VERITA

IMPROVEMENT THROUGH INVESTIGATION

# An independent investigation into the care and treatment of Mr Q

A report for
NHS South of England (formerly NHS South East Coast)

November 2012

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Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

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# Contents

# 1. Introduction

**1.1** Mr Q fatally stabbed Mr R in the street in Worthing on the evening of 23 June 2005. Mr R was 27, married with two children. He was a stranger to Mr Q. At the time of the incident Mr Q was in the care of West Sussex Health and Social Care NHS Trust, now part of Sussex Partnership NHS Foundation Trust[1] (the trust).

**1.2** Mr Q had been in contact with mental health services since 1998. He was diagnosed with paranoid schizophrenia and was cared for by both Worthing and Littlehampton community mental health teams (CMHTs).

**1.3** Mr Q pleaded not guilty at his trial and was convicted of manslaughter on the grounds of diminished responsibility at Lewes Crown Court in May 2006. The court made him the subject of a hospital order under section 37 of the Mental Health Act (1983). The court also imposed a restriction order without limit of time under section 41 of the Mental Health Act (1983). Mr Q is a patient in a medium secure unit.

**1.4** The trust commissioned a review into the incident, chaired by a non-executive director. The review team consisted of members from Sussex Partnership NHS Foundation Trust, West Sussex County Council and Surrey and Borders Partnership NHS Trust.

**1.5** The internal review report was completed in October 2006. The trust submitted the report to NHS South East Coast – the responsible strategic health authority at the time. NHS South East Coast became part of NHS South of England in October 2011.

**1.6** In November 2011 NHS South of England commissioned Verita to carry out this independent investigation into the care and treatment of Mr Q.

**1.7** Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Tariq Hussain, senior consultant of Verita, carried out the review. His biography appears at the end of the report.

[1] Sussex Partnership NHS Foundation Trust was formed in April 2006 from the merger of West Sussex Health and Social Care NHS Trust, East Sussex County Healthcare NHS Trust and the mental health, learning disability and substance misuse services from South Downs Health NHS Trust. It became a foundation trust with teaching status in August 2008.

**1.8** Lesley Sargeant, partner, peer-reviewed this report.

**1.9** This investigation was commissioned along with another investigation of care provided by the same trust. The original intention was to carry out both investigations at the same time. Due to unforeseen difficulties the other investigation's start was delayed thereby delaying the completion of this investigation. This report was submitted in draft to the trust for factual accuracy checks and comment on 7 August 2012.

## 2. Terms of reference and approach

### Commissioner

**2.1** This independent investigation was commissioned by NHS South of England with the full cooperation of Sussex Partnership NHS Foundation Trust. It was commissioned in accordance with guidance published by the Department of Health in HSG 94(27), *Guidance on the discharge of mentally disordered people and their continuing care in the community,* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the *Good practice guidance: independent investigation of serious patient safety incidents in mental health services* issued by the National Patient Safety Agency in February 2008.

### Terms of reference

**2.2** The independent investigation will be carried out by a documentary review. The following areas will be examined:

- the internal review, including the methodology, appropriateness of the panel members, the interviewees and the evidence considered

- the extent to which care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, in particular:

    - the adequacy of any risk assessments and risk management plans carried out for Mr Q, including specifically any relating to the potential for him to harm others;

    - any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided to Mr Q, from his last episode of care with services to the time of the offence on 24 June 2005;

- the care programme approach and how it was carried out in relation to Mr Q's care and trust policy;

- the progress made against the recommendations from the trust's internal investigation;

- any new developments or improvements in services since Mr Q's engagement with mental health services.

A report will be written for NHS South of England that includes:

- a general overview of the care and treatment of Mr Q from his first contact with services; this will be followed by a detailed chronology of events of the last episode of care leading up to the offence

- an analysis highlighting any missed opportunities and findings based on the evidence received

- any areas of notable good practice, new developments or improvements put in place since this incident which are relevant to this case

- measurable, achievable recommendations for action to address the learning points to improve systems and services.

**Approach**

**2.3** Consent to access Mr Q's clinical records was sought and given. The investigator met with Mr Q to explain the investigation process.

**2.4** This investigation was scoped principally as a documentary review. Therefore no interviews were carried out but communication took take place with trust managers to assess the progress they have made in implementing the recommendations from the trust's internal review.

**2.5** This investigation is not part of any disciplinary process.

# 3. Executive summary and recommendations

**3.1** Mr Q fatally stabbed Mr R, a 27-year-old man, in Worthing on 23 June 2005. Mr Q had been in contact with the former West Sussex Health and Social Care NHS Trust (now Sussex Partnership NHS Foundation Trust) since 1998. He was diagnosed with paranoid schizophrenia and was cared for by both Worthing and Littlehampton CMHTs.

