Independent Investigation

into the

Care and Treatment Provided to Mr. X

by

Lancashire Care NHS Foundation Trust

Executive Summary

Commissioned by
NHS North West
Strategic Health Authority

Independent Investigation: Health and Social Care Advisory Service

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1. Executive Summary

1.1. Background to the Case, Incident Description and Consequences

Background

Mr. X was born and brought up in the Wigan area. His early family life was characterised by parental discord, separations and physical punishment. Mr. X's father committed suicide when Mr. X was a teenager and he and his mother found his father's body (he had gassed himself). His death resulted in Mr. X being cared for by foster parents and then a care home placement with no further family contact. Mr. X reported that his mother remarried and he was *"thrown out to survive"*. He had little formal schooling, found some employment as a labourer but was unemployed from 1991. Mr. X was married twice. He had two sons from the first marriage and two daughters and a son from the second. After the breakdown of his second marriage he brought up the three children on his own.

Mr. X first became known to mental health services in the Preston area on 10 July 2002 when he was aged 45. He was admitted to hospital after presenting at the Accident and Emergency Department. He was low in mood, refused to sit down, was agitated and tearful and felt that he wanted to kill himself by walking in front of traffic. He was transferred to the local psychiatric in-patient unit where he was treated until 27 July 2002 when he was discharged from psychiatric care. He had been diagnosed with mild depression and anxiety and was followed up on discharge through out-patient appointments with a Consultant Psychiatrist and support from a Care Coordinator.

Following this discharge Mr. X lived with his daughter, her partner and two children and his youngest son. It was noted that the accommodation was overcrowded and Mr. X had to sleep in the lounge of the property. There were also problems with the school attendance of his son at this time and the local education welfare service was involved with the family because of his poor school attendance.

Mr. X was admitted to the local accident and emergency unit on 7 December 2002 after stabbing himself in the stomach with a breadknife. Whilst on the medical ward he had

believed staff were trying to poison him with potassium and oxygen and he removed all of his intravenous lines. He had also absconded and refused to come out of a lift within the hospital building. His behaviour on the unit was disturbed and after assessment by a psychiatrist he was transferred to the local psychiatric unit under Section 2 of the Mental Health Act (1983). Later that month, on 24 December 2002, he was detained for treatment under Section 3 Mental Health Act (1983). He remained in treatment for some months and was assessed by a Consultant Psychotherapist as part of the assessment process. After improvements to his mental state and periods of home leave, he was discharged from the unit on 3 September 2003. He was allocated a Care Coordinator and had a Support Worker who helped him with some of the practical difficulties he faced.

Mr. X was re-admitted to the mental health unit on 18 November 2003 under Section 3 Mental Health Act (1983). The admission notes commented that he was suffering from a severe depressive illness, that he did not want to live alone and that he was lonely. He had no social contacts. Mr. X was discharged from this period of treatment on 26 January 2004 and received support at home from the Crisis Resolution and Home Treatment Team. Before discharge an unsuccessful application was made for supported accommodation because Mr. X thought that he could not cope with the demands of living alone. On discharge he went to live in a flat with two of his children.

During 2004 Mr. X was visited regularly by a Care Coordinator who noted that there were difficulties in the household and that Mr. X was often agitated, anxious and depressed. The accommodation was overcrowded and there were relationship problems between family members. Mr. X was admitted to hospital again on 18 October 2004 after being found in a public place and in a distressed state by the Police. He was detained for assessment under Section 2 Mental Health Act (1983) on 26 October 2004 because he was refusing to eat and drink, was suicidal and had paranoid beliefs about other people. He repeatedly tried to leave the ward and had to be restrained. On 17 November 2004 he was detained for treatment under Section 3 Mental Health Act (1983).

After discharge from this period of treatment on 4 February 2005, Mr. X returned to live with his son in a flat and was visited regularly by the Crisis Resolution and Home Treatment Team and then by a Care Coordinator and a Support Worker. He continued to see a Consultant Psychiatrist as an out-patient. There were suggestions that he was being financially exploited

by family members and there were continuing discussion about the possibility of moving to a more supportive setting.

By the time of a review meeting with his Consultant Psychiatrist on 30 November 2005 it was noted that the situation at home remained unchanged with Mr. X's son reportedly taking money from him, that Mr. X was not making use of the support offered to him, and that his mood remained flat. It was agreed that if Mr. X wanted to move to supported housing he would have to ask his son to leave the property but he was reluctant to take this step.

