed for a Mental Health Act Assessment, or Crisis Team input was indicated.
- Referrals for a routine service would be made following the Choose and Book pathway.
- There might have been limited occasions when an individual could refer in person to the duty worker.

The access criteria for referrals into the Community Mental Health Services were prioritised against the following categories and an assessment could only be completed when all necessary information was provided.

- Diagnosis – A confirmed diagnosis of mental ill health, however the absence of a formal diagnosis will not exclude access to the service.

- Duration / Onset – This will be measured from the onset of disability, not from the date of diagnosis.

- Disability – The assessed and expressed difficulties experienced in the activities of daily living, and the significance on the ability to function effectively in the community.

- Risk of harm – To self or others, intentionally or unintentionally, through neglect, or lack of awareness.

- Carers need – the assessed and expressed impact of providing a caring function to a person with mental health needs.

- Interventions tried – Failure to or difficulty in resolving a mental health problem through the resources available within Primary Care, which would indicate that a referral to Community Mental Health services would be appropriate.

How were referrals allocated?

Following prioritisation screening by the duty / triage workers in the Team, the referral would be transferred to the manager of the appropriate service for allocation.

- The Service Manager would take responsibility for the individual to be allocated for an assessment.

- Prior to the referral being allocated medical cover would be confirmed / agreed. This need not be the Consultant Psychiatrist but may be the GP in many cases.

Configuration and Function of Teams

Configuration of the Community Mental Health Services in the City Partnership

Community Mental Health Services were provided in the City Partnership by three Teams. These three teams covered the geographical area of Derby City Central and Greater PCT's.

Each of these areas comprised Community Mental Health Teams with the following multi-professional components:

- Community Psychiatric Nurses
- Mental Health Social Workers
- Occupational Therapists

- Consultant Psychiatrists and Junior Medical Staff
- Community Support Workers
- Psychologists
- Administrative support

The Community Mental Health Services were supported by other linked professionals on a sessional basis as specified in Service Level Agreements

Key function provided by the Service

The teams provided the following key functions:

- Access to Specialist Mental Health Services with appropriate screening and rapid signposting of individuals to the most appropriate resource or part of the Service to meet their needs.

- Comprehensive evidence based assessment (including a comprehensive risk assessment and risk management plan), care plan formulation, intervention delivery and review for individuals with severe mental illness and who were registered as having enhanced level needs under the CPA system. (The Care Co-ordination function).

- Comprehensive evidence based assessment, treatment and review for individuals whose needs could be met by time limited specialist interventions.

- Access to Day Services, Respite Care, Supported Accommodation, and other specialist services, including inpatient care (via the Crisis and Home Treatment Team).

- Access to leisure, education, training, and employment opportunities, and a range of self-help and non-statutory resources.

- Support / information and education to Primary Care to provide appropriate assessment, treatment and maintenance of individuals with mild to moderate mental health problems

- Consultative function.

Interventions offered by the Service

- Comprehensive assessment
- Risk assessment and monitoring
- Care planning
- Carer assessment
- Psychosocial interventions approach (Recovery Model of Care)
- Therapy around specific disorders including eating disorders
- A range of formal and integrative psychotherapies including cognitive behavioural Therapy
- Intensive support at home
- Assertive engagement
- Care Co-ordination
- Statutory Mental Health Act work
- Support and representation at MHRT's and Managers Panels
- Administration of medication
- Social Care and practical support
- Mental state monitoring
- Relapse prevention
- Advice and guidance
- Monitoring and review of both simple and complex packages of care
- Assessment in relation to nursing and residential care
- Care management

Prioritisation of Referrals

Referrals were prioritised within a four-tier system. It was anticipated that the majority of Community Mental Health Team work would be conducted in tiers three and four. In some circumstances the CMHT may work with individuals falling in tier two.

The policy guidance document regarding Fair Access to Care Services from the Department of Health suggests that local authorities should use a systemic framework in determining their eligibility criteria for services.

The framework is based upon the seriousness of risk to independence if problems and issues are not addressed, and focuses on the key factors important to maintaining an individual's independence over time. The key factors are as follows;

- autonomy
- health and safety
- management of daily routines
- involvement in family and wider community life

The eligibility framework consisted of four service tiers: critical, substantial, moderate, and low. In defining the eligibility criteria for Community Mental Health Service, the Department of Health Fair Access to Care Services had been taken into consideration. The service tiers reflected the four recommended tiers within the policy guidance.

Tier 4 – Critical

Fair Access to Care Services says "*when life is, or could be, threatened; major health problems have developed or are likely to develop; there is, or could be, an extensive loss of choice and control over the immediate environment; serious forms of abuse or neglect have occurred or are likely to occur; there is, or could be, an inability to carry out many personal care, domestic family, or other daily routines; involvement in work, education, or learning is, or could be at risk of not being sustained; many social support systems and relationships are, or could be, at great risk; or individuals cannot undertake, or will be unlikely to undertake, most of the family and social roles and responsibilities that are important to them and others"*.

People who would be prioritised within this service tier must have a diagnosed mental health problem which impacts significantly upon functioning on social, cognitive, occupational, interpersonal, or financial levels, and would include:

- Those requiring an interagency approach to care delivery;
- Those requiring possible admission under the Mental Health Act 1983 or informally for inpatient care;
- Those who require ongoing intervention within the Care Programme Approach system on enhanced levels with a designated Care Coordinator;
- Those who are identified as vulnerable adults who require protection from abuse;

Tier 3 – Substantial

Fair Access to Care Services says "*when significant health problems have developed or are likely to develop; there is, or could be, some significant loss of choice and control over the immediate environment; there is, or could be, an inability to carry out some personal care,*

domestic or other daily routines; involvement in some significant aspects of work, education, or learning is, or could be, at risk of not being sustained; some significant social support systems and relationships are, or could be, at risk; or, individuals cannot undertake, or will be unlikely to undertake, some significant family and social roles and responsibilities".

People who will be prioritised within this service tier must have complex mental health problems which are, most likely, longstanding, and recurrent, and are significantly impacting upon the quality of an individual's life and social functioning and would include:

- Those who require long term or episodic interventions;
- Those requiring ongoing interventions within the Care Programme Approach system, on enhanced levels and with a designated Care Coordinator;
- Those who are identified as, or are suspected of being vulnerable adults with a verified or suspected mental health need who require protection from abuse.

Tier 2 – Moderate

Fair Access to Care Services says "*when, there is, or could be, some inability to carry out several daily routines; several aspects of work, education or learning are, or could be, at risk of not being sustained; several social support systems and relationships are, or could be, at risk; or individuals cannot undertake, or will be unlikely to be able to undertake, several family and social roles and responsibilities*".

People who will be prioritised within this service tier should have a mental health problem which requires more specific evidence based interventions; and, unless received may deteriorate further, and develop more enhanced and complex needs; they would include:

- Those requiring specialist therapies;
- Those who require a single service approach
- Those who are identified as being on Standard levels within the Care Programme System;
- Those who are identified as not likely to improve without intervention
- Those who may receive a service within Primary Care, where appropriate services are in place to meet their needs (ie. GP counselling service);

Tier 1 – Low

Fair Access to Care Services says "*when, there is, or could be, some inability to carry out one or two daily routines; one or two social support systems and relationships are, or could*

be, at risk of not being sustained; or individuals cannot undertake, or will be unlikely to under take, one or two family and social roles and responsibilities".

People who will be prioritised within this service tier should have relatively common and transient mild mental health problems which are characterised by distress but have limited effects upon the ability to function; they would include:

- Those who are experiencing reactions to life events;
- Those who are experiencing simple grief reactions;
- Those with mild to moderate depression;
- Those who would benefit from direction to self help groups or voluntary sector involvement;
- Those who could receive support and / or counselling from appropriately trained members of the GP service;
- Those who require advice / information in accessing appropriate support for themselves.

The current Trust service delivery for the population of Derby City follows the same guidance as set out above for the functioning of the Community Mental Health Teams.

12. Chronology of the 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.

During the course of this Investigation it was not possible to speak to the friends and family of Mr. X and so it has not been possible to draw up a comprehensive chronology in the context of his life history. Mr. X was only known to Derbyshire Mental Health Services for a period of some fifteen weeks, during this time attempts were made to get to know Mr. X. However Mr. X was often reluctant to talk about himself and the subsequent information held within the clinical record is often incomplete and may not be entirely accurate. The following information has been taken from Mr. X's clinical records, probation service records and the transcript of the Coroner's Inquest.

Background Information

Mr. X was of Kurdish ethnicity born on the 24 August 1974 in Iraq. It is unclear how many siblings Mr. X had, but it would appear that at the time of his death both of his parents were still living and domiciled in Iraq, and that he had one brother living in the United Kingdom at an address close to Mr. X's home[11].

It would appear that Mr. X's life in Iraq was turbulent. When talking to his CPN/Care Coordinator at the Trust he described an event in 1983 when he had witnessed people being killed. The history that the CPN/Care Coordinator took gave a very brief account of Mr. X's childhood, however it would appear that bombings and violence were a day-to-day part of his life as a child and young person. In 1986 Mr. X stated that one of his brothers died at the family home as a result of shrapnel wounds and that he had witnessed this event[12].

Mr. X left Iraq to live in the United Kingdom, it is not clear exactly when this was, but it was likely to have been sometime in 1999 or early 2000. The clinical records suggest that his decision to leave Iraq was the direct result of an unsuccessful love affair. It is not possible to understand fully Mr. X's decision to leave his home and family behind from the clinical

records alone, and it must be borne in mind that many other factors may have influenced his decision to move to the United Kingdom[13].

30 March 2000. Mr. X made a formal application for asylum in the United Kingdom. He was served Form ISI51A, which was a notice to a person liable to removal as an illegal entrant and was given temporary admission to the United Kingdom pending a decision on his asylum claim[14].

5 June 2000. Mr. X registered with a Medical Centre so that he could receive primary care health services[15].

6 July 2000. Mr. X's application for asylum was refused, however he was granted exceptional leave to remain in the United Kingdom until 6 July 2004. Mr. X had the right to appeal. There is no trace in the Home Office Records that an appeal was lodged[16].

9 September 2003. Mr. X was convicted at Derby Crown Court of stabbing a person in the leg outside of a nightclub. Mr. X was given a Community Punishment Order of 150 hours. The person whom Mr. X stabbed was also Kurdish and known to him and both men had been involved in a previous altercation, when Mr. X had been assaulted. On the occasion Mr. X committed this offence there was evidence brought to bear that he had been provoked. Neither the Courts nor the Probation Services felt Mr. X to be dangerous and no Supervision order was sought. [17].

28 April 2004. The Home Office received an application from the Immigration Advisory Service for indefinite leave to remain in the United Kingdom on behalf of their client Mr. X[18].

22 August 2005. Mr. X was granted indefinite leave to remain in the United Kingdom. Mr. X's former conviction was noted and it was judged not to be sufficient to warrant the refusal of Mr. X's application. Full security checks were conducted into Mr. X's background, all of which proved to be negative[19].

22 August 2006. The Home Office received an application from Mr. X for naturalisation as a British Citizen[20].

16 November 2000 – 23 February 2007. Between the 16 November 2000 and the 23 February 2007 Mr. X attended his GP surgery a total of 39 times for the treatment of minor skin conditions and injuries[21].

12 April 2007. On this day Mr. X presented at his GP surgery with 'low mood and anxiety++'. It was estimated by the GP who saw Mr. X that he had probably been feeling this way for a period of some six months. It appeared that Mr. X's anxiety at this stage stemmed from an injury he had received at work. Mr. X felt that he could not return to work and he was coming under increasing pressure from his employer to do so. He was worried about paying his mortgage and meeting his financial commitments. He was prescribed Sertraline tablets 50mg once daily[22].

26 April 2007. Mr. X visited his GP surgery again. It was recorded that he had not noticed much benefit from the Sertraline and that he was still very anxious about returning back to work. The GP decided to increase the Sertraline tablets to 100mg once daily and that Mr. X would need to be seen again in two weeks time. The diagnosis at this stage was depression anxiety[23].

28 April 2007. Mr. X nearly hit a police vehicle whilst out driving his car. Mr. X appeared to smell of alcohol and he became verbally aggressive when asked to supply a sample of breath which he refused to do. He was arrested and charged with failing to supply a sample of breath[24].

10 May 2007. Mr. X was seen at the GP surgery once again. He discussed his low mood with the GP and explained that he felt isolated from his family[25].

24 May 2007. Mr. X was seen once again at the surgery. The GP who saw Mr. X on this occasion wrote 'depression + post traumatic stress'. The GP increased Mr. X's medication to Sertraline 100 mg twice daily. It was also noted that Mr. X was due to see his Occupational Therapy doctor at his place of work the following week[26].

28 June 2007. Mr. X was referred to the Derby City Community Mental Health Team by GP 1 at a Medical Centre. The referral letter stated that Mr. X was a 32 year old man with depression and post traumatic stress disorder. The letter outlined Mr. X's symptoms and sought some psychological intervention from secondary care services. It was noted that Mr. X's medication comprised Sertraline 200 mg and Diazepam 5 mg[27].

3 July 2007. On the 3 July 2007 Mr. X was sent a letter inviting him to make an appointment with the Derby City Community Mental Health Trust[28].

Between the 12 April and the 3 July 2007 Mr. X was also seen on nine other occasions for minor injuries and pain at his GP surgery.

10 July 2007. Mr. X was written to by mental health services confirming that an appointment had been made for him to see a Community Psychiatric Nurse (CPN) who had been allocated as his Care Coordinator at St. James House on the 16 August 2007[29].

16 August 2007. Mr. X was seen at St. James House by the CPN. Mr. X's history was taken and an initial assessment was commenced. It was noted that there was no evidence of paranoia or of persecutory beliefs. It was also noted that Mr. X was very angry and could not control his feelings when talking about his experiences in Iraq, Mr. X acknowledged that he was often angry and was worried that he might 'lose control and hurt his close friends'. Mr. X explained that he experienced flashbacks of traumatic events and that when this occurred he lost concentration and was vulnerable to accidental injury. Mr. X said that the antidepressant he was taking helped his mood, but that he found it difficult to sleep at times and was often tearful. This initial assessment was recorded on Trust Cognitive Behaviour Therapy Documentation, not on the Trust Care Programme Approach documentation[30].

29 August 2007. The CPN saw Mr. X at St. James House and continued the assessment process[31].

5 September 2007. Mr. X did not attend the appointment with the CPN that had been offered to him[32].

26 September 2007. Mr. X met with the CPN at St. James House in order to continue his assessment. It was recorded that Mr. X continued to struggle with his mood and that he had 'blackouts' and lapses in concentration. During this session he confessed that he often felt suicidal and that he had attempted to take his life on two previous occasions, Mr. X refused to elaborate. He did however go on to say that he definitely planned to kill himself and that the CPN would read about it in the newspapers. Mr. X was very reluctant to talk about things further but agreed to the CPN's plan to discuss his situation with the Crisis Team.

Later on the same day the CPN spoke to a member of the Crisis Team who agreed to meet with Mr. X. However Mr. X changed his mind and refused to be seen. The CPN discussed this with her line manager and the notion of a Mental Health Act (83) assessment was explored, however it was felt that this should not be pursued due to a lack of Approved Social Worker or Medical recommendation. The CPN once again contacted the Crisis Team

requesting their presence for a home visit to Mr. X that she was planning to make the following day. The Crisis Team number was given to Mr. X in case he went into crisis that night and he was agreeable to being seen[33].

27 September 2007. The CPN saw Mr. X at his home, on this occasion she was accompanied by a member of the Crisis Team. Mr. X no longer wanted to be seen by the Crisis Team citing the reason that he found it too distressing to talk about his problems. The CPN did however get Mr. X to agree to see the Consultant Psychiatrist to review his mental state and medication[34].

28 September 2007. The CPN arranged for the Sector Consultant Psychiatrist to see Mr. X on the 1 October 2007 for an Outpatient review. The CPN also arranged to visit Mr. X at his home on the 3 October 2007[35].

1 October 2007. The CPN collected Mr. X from his home in her car and accompanied him to see the Consultant, the Sector Consultant Psychiatrist. The Consultant learnt from Mr. X that he was very low in mood and had suicidal ideation. Mr. X told the Consultant that his concentration was poor and that he was worried about his financial situation. He also admitted to having angry outbursts resulting in 'black outs' with a loss of time. He alternated between not sleeping well and sleeping for excessively long periods of time. The Consultant did not think that Mr. X was psychotic and judged him to have significant depressive, anxiety and post traumatic stress disorder symptoms. Mr. X admitted to suicidal ideation, but he would not elaborate further. The Consultant assessed him as presenting a low to moderate risk of harm to himself and a low risk of harm to others. It was noted that Mr. X's compliance with medication had been variable and The Consultant decided to wean him off Sertraline and to commence him on Venlafaxine 37.5 mg twice daily. It was also decided to commence him on Diazepam 5 mg twice daily and Zopiclone 7.5 mg at night. The Consultant made another appointment to review Mr. X in two weeks time at the Outpatient Clinic[36].

3 October 2007. The CPN went to Mr. X's home for her scheduled visit however he was not in. The CPN tried to contact him on his mobile telephone but it was switched off and left a message on his answer machine requesting that he contact her. When the CPN returned to the Community Mental Health Team offices she discussed Mr. X with the Service Manager and a decision was made to request a 'safe and well' check from the local police service. The police agreed to carry out a check. Shortly afterwards Mr. X telephoned the CPN and apologised for not being in explaining that he had been in Court. The 'safe and well' check

with the police was cancelled and the CPN arranged to meet Mr. X at his home the following week[37].

9 October 2007. On this day Mr. X's Probation Officer telephoned the CPN to ascertain the formulation regarding Mr. X's mental state. The Probation Officer informed the CPN that Mr. X's driving license had been revoked that summer following an incident when he had a near miss with a police vehicle. On this occasion Mr. X had smelt of alcohol and became verbally aggressive towards the police officer when asked to provide a sample of breath. Mr. X refused to provide a sample of breath and was subsequently arrested and charged. Mr. X had suggested that if the Probation Services needed to know more about 'his circumstances' then they should contact the CPN. The Probation officer also told the CPN about Mr. X's previous conviction when he was involved in a stabbing outside of a nightclub in 2003. The Probation Officer and the CPN agreed to liaise one with the other as required[38].

10 October 2007. Mr. X's application for naturalisation as a British Citizen was refused on the grounds that he did not know enough about the British way of life[39].

11 October 2007. The CPN visited Mr. X at his home. He continued to present as being low in mood and flat in effect. Mr. X stated that he still planned to kill himself but that the medication was helping. The CPN was concerned that he was taking twice the prescribed dose of his medication at night and warned him about the effects of this when combined with alcohol which she was certain Mr. X was drinking. It was clear that Mr. X was worried about his financial situation and that he wanted to return to work. However because of his prescribed medication his employer would not allow him to. It was agreed that the CPN would ascertain whether or not he was eligible to claim benefits. The CPN recorded her intention to accompany Mr. X to his scheduled Outpatient appointment on the 15 October 2007[40].

15 October 2007. Mr. X was reviewed in the Outpatient Clinic by the Consultant. It was reported by Mr. X that he had successfully weaned himself off of the Sertraline and that the Diazepam made him feel slightly better. The CPN who accompanied Mr. X, disclosed that a close friend of his had died in Iraq over the weekend. Mr. X was close to this friend and did not want to talk about it. Mr. X told the Consultant that he was currently living at a friend's home and that his own property was under offer and in the early stages of being sold. Mr. X appeared to deeply resent being asked about his mood and suicidal thoughts stating that he only wanted medication to be prescribed. The Consultant discussed the possibility of a Mental Health Act (83) assessment with him and noted that he appeared to be a very angry

young man who did not want to be questioned. Mr. X felt that his voluntary presence and request for medication should indicate that he did not need any further action to be taken. At this meeting the medical opinion was that Mr. X had significant depressive and post traumatic stress disorder symptoms. He was assessed as being a moderate to high risk of harm to himself and a low risk to others. The impression was:

1. *Post traumatic Stress Disorder*
2. *Social problems in crisis*
3. *Recent bereavement*
4. *Unresolved psychological issues with some unhelpful personality traits*

Directly following this review the CPN approached the Consultant to inform her that Mr. X had declined her offer to drive him home and had also refused her offer of a lift to his next Outpatient appointment. The CPN was very worried that Mr. X would disengage and the Consultant decided to complete a recommendation for Section 2 of the Mental Health Act (83) in order to assess Mr. X as an inpatient and to get a better idea of his mental health problems. An urgent request was made to the Approved Social Worker to facilitate a Mental Health Act (83) assessment that very evening[41].

16 October 2007. The Consultant was informed that the Approved Social Worker had been unable to find Mr. X at either of his known addresses the day before. The same Approved Social Worker had informed the police of his concerns, the police had been able to contact Mr. X on his mobile telephone, and he told them he was well. The Consultant passed the request for the completion of the Mental Health Act (83) assessment to the Community Mental Health Team[42].

18 October 2007. A Mental Health Act (83) assessment was planned for this day. The CPN and her Service Manager had spent the previous two days trying to locate an Approved Social Worker to input into the process but were unable to do so. The Consultant had arranged for GP 1, Mr. X's GP, to be present.

The CPN collected Mr. X and his friend in her car and drove them to St. James House to be seen by the Consultant and GP 1. The purpose of the assessment was explained to Mr. X and the reasons why it was felt to be necessary. Mr. X's recent history was reviewed for GP 1's benefit, this included his suspension from work, financial problems, need to sell his house, and recent bereavement. During this meeting Mr. X did not want to talk about his problems and refused to discuss his childhood as it made him feel worse when he did.