**3.2** Mr Q was convicted of manslaughter on the grounds of diminished responsibility and made the subject of a hospital order under section 37 of the Mental Health Act (1983).

**3.3** The trust carried out a review into the care and treatment of Mr Q in 2006.

**3.4** In November 2011 NHS South of England (formerly NHS South East Coast) commissioned this independent investigation into the care and treatment of Mr Q.

**Summary overview of Mr Q's contact with services**

**3.5** Mr Q was in contact with specialist mental health services from 1998 until 2005. This investigation provides a chronology of his contact with services during that time.

**3.6** Mr Q was first referred to the trust's Worthing Community Mental Health Team (CMHT) in August 1998. He was treated in the outpatient department and stayed in touch with services until April 1999 when he made contact to say he no longer needed help.

**3.7** Mr Q was re-referred to Worthing CMHT by his GP in 2001 when Mr Q expressed concerns about his accommodation and complained of being depressed and anxious. Mr Q was supported by the CMHT throughout the year.

**3.8** In January 2002 Mr Q was admitted voluntarily to Meadowfield Hospital, Worthing for an assessment of his mental health. He refused to take medication because he said it damaged his health. As a result of his refusal he was assessed for treatment under the Mental Health Act 1983. He was diagnosed with paranoid schizophrenia and placed on section 3 of the act (admission for treatment).

**3.9** Mr Q's mental health improved and he was admitted to a trust rehabilitation unit in West Sussex on 8 May 2002.

**3.10** Mr Q was discharged from the rehabilitation unit on 20 June 2002 and put on standard Care Programme Approach (CPA)[1]. He was allocated a care coordinator and a care plan was developed to coordinate and monitor his care. Mr Q moved into new accommodation in Worthing in 2002 and started attending a day hospital (not one run by the trust).

**3.11** Police arrested Mr Q in January 2003 for being drunk in a public place. He was carrying two small penknives and a lost debit card. He received a police caution for the incident.

**3.12** Mr Q was seen by a psychiatrist in April 2003. Mr Q told the psychiatrist that he did not believe he had a psychotic illness and that being exposed to mercury had caused his problems.

**3.13** Mr Q was re-admitted to Meadowfield Hospital in May 2003. Follow-up care and treatment were put in place and he remained on standard CPA.

**3.14** Following discharge a room in supported accommodation in Littlehampton was arranged to allow Mr Q more social interactions. Mr Q did not settle in his new accommodation and an application for new accommodation was made.

**3.15** Mr Q moved back to a supported housing scheme in Worthing in August 2004. His care was transferred back to Worthing CMHT.

**3.16** The CMHT were worried that Mr Q's mental state was deteriorating in December 2004 and discussed carrying out an assessment under the Mental Health Act 1983. Mr Q's care coordinator saw him as part of the transfer arrangements from Littlehampton to Worthing. No psychotic symptoms were apparent so Mr Q was not assessed under the act. Mr Q remained on standard CPA during 2004 and had an identified care coordinator and a care plan in place.

[1] CPA is a particular way of assessing, planning and reviewing someone's mental health care needs. During the time Mr Q was being cared for by the trust there were two levels of CPA: standard CPA when only one professional was involved in his care, and enhanced CPA when more than one was involved which required a greater degree of coordination.

**3.17** A psychiatrist and a community psychiatric nurse (CPN) assessed Mr Q in February 2005. They found him amenable and cooperative. He continued to refuse medication but asked about alternatives to olanzapine.

**3.18** CMHT staff visited Mr Q at home on 16 February 2005 following complaints from his neighbours. He refused to accept that he was causing problems but said he was prepared to move. Mr Q was put on the waiting list for a housing transfer.

**3.19** A CPA review took place on 30 March 2005. The care plan was revised to include regular visits from a CPN and Mr Q was moved from standard to enhanced CPA. A risk assessment found him at low risk of self-harm or harm to others but at high risk of self-neglect.

**3.20** A senior house officer (SHO) from Worthing CMHT saw Mr Q on 20 May and found no psychotic features.

**3.21** On 1 June a CPN assessed Mr Q who had moved to his new flat in Worthing. Mr Q continued to refuse his medication. The plan was to maintain regular contact and encourage Mr Q's compliance with his medication.

**3.22** Mr Q did not attend an appointment with his psychiatrist on 20 June so he was sent another appointment for 31 August 2005.

**3.23** On 24 June Mr Q stabbed Mr R, whom he had never met before, to death. The trust's internal review says Mr Q had been drinking before the incident and that Mr R was looking for a fight with Mr Q.