On 16 May 2006 Mr. X presented himself at the local psychiatric unit and had deteriorated both physically and mentally. There were obvious signs of self-neglect. He appeared thought disordered and refused to sit down. Recommendations were completed for Section 3 Mental Health Act (1983) but there was no bed available on the unit. After a long delay a bed was found at a hospital in another part of Lancashire. Mr. X eventually returned to the local unit in Preston and was again treated for some months for depression.

Mr. X was discharged from the unit on 8 August 2006 to a supported tenancy scheme in Preston. The rationale for this move was that Mr. X had not been able to cope with daily living on his own, there were concerns that living with family members was unhelpful to him, if not exploitative, and that Mr. X himself said that he was anxious about being alone. The supported tenancy scheme was managed by Lancashire Care Mental Health Trust (now the Lancashire Care NHS Foundation Trust) in partnership with the local authority (Lancashire County Council) and a housing association. It provided 24 hour staff support to tenants with the aim of improving their living skills to the point when they could become more independent again.

When Mr. X left hospital to live at the supported tenancy scheme he was subject to supervision under Section 25 Mental Health Act (1983) and was allocated a Care Coordinator in accordance with the Trust's Care Programme Approach policy. He was on the enhanced level of support under the Care Programme Approach.

Throughout 2007 Mr. X remained as a tenant of the supported tenancy scheme. He was encouraged by staff to attend activities at a local day centre and to improve his daily living skills. Staff noted that he was sometimes lacking on confidence and motivation. He remained

anxious about his future and was often said to be low in mood. He was reviewed regularly in out-patent clinic by junior doctors and continued to be prescribed anti-depressant medication. His contact with family members was intermittent.

At his last review in out-patents on 31 March 2008 it was noted that Mr. X was due to move on to more independent living. Mr. X presented as anxious and his responses were described as limited and his outlook hopeless. He believed that other people were talking about him and had negative thoughts about his future. At this point Mr. X had a new Care Coordinator who agreed to explore the possibility of referring him for Cognitive Behavioural Therapy.

Incident Description and Consequences

Mr. A was a residential support worker at the supported tenancy scheme. He had been employed there since 2007 but usually worked in another part of the scheme. On 7 April 2008 he was allocated to work in the house where Mr. X lived with two other tenants. Mr. A had a conversation with Mr. X which prompted him (Mr. A) to telephone the Care Coordinator to discuss the case. Mr. A said that Mr. X was very anxious and worried about the future, particularly the idea that he should move on from the supported tenancy scheme. The Care Coordinator offered some advice to Mr. A but thought that it was not necessary to visit that day. Mr. A had been due to attend a team meeting but decided to stay in the house with Mr. X because he was anxious.

During the morning of 7 April 2008 Mr. X attacked Mr. A with a kitchen knife in the office of the house. Mr. A's injuries were fatal.

After the incident the Police were called and subsequently arrested Mr. X on suspicion of murder. Mr. X was assessed at the Police Station under the Mental Health Act (2007) and detained under Section 2 of the Act and admitted to Guild Lodge medium secure unit. He was then transferred to Ashworth Hospital, Merseyside, on 23 June 2008. He appeared at Preston Crown Court on 10 March 2009 and found guilty of manslaughter on the grounds of diminished responsibility and ordered to be detained under the provisions of section 37/41 of the Mental Health Act (2007).

1.2. Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS North West (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *HSG (94)27, LASSL(94) 4*.

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.

1.3. Terms of Reference

The terms of reference for this investigation were agreed by NHS North West Strategic Health Authority and Lancashire Care NHS Foundation Trust. The terms of reference were as follows:

1. **To examine:**

- the care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);

- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs;

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

- the adequacy of risk assessments to support care planning and use of the care programme approach in practice;

- the exercise of professional judgement and clinical decision making;

- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;

- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;

- the quality of the internal investigation and review conducted by the Trust.

2. **To identify:**

- learning points for improving systems and services;

- development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. **To make:**

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

4. **To report:**

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

1.4. The Independent Investigation Team

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

Independent Investigation Team Leader and Chair

Mr. Alan Watson	National Development Consultant, Health and Social Care Advisory Service. Social Work Member of the Team.

Investigation Team Members

Dr. Androulla Johnstone	Chief Executive of the Health and Social Care Advisory Service and nurse member of the team.
Dr. Jonathan Bindman	Consultant Psychiatrist Member of the Team, South London and Maudsley NHS Foundation Trust.

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service.
Ms. Tina Coldham	Service User Advisor.
Ms. Fiona Shipley	Transcription Services

Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks.