During the assessment meeting it appeared that Mr. X had very good support from the friend who had accompanied him. He told GP 1 that he had attended the meeting because he wanted medication and that he no longer had active thoughts about killing himself. During the meeting Mr. X's financial problems were discussed and it was felt that his Care Coordinator could help him to sort things out. It was noted that his sleep was improving and that he was eating well. It was felt that Mr. X's mood was a bit low but that he had no thought disorder. Mr. X appeared to have some degree of depression and anxiety but stated that he had good levels of social support to help him.

It was decided that Mr. X was not detainable. The plan was for Mr. X to continue with his medication and for another appointment with the Consultant to be scheduled in four to six weeks time. The CPN was to continue supporting Mr. X in the community once a fortnight and more frequently only if required. The meetings with the CPN were to be set on a fortnightly basis as Mr. X felt that more frequent meetings exacerbated his condition. It was agreed that that CPN would next meet Mr. X on the 31 October 2007[43].

25 October 2007. On this date Mr. X appeared at South Derbyshire Magistrates' Court. The charge was failing to provide a specimen of breath. The date of the offence was 28 April 2007. The Court report refers to his one previous offence in September 2003 of Section 20 wounding for which he was sentenced to 150 hours Community Punishment. The Probation Service recommendation (citing Mr. X's mental ill health) was that Mr. X should be made subject to a Community Order with the following requirements:

- a supervision requirement for a period of nine months;
- a requirement to complete 50 hours paid work.

At this time the probation area (Derbyshire) was one of four areas participating in a pilot intervention that would mean that should he fail to comply with the terms of the Community Order and be returned to court for a breach of the order, the Benefits Agency would be informed and should the breach be proved, his benefits would be withdrawn for a four week period.

The Magistrates made a Community Order for 12 months with a condition of 80 hours unpaid work despite the Probation Service citing Mr. X's mental ill health[44].

29 October 2007. Mr. X failed to attend his initial appointment relating to his Community Order for induction with the Probation Service. He attended three hours late because he had overslept[45].

31 October 2007. The CPN telephoned Mr. X first thing in the morning to remind him of his appointment, the CPN was not able to get through to Mr. X and left a message on his answering machine. Mr. X did not attend his appointment. The CPN informed both the Consultant and her Service Manager. The CPN offered Mr. X another appointment[46].

1 November 2007. On this date the CPN completed a Care Programme Approach (CPA) Review and Care Plan. A FACE Risk Profile assessment was also undertaken. These processes were completed in the absence of Mr. X who had not been seen by the CPN since the 18 October 2007. The CPA records that Mr. X had been placed on Enhanced CPA[47].

5 November 2007. A letter was sent to Mr. X advising him that an appointment had been arranged for him to see the Consultant on the 7 December 2007[48].

13 November 2007. The CPN received a telephone call from Mr. X who was in 'a state of panic'. The CPN recorded that Mr. X had breached his Community Service Order and that his case was due to go back to court. Mr. X had been advised by his Probation Officer to ask his Care Coordinator to write a letter providing evidence as to why he was unable to comply with the terms of his Order. The CPN told Mr. X that she would discuss this with his Probation Officer. Mr. X also demanded that the CPN assisted him with his financial difficulties as his debts were mounting on a daily basis. The CPN advised him to seek help from the Citizens Advice Bureau. Mr. X became angry when he understood that the CPN was not going to help him.

The CPN telephoned Mr. X's Probation Officer who informed her that she did not need to write a letter for the Court as Mr. X had previously agreed to the terms of the Community Order in the presence of an interpreter. It was felt that Mr. X had fully understood what had been required of him and that no mitigation could be put into place[49].

15 November 2007. The CPN saw Mr. X at St. James House. Mr. X presented as being very angry and spent most of the time explaining his current social difficulties. He had not approached the Citizens Advice Bureau. The CPN offered to accompany Mr. X but he declined her offer. The CPN explained that she had spoken to his Probation officer and that

she felt a letter was not required from her. The CPN recorded that she 'attempted to validate Mr. X's anger'. He refused to discuss his mental state or the intensity of his suicidal ideation. He reluctantly agreed to meet with the CPN again on the 29 November 2007[50].

26 November 2007. Mr. X went to visit his GP and saw GP 1. GP 1 provided a letter for Mr. X for the Court explaining that he had slept through his Community Service Order due to the effects of his medication. Mr. X was recorded as feeling better and a repeat prescription was given for a further two weeks of medication[51].

Later on this same day Mr. X visited a solicitor in order to make a will. At 4.30pm Mr. X met up with his brother outside of the shop that he (his brother) owned. Mr. X's brother stated to the Coroner that on this occasion Mr. X appeared to be 'normal' in his presentation, although he was a little tired and decided that he was going to go home[52].

Later on that afternoon at around 5.00 pm Mr. X telephoned a friend saying that he had a 'problem'. Mr. X went to this friend's house and was described by him as looking uncomfortable, his eyes were red and he was shaking. The friend was concerned because Mr. X was drinking and appeared to be swallowing tablets. Mr. X ran away out of the house and his friend telephoned the police because he was worried about Mr. X's wellbeing. Mr. X was not seen alive again[53].

Mr. X was due to appear in court for the breach on this day. He had failed to attend three of six appointments offered to him and had completed eight of the 80 hours of the order imposed by the Court. The Probation Officer preparing the report for the breach appearance recommended that the unpaid work order should be revoked in view of his inability to attend in the mornings and that the Court should resentence with a supervision requirement to enable the Probation Service to closely monitor him and "access the interventions he is so obviously in need of"[54].

27 November 2007. Mr. X was found hanging from a light fitting at his home with the body of Ms. Halimah Ahmed on the floor beside him.

13. Timeline and Identification of the Critical Issues

Root Cause Analysis (RCA) Second Stage

Timeline

The Independent Investigation Team formulated a Timeline in table format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. Please see Appendix One. 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.

Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified four critical junctures that rose directly from the care and treatment that Mr. X received from the Derbyshire Mental Health Services NHS Trust. These critical junctures are set out below.

1. No coherent plan of care was put into place following the decision not to detain Mr. X under Section 2 of the Mental Health Act (83). The timeline indicates that the clinical team providing the care and treatment for Mr. X were growing increasingly worried about him. There is no explanation why they so suddenly and completely deescalated their inputs into Mr. X's monitoring and management. Although Mr. X may not have been detainable under the Mental Health Act (83) his situation and mental state were largely unchanged.

2. The CPN/Care Coordinator completed a CPA Review and a FACE Risk Profile assessment on the 1 November 2007. This assessment raised serious concerns with regard to Mr. X's risk of harm to himself. However the seriousness of these findings did not translate into a plan of care.

3. It is clear from the timeline taken from the clinical records that Mr. X was not able to work due to his medication and mental state. It is unclear why neither the Probation nor Health Services intervened more conclusively with the Court on the 25 October 2007 on Mr. X's behalf, as common sense would dictate that if he was too unwell to undertake paid work he would also be too unwell to undertake unpaid work.

4. The timeline gleaned from the clinical records clearly demonstrates that Mr. X's life was subject to a great many stressors that all seemed to be building up into a great crescendo. Mr. X was on an Enhanced Level of the Care Programme Approach. It is apparent that he received no comprehensive and holistic assessment and care management plan and that he had no real Care Coordination of his case.

The four critical junctures 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.

Critical Issues Arising from the Review of other Data

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

1. **Diagnosis and Medication.** The Independent Investigation Team believes that the initial diagnosis of depression made by the GP was probably the correct one. The notion of Post Traumatic Stress Disorder (PTSD) was never properly addressed or clinically assessed. The notion of PTSD was accepted by secondary care services to the detriment of any other diagnostic process or further exploration. However it is possible for depression and PTSD to coexist and it was possible that Mr. X had aspects of both caused by different triggers, some past, some present. Whatever the diagnosis, symptomatic management occurred as opposed to a systematic treatment plan. Therefore Mr. X's condition was not alleviated. The medication prescribed is deemed by the Independent Investigation Team to be appropriate, however the drowsiness that the Valium caused was not considered by his clinical team to be a barrier to Mr. X living his life or complying with his Court Order, which it clearly was.

2. **Post traumatic Stress Disorder (PTSD).** Mr. X was referred to secondary care services for his PTSD for which he received no treatment. It is the view of the Investigation Team that the notion of PTSD was accepted with little evidence and that no consideration of Mr. X's stressful current social situation was taken into account, e.g. pending homelessness, no job, broken relationship, recent bereavement, court case, insomnia and dire financial issues. It is true that PTSD often emerges 10 or more years after traumatic events. However Mr. X's clinical team did not consider the significance of his presenting distress perhaps being due to the current stressors in his life, and not past ones. If Mr. X did in fact have PTSD his case was not managed appropriately.

3. **Clinical Risk Assessment and Forensic Risk History.** The FACE Risk Profile assessment tool has inherent difficulties. The front sheet bears no objective scoring system and relies on subjective inputs from the assessor. The tool itself is a simple behavioural checklist which does not correlate with the scoring sheet. The CPN filled in the front sheet of the risk assessment seemingly in isolation from the narrative content in the main body of the document. Her assessment is highly confusing and contradictory. The assessment appears to have been filled in without a direct input from Mr. X and led to no dynamic plan; this was an inadequate clinical response.

4. **Care Programme Approach (CPA).** There was no coherent CPA plan in operation. No holistic assessment was undertaken in consultation with Mr. X, no timely risk assessment was considered. Appropriate referrals to a social worker for Mr. X's life stressors were not made, this would have been highly appropriate as most of his stressors appeared to have been of a social nature. The Independent Investigation Team could not understand why Mr. X was in secondary care at all as his plan of care was nonexistent. The CPN did not demonstrate a professional response as a Care Coordinator. The Trust system regarding CPA did not help this in that no Care Coordinator was obliged to use the Trust CPA documentation at the time Mr. X was receiving his care and treatment. Initially the CPN chose to use an inappropriate Cognitive Behavioural Therapy format to record her first sessions with Mr. X which she was not qualified to use. Mr. X was on CPA and CPA processes should have been followed.

5. **Use of the Mental Health Act (83).** Whilst the Independent Investigation Team appreciates that had an Approved Social Worker been present on each occasion that The Consultant was attempting an assessment of Mr. X under the Mental Health Act (83) the outcome could have been different, we believe that this would not have been likely. The Independent Investigation Team concurs with the decision that the GP and the Consultant made not to section Mr. X. However an appropriate alternative plan of care should have been put into place. The concern about Mr X at this time, whilst not justifying action under the Mental Health Act (83), should have prompted a period of more assertive involvement. It is inexplicable why Mr. X was not followed up for four weeks following the decision not to section him. We do not believe that sectioning Mr. X would necessarily have prevented the events of November 27 2007 due to his fluctuating mental state, however he should have been more appropriately

assessed and treated. We believe that the issues regarding the Approved Social Worker rota are not central to the outcome of this case.

6. **Cultural Diversity.** Mr. X was a young man who had been born and bred in Iraq. It is not uncommon for service users from black and minority ethnic (BME) communities to exhibit a high degree of ambivalence when accessing Mental Health Services in the United Kingdom. It is clear that Mr. X displayed such ambivalence. It is also not uncommon for Middle Eastern men to find discussing their emotions and to be seen losing emotional control as something shameful. The focus of the care and treatment that Mr. X received required him to talk about his feelings. Mr. X was clearly uncomfortable with this approach and grew impatient with it.

7. **Adherence to National and Local Policy.** It is clear that CPA and risk assessment guidance was not adhered to.

8. **Competency and Experience of the Clinical Team.** The Consultant had limited experience as demonstrated by her training grade. She had no higher training experience and no specialist knowledge of PTSD; she also had no Part Two Certificate of Completion of Specialist Training Membership of the Royal College of Psychiatry. The CPN whilst an experienced Care Coordinator did not appear to function as a Care Coordinator. It is evident from her notes that she used Cognitive Behavioural Therapy documentation, in our view, entirely inappropriately. The supervision that she sought was not for her nursing practice as it ought to have been, because she preferred to receive it from a psychologist. It would appear that the CPN became unduly fixated on the presumptive diagnosis of PTSD to the detriment of Mr. X's actual needs. His practical problems were not addressed and the initiative for dealing with those was largely left to him. His involvement with the criminal justice system, and his failure to comply with a court order, were underplayed in the analysis of his needs.

9. **Clinical Supervision** There is no recorded evidence of clinical or caseload supervision having occurred in Mr. X's clinical record. The Independent Investigation Team understands that the CPN chose to receive her supervision from a psychologist, this may have had a detrimental effect on her effectiveness as a Care Coordinator.

10. **Documentation.** There are issues regarding the contemporaneous nature of the clinical record. However it would not appear that this is of a sinister nature. However it must also be noted that the CPN did not use Trust CPA documentation.

11. **Lone worker issues:** the Independent Investigation Team noted that the CPN went to Mr. X's flat alone and also drove him around in her car.

12. **Management of Clinical Care and Treatment.** The care and treatment that Mr. X received was based on a series of assumptions which were not tested, as a result his condition was only partially treated. The CPN appeared to have worked outside of CPA guidance and pursued her own psycho-therapeutic route rather than that of a Care Coordinator. The clinical team did not appear to work in a structured manner to ensure that the service user received a full Multidisciplinary Team input as required. No holistic assessment was conducted with Mr. X and no coherent care plan emerged. Whilst we recognise that the CPN engaged with Mr. X the Independent Investigation Team are not convinced that she assessed his needs correctly and proceeded appropriately.

The above twelve critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident. The Trust Clinical Governance systems have also been examined and the findings of the Independent Investigation Team are set out below.

The Independent Investigation Team also conducted a review into the Derbyshire Mental Health Services NHS Trust Internal Investigation process, reporting, and action planning implementation outcomes. This is explored in section 16 below.

14. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

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 causal, 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 critically 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', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the events of 26-27 November 2007. 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 care and treatment that a service user receives and any subsequent homicide perpetrated by them.

Contributory Factor. 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 in Mr. X's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 26-27 November 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

14.1. Critical Issue Number 1. Diagnosis, Medication and Treatment

The Independent Investigation Team identified issues regarding the diagnosis, medication and treatment offered to Mr. X as key factors in the management of his case. In order to provide clarification for the reader these aspects are examined first as certain assumptions made regarding his diagnosis ensured that his case was managed in the way that it was.

.

14.1.1. Diagnosis

14.1.1.1. Context

'*Diagnosis... is the art or act of identifying a disease from its symptoms and signs. The concept of diagnosis also has a broader definition - the analysis of the cause or nature of a condition, situation or problem*[55].'

The Independent Investigation Team acknowledges the fact that the notion of the validity of a 'diagnosis' in the context of psychiatry is often hotly disputed. Diagnoses can be stigmatising and sometimes unhelpful or wrong. The prevalence of mental disorders in the community is high, yet many remain unrecognised, misdiagnosed or poorly managed within primary care. Hence, guidelines for diagnosing and managing mental disorders in primary care, ICD-10 PHC (A World Health Organisation Tool), have been developed[56]. The Royal College of Psychiatrists describes the published ICD10 guidelines as a diagnostic manual that provides the means by which general practitioners and psychiatrists can make diagnoses and look at clusters of symptoms[57].

The National Institute of Clinical Excellence also provides guidelines to support diagnoses and treatment.

14.1.1.2. Findings

Mr. X's Diagnosis in General Practice

It would appear from his clinical records that Mr. X presented to his GP Practice with symptoms of depression between the 12 April and the 28 June 2007. On the 12 April 2007 he was seen by GP 2. Mr. X reported feeling anxious and having difficulties in sleeping. He was worried about his employment and his mortgage repayments and was expressing worries about going out and what people might say about him. Mr. X also reported anhedonia, the difficulty of not being able to take pleasure from normally enjoyable experiences. At this stage Mr. X had good eye contact and a well kept appearance. He expressed no suicidal thoughts[58]. On the 12 April 2007 the PHQ-9 assessment for

depression was conducted by GP 2 and Mr. X scored 20 out of 27 which placed him in the 'severe range' assessment banding[59]. A diagnosis of depression was subsequently made by the GP and recorded in Mr. X's clinical record.

Mr. X's condition would appear to have been correctly diagnosed at this stage. Patients presenting with depression are a routine phenomena in General Practice and General Practitioners have sound experience in diagnosing this kind of mental health problem.

On the 24 May 2007 GP 2 who saw Mr. X on this occasion wrote 'depression + post traumatic stress'[60]. There is no evidence contained in the GP records to explain which psychiatric criteria or cluster of symptoms were used to inform the diagnosis of Post Traumatic Stress Disorder. It would appear that this diagnosis was made mainly because Mr. X came from a background in which he had been exposed to significant traumatic events. Most General Practitioners would not have the experience to make a definitive diagnosis of PTSD. However based on the evidence presented to GP 2 it was not unreasonable for him to consider the notion of a post traumatic stress related disorder.

On the 28 June 2007 a referral to secondary care services was made because Mr. X did not appear to be making progress. The referring GP, GP 1, made the referral with a view to Mr. X receiving psychotherapy for post traumatic stress. The referral letter stated that GP 1 would be 'grateful for your opinion', implying that specialist assessment as well as treatment was being sought[61].

Mr. X's Diagnosis in Secondary Care

Mr. X's referral was received by the Community Mental Health Team and the allocation decision was made at the weekly Multi-Disciplinary Team meeting to refer the case directly to the CPN, a community psychiatric nurse, for 'partial booking' and initial assessment (partial booking is where a service user is offered the secondary care mental health service, the case is fully booked once the service user has agreed to assessment and treatment). It would have been reasonable for the Team at this stage to have realised that PTSD assessment and treatment requires a high level of input from an experienced and skilled qualified therapist however the case was not deemed to be urgent at this juncture and psychological therapy services had a long waiting list within the Trust at this time.

The CPN was allocated as Mr. X's Care Coordinator and he was seen for the first time by secondary care services on the 16 August 2007. At this stage the referring GP's diagnosis was not challenged or tested. Mr. X was not seen by a Consultant Psychiatrist or

Psychologist and no formal psychiatric opinion was sought in response to the GP's referral request.

Mr. X's initial assessment was conducted by the CPN on the 16 August 2007 and was compiled on Cognitive Behaviour Therapy documentation and gives rise to the conclusion that secondary care services were happy to progress the GP's request for psychotherapy without any further clinical assessment input by psychiatric specialists. As a direct result the initial assessment focused on Mr. X's traumatic past experiences and did not adequately explore his current needs or form the basis for a broader assessment of Mr. X's presentation. It was not possible to interview the CPN but her manager stated to the Independent Investigation Team that the CPN did not have any Cognitive Behaviour Therapy Training or past experience of managing or treating Post Traumatic Stress Disorder. This however did not deter the CPN from focusing on Mr. X's unverified diagnosis of PTSD.

By the 26 September 2007 it became clear to the CPN that Mr. X's mood was very low and that there was a possibility that he may require an assessment under the Mental Health Act (83). The CPN was advised by her manager that a Mental Health Act (83) assessment was not appropriate at this stage as there was no supporting Approved Social Work or Medical recommendation. It is unclear why a psychiatric opinion had not been sought prior to this juncture[62].

On the 1 October 2007 Mr. X was seen for the first time by the Consultant, the Locum Consultant Psychiatrist. This meeting was described as being an 'URGENT PSYCHIATRIC ASSESSMENT' in the clinical records. During this meeting Mr. X was accompanied by the CPN. The Consultant recorded that Mr. X presented as being low in mood and lacking in concentration. Mr. X had 'significant financial difficulties' and was often distracted by thoughts of traumatic events during his childhood. Mr. X's appetite was described as poor and he was noted as often experiencing insomnia. The Psychiatrist noted that Mr. X had significant depressive, anxiety and post traumatic stress disorder symptoms. On this occasion Mr. X was assessed as being a low to moderate risk of harm to himself, (he had admitted to suicidal ideation) and a low risk to others.[63] Although the ensuing psychiatric assessment was not formally conducted or recorded the Consultant was able to match Mr. X's presentation to the ICD-10 classification for PTSD.

At this juncture the Consultant demonstrated best practice by referring Mr. X for both an Electroencephalography (EEG) and a CT scan to rule out organic factors as Mr. X was

concerned that he may have sustained a head injury following a car accident earlier that year.

On the 15 October 2007 Mr. X was reviewed by the Consultant again. On this occasion the Consultant wrote in a letter to GP 1, that Mr. X suffered from:

1. *Post traumatic Stress Disorder*
2. *Social problems in crisis*
3. *Recent bereavement*
4. *Unresolved psychological issues with some unhelpful personality traits*

Mr. X was described as presenting a moderate to high risk of harm to himself and a low risk to others. It was noted that Mr. X appeared to be irritable and angry and that it was difficult to assess him. The Consultant wrote that she was worried about the safety of Mr. X and that she had decided to complete a recommendation for a Mental Health Act (83) assessment. The Consultant also stated in her letter to GP 1 that there was no evidence of thought disorder or psychosis. There was no mention made of depression in this letter[64].

On the 18 October 2007 following a formal Mental Health Act (83) assessment it was decided by the Consultant and GP 1, that Mr. X was not detainable under the Act. It was agreed at this juncture that 'contact with mental health services exacerbated his symptoms' and future contact would be limited to fortnightly contacts unless it was thought necessary to increase them[65]. Once again at this juncture the Consultant demonstrated best practice by attending the meeting of the 18 October 2009 even though she had already made her recommendation on the 15 October 2007.