**Summary analysis**

**3.24** Mr Q had a diagnosis of paranoid schizophrenia and used alcohol to manage stress. He had long-standing contact with the trust. Mr Q proved difficult to engage in any meaningful way.

**3.25** Mr Q was on CPA, in line with trust policy. He was allocated a care coordinator and a care plan was in place that set out the need to encourage him to take his medication.

**3.26** Mr Q was offered and used a range of services from the trust. He was regularly reviewed, visited and supported at home. When his mental health deteriorated, he was risk assessed and admitted to hospital. His CPA was also changed from standard to enhanced. He was referred to and accepted other support services such as day unit provision.

**3.27** Mr Q was cared for by different CMHTs. Transfer arrangements were effective and communication between teams was good.

**3.28** Mr Q did not seem to have full insight into his illness despite an assertive and flexible approach by staff. He was reluctant to take medication. This was a continuing concern that staff took seriously.

**3.29** Mr Q drank heavily from time to time therefore a referral to alcohol and drug services could have been expected to help him reduce his drinking. There is no record of a referral. Mr Q told us that he did not think he needed treatment and therefore the absence of a referral is acceptable as alcohol treatment requires an individual to want to reduce their drinking.

**3.30** Mr Q complained on several occasions about his accommodation. He complained of not being settled and had problems with his neighbours. Housing department staff were responsive to his complaints. They also made arrangements for him to move into supported accommodation, liaised with the trust and kept it informed.

**Findings**

**F1** Mr Q was assessed and accepted under CPA. He was allocated a care coordinator and was provided with a care plan. These actions were in line with trust policy.

**F2** The trust carried out effective risk assessments on Mr Q on a regular basis, although some documentation was incomplete.

**F3** The trust now has a risk management policy and procedure based on national best practice.

**F4** Trust staff worked effectively with housing department staff to ensure that Mr Q's accommodation needs were met.

**F5** The terms of reference of the trust review do not specify the need to examine risk assessment or CPA in respect of Mr Q's care. The trust review nonetheless did so.

**Conclusions**

**3.31** The trust CMHTs made assertive, positive and consistent attempts to engage with Mr Q. They worked in flexible ways by offering outpatient appointments, home visits and day hospital placements to maintain Mr Q's engagement, with some success.

**3.32** Mr Q's care was delivered in accordance with national CPA guidance and local policies.

**3.33** We found no indicators that the homicide was predictable and no actions or inactions by trust staff that would have prevented the incident occurring.

**Recommendations**

**3.34** We make no recommendations.

# 4. Approach and structure

## Approach

**4.1** The investigation was held in private. NHS South of England's terms of reference asked us to work "*largely by means of a document review*". Our investigation therefore comprised a review of written material. The trust's records were comprehensive and the standard of the internal review and supporting papers was good. They included the notes of interviews of staff that had cared for Mr Q.

**4.2** We met Mr Q at the start of the investigation, explained the investigation process and talked to him about his care and treatment.

**4.3** Mr Q consented in writing for us to have access to his medical and other records. We told him that NHS South of England was likely to publish the report. He was given the opportunity to comment on the draft report.

**4.4** We discussed with Mr Q whether we should consult any of his family. Mr Q told us that he had little contact with them and did not want us to make contact.

**4.5** We did not seek to make contact with the victim's family because of the time that has elapsed between the incident and this investigation.

**4.6** The trust prepared an up-to-date plan in response to the recommendations in its internal review. It also provided evidence to support the changes it had made.

## Structure

**4.7** Section 5 contains the chronology of the care and treatment of Mr Q.

**4.8** Section 6 reports on the analysis of care of Mr Q.

**4.9** Section 7 discusses the trust's internal review.

**4.10** Section 8 sets out our overall analysis.

# 5. Chronology

**Background information**

**5.1** Mr Q was born in Cheltenham, Gloucestershire on 10 April 1963. He was the oldest of three boys. His family emigrated to Australia when he was six. Mr Q returned to Cheltenham in 1988 and stayed there until he moved to Worthing in 1995.

**5.2** His parents divorced in 1990. His mother still lives in Australia but his father returned to England.

**5.3** The trust's internal review noted that Mr Q said he was not close to his family. Despite this he stayed with his father while the police continued with their investigation of the killing of Mr R.

**First episode of care (1998)**

**5.4** Mr Q was first referred to Worthing CMHT by his GP in August 1998. The referral letter describes Mr Q as having a paranoid personality and says he believed he had mercury poisoning as a result of dental fillings.

**5.5** A locum clinical assistant carried out a full mental health and physical examination of Mr Q in October 1998.

**5.6** Mr Q was reviewed again as an outpatient in December 1998. A plan was put in place to review him in two months. He was referred to a psychologist because of his preoccupation with mercury poisoning.