1.5. Findings and Conclusions

Findings

The Independent Investigation Team has summarised findings under headings which are expanded in the main body of this report

1. Diagnosis

When Mr. X was first referred to secondary mental health services in 2002 he was given a diagnosis of mild depression and anxiety. Throughout the years of contact with services the diagnosis remained one of depression. On three occasions when he was admitted to hospital in a severely depressed state he had persecutory or paranoid ideas such as that people were

talking about him in a critical way, or that he might be poisoned, which resolved when his mood improved. He also had a concern that he had a bad smell and that other people were aware of this, which was more persistent even at times when he did not appear to be severely depressed. This was also often described as a paranoid idea, but may have been associated with obsessive compulsive disorder (OCD- features of which in his case included having to do things in a certain way or to a certain standard, carrying out checking rituals, having intrusive and repetitive worries, and needing to seek reassurance about these in a repetitive manner). Some accounts of his mental health difficulties also referred to personality traits that were significant in his presentation, such as appearing to be lacking in motivation and confidence, or tending to be dependent on others, he could function well at times but needed prompting and supervision to achieve tasks. In some accounts there was a suspicion that he was not doing all he could to help himself and that he liked to be passive and looked after. The view of the investigation panel was that the diagnosis of depression was correct but that greater investigation of psychological and social factors, OCD, and personality factors, would have been of benefit. In particular the role of the family in his difficulties and presentations to mental health services could have been given greater prominence.

- ***Service Issue One: the role of social care should have had a higher profile in the initial assessment and care planning for Mr X to link his presenting mental health problems to his wider family and social context.***

2. Medication and Treatment

Mr. X was treated with anti-depressant and anti-psychotic medication. This was appropriate and followed on from the diagnosis. He was adherent to medication and after leaving hospital was trusted to take the medication unsupervised. He was reviewed regularly through out-patient appointments. The focus of out-patient review in the later years of his contact with service was on compliance and reports from the staff at the supported tenancy scheme about his mood and activities. More use could have been made of psychological therapies and although this approach was referred to it was never achieved (for example Cognitive Behavioural Therapy).

- ***Service Issue Two: the full range of interventions available through the multi-disciplinary team was not exploited. In particular there were several references to Cognitive Behavioural Therapy that were not followed through.***

3. Management of the Clinical Care and Treatment

Mr. X received care from in-patient teams at the local hospital in Preston and during one period from in-patient services in Blackpool. At times he was challenging to services and from the documentary evidence these incidents were managed appropriately. After discharge he was supported by the Community Mental Health Team and at times by the Crisis Resolution Team and the Support, Time and Recovery workers.

There was good continuity in treatment from his Consultant Psychiatrist when an in-patient but following his discharge to the supported tenancy scheme in August 2006 he was under the care of a Consultant Psychiatrist who did not meet him. Contacts were with a series of Junior Doctors (at Senior House Officer grade) who reviewed his treatment at the out-patients clinic. None of these had a comprehensive and longitudinal view of the case and relied on reports from the care staff at the scheme. This placed greater onus on the Care Coordinator to provide continuity and thorough analysis and planning of care. In particular the junior doctor who reviewed Mr. X at his last out-patient review on 31 March 2008 had not met him before.

- ***Contributory Factor One: the care coordinator and responsible clinician who reviewed Mr. X on 31 March 2008 had only recently met him and had little chance to build a rapport with him. At their meeting the plan to move Mr. X from his present home in the supported tenancy scheme was discussed.***
- ***Service Issue Three: changes to the organisation of service in response to Department of Health guidance led to more transitions in the care pathway. This in turn opened the possibility that information would not be successfully passed to the next stage of the treatment programme.***

4. Mental Health Act (1983 and 2007)

Mr. X was detained under Sections 2 and 3 of the Mental Health Act and at times under the holding powers of Section 5(2). These statutory provisions were used appropriately and Mr. X's rights were made known to him although he chose not to appeal against the orders. When

he was discharged from hospital in August 2006 it was a condition of his acceptance at the Supported Tenancy Scheme that he was supervised under the provisions of Section 25 of the Act. This was in practice unnecessary and ineffective because he was compliant with residence and medication requirements, and the Care Coordinator did not fulfil his role as supervisor under the Act.