14.1.1.3. Conclusions*.*

The Independent Investigation Team believes that the initial diagnosis of depression by the GP between the 12 April and the 28 June 2007 was probably correct. Mr. X had many of the signs and symptoms of a severe depressive state. It is also possible that Mr. X did have a Post Traumatic Stress Disorder as his symptoms matched those found within the National Institute of Clinical Excellence Guidance (2005), but this was not formally tested although the Consultant was able to match some of his symptoms to the ICD-10 PTSD criteria on the 1 October 2007. [66]

It is unfortunate that following the initial referral to the Community Mental Health Team Mr. X's case bypassed both medical and psychological assessment. This ensured that a medical opinion was sought only once Mr. X reached a state of crisis. The notion of post traumatic

stress disorder was never properly clinically assessed, or addressed with an appropriate clinical management plan. The diagnosis of post traumatic stress disorder was accepted by secondary care services at the point of referral to the detriment of any other diagnostic process. No further exploration was undertaken based either on a holistic Care Programme Approach process or a full psychiatric mental state examination and assessment. Symptomatic management occurred as opposed to a systematic treatment plan based on formal assessment criteria.

Contributory Factor Number One. Mr. X did not receive a diagnosis based on formally recognised assessment criteria directly following his referral to mental health specialist services.

14.1.2. Medication and Treatment

14.1.2. 1.Findings

On the 12 April 2007 Mr. X visited his GP, GP 2, presenting with low mood and anxiety. He was prescribed Sertraline 50 mg once daily. On the 26 April 2007 Mr. X's GP noted that there was no change in his condition and increased his medication to Sertraline 100 mg once daily. On this occasion the GP recorded a diagnosis of 'depression anxiety'. On the 24 May 2007 his medication was increased to Sertraline 100 mg twice daily with Diazepam 5 mg being prescribed at night because Mr. X could not sleep and reported tense, tight shoulders[67].

The Independent Investigation Team believes that the GP prescribed medication was appropriate and fell within clinical guidelines. Sertraline is an antidepressant that is indicated in the treatment of depression, obsessive compulsive disorder and post traumatic stress disorder.

When Mr. X was assessed by the Consultant Psychiatrist on 1 October 2007 the Consultant decided to wean him off Sertraline and to commence him on Venlafaxine 37.5 mg twice daily. It was also decided to commence him on Diazepam 5 mg twice daily and Zopiclone 7.5 mg at night[68]. The change to Mr. X's medication appears to have been made on reasonable grounds as he did not appear to be responding to Sertraline (although as a first step it could have been increased to its maximum dose of 200mg before deciding that it was ineffective). Venlafaxine is used to treat depression. Venlafaxine extended-release (long-acting) capsules are also used to treat generalized anxiety disorder. Zopiclone is a hypnotic used in the short-term treatment of insomnia. The decision to continue with Valium could be

questioned as it was apparent that it made Mr. X drowsy and unable to go about his daily business.

It is not clear how well Mr. X understood the medication that he was prescribed. Nowhere in his clinical records is it recorded that the benefits and possible side effects of his medication were explained to him. On the 11 October 2007 Mr. X reported to the CPN that he was taking double the dosage of his prescribed medication at night with alcohol to help him sleep. The CPN told him to stop doing this and explained what the effects of taking his medication with alcohol could be[69].

The extent of Mr. X's adherence to his medication regime was described as 'variable' in the clinical record following the meeting he had with the Consultant on the 1 October 2007. It was noted in the FACE Risk Profile assessment on the 1 November 2007 that the CPN did not know whether Mr. X was taking his medication or not[70]. The clinical team appears to have thought that Mr. X was compliant with his medication because he asked for it to continue during his appointments with the Consultant in October 2007. This 'variable' adherence was not taken into consideration when devising his overall management plan.

Between 16 August 2007 and the 27 November 2007 no care and treatment plan was formulated to address either the 28 June 2007 GP referral request or the problems that Mr. X presented with to secondary care services. The prevailing view of the CPN and the Consultant Psychiatrist appeared to be that Mr. X was somehow not ready for psychological therapy input due to the fact that he did not want to discuss his emotional turmoil. At no point was a treatment plan formulated to address the problems that he was actually presenting with and the probable depression that he was also suffering from. It would not have been unreasonable for Mr. X to have been more assertively treated regarding his anxiety, depression, insomnia, suicidal ideation and social stressors.

The CPN was not available to talk to the Independent Investigation Team. However the Consultant recalled that she thought the CPN had been working with Mr. X to alleviate his social problems, particularly with regard to his employment situation. However this was not recorded anywhere in the clinical record. It may well be that Mr. X's care and treatment did address his social stressors, however there is no way that this can be either understood or verified by the Independent Investigation Team.

During the period that Mr. X was receiving his care and treatment from the Trust, Consultant Psychiatrists were not directly allocated as core members to the Community Mental Health

Teams (CMHTS). The Consultant Psychiatrist role consisted of inpatient and outpatient responsibilities and they acted more as a resource to the CMHTS. A case like that of Mr. X would have been held by the CMHT and not by the Consultant Psychiatrist. In this kind of clinical service model the role of the Care Coordinator is pivotal to the care and treatment of each service user. It would appear that the Consultant made herself available as a resource with regard to Mr. X in a timely manner and that many of the difficulties encountered were generated by the service model.

14.1.2.2. Conclusions

Between the period of the 12 April and the 28 June 2007 Mr. X's anxiety and depression appeared to grow worse. The GPs at Mr. X's General Practice recognised that he was not responding to medication and were concerned that he may be suffering from both depression and Post Traumatic Stress Disorder. Quite correctly a referral to secondary care services was made so that an opinion could be sought and some psychological therapy deployed if appropriate.

Between the 16 August and the 27 November 2007 Mr. X's condition did not improve as the result of the inputs he received from secondary care services. Mr. X's medication regime did not appear within the context of an overall care and treatment plan and it remains unclear exactly what secondary care services were hoping to achieve with regards to Mr. X's mental condition. Mr. X was seen nine times by the CPN, his Care Coordinator, and three times by his Consultant Psychiatrist. Numerous contacts between the Care Coordinator and Mr. X were also made by telephone. It is difficult to see how Mr. X benefitted from his referral to secondary care services as his 15 weeks of contact did not result in an assertive approach that addressed either his depression or his suicidal ideation, (on six separate occasions Mr. X was recorded as having suicidal ideation). During this period Mr. X received medication the efficacy of which was never established and his compliance was variable.

It is the view of the Independent Investigation Team that a broader model should have been considered following a holistic examination and assessment of Mr. X's background history, mental state and needs. It was clear that Mr. X's condition was not responding to medication alone. Mr. X's current social situation was never seriously considered as being the key factor in his distress or that this may have been the reason why he was failing to respond to his antidepressants. The diagnosis of Post Traumatic Stress Disorder was fixated upon to the detriment of any other diagnostic process. It is entirely possible that Mr. X did have a Post Traumatic Stress Disorder but his reluctance to talk about his emotions should not have

created a barrier to his depression, anxiety and suicidal ideation being treated and alleviated.

14.1.3. Summary

Mr. X was not medically or psychologically assessed on referral, with the benefit of hindsight a person with his history and presumptive diagnosis should have been regarded as a higher priority, and his case should have been allocated to a professional with specific experience in PTSD. The only psychiatric input came in the form of crisis management. Crisis management did not lead to a coherent management plan based on clear diagnostic indicators. No holistic assessment was conducted and the only treatment offered to Mr. X was in the form of medication with which he had variable compliance. As a result Mr. X's condition remained partially treated and the severe risks regarding his suicidal ideation were ignored following the decision not to detain him on 18 October 2007.

Mr. X was a complex individual who presented with depression, anxiety, a possible Post Traumatic Stress Disorder and a range of social stressors. It has to be remembered that Mr. X was from a minority ethnic background and that English was not his first language. Mr. X's ambivalence towards mental health services is commonly to be found in many minority ethnic cultures. It would appear that no patient centered model was deployed and that Mr. X was allowed to disengage with mental health services once it became obvious he did not wish to engage with what they were prepared to offer. No alternative approach was formulated and Mr. X did not receive access to the help that he needed during the last four weeks of his life.

It is the view that Mr. X's mental ill health was not adequately assessed or treated. No effective management plan was developed. However it cannot be known to what extent his mental ill health led to the events of the 26/27 November 2007.

Contributory Factor Number Two. Mr. X did not receive a coherent care and treatment plan.

14.2. Critical Issue Number 2. Post Traumatic Stress Disorder

14.2.1. Context

The National Institute for Clinical Excellence (NICE) quick reference guide for Post Traumatic Stress Disorder states that:

'*PTSD can develop in people of any age following a stressful event or situation of an exceptionally or catastrophic nature...symptoms often develop immediately after the traumatic event but the onset of symptoms may be delayed in some people (less than 15%)... Assessment can present significant challenges as many people avoid talking about their problems.'*[71]

The NICE quick reference guide lists the following symptoms associated with PTSD:

- *'Re-experiencing – flashbacks, nightmares*
- *Avoidance- avoiding people, situations or circumstances associated with the event*
- *Hyperarousal-hypervigilence for threat, sleep problems and irritability*
- *Emotional numbing-lack of ability to experience feeling*
- *Depression*
- *Drug or alcohol misuse*
- *Anger*
- *Unexplained physical symptoms'*[72]

The NICE quick reference guide recommends the following action be taken:

- *'Assessment should be comprehensive and should include a risk assessment, assessment of physical, psychological and social needs*
- *Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment*
- *Provide practical advice to enable people with PTSD to access appropriate information and services for the range of emotional response that may develop*
- *Identify the need for social support and advocate for the meeting of this need*
- *Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers*
- *Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions'*[73]

Additional recommendations include:

- Ensure sufferers understand the emotional reactions and symptoms that may occur
- Respond appropriately if a PTSD sufferer avoids treatment
- Keep technical language to a minimum
- Only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed
- Ensure treatment is delivered by competent individuals
- Where depression is present consider treating the PTSD first, unless the depression is severe
- Prioritise any high risk of suicide or risk of harming others

Other recommendations from the NICE guidance suggest avoiding single sessions that focus on the traumatic incident. Psychological therapy is the treatment of choice, delivered once a week by the same person. Several sessions may be required in order to build up a therapeutic relationship based on trust prior to traumatic events being discussed. Drugs should not be offered as a routine first-line treatment for adult PTSD sufferers unless the patient prefers not to engage in trauma-focused psychological therapy.

14.2.2. Findings

Resources within the CMHT were limited with regard to accessing psychological therapies. Derby City has a diverse population with a steadily rising number of individuals who are/have been asylum seekers. PTSD will remain an ever present concern and trauma-focused therapy will continue to be a requirement that requires commissioning attention. It would not be reasonable to expect an ordinary CMHT to be able to provide a specialist trauma focused therapy service; therefore the following conclusions need to be read with this in mind.

Mr. X presented to both primary and secondary care services with all of the signs and symptoms of PTSD as set out in the National Institute for Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care* (2005). Therefore it is entirely possible that Mr. X did have PTSD.

Whether Mr. X had Post Traumatic Stress Syndrome or not, the Community Mental Health Team thought that he did and he should therefore have been assessed and treated according to national practice guidance.

NICE sets out a clear set of guidelines for the management and treatment of PTSD. The first requirement is that experienced and appropriately qualified individuals work with PTSD sufferers.

Neither the CPN nor the Consultant Psychiatrist had any experience in working with PTSD sufferers. The GP referral specified that an opinion and psychological therapy was being sought. Instead of this occurring Mr. X was retained by the Community Mental Health Team and was not appropriately assessed and allocated.

An appropriate allocation, following assessment and verification of PTSD, would have been to a trained and experienced psychological therapist with the required skills to undertake trauma-focused therapy.

It would appear that inadvertently the CPN did the very worst thing that a clinician could do when faced for the first time with a PTSD sufferer. She launched straight into taking a detailed history from Mr. X which focused specifically on the traumatic events that had probably contributed to his mental ill health. This approach is contraindicated by the NICE guidance.

It is usual for sufferers to want to disengage with treatment when suddenly confronted with the events that they are having so much difficulty in coming to terms with. The CPN asked Mr. X to go into a great deal of detail about his traumatic past during their first session together and then finished the session possibly leaving him to deal with the aftermath that the reminiscence may have provoked. All of the CPN's subsequent sessions with Mr. X revolved around her pushing him for more information about the traumatic events that he had witnessed. Mr. X's constant reiteration that this was making him feel worse was ignored by the CPN.

Eventually Mr. X's refusal to talk about past events and his emotions were seen as reasons why psychological therapy could not be given to him. On the 1 October 2007 he was diagnosed as having 'unhelpful personality traits' by the Consultant Psychiatrist because she failed to understand that the approach both she and the CPN was adopting was probably making the situation worse. It was only during the Mental Health Act (83) assessment on the

18 October 2007 that the Consultant acknowledged the fact that contact with mental health services appeared to make Mr. X's situation worse. She then made the decision to limit Mr. X's sessions with the CPN to once a fortnight.

Unfortunately the CPN took this to be a sign that Mr. X should be sorting out his social situation more independently and she declined to assist him with his finances and his Court case issues. It was apparent from the clinical record that the CPN would only re-engage fully with Mr. X once he was prepared to discuss his emotions, suicidal ideation and traumatic past.

The NICE guidance acknowledges that sometimes PTSD sufferers have to be treated with medication prior to trauma-focused therapy taking place. But medication alone will often prove insufficient means to 'bring a patient around' to engaging with a therapist or discussing their emotions. This is the pathway that was chosen by Mr. X's clinical team and which led to the clinical team gradually withdrawing from Mr. X even though his situation appeared to worsen.

The steps that Mr. X's clinical team should have considered, based on national guidance, would have looked something like this:

1. Mr. X should have been assessed by a psychiatrist or psychologist against formal criteria to diagnose the presence of Post Traumatic Stress Disorder.
2. Information should have been given to Mr. X about his condition and its signs and symptoms.
3. An initial assessment should have been conducted in order to understand the severity of any suicide risk or risk of harm to others.
4. A comprehensive assessment should have taken place that included a risk assessment and assessment of physical, psychological and social needs. This should also have assessed the requirements for medication. Full support should have been provided to assist Mr. X with his social situation and stressors.
5. An allocation to an appropriately experienced and qualified psychological therapist with the ability to provide trauma-focused therapy should have been made.
6. Familiarisation with the patient's cultural background should have taken place to ensure that an appropriate treatment pathway was chosen.
7. The therapist should have established a rapport prior to any discussion taking place with regard to the traumatic events themselves.
8. Once all of the above had taken place Mr. X should have been offered psychological therapy sessions, e.g. Cognitive Behaviour Therapy.

14.2.3. Conclusions

It is the view of the Independent Investigation Team that Mr. X's allocated Care Coordinator did not have the experience to provide an appropriate care and treatment package for Mr. X. His clinical team accepted an unverified diagnosis of PTSD but did not go on to allocate it appropriately or treat it in accordance with the NICE guidance.

It would appear that the CPN was not adequately supervised regarding her management of Mr. X's case. It is clear that she was out of her depth and not aware of the NICE guidance in relation to PTSD.

It is always an easy task to review a case with the benefit of hindsight. However Mr. X was diagnosed as suffering from depression, anxiety and post traumatic stress disorder for which he received inadequate assessment and inappropriate treatment set outside of the context of a coherent management plan. This ensured that Mr. X's condition, at best, remained partially treated.

Contributory factor Number Three. Mr. X did not receive an appropriate care and treatment package for his presumed diagnosis of PTSD. As a result Mr. X may have been placed at significant risk of deterioration and harm.

14.3. Critical Issue Number 3. Risk Assessment and Forensic Risk History

14.3.1. Context

Safety is at the heart of all good healthcare. There has been an implied requirement under the Health and Safety at Work Act for clinical risk assessments to be carried out since 1974[74]. No mental health organisation can afford not to have a programme that actively seeks to reduce and eliminate risk, not only because of financial consequences, but more importantly, solid risk management programmes can significantly improve patient care.

The Derbyshire Mental Health Services NHS Trust has comprehensive risk management policies available, these policies reflect national guidance.

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 users' risk is assessed and managed to safeguard their health, well being 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 (DH 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'[75].

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 and unclear.

Derbyshire Mental Health Services NHS Trust uses the Functional Analysis of Care Environments (FACE) risk assessment system. FACE uses the following domains as the core of its approach to profiling people:

- Psychological
- Physical
- Activities of daily living
- Interpersonal relationships
- Social circumstances
- Family and carers
- Risk

This multi-dimensional framework provides a universal structure for thinking about people. All FACE assessments use this framework, which is designed to accommodate the range of assessment models employed by professionals who work with people, whether they be doctors, nurses, psychologists, social workers, occupational therapists, speech and language therapists, physiotherapists, podiatrists or dieticians[76].
The FACE Risk Profile scoring is as follows:

- **0 = no apparent risk.** No history or warning sign indicative of risk.
- **1 = low apparent risk.** No current behaviour indicative of risk but patient's history and/or warning signs indicate the possible presence of risk necessary level of screening/vigilance covered by standard care plan i.e. no special risk prevention measures are required.
- **2 = significant risk.** Patient's condition and history indicate the presence of risk and this is considered to be a significant issue at present i.e. risk management plan is to be drawn up as part of the patient's management plan.
- **3 = serious apparent risk.** Circumstances as such that a risk management plan should be/has been drawn up and implemented.
- **4 = serious and imminent risk.** Patient's condition and history indicate risk and this is considered imminent (i.e. evidence of preparatory acts) highest priority to be given to risk prevention[77].

The Trust Community Mental Health Team Operational Policy (June 2007) stated that all service users should receive a comprehensive assessment that would include risk assessment and monitoring[78]. The Trust risk policy (2006) stated that 'the FACE Risk Profile must be utilised across the Trust as the tool for the **initial** assessment and management of risk' (the bold definition is the Trust's own) [79].

The Trust Risk Policy that was in operation during the period that Mr. X was receiving his care and treatment stated that all reviews should include the assessment of the risk of violence, self harm, suicide, neglect, physical health and living conditions. The risk assessment process was also expected to consider the effects of poverty, homelessness and social isolation[80].

The Trust 2006 Policy clearly stated that a risk assessment should be conducted as soon as possible following the initial period of assessment. The FACE Risk Profile was intended to

be used as part of the process and it was not considered to be a comprehensive assessment process *per se*. Supplementary tools were advised particularly in instances where a high risk of suicide was identified. The Trust Policy stated that service users were to be fully engaged at every stage of the risk assessment and that they should be given a copy of the risk profile and management plan. If a service user scored a '2' or higher then this would indicate that the entire risk profile documentation had to be completed and further assessment undertaken as indicated by the multidisciplinary team.

The National NICE guidance for PTSD, as set out in section 14.2, places emphasis on the timely assessment of harm to self and harm to others. The risk of suicide is seen as having a significant place within the profiling of a person diagnosed with PTSD.

14.3.2. Findings

Mr. X was first seen by secondary care services on the 16 August 2007. Risk assessment was undertaken by the Consultant Psychiatrist in October 2007 but only as a response to the crisis management of Mr. X's condition. This assessment focused on Mr. X's immediate risk and as such was a very basic response, the function of which was to manage his present situation.

On the 1 November 2007 the CPN/Care Coordinator conducted a partial risk assessment utilising the FACE Risk Profile. It is clear that this assessment was not conducted in the presence of Mr. X and that he was not consulted as part of the information gathering process. The FACE Risk Profile contains 42 risk factors and warning signs; each of these requires two responses relating to both the services user's past history and current situation. In short there are 84 separate responses required from the clinical assessor.

The profile filled in for Mr. X looked like this:

- 22 responses were marked with a '9' which represented a 'not known' answer
- 27 responses were marked with a tick which represented a 'yes' answer (i.e. a positive indicator of risk was identified)
- 25 responses were marked with a cross which represented a 'no' answer (i.e. no indicator of risk was identified)
- 10 responses were left blank[81]

There are five specific headings in the FACE Risk Profile under which risk factors and warning signs are collated, they are as follows:

- Clinical Symptoms indicative of risk
- Behaviour indicative of risk
- Treatment-related indicators
- Forensic history
- Personal behaviours indicative of risk

It is not easy to understand why the CPN/Care Coordinator completed the FACE Risk Profile assessment documentation in the way that she did. The risk assessment summary for Mr. X is set out below:

- Risk of violence to others = 2 (significant risk)
- Risk of suicide = 3 (serious risk)
- Risk of self-harm = 3 (serious risk)
- Risk of accidental harm to self = 2 (significant risk)
- Risk of severe self neglect = 3 (serious risk)
- Risk related to psychical condition = 0 (no apparent risk)
- Risk to child and vulnerable other = 0 (no apparent risk)
- Risk of abuse/ neglect/ exploitation by others = 1 (low apparent risk)

It is debateable whether the CPN had sufficient information to complete a robust risk assessment. Despite all of the meetings that she had undertaken with Mr. X it would appear that many aspects of his life and behaviour were unknown to her. It is clear that the interactions that the CPN had with Mr. X were not structured in such a way that a comprehensive assessment, including one that focused on risk, could occur.

A quarter of the responses on the risk assessment profile form were marked as being 'unknown'. At the time the CPN filled in the assessment form she had not seen Mr. X for a period of two weeks. On the form she ticked the box that indicated the assessment had not been conducted in a crisis situation. However all of her contacts with Mr. X in the preceding month had been during crisis situations, and all of the medical risk assessments had occurred in this context. The form indicated that the assessment the CPN conducted was an 'initial' assessment even though Mr. X had been within the service for a period of eleven weeks.