**5.7** Consultant psychiatrist 1 reviewed Mr Q in March 1999. Mr Q was offered the following:

- a short period of trial medication
- a second opinion from another psychiatrist
- a CPN to visit him.

**5.8** Mr Q declined these interventions and left the clinic dissatisfied. Consultant psychiatrist 1 wrote to Mr Q's GP saying that Mr Q could be re-referred to services if his condition deteriorated.

**5.9** Later in March Mr Q contacted services saying he would like a visit. Mr Q was reviewed by two CPNs who found him difficult to assess and engage. The case was discussed at a multidisciplinary team meeting. The decision was made to discharge Mr Q back to the care of his GP because of his reluctance to engage with the CMHT.

**5.10** In April 1999 an appointment was made for Mr Q to be assessed by a psychologist but he cancelled it, saying he no longer wanted help.

**2001**

**5.11** Mr Q's GP referred him to Worthing CMHT in July 2001 after Mr Q expressed concerns about his accommodation and complained of being depressed and anxious.

**5.12** Mr Q attended an outpatient appointment at the CMHT with an advocate in August. Staff grade psychiatrist 1 saw him. A letter from staff grade psychiatrist 1 to Mr Q's GP says Mr Q felt tense, was not sleeping well and hearing voices when he was tired.

**5.13** Staff grade psychiatrist 1 felt that Mr Q had a schizotypal personality with isolated borderline psychotic symptoms and isolated depressive symptoms. Mr Q did not like taking medication. A further outpatient appointment was made for four weeks later.

**5.14** Locum staff grade psychiatrist 1 reviewed Mr Q at the CMHT in September. Mr Q was prescribed olanzapine and offered admission to hospital but he refused.

**5.15** Staff grade psychiatrist 1 reviewed Mr Q again in October. Staff grade psychiatrist 1's letter to Mr Q's GP said he was compliant with medication and was feeling better. Mr Q's diagnosis was recorded as:

- schizotypal personality disorder
- borderline psychotic and depressive symptoms
- paranoid schizophrenia.

**5.16** Staff grade psychiatrist 1 also wrote a letter to the council supporting Mr Q's wish for a change in accommodation.

**5.17** In November staff grade psychiatrist 1 reviewed Mr Q as an outpatient and suggested depot medication[1]. Mr Q said he did not want to be on depot medication.

*Comment*

***A depot injection would have helped Mr Q avoid taking daily medication, which he was reluctant to do.***

**5.18** The housing services wrote a letter to staff grade psychiatrist 1 saying Mr Q was a low priority so would not be offered permanent accommodation.

**2002**

**5.19** Mr Q was admitted on a voluntary basis to the Meadowfield Hospital on 10 January for an assessment of his mental health. He refused to take medication because he said it damaged his health. He was therefore assessed for treatment under the Mental Health Act 1983 and placed on section 3 (admission for treatment). A formal risk assessment in April showed him to be at low risk of suicide, neglect and aggression. Mr Q started taking prescribed medication and his mental state improved. He was diagnosed with paranoid schizophrenia.

**5.20** Mr Q was transferred to Crescent House, a rehabilitation unit in West Sussex, on 8 May.

[1] A depot injection is given by injection and is a slow release medication usually repeated monthly.

**5.21** Mr Q was put on standard CPA the next day and allocated a care coordinator. A care plan was devised with the aim of monitoring his mental health, providing support and liaising with housing. Mr Q was discharged on 20 June. The following plan was put in place:

- outpatient appointments
- key worker follow-up
- medication.

**5.22** Staff grade psychiatrist 1 regularly followed up with Mr Q throughout the year. A social worker wrote to the Worthing Housing Department on 13 November supporting Mr Q's request for re-housing.

*Comment*

***Accommodation problems were a prominent theme throughout Mr Q's contact with the trust's service. Staff from the trust and the housing department took these issues seriously and tried to help Mr Q to find and retain suitable accommodation.***

**5.23** Mr Q moved into his new accommodation in December 2002. He agreed to attend Rivendell, a non-statutory day service in Littlehampton, to increase his social interactions. He told staff grade psychiatrist 1 that he was taking his prescribed medication.

**2003**

**5.24** Police arrested Mr Q on 7 January 2003 for being drunk in a public place. He was carrying two small penknives and a lost debit card. A forensic medical examiner considered him fit to be interviewed by police. He received a police caution.

*Comment*

***Mr Q was never diagnosed with an alcohol addiction problem but there is evidence that he drank heavily at times.***

**5.25** Locum staff grade psychiatrist 2 followed up Mr Q as an outpatient in February and April. Mr Q's health records provide evidence that he remained on standard CPA.