The Department of Health publication, Best Practice in Managing Risk, *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services* (2007) provides full guidance for all aspects of clinical risk assessment and management. This document recommends that risk assessments should be developed by a multidisciplinary team, and that a good risk management plan is only as good as the time and effort put in to communicating the plan to others.

'Risk assessment only has a purpose if it enables the care team and the service user to develop a plan of action in specific areas to manage the risks identified. This plan should be developed with the service user and their carer, and should be regularly reviewed'.[82]

It would appear that the CPN conducted Mr. X's risk assessment without directly consulting him about his risk assessment and as a result could not develop a comprehensive analysis or plan. It is clear that the risk assessment and resulting plan was not widely shared with other health care professionals who were involved in Mr. X's care and treatment.

The issue of most concern is that the full FACE Risk Profile assessment as set out in the Trust Policy guidance was not adhered to. Mr. X had two scores of a '2' rating and three scores of a '3' rating. As such a further risk assessment was indicated but did not take place. The CPN did complete the relapse and risk management plan but did not complete the risk management crisis contingency plan[83].

Even though the relapse and risk management plan forms were filled in, the input fell short of what could be described as a plan. The CPN wrote:

'To assess under the MHA (Mental Health Act [83] with a view to admission to acute inpatient care. Consider Home Treatment if Mr. X is willing to comply with this'.[84]

This response was perhaps an appropriate set of actions 'if all else failed' however it can hardly be seen as an actual care plan designed to treat Mr. X's condition and to prevent his relapse from occurring in the first place.

In short the CPN identified areas of both significant and serious concern but did not respond appropriately with the development a care and treatment plan. The assessment that the CPN conducted did not appear to occur in consultation with either Mr. X or with other members of the Multidisciplinary Team and did not culminate in a sufficiently professional response to the identified risk factors and warning signs.

Forensic History

Mr. X did have a forensic history. On the 9 September 2003 Mr. X was convicted at Derby Crown Court of stabbing a person in the leg outside of a nightclub. Mr. X was given a Community Punishment Order of 150 hours. The person whom Mr. X stabbed was known to him and both men had been involved in a previous altercation during which Mr. X had been assaulted. On the occasion Mr. X committed this offence there was evidence brought to bear that he had been severely provoked[85]. Neither the Court nor the Home Office viewed this offence as being of a serious enough nature to lead to a custodial sentence or to deportation. There is no evidence that Mr. X was ever involved in any other incident of this nature. All checks conducted by the Home Office prior to his being granted indefinite leave to remain in the United Kingdom confirmed that he had a clear record.

On the 25 October 2007 Mr. X appeared at South Derbyshire Magistrates' Court. The charge was failing to provide a specimen of breath. The date of the offence was 28 April 2007. The Court report referred to his one previous offence in September 2003 of Section 20 wounding for which he was sentenced to 150 hours Community Punishment. The Probation Service recommendation (citing Mr. X's mental ill health) was that Mr. X should be made subject to a Community Order with the following requirements:

- a supervision requirement for a period of nine months;
- a requirement to complete 50 hours paid work.

At this time the probation area (Derbyshire) was one of four areas participating in a pilot intervention that would mean that should he fail to comply with the terms of the Community Order and be returned to court for a breach of the order, the Benefits Agency would be informed and should the breach be proved, his benefits would be withdrawn for a four week period.

The Magistrates made a Community Order for 12 months with a condition of 80 hours unpaid work despite the Probation Service citing Mr. X's mental ill health[86].

It is clear from the clinical record that the CPN knew about Mr. X's forensic history, she actually mentions this on the FACE Risk Profile. However the CPN did not place this information under the section marked 'Forensic History'. This in itself is not a major issue, but the Independent Investigation Team wish to note that information should have been entered in a more appropriate manner.

There are two main issues regarding Mr. X's forensic history. First, his present risk of harm to others was not viewed through the lens of his past behaviour. Second, his need of support from, and intervention by, the Community Mental Health Team did not take place. The CPN did not assess how Mr. X's Court appearance impacted upon his mental state. It is clear that Mr. X was extremely anxious about his Court appearance, but the CPN did not regard this aspect of Mr. X's life as being something for which she was required to offer support. As a result she did not consider this to be an additional factor within the increasingly complex social situation in which Mr. X found himself to be.

Assessment of Risk pertaining to Mr. X and his Family and Friends

On the 16 August 2007 Mr. X stated that he 'was afraid of losing control and hurting his close friends'[87]. This statement does not appear to have been explored any further by the CPN. It is the only mention in the clinical record that Mr. X may have been a risk to those around him. However the CPN used this statement of concern within the FACE Risk Profile as being an indicator that Mr. X was a 'significant' risk regarding harming others.

This is problematic on two counts. First, the CPN should have tried to explore this issue with Mr. X in a systematic manner in order to understand the seriousness of the problem. Second, the CPN should have addressed this as part of the risk management plan.

It is clearly stated in the clinical record that Mr. X was not living at his own address during the summer of 2007. Mr. X was living with friends who had small children. If Mr. X's single statement of the 16 August 2007 raised sufficient concerns in the mind of the CPN that she entered it as a significant issue in his FACE Risk Profile then she ought to have considered informing his friends and should also have considered a Safeguarding Children assessment. Due to the contradictory and inconsistent nature of the CPN's clinical assessment it is impossible to understand exactly how much credence to place on the clinical records that she developed.

14.3.3. Conclusions

Mr. X did not receive comprehensive and timely risk assessment and management plan. It is clear that Mr. X presented as a complex individual and that he raised the concerns of the Multidisciplinary Team regarding his suicide risk on several occasions between the 26 August and the 1 November 2007 when the CPN compiled his first formal FACE Risk Profile. It is the view of the Independent Investigation Team that a comprehensive risk assessment

should have been undertaken by the Multidisciplinary Team. This risk assessment process should have commenced as soon as:

- Mr. X's risks were identified on the 16 August 2007, and;
- the diagnosis of PTSD was accepted, and;
- Mr. X's condition began to deteriorate in October 2007.

There is no evidence that the risk assessment was conducted as part of a multidisciplinary team discussion. There is no evidence that the Consultant Psychiatrist was aware of the FACE Risk Profile developed on the 1 November 2007. There is no evidence to suggest that the CPN discussed the risks that Mr. X presented with any other person who may have been in a position to supervise her practice.

The CPN could not obtain a detailed history from Mr. X during the consultations that she held with him to the effect that she could not undertake a comprehensive and meaningful risk assessment.

The FACE Risk Profile developed for Mr. X presented unsubstantiated information that was never fully explored or understood. It remains unclear how much value can be placed on the single statement that Mr. X made about his concerns that he might 'hurt his close friends' if he failed to control his temper. This Independent Investigation Team has been asked to consider whether the care and treatment Mr. X did, or did not, receive had a direct causal effect on the death of Ms. Halima Ahmed. Based on a single entry in the clinical notes we cannot state that Mr. X presented a definite threat to those around him. What we can state is that the CPN should have explored this aspect further and considered the nature of this potential risk. The CPN's clinical records regarding Mr. X's risk to others is inconsistent and contradictory. If she believed Mr. X to be a risk to others then it would have been reasonable to have expected her to consult with Mr. X's friends with whom he was living, conduct a safeguarding children assessment, and to record that Mr. X's risk to others had been discussed by the Multidisciplinary Team. It would also have been reasonable for the CPN to have developed an appropriative care plan. None of this occurred.

It is clear from Mr. X's clinical record that he constantly discussed his plans to commit suicide with the CPN and that he expressed suicidal ideation on a regular basis. It is evident that the CPN took these threats seriously as she successfully instigated his assessment under the Mental Health Act (83) in October 2007.

When the CPN used the FACE Risk Profile on 1 November 2007 she gave Mr. X a score of '3' placing him in the serious category for risk of suicide and self harm. The Independent Investigation Team does not understand why no care plan was put in place to manage this risk and to offer appropriate care, treatment and supervision. The Independent Investigation Team acknowledges that this was not the sole responsibility of the CPN. It would not be fair to assign blame to a single practitioner who was acting as part of a multidisciplinary team.

The Independent Investigation Team also acknowledges that Mr. X was not deemed to be presenting at such a level of risk to warrant detention when he was assessed under the Mental Health Act (83). However what remains unclear is why Mr. X was allowed to disengage with services even though his presenting condition remained unchanged and his anxieties and social stressors appeared to be escalating. Mr. X may not have warranted detention but his condition remained partially treated at best and he was assessed as having risk factors that warranted careful management and consideration.

It is the view of the Independent Investigation Team that Mr. X did not receive a comprehensive or timely risk assessment and subsequent management plan. The consultation and assessment process did not involve Mr. X and his friends or carers. The entire process appears to have been a paper exercise that did not contribute to the delivery of Mr. X's care and treatment.

Contributory Factor Number Four. Mr. X was not risk assessed in a comprehensive and timely manner. The eventual risk assessment was not communicated effectively and did not result in the development of a robust care and treatment plan which was formulated as part of a multidisciplinary team action.

14.4. Critical Issue Number 4. The Care Programme Approach, Assessment and Care Planning

14.4. 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[88]. Since its introduction it has been reviewed twice by the Department of Health[89]: in 1999 (Effective Care Coordination 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) [90].

'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 the specialist mental health services[91].' (Building Bridges; DH 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.

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 co-ordination 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 key worker 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
- 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 service users were placed on either Standard or Enhanced CPA according to their level of need.

Local Care Programme Approach Policy

The Trust Care programme Approach Procedures (2007) provided a clear framework for practitioners to follow. It stated that an initial assessment should take place when a person first came into contact with specialist mental health services. It acknowledged that an initial assessment may have required more than 'one session, meeting or appointment' however it stated that an initial assessment 'will normally be **completed within 4 weeks'** (the bold definition is the Trust's own)[92]. The Trust Policy made provision for Care Coordinators to access additional specialist assessment where required.

The Trust Policy stated that Enhanced CPA was for people:

- *'with multiple needs who require co-ordination between different agencies, such as health, social services or housing;*
- *who need more frequent and intensive interventions, perhaps with medication management;*
- *who are more likely to be at risk of harming themselves or others'.*[93]

The policy also stated that people requiring enhanced CPA may be hard to engage and difficult to maintain contact with.

The role of the Care Coordinator was defined in the Trust Policy as being an 'essential part of the Care programme approach'. The Policy made it clear that service users placed on Enhanced CPA required Care Coordinators 'with the most skill and experience'[94].The Policy listed the following as being some of the key functions of a Care Coordinator:

- *'ensure that a **systematic assessment** of the person's health and social needs is carried out initially, and again when needed (including an assessment of risk and any specialist assessments), and that the person's CPA level of need is identified;*
- *co-ordinate the formulation and updating of the **care plan**, ensuring that all those involved understand their responsibilities and agree to them;*
- *ensure that the care plan **is sent to all concerned**, including the service user and G.P;*
- *ensure that **crisis and contingency plans** are formulated, updated and circulated as part of the care plan;*
- *Ensure that the **person is fully involved** and has choice, and assist them to identify their goals;*[95]

14.4.2. Findings

It is easy for an Independent Investigation Team to be hypercritical. In the interests of being fair we would like to point out that it is very difficult for Mental Health Trusts to provide services to individuals who may not be fully compliant with treatment and who may be difficult to engage. Mr. X was highly ambivalent about the care and treatment that was being offered to him. It is clear that the CPN made a consistent series of attempts to engage with Mr. X and tried to develop a rapport with him. The points below need to be read in the light of the fact that even with the best processes and systems health care professionals often struggle to adhere to Trust policy and procedure when service users with complex needs are difficult to engage.

Mr. X was on Enhanced CPA. There is no rational within his clinical record to explain why this was so, however it would appear that enhanced CPA was appropriate. It is also unclear from reading the clinical notes when this decision was made and by whom.

Assessment

The initial information resulting from the first meeting between Mr. X and the CPN/Care Coordinator was not recorded on Trust CPA forms but on Cognitive Behaviour Therapy documentation. Clinical witnesses told the Independent Investigation Team during interview that this was considered to be acceptable practice within the Trust at the time Mr. X was receiving his care and treatment. The difficulty with this approach was that no comprehensive holistic assessment was conducted to ascertain Mr. X's health and social care needs in accordance with the Trust Policy on CPA. Mr. X had not been formally diagnosed with PTSD at this stage (or indeed ever) and it was premature of the CPN/Care

Coordinator to move forward with what we assume was a plan to provide Cognitive Behaviour Therapy. This is further compounded by the fact that the CPN/Care Coordinator was not qualified to assess Cognitive behaviour Therapy requirements or to provide Cognitive Behaviour Therapy. Neither was the CPN/Care Coordinator an experienced trauma therapist.

As a result Mr. X was launched directly into an inappropriate consultation on the 16 August 2007 which focused primarily on his traumatic past by an inexperienced and unqualified therapist and that failed to capture the initial information that the Care Programme Approach required.

Care Planning

On the 1 November 2007 the CPN/Care Coordinator filled in a CPA review and care plan. In effect instead of actions and aims being identified the CPN/Care Coordinator listed Mr. X's problems and presentation. No actions which could be said to constitute a comprehensive plan are present. This can be illustrated as follows:

'Drug/alcohol use actions: *known to use alcohol to help him to sleep however it is unclear how much Mr. X is currently drinking.'*[96]

'**Accommodation actions:** *Currently selling his house due to loss of income and inability to pay mortgage. Is dividing his time between the houses of various friends. Possibility that accommodation will need to be found once his house has been sold.'*[97]

The sum of the actual plan was to 'attempt to engage further with Mr. X to monitor his mental state and to provide supportive interventions.' The review and care plan did not focus on planned interventions to assist with, either his identified mental health or social needs, this despite the fact that the CPN/Care Coordinator had identified several areas that Mr. X required assistance with.

Mr. X was not present at this CPA review. Indeed it would appear that no one was present at the CPA review except the CPN/Care Coordinator. In line with national policy expectation the Trust Policy (2007) stated that the CPN/Care Coordinator was responsible for arranging the CPA review. The Trust Policy suggests that a review could consist of the following:

*'A review is a **process rather than a meeting**. Whatever format is decided on should take into account issues of power relationships. A review does not have any set format, and can be anything from:*

- *The Care Coordinator and the service user sitting together and reviewing the care plan, with other people contributing by post or telephone; or*
- *A series of small meetings with the people concerned; or*
- *A meeting of all the people concerned; or*
- *Members of the care team forwarding information to the Care Coordinator, who then consults the service user. If this is impossible, clear reasons must be given.*[98]

It is not known why the CPN/Care Coordinator had to conduct the CPA review on her own on the 1 November 2007. Mr. X failed to attend, and the GP was unable to attend (he was written to by the CPN). No other member of the Multidisciplinary Team appear to have been involved with the process.

14.4.3. Conclusions

It is evident that Mr. X did not receive a full CPA which consisted of both assessment and care planning. Mr. X was a complex individual with a myriad of social stressors and a potentially difficult to treat mental health condition. The CPN/Care Coordinator focused on his presumptive diagnosis of PTSD to the detriment of everything else. When Mr. X declined her inputs, with regard to discussing his traumatic past, the CPN/Care Coordinator withdrew all other supportive interventions. Mr. X's inability to discuss his past was seen as being an irrevocable barrier to his receiving any other kind of intervention. The Independent Investigation Team believes that the CPN/Care Coordinator could have continued to support Mr. X in ways that were acceptable to him. If, for example, she had worked with him regarding his Court case, pending breach, and his financial situation, a rapport may have been built and future interventions regarding his PTSD could have been advanced. As it was the CPN/Care Coordinator appeared to have been unwilling to engage with Mr. X unless he accepted her therapeutic inputs and he refused to engage with her until she stopped offering them. An *impasse* developed which left Mr. X in a vulnerable situation.

The role of the multidisciplinary team with regard to the care and treatment that Mr. X received is unknown. Aside from crisis interventions the CPN/care Coordinator was left on her own to support Mr. X. It appears that the CPN confused her role as Care Coordinator and as such intended to be both Care Coordinator and therapist to Mr. X. If the Multidisciplinary Team had been working properly a referral should have been made to an

appropriately qualified and experienced individual who could have assessed and treated Mr. X's presumptive PTSD.

The Trust Policy allowed for service Users to request a change of CPN/Care Coordinator. This may have been something that the clinical team should have considered. Mr. X was a Kurdish Iraqi man. The cultural advice to the Independent Investigation Team was that men from Mr. X's culture would be unlikely to admit to any emotional problems. Mr. X was reluctant to discuss his traumatic past, this is common in cases of people with PTSD and it is also a common factor for Mediterranean and Middle Eastern men. Mr. X's CPN/Care Coordinator was female and it is possible that her sex made it more difficult for Mr. X to discuss aspects of his past. Mr. X made it clear during his Mental Health Act (83) assessment that his contact with the CPN/Care Coordinator was making him feel worse. Perhaps the Consultant Psychiatrist and the CPN/Care Coordinator should have considered a totally different approach (in accordance with the NICE PTSD guidance) and sent Mr. X for a psychological therapy assessment. Instead the decision was to reduce contact with Mr. X.

This reduction in contact did not help Mr. X's situation. The CPN/Care Coordinator should have been able to assist and support him in coping with his current life stressors, and an experienced trauma therapist should have been able to assist Mr. X with his past stressors.

Contributory Factor Number Five. Mr. X did not receive a comprehensive and holistic CPA. The notion of Mr. X's presumed diagnosis of PTSD was formulated to the detriment of all other diagnoses and approaches. As a result Mr. X did not receive the care, support and treatment that he needed.

14.5. Critical Issue Number 5. Use of the Mental Health Act (83)

14.5.1. Context

'The Mental Health Act 1983 is an Act of the Parliament of the United Kingdom but applies only to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people suffering from a mental disorder can be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as "sectioning". Its use is reviewed and regulated by an NHS special health authority known as the Mental Health Act Commission (MHAC). The Act has been significantly amended by the Mental Health Act 2007.'[99]

In order to place a person under a section of the Mental Health Act (83) two registered medical practitioners must make an application in writing stating why assessment and/or treatment are necessary. This statement also has to explain why other options for treating the patient cannot be used and why compulsory detention is required. A Section 2 is an assessment order only and lasts up to 28 days, it cannot be renewed. It can be put into place following a Mental Health Act (83) assessment by two doctors and an Approved Social Worker (ASW). At least one of these doctors must be a Section 12 approved doctor. The other must either have had previous acquaintance with the person under assessment, or also be a Section 12 approved doctor.

The terms of reference for this Investigation include a requirement 'to examine the Mental Health Act (83) assessment process including the role and provision of Approved Social Workers and their interface with other teams.'

The Coroner's Inquest into the deaths of both Mr. X and Ms. Halimah Ahmed drew attention to the issues of assessment under the Mental Health Act (83). In particular the Coroner asked whether Mr. X should have been detained in hospital and whether problems in completing an assessment by an Approved Social Worker (ASW) had contributed to a failure to arrange treatment for X. The Coroner issued a letter under rule 43 of the Coroners Rules. It was addressed to the Chief Executive of the Trust and asked the Trust to respond to the evidence that an ASW assessment had not been completed in a timely way.[100]

The Trust Internal Investigation noted that there were 'difficulties...relating to the availability of an Approved Social Worker to participate in the mental health assessment and systemic issues relating to this require attention'. The report also noted that 'the lack of availability of an Approved Social Worker when requests were made, led to avoidable stress and tension for the other staff involved.'[101]

In her witness statement to the Trust internal investigation, the CPN said that 'the ASW system was a large frustration to me.' She referred to difficulties in engaging an ASW through the single point of entry desk which was the point of contact for the ASW duty rota. She said that the ASW rota was unclear and that 'the system feels obstructive.' [102]

It was the view of the family of the victim, Ms. Halimah Ahmed, that had Mr. X been admitted to hospital then the tragic death of their daughter could have been avoided. In a letter to the Chief Executive of the Trust Mr. A, Ms. Halimah Ahmed's father, quoted the Coroner's statement in his summary that 'I would find as a fact that had Mr. X been admitted to hospital either as a voluntary patient or more likely as a detained patient and a full and comprehensive assessment made over a period of time, then on the balance of probabilities the tragic events occurring when they did on the 26 or 27 of November would have been avoided.'[103]

14.5.2. Findings

We have reviewed the involvement of the ASW service. The first point of contact with Mr. X was on 27 September 2007. There were concerns raised about Mr. X's mental state during an out-patient appointment he kept at St James's House with the CPN the previous day. SW 1, an ASW, visited Mr. X at home with the CPN, his Care Coordinator. Mr. SW 1 was an ASW with the Crisis Team. SW 1 did not feel that Mr. X met the conditions for assessment under the Mental Health Act (83), at interview he told the Independent Investigation Team: 'I felt that – I obviously had to be guided to an extent by the CPN who was working with Mr. X. It was obvious that our team were not going to have any further involvement. My impression was yes, he probably could be managed in the community and the CPN at that stage felt that.'[104]

The decision following this joint visit was that Mr. X should have his medication reviewed at the next out-patient appointment with the Consultant on 1 October 2007. The CPN collected Mr. X from his home address and accompanied him to the appointment where his medication was reviewed. The CPN then arranged to see Mr. X on 3 October 2007 at home

to help with a claim for benefits. He was not at home that day but the CPN saw him on 11 October 2007.