**5.26** Locum staff grade psychiatrist 2 saw Mr Q again in April. Mr Q told him that he did not believe he had a psychotic illness and that being exposed to mercury had caused his problems.

**5.27** Mr Q was admitted again to Meadowfield Hospital in May because he felt frightened about his personal safety. A risk assessment on admission concluded that Mr Q was a very low risk of harm to himself and others. Alternative supported shared accommodation in Littlehampton was arranged while he was in hospital. The aim was to encourage him to increase his social contacts. He took up this accommodation when he was discharged.

**5.28** A comprehensive discharge summary was sent to Mr Q's GP. The discharge plan included the following:

- transfer of Mr Q's care to Littlehampton CMHT
- change of care coordinator
- outpatient appointment follow-up
- medication.

**5.29** Mr Q told his CPN from Littlehampton CMHT in October 2003 that he was suspicious of people around him and that he had stopped taking his medication. He also expressed concerns about moving from Worthing to Littlehampton and expressed a wish to move back to Worthing. An application was made for a housing transfer.

**5.30** Mr Q was in regular contact with his CPN and members of the Littlehampton CMHT also made joint visits.

**2004**

**5.31** In May 2004 staff from the Rivendell Day Centre in Littlehampton said Mr Q had become unsettled and was causing distress to other service-users. He was involved in an argument in the centre and was banned from the centre for a week. The CPN visited Mr Q after the day centre's call. He was agitated and upset, demanding to return to the day centre.

**5.32** On 5 May Mr Q's CPN contacted the housing support worker who said Mr Q was calm and pleasant. The support worker was not concerned about him.

**5.33** Consultant psychiatrist 2, from Worthing CMHT, wrote to consultant psychiatrist 3, at Littlehampton CMHT, on 17 May asking that Mr Q be transferred to its care.

**5.34** On 4 June consultant psychiatrist 3 confirmed that senior social worker 1 at Littlehampton CMHT would oversee the transfer and would be Mr Q's care coordinator. Consultant psychiatrist 3 thought Mr Q's mental state might be unstable.

**5.35** Mr Q met with Rivendell staff on 11 June. An argument ensued that resulted in his being banned from the day centre.

**5.36** Associate medical specialist 1 and senior social worker 1, both from Littlehampton CMHT, reviewed Mr Q on 27 July. Mr Q said he was not taking his olanzapine because of its side effects. He also said he was drinking to help him cope. He felt safer in Worthing and wanted to move back. A CPA review took place on the same day. Mr Q remained on standard CPA and a care plan was put in place to monitor his mental health and provide practical support. Mr Q was given a copy of the care plan.

**5.37** Mr Q moved to a supported housing scheme in Worthing in August 2004.

**5.38** On 23 September Mr Q's neighbours complained about him playing loud music, leaving his front door open and looking into their gardens. Mr Q told us that the neighbours did not like him and denied playing loud music or looking into their gardens.

**5.39** Senior social worker 1 visited Mr Q on 27 September. She found him agitated, not taking his medication and drinking heavily. He said he was preoccupied with his safety,

personal space and being harassed. He told senior social worker 1 he was finding it difficult to settle into his new flat.

**5.40** Associate medical specialist 1 reviewed Mr Q on 25 October. He discussed medication compliance with Mr Q who continued to refuse to take his prescribed drugs. Arrangements were made to transfer Mr Q's care from Littlehampton CMHT back to Worthing CMHT. Mr Q had started to attend the day hospital three times a week.

**5.41** Senior social worker 1 reviewed Mr Q on 8 November. A Littlehampton CMHT social worker told her there had been more concerns about Mr Q. He had left an empty pan on the electric cooker and it had set off the fire alarm. The emergency services were called and had to break into his flat. Mr Q's landlords asked him to move out and offered alternative accommodation but he refused. He complained of being persecuted and appeared agitated and distressed.

**5.42** Staff grade psychiatrist 1 and CPN 1, from Worthing CMHT, reviewed Mr Q on 16 December as part of the transfer process from Littlehampton to Worthing. Mr Q still was not taking his medication and he refused to talk about himself. Staff grade psychiatrist 1 concluded that he was experiencing persecutory delusions with florid psychotic features. Worthing CMHT discussed his care and considered assessing him under the Mental Health Act and liaised with Littlehampton CMHT.

**5.43** Associate medical specialist 1 and senior social worker 1 assessed Mr Q at the Littlehampton CMHT base on 29 December. Mr Q presented with no evidence of overt psychotic symptoms and continued to refuse medication. Associate medical specialist 1 did not feel that Mr Q was sectionable under the Mental Health Act.