The next referral to the ASW service was on 15 October 2007. The Consultant had seen Mr. X as an out-patient at St James's House and was concerned about his mental state. She wanted to arrange an ASW assessment. She contacted the Crisis Team at 17:40 and spoke to a worker on the team. Derby City Care Line took a referral for Mr. X at 18:00 (Care Line provides the out of hour's response on behalf of the City Council). SW 2 an ASW on the team took the referral from the Consultant. SW 2 arranged to visit Mr. X at home with a psychiatrist who would have been able to make a second medical assessment of Mr. X. SW 2 and the psychiatrist visited both Mr. X's address and also that of the friends with whom he was staying; he was not to be found at either address. SW 2 telephoned the Consultant to inform her of the situation and then agreed to telephone the police to request their involvement. The police made telephone contact with Mr. X after another unsuccessful visit to his home. Mr. X said that he was 'alright' and did not wish to speak to anyone. SW 2 concluded his recording of the incident with the statement 'this referral needs passing back to area team for follow up.'[105]

Comment
The Independent Investigation Team found that the response by the Care Line team was appropriate. The Consultant made the referral to the team after the day time ASW duty rota had finished. It operated from 9 am to 5 pm. The record of the referral was accurate and reflected the concerns of the Consultant in her case recording. SW 2 made efforts to interview Mr. X and included a second medical practitioner who would have been able to assess him. SW 2 communicated his findings to the Consultant in a timely way.

Following the events of 15 October 2007, a further assessment of Mr. X was arranged for the 18 October 2007 at St James's House. GP 1, Mr. X's General Practitioner, assessed him with the Consultant. The outcome of the assessment was that Mr. X was not detainable under the criteria of the Mental Health Act (83) and it was decided that he would keep in touch with his CPN/Care Coordinator every two weeks. In her recording, the CPN/Care Coordinator said that on the 16 October 2007 and 17 October 2007 'long periods spent by CPN and the Community Mental Health team Manager trying to secure ASW to attend planned Mental Health Act (83) assessment on 18 October 2007'[106]. We found that there were operational difficulties with the ASW duty rota that made for delay in the assessment

process. The difficulties were caused by a lack of clarity about the cover for an ASW who was on leave.

Comment
The Independent Investigation Team found that there was no smooth transition of information about the attempted assessment by SW 2 on the evening of 15 October 2007 to the daytime services. The ASW duty rota did not operate effectively and, on this occasion, there was not a timely response. This was due to lack of clarity about the ASW on duty. The Independent Investigation found that this was not satisfactorily explained in the Trust Internal Investigation. We noted that the Community Mental Health Team operated from St James's House, where Mr. X was seen as an out-patient, and therefore in the circumstances described by the Consultant there should have been ready access to ASWs. However, the outcome of the assessment by the Consultant and GP 1 on 18 October 2007 was that Mr. X did not meet the criteria for compulsory detention under the Mental Health Act (83). Therefore the operational difficulties in engaging an ASW in the assessment did not have a critical effect on the outcome.

After the assessment by the Consultant and GP 1 on 18 October 2007, Mr. X was again not assessed under the Mental Health Act (83). His mental state was monitored by the CPN/Care Coordinator who saw him for the last time on 15 November 2007. The initiation of a further assessment under the Act could have been prompted by her if she felt it was indicated, as she was the named worker in the case. The CPN/Care Coordinator did outline this course of action as a future option if Mr. X's condition deteriorated.

After the Coroner's inquest the Coroner wrote to the Trust on 4 November 2008 to express his concerns about the response time to a request for an ASW assessment under the provision of Rule 43 of the Coroners Rules and asked that the Trust review its policy. The Trust responded on 30 December 2008 noting that after the implementation of the Mental Health Act (2007) on 3 November 2008, the statutory functions carried out by ASWs could now be carried out by a range of professional known collectively as Approved Mental Health Practitioners (AMHPs). There is now an agreed policy between Derby City Council, Derbyshire County Council and Derbyshire Mental Health Services NHS Trust for AMPH response time standards. The policy differentiates between planned assessments when the

individual is already known to the service, and non-planned assessments requested in an urgent situation, often out of hours and normally for service users not already known.

The timescale for responding to a non-planned Mental Health Act assessment is within two hours of the receipt of the assessment request. The policy reiterates that the role of the AMHP includes the duty to interview the patient in a suitable manner and be satisfied that an application should be made. The assessment process can take a number of days and in some cases it would be appropriate to delay admission so that alternatives to detention in hospital can be put in place.[107]

14.5.3. Conclusions

The referral for assessment by an ASW on the 15 October 2007 was dealt with in a timely way by the out of hour's team although they were unsuccessful in finding Mr. X in order to complete their assessment.

There was a delay in the allocation of an ASW through the duty system on the 16 October 2007 and 17 October 2007. This was due to operational problems. Since Mr. X was already known to the CMHT the resources of the team could have been used more effectively to complete an assessment, rather than relying solely on the ASW duty system. The completion of the assessment process at this time could have led to a different outcome to that agreed on the 18 October 2007 given Mr. X's fluctuating mental state. Since the assessment process was not completed on the 16 October 2007 or the 17 October 2007 it is not possible to say whether he might have met the criteria to be detained in hospital or not. It remains a possibility that he could have been detained and that therefore the course of his treatment could have been different. This however cannot be verified in any way.

Mr. X's mental state had improved since the 15 October 2007 when the Consultant's assessment of him was that he required detention. The assessment of Mr. X by the Consultant and GP 1 under the Mental Health Act (83) on 18 October 2007 concluded that he did not, at that time, meet the criteria for compulsory detention. This assessment was carried out by two doctors with previous knowledge of the patient who were suitably qualified to do so, the Consultant Psychiatrist, and Mr. X's General Practitioner whom Mr. X knew well and with whom he had a good rapport.

After the assessment on 18 October 2007 further contact with Mr. X was the responsibility of the CPN/Care Coordinator. She completed an initial risk assessment on the 1 November 2007 the management plan for which was to consider further assessment under Mental

Health Act (83) if Mr. X's mental health grew worse. Further assessment under the Act, if required, would have been prompted by her on behalf of the team.

The Trust response to the issue of the Rule 43 letter by the Coroner placed emphasis on the introduction of a policy for Approved Mental Health Act Practitioners in December 2008 that included timescales for the completion of non-planned assessments. This policy included a provision for completing 'an annual audit...of a number of AMHP assessments that were not reported as exceptions. The aim of these audits will be to examine actual response times and provide ongoing validation of the response times, to learn from good practice and to carry out trend analysis as required.'

The Independent Investigation Team cannot state that the lack of availability of an ASW on the 16 and 17 of October 2007 had any causal bearing on the events of the 26/27 November 2007. This is for several reasons.

First, Mr. X's mental state was never appropriately diagnosed. It remains unclear exactly what kind of mental health disorder Mr. X had and to what extent this affected his behaviour and mood. It was clear that Mr. X was very distressed, but it is the view of the Independent Investigation Team that he had an overwhelming number of current social stressors in his life which contributed to his anger and anxiety. Stress in itself does not automatically equate to having a mental illness. It was never established exactly to what extent mental illness and social stressors interacted one with the other to create Mr. X's volatile condition.

Second, it is a fact that on the 18 October 2007 Mr. X was found not to meet the criteria for compulsory detention under the Mental Health Act (83). It is clear that his mental state fluctuated considerably and whilst it is the view of the Independent Investigation Team that a more supportive package should have been put in place following this assessment, the Mental Health Act (83) was quite clear about the criteria that an individual had to meet in order to be detained. Mr. X did not meet them at this juncture.

Third, it is not possible to ascertain what Mr. X's mental state was on the 26/27 of November 2007. The Coroner concluded that Mr. X was not suffering from any abnormality of mind as his behaviour and general demeanour appeared to suggest this to be the case. It is a fact that the Coroner declined to deliver a verdict of manslaughter because it could not be verified that Mr. X was in fact mentally ill at the time his death and the death of Ms. Halimah Ahmed. [108]

Because of these three reasons the Independent Investigation Team cannot assign any definitive causal or contributory factors regarding the Trust's use of the Mental Health Act (83) and the availability or otherwise of an AWS on the 16 and 17 October 2007 to the events of the 26 and 27 November 2007.

The Rule 43 letter by the Coroner has had the effect of ensuring that the Trust can undertake assessments under the Mental Health Act (07) in a more robust manner in the future and this will have the effect of ensuring a more responsive and safer service.

Service Issue Number One. The Trust was unable to provide an ASW to undertake a Mental Health Act (83) assessment in a timely manner.

14.6. Critical Issue Number 6. Cultural Diversity

14.6.1. Context

The terms of reference for this Investigation asked the Independent Investigation Team '*to consider any issues arising regarding cultural and diversity sensitivities, and consider whether they were appropriately handled, this to include language and communication issues.*'

Black and Minority Ethnic (BME) individuals often appear to be subject to a paradoxical effect when accessing mental health services. The paradox is that many BME groups actively avoid mental health services and yet these same groups are represented by a significantly high presence within the mental health system. Research informs us that current mental health services within the United Kingdom have been based on a westernised model of psychiatry. It is a fact that some cultures accept the notion of mental illness more readily than others, these cultures will access mental health services and accept treatment programmes. Other cultures may be reluctant to consider the notion of mental illness with issues such as cultural stigmatisation, fear of the unknown and basic communication and language difficulties becoming barriers to accessing help[109].

It was stated within the Department of Health's *Delivering Race Equality in Mental Health Care* (2005) action plan that healthcare organisations must challenge discrimination, promote equality and respect human rights, and that organisations must enable all members of the population to access services equally[110]. The Government's expectation for the future of mental health services is set out below.

The vision for Delivering Race Equality is that by 2010 there will be a service characterised by:

- *less fear of mental health services among BME communities and service users;*
- *increased satisfaction with services;*
- *a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;*
- *a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;*
- *fewer violent incidents that are secondary to inadequate treatment of mental illness;*
- *a reduction in the use of seclusion in BME groups;*
- *the prevention of deaths in mental health services following physical intervention;*
- *more BME service users reaching self-reported states of recovery;*
- *a reduction in the ethnic disparities found in prison populations;*
- *a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;*
- *a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and*
- *a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.*

The World Health Organisation estimates that at least one third of the world's population have thoughts about suicide at some point in their life. However the suicide rate in Islamic countries has been found to be much lower than that in non-Islamic countries. This is because Islam rejects the notion of the taking of one's own life.[111]

14.6.2. Findings

In order to understand Mr. X's care and treatment it has been necessary to try and understand him in his cultural context. The media reporting of both his death and the death of Ms. Halimah Ahmed has consistently failed to provide a level of factual accuracy. The *Derby Telegraph* for example stated that 'A FAILED asylum seeker had been deemed a risk to others before he was found dead beside a teenager who was suffocated' (Capitalisation is the newspapers own).[112] The notion that Mr. X was a failed asylum seeker was also reported by the BBC on the 10 October 2008.

It is difficult to understand why the term 'failed asylum seeker' was used to describe Mr. X. Mr. X was an asylum seeker and on the 30 March 2000 he was given temporary admission to the United Kingdom pending a decision on his asylum claim. On the 6 July 2000 Mr. X's application for asylum was refused, however he was granted exceptional leave to remain in the United Kingdom until 6 July 2004. On the 22 August 2005 Mr. X was granted indefinite leave to remain in the United Kingdom. Mr. X's former conviction was noted and it was judged not to be sufficient to warrant the refusal of Mr. X's application. Full security checks were conducted into Mr. X's background, all of which proved to be negative.

The phrase 'failed asylum seeker' brings to mind either images of detention centres or of illegal immigrants who are somehow living on the margins of society. This was far from being the case for Mr. X. Mr. X had a job, paid taxes, and owned his own home. He had a small circle of close friends and a brother who lived close by. It is reported that Mr. X played football, owned a car and enjoyed most of the activities usual for a man of his age. Mr. X was also registered with a GP and from the 5 June 2000 received full and regular health care as and when he required it.

Far from fitting the profile of a failed asylum seeker, Mr. X appeared to have been fully integrated into the society in which he found himself and could be considered to be a 'success' for at least the first six years that he resided in the United Kingdom. What caused his situation to unravel is not clear. However it would appear that a sequence of events occurred that destabilised his life and resulted in an abrupt change to his wellbeing. It is recorded that Mr. X may have been depressed for several years because he told his Care Coordinator that he had been thinking about suicide for two years or more and that he had made attempts on his life before (there are no records of this in his GP record). It will probably never be clear whether he had PTSD or not, however it is entirely possible that he had difficulties coming to terms with his traumatic past, and that this coupled with the life stressors that enveloped him during 2007 led to him becoming increasingly depressed and anxious.

In order to examine the effectiveness of the care and treatment that Mr. X received the Independent Investigation Team has had to accept the possibility that Mr. X had PTSD as this was the working diagnoses allocated to him. As has already been mentioned in section 14.2.1 the NICE guidance for PTSD states that the therapist needs to familiarise themselves with the cultural background of the service user that they are treating. There is no evidence that this occurred.

Mr. X described witnessing acts of extreme violence as a child. The events that he witnessed would have been difficult for most people born and raised in this country to comprehend and to truly understand. Mr. X was also an Iraqi of Kurdish decent which would have presented many cultural and political challenges to Mr. X and any therapist would need to understand how this history would have impacted upon his life. The experiences that Mr. X had encountered would have required a skilled and sure-footed response from a therapist, one who not only could conduct trauma focused therapy, but one who had experience in working with this particular kind of patient experience.

We can tell from the clinical record that Mr. X could speak English, but that it was not his first language and sometimes he required a translator, for example during his Court hearing on the 25 October 2007. It is not certain how much Mr. X understood about his presumptive diagnosis and the medication that he was prescribed.

The Independent Investigation Team ensured that its composition held within it the experience required to assess Mr. X's cultural needs. The Team comprised two individuals of Eastern Mediterranean/Middle Eastern backgrounds, one of whom was a Kurdish Iraqi whom had at one time himself been an asylum seeker. This individual was the Consultant Psychiatrist member of the Team who has had extensive experience of treating mental illness both in Iraq and in the United Kingdom. The advice given to the Panel with regard to Mr. X's cultural needs was as follows:

- Iraqi men often feel uncomfortable talking about their emotions and would not wish to be seen crying or showing weakness to a stranger, this may have compounded his reluctance to talk about his feelings;
- mental illness still carries a degree of stigma and Iraqi service users may show ambivalence when accessing mental health services, therefore the 'threat' of a section under the Mental Health Act (83) may have driven Mr. X to disengage;
- Mr. X may have been more comfortable with a male Care Coordinator;
- the experiences that Mr. X reported would require a high degree of support and understanding from an appropriately experienced specialist.

It is evident that Mr. X's cultural profile when seen in conjunction with a possible diagnosis of PTSD explains his extreme reluctance to discuss his problems. It is possible that if Mr. X's specific cultural profile had been taken into consideration then a more appropriate engagement plan could have been devised.

The Trust and the clinical witnesses interviewed were aware of the fact that the Derby City population continues to present challenges to their services when delivering culturally sensitive care and treatment. The Trust is currently embarking on a series of processes to outreach to the local community and to form networks and links with local ethnic communities to examine this matter further.

14.6.3. Conclusions

The Mental Health Trust clinical team was not in a position to take Mr. X's cultural profile into consideration when devising his plan of care and treatment. The Consultant realised on the 18 October 2007 that the sex of both herself and the CPN/Care Coordinator may have created a barrier to forming a therapeutic relationship with Mr. X. With the workforce composition being what it was within the resource available to her, The Consultant knew that it would not be a simple matter to rectify this, however at the time of Mr. X's death she was considering how to do exactly that.

Contributory Factor Number Six. The services that were offered to Mr. X did not take his cultural needs and requirements into account. This contributed to the provision of an approach which was not sensitive to his needs which may have led to his difficulties in engaging with the services that were offered to him.

14.7. Critical Issue Number 7. Adherence to National and Local Policy and Procedure

14.7.1. 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.*[113]' 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 14.13 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.

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.

14.7.2. Findings

The Independent Investigation Team found that the Derby Mental Health Services NHS Trust clinical policies that were in place during the period that Mr. X was receiving his care and treatment to be sound and in line with evidence-based practice and national best practice guidelines. The clinical policies reviewed relevant to this Investigation were as follows:

- Care Programme Approach Clinical Policy
- Care Programme Approach – Managing Informal Service User's Non-Compliance
- Minimum Standards for Clinical and Practice Records
- Clinical Risk Management Standards
- Policy on the Assessment and management of Clinical Risk
- Protocol for the Assessment and Management of Risk in Mental Health and Learning Disability Practice: Us of the FACE risk Profile
- Supervision Policy
- CMHT Operational Policy

It was apparent that these policies were not adhered to. As has already been set out above in sections 14.3 (risk) and 14.4 (CPA) specific actions were not completed within the expected timeframes, it is a fact that at the time of Mr. X's death, and after 15 weeks of contact with the Trust, many actions were still outstanding, some of which should have been

completed within the first four weeks of his case being accepted by the Community Mental Health Team. The impression that the Independent Investigation is left with is of a clinical team that did not feel compelled to operate within any formal framework. Had these policies been properly implemented they should have allowed for Mr. X to have been appropriately assessed in a timely manner, for his condition and his needs to be discussed by the Multidisciplinary Team, and for a coherent care and treatment plan to be devised. This was not done.

14.7.3. Conclusions

If all Trust clinical policies had been adhered to it is entirely possible that Mr. X's case would have been managed entirely differently. The Trust policies and procedures have much to commend them, however it is clear that during the period in which Mr. X was receiving his care and treatment they were not being implemented, to the detriment of patient care. The implementation of policy and procedure presents a challenge to all healthcare providers. Implementation requires clear dissemination, training, audit and clearly defined clinical supervision arrangements. It would appear that dissemination and training was robust, but when set within the context of competence, experience and clinical supervision other factors emerge. These are explored in sections 14.8 and 14.9 below.

It cannot be concluded beyond any reasonable doubt that the non adherence to Trust policy and procedure led directly to the events of the 26/27 November 2007 as the nature of Mr. X's mental health condition and state cannot be determined with any degree of certainty. However it can be said that Mr. X did not receive the assessment, care and treatments inputs that he required and that this contributed to his mental health condition remaining partially treated at best.

Contributory Factor Number Seven. Clinical practice within the Trust did not adhere to internal policies and procedures.

14.8. Critical Issue Number 8. Competence and Experience of the Clinical Team

14.8.1. Context

The Nursing and Midwifery Council Code of Conduct has this say regarding the competency of all registered nurses and midwives:

'Keep your skills and knowledge up to date

- *You must have the knowledge and skills for safe and effective practice when working without direct supervision*
- *You must recognise and work within the limits of your competence*
- *You must keep your knowledge and skills up to date throughout your working life*
- *You must take part in appropriate learning and practice activities that maintain and develop your competence and performance...*
- *You must deliver care based on the best available evidence or best practice.'*[114]

The General Medical Council has this to say regarding the competencies of all registered medical practitioners:

'Provide a good standard of practice and care

- *Keep your professional knowledge and skills up to date*
- *Recognise and work within the limits of your competence*
- *Work with colleagues in the ways that best serve patients' interests'*[115]

The message is clear, all nurses, midwives and medical practitioners on a United Kingdom professional register are expected to work within their levels of competence and should operate within best practice guidance.

14.8.2. Findings

Consultant Psychiatrist

The Consultant qualified in medicine at the University of the West Indies in 1997. She then occupied pre-registration posts for 18 months, and then worked for a further 18 months as a Senior House Officer, part-time casualty officer, and part-time GP, all in Trinidad. From January 2001 she has worked continuously in the United Kingdom, first of all in two locum Senior House Officer (SHO) posts, until in February 2001 she worked for the first time in psychiatry. She occupied a mix of SHO and Staff Grade posts in psychiatry until August 2005, when she was appointed as locum Consultant Psychiatrist, the post she held at the time of the incident. As far as her professional training is concerned, she passed the Part 1 Membership examination of the Royal College of Psychiatrists (MRCPsych) in 2004, and passed the Part 2 Membership examination in June 2008.[116]

At the time of the incident she had therefore not passed the full membership examination, and had not obtained the Certificate of Completion of Training (CCT) from the Post Graduate Medical Education and Training Board that would enable her to be appointed to a

substantive Consultant post. However, the Royal College of Psychiatrists have informed the Independent Investigation Team that a Trust is entitled to appoint as a locum consultant a person who they deem to be competent to fill the post.

In the interview with the Trust CEO and Director of Nursing on the 9 March 2009 the question of the Consultant's qualification for appointment was raised. The Trust CEO was not aware at interview that the Consultant did not possess the full MRCPsych at the time of the incident. However the responses at that interview indicate that the Trust had arrangements in place for back-up advice to the Consultant.

The Independent Investigation Team found the following:

- The locum Consultant Psychiatrist was not suitably qualified at the time of the incident to hold a substantive Consultant position, however The Royal College of Psychiatry acknowledged that it was acceptable for her to hold a locum Consultant position if she was deemed competent by her employer.

- Mr. X had been assessed by the Consultant as being a high risk to himself several days earlier, and although he did not meet the criteria for compulsory detention it would have been reasonable to have seen a more assertive plan put into place to monitor, manage and treat his condition.

- Mr. X's medication was changed on the 1 October 2007 by the Consultant perhaps on reasonable grounds, however his lack of response to two types of medication was not reviewed and Mr X's lack of compliance was not taken into consideration on the management of his care as a whole.

CPN/Care Coordinator

It was not possible to interview the CPN/Care Coordinator as she no longer resides in the United Kingdom. Neither has it been possible at the time of writing this report to make contact with her. The Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed stated that the CPN/Care Coordinator had been a qualified Psychiatric Nurse for six years. The CPN/Care Coordinator explained to the Coroner, that following allocation, part of the function of a Community Psychiatric Nurse is to assess the mental health and social care needs of patients referred into the Community Mental Health Team. The CPN/Care Coordinator described how the patient would then be discussed with the Multidisciplinary Team and way forward agreed and planned.