**2005**

**5.44** Associate medical specialist 1 from Littlehampton CMHT wrote to staff grade psychiatrist 1 at the Worthing CMHT on 13 January saying that Mr Q had been seen and that there were no overt psychotic symptoms. Associate medical specialist 1 did not think that the Mental Health Act applied but said Mr Q would be formally assessed under the Mental Health Act if he continued to refuse medication and his mental health state deteriorated.

**5.45** Mr Q continued to refuse medication and therefore associate medical specialist 1 assessed him under the Mental Health Act on 28 January. Associate medical specialist 1 recorded that Mr Q behaved normally throughout the assessment and displayed no signs or symptoms of psychotic illness.

**5.46** Staff grade psychiatrist 1 and a CPN from Worthing CMHT assessed Mr Q on 14 February. They found him amenable and cooperative. He continued to refuse medication but asked about alternatives to olanzapine.

**5.47** Worthing CMHT staff visited Mr Q at home on 16 February after more complaints from his neighbours. He refused to accept that he was causing problems but said he was prepared to move. An appointment was made for him to see the housing manager on 1 March. Mr Q attended this appointment and he was put on the waiting list for a housing transfer.

**5.48** Staff grade psychiatrist 1 and CPN 1 assessed Mr Q on 14 March and recorded that he appeared stable. The clinical notes record that he was willing to consider restarting medication but not yet. He wanted to remain involved with Worthing CMHT.

**5.49** CPN 1 saw Mr Q again on 30 March. His mood and mental state seemed stable. His accommodation transfer was in hand with a visit planned to another supported flat. A risk assessment was carried out that identified Mr Q as a low risk of harm to himself and others.

**5.50** A CPA review took place on 30 March. The care plan was revised to include regular visits from a CPN. Mr Q moved from standard CPA to enhanced CPA. A risk assessment also took place which confirmed that Mr Q was at low risk to self-harm or harm to others and a high risk of self-neglect.

**5.51** On 1 June CPN 1 assessed Mr Q who had moved to his new flat in Worthing. He continued to refuse medication. The plan was to maintain regular contact and encourage Mr Q to take his medication.

**5.52** SHO 1 from Worthing CMHT saw Mr Q on 20 May. He identified no psychotic features.

**5.53** CPN 1 met Mr Q at home on 1 June. The plan was to continue with regular contact and encourage compliance with medication.

**5.54** Mr Q did not attend his planned appointment with SHO 1 on 20 June and another appointment was made for 31 August 2005.

**5.55** On 24 June Mr Q stabbed to death Mr R. The trust's internal investigation review says Mr Q had been drinking before the incident and that Mr R was looking for a fight with Mr Q. He confirmed this to us.

**Meeting with Mr Q**

**5.56** We met with Mr Q at the beginning and the end of the investigation in the medium secure unit where he is currently placed. He had been recalled to the unit after being released for a year because he had started to drink excessively. He told us that whilst he did on occasion drink heavily, he did believe he had an alcohol problem and would not have accepted a referral for treatment

**5.57** Mr Q did not agree with the finding of the court (manslaughter due to diminished responsibility). He believed that he had acted in self-defence. He said he had been drinking but was not drunk. Two men (one the victim) approached him in the street. They were drunk, threatening violence and wanted to rob him.

**5.58** Mr Q had no complaints about the care he had received from the trust. He said he used to drink heavily from time to time but he did not think he needed treatment for it. He said he did not hear voices and did not like taking medication because it gave him tremors and tranquilised him. He described himself as lazy, friendly and not dangerous.

**5.59** He had had not seen his family for seven years and did not want them to know where he was.

# 6. Comment and analysis

**6.1** In this section we analyse the documentary evidence of Mr Q's care.

**6.2** The terms of reference require us to examine the extent to which care and treatment of Mr Q corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies. We have therefore used the following trust policies and procedures as benchmarks and examined whether Mr Q's treatment and care met these standards. Those of particular relevance to this investigation are polices in relation to the care programme approach and the risk assessment framework.

**Care programme approach**

**6.3** CPA is the process that mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991. In 1999 *Effective care coordination in mental health services - modernising the care programme approach* set out arrangements for all adults of working age (usually 16-65) under the care of secondary mental health services. The key elements of CPA are:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist mental health services
- a care plan that indentifies the health and social care to be provided from a range of sources
- a named care coordinator to keep in touch with the service user and to monitor and coordinate care
- regular reviews and agreed necessary changes to care plan.

**6.4** The trust's CPA framework document says that all people receiving specialist mental health services will receive CPA regardless of setting. The document describes two levels, standard and enhanced CPA.