The Independent Investigation Team interviewed the CPN/Care Coordinator's Manager, in order to understand how the Team and the CPN/Care Coordinator worked at the time Mr. X was receiving his care and treatment. The Manager recalled that in the summer of 2007 the Community Team comprised one Band 5 nurse, the rest being Band 6. There was an Occupational Therapist who was Cognitive Behaviour Therapy trained, however she was on maternity leave at the time. There was an Approved Social Worker and Psychiatrists. The Team comprised a total of 20 people. During this period case loads averaged 30, which fell within National Guidance parameters.

The Manager understood that the CPN/Care Coordinator felt that at some stage she had a caseload of 48 although the Manager felt that this could not have been the case. Part of the Manager's job was to identify patients who could be discharged and moved forward and discharged. The CPN/Care Coordinator had a mixed caseload and she liked assessments and formulating plans. She was 'psychologically minded' and wanted to expand this aspect of her practice. The CPN/Care Coordinator was keen to join the psychological therapy supervision group and as a result the CPN/Care Coordinator had supervision which was psychodynamic in nature on a monthly basis. At the time she acted as Mr. X's Care Coordinator the CPN had no Cognitive Behaviour Therapy qualification and no experience in the care or treatment of people with PTSD or who required trauma therapy.[117]

14.8.3. Conclusions

It would appear that both the Consultant and the CPN/Care Coordinator had the required levels of qualification and experience to treat most patients coming into the Community Mental Health Team on a daily basis. However Mr. X had a complex and unusual presentation. The Team accepted that Mr. X probably had PTSD, but it is clear that they did not have the appropriate levels of experience to manage and treat this condition.

At the time of the incident, the Consultant had not passed the full membership examination of the MRCPsych, nor completed full training to be eligible for a Certificate of Completion of Training. Under these circumstances the Trust had a responsibility to arrange appropriate ongoing supervision or mentoring, and to ensure rapid access to advice if she needed to make a major clinical decision in a complex clinical situation, which it provided

The CPN/Care Coordinator was placed in a position that exceeded her levels of competence. The Internal Investigation report stated that she had access to 'expert psychological advice'. No matter how sound this advice may have been it could never be regarded as best practice for an inexperienced (she had not treated PTSD before) and

unqualified practitioner (she had no therapy qualification) to undertake a skilled role for which they were not trained whilst receiving 'remote' supervision. It is not clear whether or not the Community Team would have considered referring Mr. X on to an appropriate therapist at some stage, however the 15 weeks that he remained with the Community Mental Health Team represents a lost opportunity. His condition was not appropriately assessed, diagnosed, treated or managed.

Contributory Factor Number Eight. Failure to adhere to Trust local policy and national guidance compromised the quality of care that Mr. X received.

14.9. Critical Issue Number 9. Clinical Supervision

14.9.1. Context

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'[118]

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.

Throughout the entire period that Mr. X received his care and treatment from the Trust sound clinical supervision guidelines were in place. The Trust Supervision Policy (August 2007) made clear distinctions between professional supervision, clinical/practice supervision and managerial supervision. This policy stated that specialist psychotherapy supervision could also be provided for those individuals requiring it.

Professional supervision was meant to cover current professional issues and also encompassed individual performance review. Clinical/practice supervision was meant to cover therapeutic and practice issues and detailed case examination. Managerial supervision was meant to cover day to day practical issues and caseload management.
The August 2007 policy stated that all practitioners should have access to no less than 12 sessions per year for a full time post. It is not clear from the policy whether doctors were

expected to receive access to clinical supervision in a formal manner or how the arrangements were to be managed for medics.

14.9.2. Findings

The Service Manager explained to the Investigation Team that in the summer of 2007 the service was subject to a great many pressures. Amongst other things the Service Manager was at this time engaged in the process of conducting a clinical supervision audit and as a result she was not able to monitor the supervision arrangements for the Community Team. The Service Manager recalled that the CPN had wanted to receive specialist psychotherapy supervision, and that she had joined this group. This meant that the CPN was probably not receiving specific clinical supervision for her role as a Care Coordinator and Community Psychiatric Nurse. The Service Manager continued to provide managerial supervision to the CPN but could not recall ever having discussed Mr. X.

The Consultant had an allocated mentor and supervisor, with whom she could discuss difficult cases. The Consultant did not discuss any aspect of Mr. X's case with her supervisor. The Consultant did not feel that Mr. X's case required any in depth discussion as the difficulties that were being encountered appeared to be process issues regarding assessment and access to an ASW. These issues she discussed with the Community Mental Health Team Manager.

14.9.3. Conclusions

Both the CPN and the Consultant had access to clinical supervision and mentoring. It would appear that the CPN did not receive specific clinical supervision for her Care Coordination and nursing practice having chosen to take specialist psychotherapy supervision. It is difficult to understand how psychotherapy supervision could benefit a person with no psychotherapy training especially if is at the expense of receiving more appropriate supervision relevant to their actual role and professional status.

It is possible that had the CPN presented Mr. X within a clinical supervision context with a Care Coordination or nursing focus, then the fact that Mr. X's assessment was not following traditional CPA lines could have been detected and remedial action could have taken place. It is also possible that the appropriate response to the NICE guidance for PTSD would have been discussed and a more appropriate course of action taken. It is the view of the Independent Investigation Team that appropriate clinical supervision, had it been given to the CPN, could have led to Mr. X receiving a care and treatment package that would have

met his needs more actively. This in turn could have alleviated the levels of distress that he was experiencing and provided a better clinical outcome for him.

Contributory Factor Number Nine. Inappropriate clinical supervision contributed to the incomplete CPA that Mr. X received.

14.10. Critical Issue Number 10. Documentation

14.10.1. 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 works in two ways. ... it 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*[119]'

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 was considered necessary; or 8 years after the patient's death if the patient died while still receiving treatment.

14.10.2. Findings

As a point of good practice it must be noted that the CPN/Care Coordinator wrote on a regular basis to both Mr. X and his GP. This is to be commended.

Generally the clinical records appear to be set out well. All entries are dated and signed clearly. However there are issues regarding the contemporaneous nature of some of the

clinical record. On first viewing the records look to be complete and well set out. On closer examination it is obvious that certain entries have not been entered in a timely manner.

The CPN made a hand written entry on the 3 October 2007. The next entry was made by SW 1 on the 16 October 2007 following the intervention by the Home Treatment Team. The CPN then added at later dates her entries for the 9 October, the 11 October, and the 15 October. It is not clear whether these entries were made from memory or with the assistance of a notebook. The entries run to several pages and it would appear that the entry for the 9 October 2007 was made at least a week after the events that they record. It is difficult to understand how the CPN could remember all of the interventions that she recorded in such detail. Indeed because of this anomaly in the record the Independent Investigation Team cannot be certain that the CPN did not enter all of her entries at a much later date than the record would suggest.

It is important that health care professionals keep contemporaneous documentation. The clinical record is primarily a communication tool. It was apparent that during this period Mr. X's condition was giving cause for concern. It could have been very difficult for another team member to have picked up the case if required to do so as the entire period was not documented at the time that the events were occurring.

The risk assessment and CPA review was dated the 1 November 2007. A copy was received by the GP surgery on the 9 November 2007. There can be no doubt that this documentation was contemporaneously developed, copies were also to be found in the probation records.

The CPN chose not to utilise the CPA documentation. By not doing she was not breaching any Trust policy or guidance that was in operation at the time. However the Cognitive behaviour Therapy (CBT) paperwork did not directly equate with the CPA documentation. The CBT documentation focused primarily on the assessment of behaviour, cognition and emotion. The CPA documentation focused on holistic assessment and also included a full social assessment of needs that included accommodation, finances and employment, all issues that were providing Mr. X a great deal of anxiety.

It is clear from the information gathered at the clinical witness interviews that many more assessments, decisions and meetings probably took place than those that were recorded in the clinical notes. This is regrettable as it is not possible to either understand, or verify, how these actions may have impacted upon the care of Mr. X. The CPN could not be interviewed

and so her extant records have to stand on their own as no supporting narrative could be satisfactorily sourced.

14.10.3. Conclusions

After conducting a full documentary analysis the Independent Investigation Team does not believe that the recording issues regarding Mr. X's clinical record was sinister in nature (in that the records do not appear to be a deliberate attempt to misled the reader regarding either the sequence of events or the account of what actually occurred). However all clinical records should be entered contemporaneously in order to provide the safe delivery of patient care. When this is not possible, for whatever reason, a file note should be entered in the record. When this is not done the credibility of the clinician can be called into question and the Trust can be left in a vulnerable position.

The current Trust CPA Policy now demands that CPA documentation only is used when assessing a patient subject to the Care Programme Approach.

Service Issue Number Two. Some of Mr. X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry could leave both healthcare professionals and the Trust vulnerable.

14.11. Critical Issue Number 11. Lone Worker Issues

14.11.2. Findings

On several occasions it was noted in the clinical record that the CPN collected Mr. X in her car to take him to appointments. This kind of action is generally frowned upon for the following reasons:

- **Safety:** service users who are still undergoing assessment and are likely to exhibit impulsive behaviour should not be transported in a lone health care professional's car (for example the CPN collected Mr. X in her car on the day that he received his assessment under the Mental Health Act and drove him to his appointment)
- **Insurance:** most nurses are not insured to transport patients in their cars

14.11.3. Conclusions

This issue has no direct bearing upon the events of the 26/27 November 2007. However the Independent Investigation Team wishes to make the observation that this practice potentially put both the CPN and Mr. X at risk.

Service Issue Number Three. The CPN drove Mr. X around in her car prior to having conducted a full risk assessment and without the required insurance for her car.

14.12. Critical Issue Number 12. Management of Clinical Care and Treatment

14.12.1. Management of the Clinical Care that Mr. X Received

This section examines the context in which the clinical care and treatment that Mr. X received was given and seeks to give an account of how services were managed during the period that Mr. X was receiving his care and treatment. This section serves to provide a general summary of the total quality of the clinical care and treatment that Mr. X received.

The above sections have examined all of the separate components of the care and treatment that Mr. X received. It is important to bring all of these factors together when examining Mr. X's case in order to understand why his case was managed in the way that it was.

14.12.2. Findings

Mr. X was referred to secondary care mental health services on the 28 June 2007 by his General Practice. At this stage the referring GP felt that Mr. X had a possible diagnosis of depression and PTSD and sought an opinion and some psychological therapy intervention.

The Derby City Community Mental Health Services received the referral and after discussion at a team meeting felt that it was not an urgent case and Mr. X was duly allocated to a Community Psychiatrist Nurse[120]. No one on the team had any experience of treating PTSD or of providing trauma counselling.

Mr. X was seen for the first time on the 16 August 2007 by the CPN who had been allocated as Mr. X's Care Coordinator. On this occasion she began the process of history taking and assessment. The CPN documented the first and second meeting with Mr. X on Cognitive Behaviour Therapy forms. This would indicate that the CPN and the Team had decided to accept the initial GP diagnosis of PTSD and were planning to provide a psychological therapy approach. It is unclear whether or not Mr. X would have been referred on to an experienced therapist once the CPN had conducted her initial assessment. At this stage none of the following occurred:

- an assessment to indicate the degree to which Mr. X was depressed;
- an assessment by a health care professional trained to recognise the symptoms of PTSD;
- the development of a risk assessment in accordance with the NICE guidance for PTSD;
- the development of a care plan that focused on the rapport building necessary in order to provide the safe and therapeutic treatment of PTSD.

The CPN focused on Mr. X's history and tried to ascertain the details of his past trauma. She also wanted him to discuss his feeling and emotions with her. Mr. X was reluctant to do as this made him feel worse. Had the CPN read the NICE guidance she would have realised that her approach was ill considered and placed Mr. X at the risk of having to confront his issues in an unsafe and unsupportive environment.

Mr. X's condition appeared to grow worse. It cannot be known whether the CPN's approach was instrumental in this or not. The CPN made her concerns known to the Consultant Psychiatrist who saw Mr. X on the 1 October 2007. During this consultation Mr. X's reluctance to discuss his history and his emotions were seen as being a barrier to his being

able to commence psychological therapy. When he was seen by the Consultant again on the 15 October his continued reluctance to discuss his condition and his angry presentation were attributed to him having 'unhelpful personality traits'.

Quite correctly at this juncture the Consultant Psychiatrist decided that an assessment under the Mental Health Act (83) was indicated due to Mr. X's suicidal ideation. On the 18 October 2007 Mr. X was seen by his Consultant Psychiatrist and his GP in order for this to take place. It was decided at this stage that Mr. X did not meet the criteria. On the day of the assessment Mr. X said that he still had thoughts of committing suicide, but that they were passive at present. He agreed to continue with his medication and to continue to engage with mental health services and it was agreed that he would only be seen on a fortnightly basis as more frequent meetings made him feel worse. At this stage none of the following occurred:

- a formal risk assessment;
- the development of a care and treatment plan;
- the development of a crisis/relapse plan.

The Independent Investigation Team do not dispute that on the 18 October 2007 Mr. X did not meet the criteria for compulsory detention under the Mental Health Act (83). However Mr. X had given the Community Team genuine and appropriate cause for concern. The abrupt 'standing down' from the case is not easy to understand. A patient who is not detainable may still require prioritised care and careful monitoring. On the 18 October the following was known about Mr. X:

- he was depressed and often had suicidal thoughts;
- he had the symptoms of PTSD;
- he was anxious and had difficulty sleeping;
- he had some possible issues with alcohol and cocaine consumption;
- he had employment and financial difficulties;
- he had experienced a recent bereavement;
- he was about to become homeless;
- he had a criminal history and was requesting support from the mental health team in relation to his pending Court appearance.

Despite all of this knowledge no full assessment had been undertaken and no plan of care had been developed for Mr. X. On the 1 November the CPN undertook a FACE Risk Profile assessment in the absence of Mr. X who she had not seen since the 18 October 2007. The CPN described this assessment's status as being 'initial'. The tick box indicators and the narrative indicated that Mr. X was a serious risk to himself; this was correctly assigned within the assessment summary[121]. The tick box indicators and the narrative did not indicate that Mr. X was a risk to others. The box labelled 'persons potentially at risk' did not indicate that any member of the public or person of Mr. X's acquaintance was at risk[122]. However in the assessment summary the CPN assigned Mr. X to the 'significant risk of harming others' category[123]. It is unclear on what evidence she was basing this.

Regardless of whether the CPN filled the FACE Risk Profile in correctly or not, the fact remains that she did not put an appropriate care plan in place to adequately deal with the risks identified. It is also clear that whilst the CPN sent the risk assessment off to the GP, the Consultant Psychiatrist remained unaware of it and that no Team-based discussion took place to ensure that Mr. X received a multidisciplinary review[124].

On the 1 November 2007 the CPN also held a CPA review to which no one attended. The plan consisted primarily of describing Mr. X's presenting difficulties. The required actions were not filled in. As a result the plan consisted of the CPN remaining engaged with Mr. X to 'monitor his mental state and involve to other professional agencies if appropriate or necessary'[125]. The CPN also stated that she would offer practical or psychological support if Mr. X were to indicate that he would like this.

Following the 18 October 2007 Mr. X was seen on one further occasion and was spoken to on the telephone on two occasions. On the 13 November 2007 Mr. X telephoned the CPN in 'a state of panic'. He was experiencing difficulties with his Community Service Order and he was also experiencing financial problems. The CPN recorded in the notes that Mr. X was 'cross' and that she reminded him that she had offered to help him several weeks ago and that he would now possibly get help more quickly if he approached the Citizens Advice Bureau.

On the 15 November 2007 Mr. X met with the CPN for the last time. She recorded that Mr. X was angry. He had not been to the Citizens Advice Bureau. The CPN offered to accompany him, but he declined her offer. The CPN explained that the probation officer had stated that she could not help Mr. X by writing him a letter for court. The CPN wrote that she 'attempted

to validate Mr. X's anger', it was also noted that Mr. X would not discuss his mental state or the intensity of his suicidal ideation and that he appeared to be low in mood[126].

14.12.3. Conclusions

The Independent Investigation Team is of the view that Mr. X was a complex individual who presented with many issues and difficulties. It is easy to critically evaluate a case with the benefit of hindsight. There are some things that the clinical team treating Mr. X did not know about him at the time he was receiving care and treatment from them, such as the fact that he had a recent broken relationship and that his application for British citizenship had been declined, both factors that may have exacerbated his depression and anxiety.

Few mental health professionals in secondary care settings have the required experience to treat PTSD, and few will have either the experience or the training to provide trauma focused therapy. It is entirely probable that patients like Mr. X are presenting on a regular basis to Mental Health Trusts across the country and are allocated to Community Teams who do not have specialist experience and training. In this the Derby City Community Team was not alone.

However local policy and national guidance is put into place specifically to support clinical teams when managing both the routine and the more challenging patient presentations. Trust local policy, for example, specified the importance of risk assessment and the NICE national guidance set out best practice when treating PTSD. It would appear that neither the CPN/Care Coordinator nor the Consultant Psychiatrist had sufficient experience to manage Mr. X's problems, but it is possible that had they worked within their areas of competence Mr. X may have been referred on to a more appropriate health professional/service.

One feature regarding the management of Mr. X's care and treatment is the distinct absence of clear clinical leadership. On referral the allocation of Mr. X's case to the CPN was a multidisciplinary team decision. It was deemed that Mr. X's case was not urgent. However it would appear that throughout September 2007 the CPN became increasingly concerned about Mr. X. A referral was made for him to be seen by the Consultant Psychiatrist on the 1 October, but not before the CPN had contacted the Crisis Team seeking additional help and support. It would appear that this decision to involve the crisis team was taken without discussion with the MDT or the Consultant Psychiatrist. The CPN did discuss the case with her Community Team Manager, but no multidisciplinary discussion was documented.

Mr. X was seen by the Consultant Psychiatrist on the 1, 15 and 18 of October 2007. As a result of these meetings Mr. X's medication was reviewed, he was assessed under the Mental Health Act (83) and was passed back to the care of the CPN/Care Coordinator. His diagnosis had still not been confirmed, his care and treatment needs not identified and no coherent management plan was developed.

In short Mr. X did not receive a multidisciplinary review of his case. At no point did he receive a full assessment that led to a coherent management plan. Mr. X did not receive a holistic approach to his health and social care problems, which were considerable, and as a result he continued to encounter difficulties with which he could not deal. As his life appeared to spiral out of control ill equipped professionals from secondary care mental health services continued to misread his clinical presentation and reluctance to engage fully with them.

Prior to Mr. X being assessed under the Mental Health Act (83) on the 18 October 2007 mental health services had sought to engage with him, almost to excess. After the 18 October 2007 services virtually withdrew. At no point did the Team consider how best to work with a person of Mr. X's ethnicity and potential diagnosis. Mr. X's condition remained partially treated and it is not possible to see what benefit he received from his referral to secondary care services. This being said, it is not possible to assign direct causality to the quality of the care and treatment that Mr. X received and the events of the 26/27 November 2007. The reasons for this are set out below.

Mr. X was not considered to have been dangerous by the criminal justice system, he had been in receipt of a punishment order only and not a supervision order which would normally have been the case had he been considered a risk to the safety of others[127]. Throughout his time with secondary care mental health services Mr. X was not considered to be a risk to others as a result of his psychiatric diagnosis. It was noted that he was often angry and that he had concerns about being able to control his temper however it was never established that this was a direct result of any treatable psychiatric condition. The Consultant Psychiatrist recorded that Mr. X was not psychotic and was not suffering from any delusional thought processes. It is not possible for this Independent Investigation to find any definitive causal link between the death of Ms. Halimah Ahmed and Mr. X's psychiatric condition, whether this had been appropriately treated or not. The nature of the relationship between Mr. X and Ms. Halimah Ahmed has never been established and it is therefore not possible to know what may have taken place between them. The Coroner ruled that in his view Mr. X's mental state did not contribute to the death of Ms. Halimah Ahmed and therefore declined to provide a verdict of manslaughter and ruled that she was unlawfully killed by him. It is a fact that

people kill other people. In this case the Independent Investigation Team was not able to understand what exactly led to Ms. Halimah Ahmed's death. It is possible that Mr. X's mental state contributed to his losing control of his temper, it is also possible that Mr. X's actions had absolutely nothing to do with his mental state. It cannot be known or proved and no causal link can be made.

Mr. X was considered to be a high risk of harm to himself, by secondary care mental health services. Mr. X's social situation grew steadily worse throughout the summer and autumn of 2007. It is certain that Mr. X presented as being depressed and possibly had PTSD. It cannot be known what the final trigger was for Mr. X to end his own life, it is not possible to say whether or not Mr. X would have killed himself had Ms. Halimah Ahmed not also met her death, but it is likely that this was the final factor. It cannot be known to what extent Mr. X's mental illness contributed to the tragic events of the 26/27 November 2007. Neither can it be known how to what extent Mr. X's social stressors contributed to them. However it is certain that Mr. X was an individual whose life was falling apart in such a way that he was ill equipped to deal with it. It has to remain conjecture as to whether or not mental health services could have altered the outcome of the events of the 26/27 November 2007 as there are many facts that remain unknown about the lives of Mr. X and Ms. Halimah Ahmed. However it can be said that Mr. X's condition was partially treated at best and that he did not receive care and treatment from Derbyshire Mental Health Services Trust in accordance with either local policy or national guidance.

Contributory Factor Number Ten. Mr. X's case was not subject to coherent clinical case management; as a result his condition was at best partially treated. This contributed to Mr. X's continued distress and inability to manage his affairs.