**6.5** Evidence from healthcare records shows that Mr Q was assessed under the trust's CPA policy and was placed on standard CPA. He was allocated a care coordinator who was responsible for planning and coordinating his care and treatment.

**6.6** The healthcare records show that CPA meetings took place and that care plans were put in place to direct and coordinate Mr Q's care and treatment.

**6.7** The records also show that some CPA plans were not fully completed and some not signed. It is important that care plans are fully completed as they provide the vehicle for agencies and practitioners to share information about a service-user.

**6.8** The trust has since introduced an electronic care planning system which makes it easier for staff to complete and update the CPA forms.

*Finding*

**F1** Mr Q was assessed and accepted under CPA. He was allocated a care coordinator and was provided with a care plan. These actions were in line with trust policy.

**Risk assessment framework**

**6.9** Terms of reference require us to examine and comment on the adequacy of any risk assessments and risk management plans carried out for Mr Q, including specifically any relating to the potential for him to harm others.

**6.10** National best practice guidance was not in place for clinical risk assessment and management while Mr Q was under the trust's care. Clinical risk assessment tended to be less structured than it is today.

**6.11** The trust had risk assessment procedures to assess service-users. The record shows that clinical staff carried out regular risk assessments on Mr Q, although some of the documentation was not fully completed or signed.

**6.12** National best practice for clinical risk assessment and management has been developed since this incident[1]. The trust has developed its policy and procedure for clinical risk assessment and management based on best practice. The risk assessment and management policy and procedures outline the need to carry out risk assessment as part of the care programme approach.

*Findings*

**F2** The trust carried out effective regular risk assessments on Mr Q, although some documentation was incomplete.

**F3** The trust now has a risk management policy and procedure based on national best practice.

**Coordination with other agencies**

**6.13** The involvement of housing departments was important to Mr Q and key to his support in the community. The records show that the housing departments and the CMHTs worked closely together to offer him suitable accommodation. His behaviour sometimes caused neighbours difficulties and he was at times asked to move. Trust and housing staff responded effectively on these occasions.

*Finding*

**F4** Trust staff worked effectively with housing department staff to ensure that Mr Q's accommodation needs were met.

[1] Department of Health, 2007. *Best practice in managing risk*.

## 7. The trust's internal review

**7.1** The terms of reference request that we consider and comment on the appropriateness of the trust's internal review, including the methodology, the panel members, the interviewees and the evidence it considered.

**7.2** The trust's review team included:

- a non-executive director (chair, Sussex Partnership NHS Trust)
- an associate director of adult services (Sussex Partnership NHS Trust)
- a consultant psychiatrist (Sussex Partnership NHS Trust)
- head of forensic services (Sussex Partnership NHS Trust)
- social care manager (West Sussex County Council)
- a director (Surrey and Borders Partnership Trust).

**Comment**

***The membership of the trust's review team was appropriate. The panel was multi-agency and included specialist staff such as the head of forensic services. It was also senior enough to ensure that the review could follow any line of inquiry.***

**7.3** The following staff were interviewed as part of the investigation:

- the CPN/care coordinator
- a social work practitioner
- a locum consultant
- Mr Q's GP.

**Comment**

***Mr Q's care covered about seven years. He was also cared for by two different CMHTs. In light of this, the number of staff interviewed appears inadequate to review fully the care he received. On the other hand, Mr Q's care was not complex and no areas of care needed to be examined in depth because practice appeared inadequate.***

**Terms of reference**

**7.4** The terms of reference for the trust's internal review provide the scope for the investigation:

- to undertake a thorough review of the care and treatment provided
- review the liaison and communication with key services involved in the care of Mr Q to identify underlying causes of concern and to learn from good practice
- make recommendations to ensure any problems are addressed
- ensure that staff, carers, relatives and service users are supported.

*Finding*

**F5** The terms of reference of the trust review do not specify the need to examine risk assessment or CPA in respect of Mr Q's care. The trust review nonetheless did so.

**Methodology**

**7.5** The review was carried out using Root Cause Analysis (RCA), a method developed by the National Patient Safety Agency to provide a structured approach to identifying the factors that resulted in the nature, the magnitude, the location and timing of the harmful outcomes of an event or events.

**7.6** The review team used a tabular timeline tool to develop the chronology of care and treatment of Mr Q.

**7.7** It is not clear from the internal report when the review began. The date on the report is 3 October 2006.

*Comment*

**The trust review was not completed until 16 months after the incident. This was too long and we do not know why it happened.**

**Trust's review recommendations**

**7.8** The panel identified six areas of learning/development that were addressed in an action plan with seven recommendations. The action plan included a designation of responsibility to implement the recommendations and a timescale for completion.

**7.9** The findings of the trust review cover the following areas of practice:

- out-of-hours duty log being available to the CMHT
- revising risk assessments after serious incidents
- preventing risk when working alone
- involvement of the court diversion scheme and the CMHT when bail is granted
- recording of service-user team discussions
- recording medication information more fully.

**7.10** The final report is dated October 2006. All the actions are listed to be completed before this, in June and July 2006. We therefore assume that the recommendations were implemented on the basis of an earlier draft of the report.

*Comment*

***Taking action at the earliest opportunity as a result of a serious incident investigation is clearly good practice as long as a review panel has completed its analysis of the care issues arising.***

**Completion of the trust's action plan**

**7.11** The trust action plan relates to issues identified in 2006 so we asked the trust to provide us with a report on the current position with the plan and any developments that relate to the issues identified within it.

**7.12** The trust provided us with an update of the action plan which we attach as appendix B to this report. We have reviewed the plan and it shows that the issues identified in 2006 have been effectively addressed.

# 8. Overall analysis

**8.1** Our review of the care that Mr Q received shows that the teams and individuals supported him with care. They had a good understanding of his needs and responded in a timely manner when his mental health deteriorated.

**8.2** Mr Q was offered a range of services that included outpatient appointments, home visits, day hospital placements and admission to hospital when his mental health deteriorated. His care was delivered in accordance with national CPA guidance and local policies. Trust staff also liaised well with staff from the housing departments who also provided an exemplary service for Mr Q.

**8.3** We found nothing to indicate that the homicide was predictable. We think that nothing the staff did or failed to do would have prevented the incident.

## Appendix A

## Documents reviewed

- Sussex Partnership NHS Trust SUI review Oct 2006
- CPA policy and practice guidance
- Policy and practice guidance for effective care co-ordination and resource allocation
- Court Diversion scheme records
- Clinical records – 1999 to 2006
- General correspondence

## Appendix B

# Action plan update provided by Sussex Partnership NHS Foundation Trust

**Action 1: out-of-hours duty log being available to the CMHT & Action 6: recording of service-user team discussions**

The trust developed an electronic clinical record some years ago. The system is accessed by community and inpatient staff and has superseded the need for a paper based duty log. The system can be accessed twenty four hours a day at all sites around the trust. Team discussions are also recorded on individual service user records on the system described. The service user clinical record is the central point of clinical information for all service users.

**Action 2: revising risk assessments after serious incidents**

The clinical risk assessment policy and the serious incident policy have both been revised a number of times since this incident. The most recent and significant revision of the clinical risk policy was in 2009 which marked a new trust wide approach which is evidenced based, written following extensive multidisciplinary consultation and is supported by a professionally led development group. The policy and procedure has been subject to an annual review since this time, one outcome has been the introduction of trust wide integrated clinical risk documentation which is audited regularly for compliance and quality.

The clinical risk assessment policy clearly indicates when risk assessments should be reviewed and this would include the period following a serious incident.

**Action 3: preventing risk when working alone**

The lone working policy has been extensively reviewed and is implemented across all services. In January 2011 the trust was subject to an NHSLA assessment and full compliance was achieved regarding a safe and consistent approach to lone working.

**Action 4: involvement of the court diversion scheme and the CMHT when bail is granted**

The court diversion scheme continues and has been revised since the time of the incident. The trust are proud to be a part of a regional team who successfully bid to take part in a health and criminal justice liaison service national pilot which is already having a positive impact on the service offered and can offer further assurance that any service user involved in the criminal justice system will be supported by the most appropriate service. The pilot is supported by the SHA.

**Action 7: recording medication information more fully.**

The trust has a much improved governance in relation to trust wide medication management which is evidence by the medicines code, drugs and therapeutics committee, the leadership structure including two chief pharmacists one for a lead in governance the other clinical practice and the significant scrutiny and reporting of medication incidents of all sorts. In addition the trust has investigated in medication management training for junior doctors at the point they join the trust and registered nurses at the point of joining the trust with bi – annual update training. The trust also has a structure for pharmacy technicians to work closely with services in the prescribing and administration of medications; this includes ongoing scrutiny of prescriptions on inpatient wards and in community settings.

## Appendix C

# Biography

**Tariq Hussain**

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

**Lesley Sargeant**

Lesley was one of Verita's founders. Since joining Verita in an executive role in February 2009, she has taken an active role in a number of high-profile reviews and leads in the independent review of complaints. She also advises on all aspects of communication relating to investigations including media handling. Before joining Verita, she was a director of Freshwater Healthcare (formerly CLEAR), a consultancy offering specialist communication advice, training and change management to public sector organisations. Between 1984 and 1994 she held senior posts in the NHS at local, regional and national level. Before that she worked for the World Health Organisation in Geneva.