14.13. Critical Issue Number 13. Clinical Governance Processes

14.13.1. 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'[128]

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.

The Healthcare Commission was a non-departmental public body sponsored by the Department of Health of the United Kingdom. It was set up to promote and drive improvement in the quality of health care and public health in England and Wales. The Healthcare Commission deemed that Derbyshire Mental Health Services NHS Trust received the highest score for all applicable assessments that contribute to the overall quality of services in the year 2007/2008. The Trust scored 'excellent' for quality of services because it scored 'fully met' for both core standards and existing national targets, and 'excellent' for new national targets. Derbyshire Mental Health Services NHS Trust met all of the core standards set by Government by the end of the assessment year 2007/2008[129].

Service User feedback to the Trust has been positive with the following comments having been made:

'We have received excellent and well co-ordinated care'.

We had confidence in the caring staff who treated us with respect'.

We received good information and support throughout'.[130]

14.13.2. Findings

The Trust has been awarded 'Excellent' for both quality of service and good use of resources in terms of the annual Healthcare Commission rating for the last two years.

During the period that Mr. X was receiving his care and treatment from the Trust it would appear that robust clinical governance procedures were in place. The Trust governance structures had strong support from the Trust Board Chair and Non Executive Directors and also from Trust Executive Directors and Senior Managers. The Trust had a sound suite of clinical policies and procedures supported by an appropriate audit programme.

The Trust also had a sound Untoward Incident Policy in place at the time of the events of the 26/27 November 2007 with sensible and pragmatic strategies in place in order to learn lessons and disseminate information.

14.13.3. Conclusions

Many of the everyday actions and decisions that take place in clinical practice fall 'sub audit'. Governance systems often measure compliance and quantity rather than content and quality.

In the case of Mr. X it is apparent that local policy and national guidance were not adhered to. All healthcare professionals can at times 'make the wrong call'. It is a salutary reminder to all healthcare professionals to ensure that they stay up-to-date and alert to any changes to national treatment guidance and that all local policies are adhered to, these provide a vital safety net of care which become even more relevant when faced with patients with complex presentations.

It must be remembered that a single case can provide no sweeping generalisations for an entire organisation. Clinical witnesses who gave evidence to the Independent Investigation Team described a service that could at times be pressured but that worked within reasonable resource allocations. Clinical witnesses were aware of Trust policy and guidance and all appeared to take their roles and responsibilities seriously. The Independent Investigation Team, whilst acknowledging that Mr. X's case should have been managed differently, does not believe any acts of omission were due to poor clinical governance systems.

15. Findings and Conclusions

Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the homicides that occurred in November 2007. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

2. **Contributory Factor.** 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 in Mr. X's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of November 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Causal Factors. The Independent Investigation Team concluded that there were no direct acts of omission or commission that could be positively identified to have had a direct causal bearing on the events of November 2007. The reasons for this are set out in section 14.13.3.

Contributory Factors

The Independent Investigation Team found eight factors that contributed to the less than effective care and treatment package that Mr. X received.

Contributory Factor Number One. Mr. X did not receive a diagnosis based on formally recognised assessment criteria directly following his referral to mental health specialist services.

Contributory Factor Number Two. Mr. X did not receive a coherent care and treatment plan.

Contributory factor Number Three. Mr. X did not receive an appropriate care and treatment package for his presumed diagnosis of PTSD. As a result Mr. X may have been placed at significant risk of deterioration and harm.

Contributory Factor Number Four. Mr. X was not risk assessed in a comprehensive and timely manner. The eventual risk assessment was not communicated effectively and did not result in the development of a robust care and treatment plan which was formulated as part of a multidisciplinary team action.

Contributory Factor Number Five. Mr. X did not receive a comprehensive and holistic CPA. The notion of Mr. X's presumed diagnosis of PTSD was formulated to the detriment of all other diagnoses and approaches. As a result Mr. X did not receive the care, support and treatment that he needed.

Contributory Factor Number Six. The services that were offered to Mr. X did not take his cultural needs and requirements into account. This contributed to the provision of an approach which was not sensitive to his needs and which may have led to his difficulties in engaging with the services that were offered to him.

Contributory Factor Number Seven. Clinical practice within the Trust did not adhere to internal policies and procedures.

Contributory Factor Number Eight. Failure to adhere to Trust local policy and national guidance compromised the quality of care that Mr. X received.

Contributory Factor Number Nine. Inappropriate clinical supervision contributed to the incomplete CPA that Mr. X received.
Contributory Factor Number Ten. Mr. X's case was not subject to coherent clinical case management; as a result his condition was at best partially treated. This contributed to Mr. X's continued distress and inability to manage his affairs.

Service Issues
The Independent Investigation Team found three Service Issues

Service Issue Number One. The Trust was unable to provide an ASW to undertake a Mental Health Act (83) assessment in a timely manner.

Service Issue Number Two. Some of Mr. X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry could leave both healthcare professionals and the Trust vulnerable.

Service Issue Number Three. The CPN drove Mr. X around in her car prior to having conducted a full risk assessment and without the required insurance for her car.

Conclusions
Mr. X was a young man with a complex presentation. He had been an asylum seeker and had experienced traumatic and violent events in his native Iraq. During the years that he lived in the United Kingdom it would appear that he integrated well, however Mr. X was subject to the isolation and loneliness often experienced by refugees.

Mr. X's life started to unravel early in 2007. He experienced a series of difficulties which led to employment, financial and housing problems. Mr. X experienced a broken relationship during this time and also suffered from bereavement. He began to drink and abuse cocaine which in turn led to his being arrested for dangerous driving and refusing to provide a sample of breath. Mr. X then had to encounter the Criminal Justice system and his mental health began to suffer.

Mr. X's GP diagnosed him as suffering from depression and PTSD. As no formal assessment was conducted by secondary care mental health services it is now not possible to understand what his definitive diagnosis would have been. It would however seem likely that Mr. X had difficulty in both resolving past events and living with his current social stressors.
Mr. X's care and treatment as provided by the Derbyshire Mental Health Services NHS Trust did not always adhere to local policy and procedure or fall within national guidance. Mr. X did not receive a comprehensive assessment, care or treatment plan. The approach that the Derby City Community Mental Health Team chose to pursue could not always be seen as best practice.

The Independent Investigation Team would like to acknowledge that Mental Health Trusts face considerable challenges when faced with delivering care and treatment to service users who are ambivalent and who do not wish to either fully engage or comply with the services being offered. Mr. X was ambivalent and as well as being a complex individual was at times difficult to engage with. The Trust personnel did try to build a rapport with Mr. X and did a great deal to engage meaningfully with him.

However the approach adopted by the CPN/Care Coordinator went against all of the NICE guidance for the treatment of PTSD and trauma focused therapy. It is unfortunate that the clinical members of this team did not work within their levels of competency and experience. It is the view of the Independent Investigation Team that Mr. X required a skilled and appropriately qualified therapist to assess and to treat him. It is entirely possible that the somewhat clumsy approach that was adopted by the CPN/Care Coordinator and the CMHT exacerbated Mr. X's ambivalence in engaging with services which ultimately left him estranged and vulnerable.

The Independent Investigation Team could make no definitive causal link between the care and treatment that Mr. X received and the events of 26/27 November 2007. However the Team was able to identify ten contributory factors which each played a part in the less than

satisfactory management of Mr. X's care and treatment package. It is the view of the Independent Investigation Team that Mr. X's mental health problems were not fully assessed, understood or managed. As a result Mr. X's condition was at best partially treated.

16. Derbyshire Mental Health Services NHS Trust's Response to the Incident and the Internal Investigation

The following section sets out the Trust response to the events of November 2007. Directly following the events of 26/27 November 2007 the Trust reported the incident to the Strategic Health Authority and it was graded 'red' which meant it was regarded as being an incident of the most serious kind. On the 28 November 2007 the police took statements from both the CPN and the Consultant.

16.1. The Trust Serious Untoward Incident Process

The Trust had in place an excellent untoward incident reporting and investigation procedure in place at the time of the events of the 26/27 November 2007. This procedure document stated that:

'Human error is routinely blamed for untoward incidents, and while an act or omission by a member of staff may appear to be the immediate cause of an incident, investigation often identifies a series of events and departures from safe practice influenced by the working environment and wider organisational issues.'

It must be noted here that the last incident of this kind had occurred some ten years previously. The Trust had not instituted an internal homicide/suicide investigation process against *current* best practice before.

In accordance with Trust procedures an initial fact finding report was conducted by the Community Mental Health Team Manager. This report stated that Mr. X had been seen for the first time on the 16 August 2007 and that his initial assessment had been completed on the 29 August 2007 (this in fact was not the case). The report on the whole provided an extremely sound chronology of events. This reports states that Mr. X's care plan was detailed and that it had actions under every section except for physical health for which no

problems were identified. This conclusion is not shared by the Independent Investigation Team as the care plan does not in fact detail actions but lists problems. This report makes no comment regarding the fact that both the risk assessment and care plans were completed eleven weeks after his first contact with services, and that this might not have been a timely response. The report states that the CPN in accordance with Mr. X's relapse plan requested a Mental Health Act (83) assessment on the 26 September 2007 but failed to notice that the relapse plan had not been written until the 1 November 2007.

In short this report found that the standard of record keeping was good and that there was a consistency of information and congruence between the logs, the care plan, the risk screen and the risk plan.

16.2. The Trust Internal Investigation (Structured Investigation Report)

In accordance with Trust procedures an Internal Review into the care and treatment of Mr. X was arranged. The purpose of this Review was:

'to ensure that the Trust fulfilled its accountability for the reporting of serious incidents to the NHS Executive , and to enable the Trust to respond to the Coroner's enquiries and to ensure that any immediate lessons learned from experience can lead to quality improvements.'

The Internal Review Team consisted of:

- The Area Service Manager, Community Care North
- A Consultant Psychiatrist
- The Associate Director of Nursing- Practice and Standards
- The Clinical Governance manager NHS Derby City PCT

The Internal Review Team was supported by the input from a Clinical Psychologist.

The Internal review team Terms of Reference were:

1. To establish the factual circumstances leading up to the incident as accurately as possible and compile a chronological sequence of events.

2. To thoroughly examine the care and treatment afforded to Mr. X, whilst under the care of Derbyshire Mental Health Services NHS Trust.

3. To interview key members of the clinical team (including the RMO and Care Coordinator), and to take statements from them as appropriate.

4. To review all clinical records and to consider the effectiveness of Care Planning in respect of Mr. X, including the decision not to pursue a mental health Act Assessment and the access to Crisis Services.

5. To review care and treatment in relation to national and Trust Policy, e.g. CPA, Mental Health Act etc.

6. To identify any risk factors or management issues which warrant action at the next level.

7. To work with representatives from Derby City PCT to ensure the internal review includes an examination of the care and treatment of Mr. X by primary care.

8. To include a clinical review of the case from a specialist in PTSD

9. To compile and present a report to the Risk management Group by Wednesday 30 January 2008.

Findings of the Internal Review

The findings were as follows:

What went well:

1. The general standard of record keeping was found to be good.
2. That Mr. X probably did have PTSD and that it was treated appropriately with the exception of not providing him with more information about his condition.
3. That the Consultant Psychiatrist had assessed Mr. X very thoroughly and that she had linked well with the CMHT staff. However it was felt that the Consultant could have offered a follow up appointment a little sooner than she did.
4. That clinical staff had acted appropriately in terms of the Mental Health Act (83).
5. That the prescribed medication was appropriate.
6. It was felt that the CPN/Care Coordinator had adopted an engaging approach in a practical holistic fashion which was sensitive to his difficulty in relating to discussing the experiences which were troubling him.
7. That sound multidisciplinary discussion took place and that sound formal clinical supervision arrangements were in place for the CPN/Care Coordinator to discuss Mr. X's case with a psychologist colleague.

What did not go so well:

1. Difficulties were noted relating to the availability of an Approved Social Worker. It as stated that best practice would have required that the assessment should have occurred jointly with the medical and social worker inputs together.
2. It was noted that the CPN/Care Coordinator was visiting Mr. X alone and that she may have been at risk.

Independent Investigation Team Analysis of the Internal Review

The internal review conducted by the Trust complied with the requirements of Trust policy and procedure and was completed within the timescales set out in the National Guidance which is to be commended. The internal review team was comprised of a suitably qualified and experienced panel.

However it is the view of the Independent Investigation Team that the internal review did not adequately explore all of the issues relating to the care and treatment of Mr. X. It is taken as fact that Mr. X received a comprehensive and holistic assessment and CPA. He did not. The forms were filled in but careful analysis of the content will determine that no holistic assessment actually occurred and no resulting plan was developed.

The notion that the multidisciplinary team was working well because the doctor and nurse interviewed Mr. X together is misleading. The meetings that the doctor and nurse attended together were meetings brought about due to Mr. X's crisis situation. No coherent plan was constructed as a result. Best practice would have expected the multidisciplinary team to have been working together both before Mr. X's crisis and after it, there is no evidence of how, or whether this occurred.

No mention is made of the timeliness of Mr. X's risk assessment, or the absence of any adequate relapse or crisis plan. The risk assessment had not been compiled in accordance with Trust policy and procedure.

It was the view of the Internal Review that the CPN had managed Mr. X's presumptive diagnosis of PTSD appropriately, even though the NICE guidance would beg to differ. The fact that she was not qualified to conduct Cognitive Behaviour Therapy or trauma focused therapy seems to have been ignored. The fact that Mr. X had been referred for such treatment and an opinion, by his GP, was not considered to be relevant.

The Internal review felt that the fact the CPN received her clinical supervision from a psychologist colleague as evidence of good practice; however this may not have been the best model of supervision for the CPN to follow in her role as a Care Coordinator.

The Independent Investigation Team concurs with the Internal Review findings in relation to Mr. X's medication, lone worker issues and the use of the Mental Health Act (83).

The Independent Investigation Team understands that this is the first internal review that the Trust has conducted for ten years inquiring into the care and treatment of a service user who has been linked to a homicide. As such none of the Internal Review Team members had been involved in an exercise of this kind before. Whilst the findings may have been a little superficial the internal review appears to have been conducted appropriately. Witnesses supplied statements and were adequately prepared for their contribution to the investigation.

One thing that the Trust needs to consider for all future serious untoward incidents is how to disseminate findings. Most of the clinical witnesses that were interviewed by the Independent Investigation Team had not seen a copy of the completed internal review report and could not identify any subsequent changes in practice that had occurred as a result of the ensuing action plan.

16.3. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[131]. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;

- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[132].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

No contact was made by the Trust with members of either Mr. X's family or the family of Ms. Halima Ahmed following the events of the 26/27 November 2007. Neither family was consulted about the internal investigation or involved in any aspect of its process, neither family was offered any counselling or support in the immediate aftermath of the deaths.

This lack of communication has been the cause of great distress to the parents of Ms. Halimah Ahmed. The Trust wrote to the family for the first time immediately following the Coroner's Inquest in the winter of 2008. The family felt that this response was 'too little and too late'.

The Trust Chief Executive has acknowledged to the Independent Investigation Team that this is something that the Trust could have managed better and is working on in order to bring about change. The Chief Executive acknowledged the sensitivity of this kind of situation and is considering exploring how support could be offered to families utilising the inputs of neighbouring Mental Health Trusts if a conflict of interest, for example, is identified. The Independent Investigation Team was also informed that the Strategic Health Authority had issued new guidance at the end of September 2008 detailing how victim's families should be communicated with following a situation involving a homicide.

In June 2008 the Trust issued its own Being Open Policy which detailed how it would work with families in the future. This new policy states that 'Being Open' involves acknowledging, apologising and explaining when things go wrong. It also involves conducting a thorough investigation into the incident and reassuring patients and /or their carers that lessons learned will help prevent the incident reoccurring. The policy also makes provision for providing support for both services users, victims and their families (where appropriate) to cope with the physical and psychological consequences of what has happened.

16.5. Staff Support

Throughout the Internal Review process witnesses were offered support from the Head of Community Care Clinical Psychology. The Internal Review Team felt that all witnesses received positive support from both a personal and managerial point of view. This was borne out during the interviews held with witnesses during the Independent Investigation process.

16.6. Trust Internal Review Recommendations

The recommendations from the Internal Review were as follows:

1. *'The staff involved in the investigation should be provided with clear feedback as to the findings.*

2. *The current system relating to the Approved Social Worker rota in Derby City should be reviewed. The role of the second on call Approved Social Worker requires specific attention in terms of deployment and the interface between Community Mental Health Team Approved Social Workers and Crisis Assessment Home Treatment Approved social Workers.*

3. *The recording of Crisis Team assessments for Home treatment should be further discussed with the individual member of staff involved with the incident. The team practise regarding the issue to be reviewed to ensure consistency of approach.*

4. *That Derbyshire Mental Health Services NHS Trust practice in relation to the term 'police safe and well check' should be clarified by means of Blue Light information to more clearly reflect the roles and responsibilities of the respective agencies.'*

The Internal Review did not write a recommendation regarding the issue of staff safety but noted that more work may be required in this area subject to the information pending from the police investigation into Mr. X's background.

16.7. Progress against the Trust Internal Review Action Plan

The Trust developed a joint action plan that incorporated both the findings from their Internal Investigation and the Coroner's Inquest. The required recommendation headings and resultant actions are set out below.

HM Coroner's Rule 43 Recommendation

Her Majesty's Coroner ruled that the Trust should ensure *'when considering the organisation of Approved Social Workers (ASWs) it should inculcate a specified reasonable time for ASWs to respond to requests for Mental Health Act assessments.'*

The Trust has worked collaboratively with Social Care and the Local Authority to ensure an effective response to the recommendation within set timescales. The Trust formally responded to the Rule 43 letter and this has been acknowledged by the Coroner. The rotas for Approved Mental Health Professionals (AMHPs, the new amended Mental Health Act definition) have been revised in Derby City and Derbyshire County to ensure that teams are able to cover assessments both within and outside office hours. The number of staff on the rota was increased in Derby City in effect from February 2009. Revised standards and procedures have been implemented that specifically address the requirements of the Coroner's office.

Staff Feedback

A feedback meeting was held on the 23 April 2008. This meeting gave all staff involved in the Internal Investigation with clear feedback regarding the findings.

Crisis Team Assessments

Feedback and support was offered to the individual concerned. Supervision and monitoring have been revised in order to ensure team practise has been improved.

Blue Light Clarification

Roles and responsibilities have been clarified. The revised procedure has been cascaded to all relevant parties.

17. Notable Practice

During the course of the Independent Investigation several areas of notable practice were identified. It is the view of the Independent Investigation Team that other Mental Health Trusts could benefit from the work that has been undertaken by the Derbyshire Mental Health Services NHS Trust.

1. Policies and Procedures

The Derbyshire Mental Health Trust has a series of well written clinical policies. Their current Risk Assessment and Care Programme Approach policies are particularly worth drawing to the attention of other Mental Health Trusts.

2. Recruitment of Consultant Psychiatrists

Prior to the Mr. X incident the Trust employed a number of Locum Consultant Psychiatrists. This was as a consequence of the difficulty in recruiting to substantive positions.

Following the Mr. X incident the Trust reviewed its position regarding the continued employment of Locum Consultants. All those we employed were deemed to be competent to fulfil the role of a Locum Consultant. It was agreed that they would continue to be employed as a Locum Consultant until July 2011 to enable them to apply for Article 14 in order to gain their Certificate of Completion of Specialist Training. However this was dependent upon certain conditions being met, e.g.:

a) They receive regular clinical supervision from a Substantive Consultant colleague.

b) They are registered with the Royal College of Psychiatrists for Continued Professional Development and that they remain in good professional standing for this.

c) They are subject to the Annual Appraisal Process where their training and development needs will be reviewed. They will also be subject to the Royal College 360° Appraisal.

If they obtain their CCST by July 2011, then the post they occupy will be advertised and they will be eligible to apply. However if they don't obtain their CCST by July 2011, they will cease to be employed as a Locum Consultant and the post will still be advertised.

3. Improving the Patient Experience

The Trust initiated a programme of work to support the patient experience through the adult care pathway in April 2009. The Releasing Time to Care – Productive Care Pathway has offered clinical teams a systematic way of measuring quality and patient outcomes through the application of service improvement methodology in day-to-day working practice. Releasing Time to Care – Productive Care Pathway is a no-nonsense programme of modules that are specific to the patient care pathway and are based upon the Productive Series of service improvement toolkits that were developed by the NHS Institute of Improvement and Innovation. The Trust has been delivering a unique and bespoke programme of service improvement in support of the patient journey through services by working with the clinical teams.

The programme is equipping front line staff to maximise the time they are able to spend in therapeutic engagement and increases reliability and safety of care to give the patient and improved experience. The programme helps to reduce variations in practice for core systems and processes. The programme of work has proven to be a vehicle in the trust for involving staff in the delivery of patient focused care. The clinical teams now have increased control of their working environment and are enabled to eradicate waste through their own application of service improvement tools

The advantage of bringing together teams who are across a patient care pathway (crisis and home treatment, community mental health team, occupational therapy team and ward teams) has meant that service improvements are being understood, tested and evaluated across the care pathway in a way that has not been previously adopted in the Trust. The success so far indicates clinical outcomes that support an improved patient experience and an increase in staff well being.

4. Care Programme Approach (CPA) – recent developments

Throughout 2008 / 09 the Trust has developed its training programme on CPA with the addition of specialised training on Assessment and Care Planning and Care Coordinators underpinning knowledge. Both courses have won awards from the Care Programme Approach Association.

The Trust has implemented and revised standardised documentation for use in all clinical areas across the Trust. In November 2008 the Trust implemented the requirements of the document 'Refocusing CPA', training approximately 800 staff prior to implementation.

The Care Programme Approach Team has produced a variety leaflets and booklets for staff, service users and carers :

- CPA Handbook
- Writing Good Care Plans
- Standards of mental health care and the Care Programme Approach (Information for Service Users & Information for Carers)
- CPA Statement of Values and Principles
- Criteria for 'new CPA'
- Confidentiality and Carers
- Infolink
- What is CPA

The information in the CPA Handbook gives specific advice on how the assessment and management of risk is integrated into CPA. This handbook has been issued to all Care Coordinators. The good practice guide 'Writing Good Care Plans' provides clear information to staff on what should be included in a care plan and that it should include the management if risk. The crisis card produced by the Care Programme Approach Team highlights the central role of the Care Coordinator in being a contact point for the service user or carer in periods of crisis.

18. Lessons Learned

The examination into the care and treatment of Mr. X raised four key points which could be considered useful for learning on a national basis. The points identified focus on basic and fundamental building blocks of care.

First, all Mental Health Trusts face a continued challenge when trying to provide care and treatment to service users who do not wish to engage with services. Ambivalence and non adherence to medication regimens on the part of the service user contribute at times to the delivery of less than satisfactory clinical outcomes. This difficulty has been recognised for many years and in 1999 the Confidential Inquiry into Homicides and Suicides perpetrated by mental health services users stated that all Mental Health Trusts should have polices in place to address this issue. However ambivalence and non-engagement remain persistent challenges. All Health and Social Care professionals need to follow guidelines carefully, record all Multidisciplinary Team decisions and actions, and ensure that service users don't 'slip off the radar' as a default position.

Second, risk assessment and the Care Programme Approach are recurrent themes in many Independent Homicide Investigation reports. It remains a fact that health and social care professionals do not always comply with either local or national policy and procedure guidance, this leaves both the service user and the professional vulnerable. Each professional should see risk assessment and the Care Programme Approach as being the vehicles by which good care is delivered rather than additional bureaucratic tasks unrelated to patient care.

Third, all clinical staff should remember that the clinical record exists for many reasons. The primary one being that of communication to ensure the safe continuity of patient care. A secondary reason is that the quality of the clinical record remains one of the best tests of the quality of the care and treatment that a patient receives The old adage of 'if it was not recorded then it did not happen' remains true. The Independent Investigation Team are certain that Mr. X received a better thought out care and treatment package than that which was recorded, however with the passage of time nothing can now be verified and the extant record has to 'stand alone'. The failure to record full accounts of assessment, care and treatment processes leave clinical and social care staff vulnerable to their practice being

challenged, criticised and misunderstood during an Independent Investigation process of this kind.

Fourth, individual health and social care professionals form part of a Multidisciplinary Team. All service users should expect to receive the expert inputs of individuals with the diversity of skill and experience to meet their care and treatment needs. New ways of working and new service models of delivery should ensure that all cases receive the appropriate inputs from the required professional discipline on referral. All cases should receive regular monitoring and review with input from a Multidisciplinary Team.

19. Recommendations

The Trust worked with the Independent Investigation Team in the spirit of Root Cause Analysis and took a proactive stance deciding to take the opportunity to learn lessons. As a result the recommendations have been framed with the full cooperation of the Trust which has taken the initiative to commence the implementation of revised procedures. This is to be commended.

The recommendations set out below have been derived directly from the Independent Investigation findings as defined in the identified contributory factors and service issues.

19.1. Diagnosis and Treatment

Contributory Factors one, two and three identified issues relating to Mr. X's diagnosis and treatment. They are set out below:

Contributory Factor Number One: *Mr. X did not receive a diagnosis based on formally recognised assessment criteria directly following his referral to mental health specialist services.*

Contributory Factor Number Two: *Mr. X did not receive a coherent care and treatment plan.*

Contributory Factor Number Three*: Mr. X did not receive an appropriate care and treatment package for his presumed diagnosis of Post Traumatic Stress Disorder (PTSD). As a result Mr. X may have been placed at significant risk of deterioration and harm.*

Recommendation Number One. All Trust clinicians should use the formal ICD-10 criteria for making a diagnosis. All decisions and rationales for diagnostic decisions should be clearly recorded in full in the patient clinical record.

Recommendation Number Two. All care and treatment plans should follow NICE Guidance where applicable. If this is not possible or clinically indicated then a clear rationale should be provided within the patient clinical record.

Recommendation Number Three. PTSD assessment and treatment, and trauma focused therapy requirements should be ascertained by the Derbyshire County Primary Care Trust and appropriate commissioning arrangements should be put into place to ensure that specialist services are available to compliment the services currently provided by the Mental Health Trust.

19.2. Risk Assessment

Contributory Factor Number Four: *Mr. X was not risk assessed in a comprehensive and timely manner. The eventual risk assessment was not communicated effectively and did not result in the development of a robust care and treatment plan which was formulated as part of a multidisciplinary team action.*

Since the Incident the Trust has distributed specific information to staff stating how risk information should be communicated both within the multidisciplinary team and across agencies. In October 2008 a briefing sheet was issued to clarify and highlight the main points to consider when conducting a FACE Risk Profile. The assessment and management of risk now forms part of the Trust combined CPA, Clinical Records and Risk Audit, this audit is bi-annual. The Trust Director of Nursing has recently commissioned a review into the objectivity of the FACE Risk Profile the outcome of which will inform all future Trust risk management policies and procedures. The Independent Investigation Team is of the belief that this approach will provide the Trust with a sound basis upon which to provide training (risk training is mandatory within the Trust) and to revise their policies and procedures as necessary.

Recommendation Number Four. The Trust should take all recent audit findings together with the results of the FACE review to reinforce its risk training programme and to revise their risk management policies and procedures as necessary.

19.3. Care programme Approach

Contributory Factor Number Five: *Mr. X did not receive a comprehensive and holistic Care Programme approach (CPA). The notion of Mr. X's presumed diagnosis of PTSD was formulated to the detriment of all other diagnoses and approaches. As a result Mr. X did not receive the care, support and treatment that he needed.*

Since the time of the incident the Trust has made significant developments in the management of CPA. As a result the Trust has received national recognition at the Care Programme Approach Association Awards for its training programme on assessment and care planning.

In November 2008 the Trust implemented new CPA arrangements in accordance with the Department of Health document *Refocusing the Care Programme Approach.* The implementation of the new arrangements was supported by an extensive training programme for all clinical staff.

The Trust conducted a comprehensive Care Programme Approach audit in 2009. This audit yielded a series of findings which was developed into an action plan. This action plan has been disseminated across the Trust and all required changes are currently being implemented.

It is the view of the Independent Investigation Team that the Trust demonstrates notable practice in this area at the current time and no recommendation is necessary.

19.4. Cultural Sensitivity

Contributory Factor Number Six: *the services that were offered to Mr. X did not take his cultural needs and requirements into account. This contributed to the provision of an approach which was not sensitive to his needs which may have led to his difficulties in engaging with the services that were offered to him.*

The Independent Investigation Team acknowledges the difficulties that mental health trusts encounter when trying providing culturally sensitive services within pre-existing workforce profiles and resources. The following recommendation is offered as a means of identifying pragmatic actions to support the development of services that can meet the needs of the local population.

Recommendation Number Five. The Trust should liaise with local community-based BME groups and networks in order to understand better the cultural sensitivities of the population that it serves. Using an outreach model the Trust should develop:

- culturally appropriate allocation criteria;
- systems to facilitate the transfer of service users to staff who can provide the most culturally acceptable 'fit' for them;
- appropriate anti-stigmatisation outreach programmes to key BME stakeholders within the Derby City community.

19.5. Trust Adherence to Internal Policies and Procedures

Contributory Factor Numbers Seven and Eight: *clinical practice within the Trust did not adhere to internal policies and procedures.*

Since the time of the incident the Trust has delivered a comprehensive series of training programmes to support the implementation of local risk management and CPA procedures, one of which has received a national award (see section 19.3). The Trust has also instituted a comprehensive whole systems audit process to monitor policy and procedure adherence. It is the view of the Independent Investigation Team that the Trust demonstrates best practice in this area at the current time and no recommendation is necessary.

19.6. Clinical Supervision

Contributory Factor Number Nine: *inappropriate clinical supervision contributed to the incomplete CPA that Mr. X received.*

Since the time of the incident the Trust has conducted a full clinical supervision review. As a result a revised policy was developed which was ratified by the Trust Clinical Governance Committee on the 13 August 2009. To underpin this policy a full audit has been commissioned in order to analyse the quality and effectiveness of the Trust process (Phase

One). The Trust also intends to analyse clinical supervision activity against clinical outcomes (Phase Two).

Recommendation Number Six. The Trust should commission Phase Two of the Clinical Supervision audit as planned and the findings should be incorporated into any further required revisions of the policy.

19.7. Caseload Management

Contributory Factor Number Ten: *Mr. X's case was not subject to coherent clinical case management; as a result his condition was at best partially treated. This contributed to Mr. X's continued distress and inability to manage his affairs.*

Since the time of the incident the Trust has developed a revised clinical supervision policy which supports caseload management. The policy states that operational managers have responsibility for ensuring that staff receive case management. The aim is for effective caseload management to ensure that service users are treated at all times in the appropriate service and by the appropriate health or social care professional. Activity levels are being monitored so that managers can target resources and support workers who have caseloads with high activity.

The Trust is also establishing a care pathway model of service delivery which will ensure that service users are allocated to the most appropriate health or social care professional at the point of referral.

Recommendation Number Seven. The Trust should audit the new clinical supervision policy within six months of the publication of this report to establish the effectiveness of new processes regarding caseload management. The necessary revisions to the policy should then be made in the light of the findings.

19.8. Service Issues

Service Issue Number One: *The Trust was unable to provide an Approved Social Worker (ASW) to undertake a Mental Health Act (83) assessment in a timely manner.*

The Trust has responded to the requirements of Her Majesty's Coroner Rule 43 letter and has put into place rota systems that ensure AMHPs are available both within and outside of office hours. No further recommendation is required.

Service Issue Number Two: *Some of Mr. X's clinical records were not contemporaneously made. The entries were significant in their content and the practice of retrospective record entry could leave both healthcare professionals and the Trust vulnerable.*

The Trust minimum standards for record keeping were reviewed in January 2008. As a result all clinical areas have laminated standards clearly visible to all health and social care staff. A mandatory training day has been also been developed. The audit of the Trust Minimum Standards for Record Keeping is a component of the combined CPA/Records/risk audit programme. It is the view of the Independent Investigation Team that the Trust has both initiated and implemented sound performance management processes with regard to clinical records and that no recommendation is required.

Service Issue Number Three*: The CPN drove Mr. X around in her car prior to having conducted a full risk assessment and without the required insurance for her car.*

Recommendation Number Eight. That the Trust issues a clear policy statement with regard to the transportation of service users in health and social care worker's cars. This policy statement needs to cover:

- risk assessment;
- insurance;
- lone worker safety.

19.9. Recommendation Leading from the Trust Internal Investigation Process

Recommendation Number Nine. The Trust Being Open Policy should be revised to incorporate a specific section which offers direct guidance to staff regarding the communication and support that should be offered to both victim and perpetrator families following a homicide committed by a mental health service user known to the service.

Glossary

Anhedonia	The difficulty of not being able to take pleasure from normally enjoyable experiences
Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders
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
Case management	The process within the Trust where a patient is allocated to a Care Coordinator that is based within a Community Mental Health Team
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
Computerised tomography	A **CT** (computerised tomography) scanner is a special kind of X-ray machine.
Diazepam (Valium)	This is a drug used for the short-term relief of symptoms related to anxiety disorders
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.
Early Onset Team	The aims of this service are to improve clinical and social outcomes through early identification, assessment, treatment and support of people with psychosis using a multi-disciplinary framework. The service is usually provided for people aged between 16 and 35 years of age
Electroencephalography	The most common reason an EEG is performed is to diagnose and monitor seizure disorders. EEGs can also help to identify causes of other problems such as sleep disorders and changes in behaviour. EEGs are sometimes used to evaluate brain activity after a severe head injury

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
Factoid	A factoid is a spurious unverified, incorrect, or fabricated statement formed and asserted as a fact, but with no veracity
Haloperidol	Haloperidol is a major tranquilizer used to treat psychoses
Lorazepam	A sedative and anti anxiety drug
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
National Treatment Agency	The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England
PHQ-9	PHQ is a Patient Health Questionnaire. The PHQ-9 module is the depression module the scoring is Depression Severity: 0-4 None, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.
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
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place
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
Section 2 Mental Health Act (83)	Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.
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.

Sertraline Tablets	Sertraline belongs to a group of antidepressant or antiobsessional medicines called the Selective Serotonin Re-uptake Inhibitors (SSRIs). Sertraline tablets are used to treat depression, Obsessive Compulsive Disorder (OCD) or Post Traumatic Stress Disorder (PTSD).
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.
Standard CPA	Denotes a lower level than enhanced CPA that requires lower levels of input from the Care Coordinator
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other
TTOs	A prescription which is prepared for a patient to take out or away. Literally medication 'to take out'
Venlafaxine	Venlafaxine is used to treat depression. Venlafaxine extended-release (long-acting) capsules are also used to treat generalized anxiety disorder
Will	As in Last Will and Testament
Zopiclone	Zopiclone is a hypnotic (sleeping drug) used for short-term treatment of insomnia

Notes

1. HSG (95) 27
2. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 1.
3. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP. 136-140
4. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 14
5. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 15
6. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP. 32-33
7. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 22
8. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP. 35-37
9. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 24
10. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP 136-140
11. Independent Investigation Archive. Clinical Records File 1. PP. 2-3
12. Independent Investigation Archive. Clinical Records File 1. PP. 4-5
13. Independent Investigation Archive. Clinical Records File 1. P. 4
14. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P.R2. P.1
15. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. R2. P.2
16. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. R2. P.2
17. Independent Investigation Archive. Clinical Witness/ probation records.
18. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. R2. P.2
19. Independent Investigation Archive. GP Records. P.1

20. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. R3. P.2

21. Independent Investigation Archive. GP Records. PP. 1-5

22. Independent Investigation Archive. GP Records. P. 5

23. Independent Investigation Archive. GP Records. P. 5

24. Independent Investigation Archive. Probation Records.

25. Independent Investigation Archive. GP Records. P. 5

26. Independent Investigation Archive. GP Records. P. 5

27. Independent Investigation Archive. GP Records. P. 6

28. Independent Investigation Archive. Clinical Records File 1. P. 86

29. Independent Investigation Archive. Clinical Records File 1. P. 85

30. Independent Investigation Archive. Clinical Records File 1. PP. 2-3

31. Independent Investigation Archive. Clinical Records File 1. P. 22

32. Independent Investigation Archive. Clinical Records File 1. P. 22

33. Independent Investigation Archive. Clinical Records File 1. PP. 22-23

34. Independent Investigation Archive. Clinical Records File 1. P. 23

35. Independent Investigation Archive. Clinical Records File 1. P. 23

36. Independent Investigation Archive. Clinical Records File 1. PP. 80-81

37. Independent Investigation Archive. Clinical Records File 1. PP. 23-24

38. Independent Investigation Archive. Clinical Records File 1. PP.24-25

39. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. R3 P. 2.

40. Independent Investigation Archive. Clinical Records File 1. P. 25

41. Independent Investigation Archive. Clinical Records File 1. PP. 77-78

42. Independent Investigation Archive. Clinical Records File 1. P. 79

43. Independent Investigation Archive. Clinical Records File 1. PP. 94-98

44. Independent Investigation Archive. Probation Records

45. Independent Investigation Archive. Probation Records.

46. Independent Investigation Archive. Clinical Records File 1. P.27

47. Independent Investigation Archive. Clinical Records File 1. PP 6-21

48. Independent Investigation Archive. Clinical Records File 1. P. 31

49. Independent Investigation Archive. Clinical Records File 1. PP.27-28

50. Independent Investigation Archive. Clinical Records File 1. PP. 28-29

51. Independent Investigation Archive. GP Records. P. 8

52. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP. 35-37

53. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. PP. 35-37

54. Independent Investigation Archive. Probation Records.

55. Meyer, A. (1951/52) *Collected Papers* (Four Volumes) (Ed. E. Winters). Baltimore: John Hopkins Press

56. *The British Journal of Psychiatry* 175: 476-482 (1999)
The Royal College of Psychiatrists Evaluation of ICD-10 PHC mental health guidelines in detecting and managing depression within primary care

57. http://www.rcpsych.ac.uk/specialtytraining/students/yourpsychiatryattachment/usefultipsandtools.aspx

58. Independent Investigation Archive. GP Records. P. 5

59. Independent Investigation Archive. GP Records. PP. 33-34

60. Independent Investigation Archive. GP Records. P. 5

61. Independent Investigation Archive. GP Records. P. 37

62. Independent Investigation Archive. Clinical Records File 1. PP. 22-23

63. Independent Investigation Archive, X File. PP. 80-81

64. Independent Investigation Archive, X File. PP. 77-79

65. Independent Investigation Archive, X File. PP. 26-27

66. Independent Investigation Archive. Clinical witness transcription.

67. Independent Investigation Archive. GP Records. PP. 5-6

68. Independent Investigation Archive. Clinical Records File 1. PP. 80-81

69. Independent Investigation Archive. Clinical Records File 1. P. 25

70. Independent Investigation Archive. Clinical Records File 1. P. 11

71. National Institute for Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26. P. 5

72. National Institute for Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26. P. 6

73. National Institute for Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26. PP. 8-10

74. Health and Safety at Work etc Act; HSE; 1974

75. Best Practice in Managing Risk; DH; 2007

76. http://www.face.eu.com/whatisface.html

77. http://www.scribd.com/doc/9267067/FACE-Risk-Assessment

78. Operational Policy Community Mental Health Teams (2007) P. 9

79. Policy on the Assessment and Management of Risk in Mental Health and Learning Disability Practice. P. 3
80. Trust Protocol for the Assessment and Management of Risk in Mental Health and Learning Disability Practice: Use of the FACE Risk Profile. (2006) P.8
81. Independent Investigation Archive. Clinical Records File 1. P. 19
82. The Department of Health publication, Best Practice in Managing Risk, *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services* (2007). P.19
83. Independent Investigation Archive. Clinical Records File 1. PP. 18-21
84. Independent Investigation Archive. Clinical Records File 1. P. 21
85. Independent Investigation Archive. Clinical Witness/ probation records.
86. Independent Investigation Archive. Probation Records
87. Independent Investigation Archive. Clinical Records File 1. P. 2
88. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DH; 1990
89. Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach; DH; 1999
90. Refocusing the Care Programme Approach, policy and positive practice; H; 2008
91. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DH 1995
92. Trust Care Programme Approach Procedures (2007) P. 7
93. Trust Care Programme Approach Procedures (2007) P. 8
94. Trust Care Programme Approach Procedures (2007) P. 10
95. Trust Care Programme Approach Procedures (2007) PP. 11-12
96. Independent Investigation Archive. Clinical Records File 1. P. 7
97. Independent Investigation Archive. Clinical Records File 1. P. 7
98. Trust Care Programme Approach Procedures (2007) P. 17
99. http://en.wikipedia.org/wiki/Mental_Health_Act_1983
100. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 189
101. Independent Investigation Archive. Clinical Records File 1. P. 137
102. Independent Investigation Archive. Clinical Records File 1. P. 221
103. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 227
104. Independent Investigation Archive. Clinical witness transcription.
105. Independent Investigation Archive. Clinical Records File 1. P. 83
106. Independent Investigation Archive. Clinical Records File 1. P. 26
107. Independent Investigation Archive. Clinical Records File 1. P. 193

108. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed. P. 136

109. http://www.rethink.org/about_mental_illness/who_does_it_affect/black_minority_ethnic_groups/index.html

110. Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett,* (2005)

111. Mofidi, Ghazinour, Salander, Renberg, Richter, *Attitudes towards suicide among Kurdish people in Iran.* Social Psychiatry and Psychiatric Epidemiology (2008) 43:291-298

112. *Derby Telegraph,* Friday, October 10, 2008

113. Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

114. The Code - Standards of conduct, performance and ethics for nurses and midwives (April 08)

115. GMC Good Medical Practice Guidance (2006)

116. Independent Investigation Archive. Witness statements and interview transcriptions

117. Independent Investigation Archive. Witness statements and interview transcriptions

118. Nursing and Midwifery Council, Advice Sheet C. (2006)

119. Information Commissioner's Office Website 2009

120. Independent Investigation Archive. Witness statements and interview transcriptions

121. Independent Investigation Archive. Clinical Records File 1. P. 18

122. Independent Investigation Archive. Clinical Records File 1. P. 20

123. Independent Investigation Archive. Clinical Records File 1. P. 18

124. Transcript of Evidence heard at the Inquest into the death of Mr. X and Ms. Ahmed.

125. Investigation Archive. Clinical Records File 1. P. 17

126. Investigation Archive. Clinical Records File 1. PP. 28-29

127. Independent Investigation Archive. Witness statements and interview transcriptions

128. Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

129. Health Care Commission Derbyshire Mental Health Services NHS Trust Annual Health Check Rating 2007/2008

130. Health Care Commission Derbyshire Mental Health Services NHS Trust Annual Health Check Rating 2007/2008

131. National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.

132. National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005. P. 4.

NHS East Midlands
Octavia House
Interchange Business Park
Bostock's Lane
Sandiacre
Nottingham
NG10 5QG

www. eastmidlands.nhs.uk

HASCAS
11-13 Cavendish Square
London
W1G 0AN

www.hascas.org.uk