- ***Contributory Factor Two: when Mr. X was discharged from hospital in 2006 he was subject to Section 25 supervision and Section 117 aftercare under the Mental Health Act. This should have prompted a high degree of involvement from the care coordinator and multi-disciplinary working but this was not achieved.***

5. Care Programme Approach (CPA)

Mr. X was on the enhanced level of CPA and had a number of Care Coordinators allocated to him during his contact with the Trust. The investigation team found that the CPA did not work effectively in Mr. X's case. CPA documentation was not always completed and the processes behind the documentation were not achieved. This was particularly significant after his last discharge from hospital in August 2006 to the time of the incident in April 2008. There is evidence that the Care Coordinator during most of this period did not meet the professional standards required for the role. It is significant that Mr. X was also subject to supervision under Section 25 Mental Health Act and Section 117 aftercare during this period, this placed him in a category of high level of need and should have resulted in a high quality of care planning. In fact the contact with the Care Coordinator was superficial and poorly managed. The full range of care planning activity envisaged by the Trust policy on CPA was not achieved.

One of the results of poor care coordination was that there was not a comprehensive and analytical view of Mr. X's needs. Mr. X was seen by a number of different Junior Doctors and was supported by the care staff at the supported tenancy scheme. Their recording focused on adherence to medication, daily living at the scheme and the practicalities of living in the community. There was no long-term view about Mr. X as a vulnerable adult and the implications of this for his long-term care. This view should have been provided by the Care Coordinator in a system where the Junior Doctors rotated to different roles on a regular basis and the Community Psychiatrist with overall clinical responsibility had not met Mr. X.

The care coordination offered to Mr. X failed to bring together the elements of health and social care that would have led to good decision-making. One example of the impact of this was that the evidence from the supported tenancy scheme that Mr. X was not making progress towards greater independence (in March 2008) was used to support the view that he should move on, rather then that he should be either maintained for longer at the scheme or offered a setting with higher levels of support. The view that there was a two year length of placement at the supported tenancy scheme was not in fact supported by its operational policy. The notion that Mr. X had to move on became embedded in his thoughts and caused him great anxiety.

- ***Contributory Factor Three: the quality of care coordination offered to Mr. X over a period of eighteen months from June 2006 was poor. One consequence was that there was inadequate preparation and planning for working with Mr X on his potential move from the supported tenancy scheme.***

- ***Service Issue Four: the framework of the Care Programme Approach was not used to bring together professionals and the service user to develop a care plan that all were committed to.***

6. Risk Assessment

Formal risk assessment documentation was completed when Mr. X was an in-patient, but not after his last discharge from hospital. The risks identified were mainly seen as those of self-harm and self-neglect. He was not assessed as a risk to other people. The care staff at the supported tenancy scheme who had worked closely with Mr. X did not regard him as a risk to them and did not feel intimidated by him. The timing and level of violence used against Mr. A was not predicted nor could have been.

During the time that Mr. X was known to the mental health services issues associated with safeguarding vulnerable adults became higher profile[1] and were the subject of an inter-agency agreement and policy guidance.[2] The Independent Investigation Team found that there were shortcomings in the appreciation of safeguarding issues as an element of the risk assessment.

1 No Secrets: Department of Health 2000
2 Safeguarding Vulnerable Adults Policy and Adult Protection procedure for Provider Services: NHS Lancashire 2010

- When Mr. X was living with his son in the community it was reported that there was clear evidence that he was being exploited financially.
- Mr. X's difficulties in giving up his tenancy to move to a more supported setting were exacerbated by the presence of his son and worries for Mr. X about his son's status as a tenant.
- Earlier in the history, Mr. X was caring for three children alone and there were problems in school attendance that were not followed through effectively by the Care Coordinator.
- There was a lack of social care input to the case and a failure to describe and understand Mr. X's family situation that weighed heavily on him.
- Later in the history Mr. X was left in sole charge of his grandchild at a time when he was unwell.
- The views of Mr. X's children were under-represented in the case formulation.
- There would have been value in a comprehensive social history that brought together all the elements of family background.

- ***Contributory Factor Four: risk assessments were only partially completed and the risk assessment tool used by the supported tenancy scheme was inadequate to assess the risk to others from service users.***

- ***Contributory Factor Five: successive care coordinators failed to assess Mr. X as a vulnerable adult and use the inter-agency agreement to pool knowledge about the family.***

- ***Service Issue Five: the development of policies and practice in relation to vulnerable adults and safeguarding was not well understood by Trust staff.***

7. Referral, Discharge and Handover Processes

The Independent Investigation Team found that the process of referral was effective, for example when Mr. X was admitted to hospital after a self-inflicted injury he was seen in a timely way by a psychiatrist and transferred to the local psychiatric unit. After Mr. X's period of in-patient treatment he was gradually introduced to independent living through the use of home leave and was then supported for a period by the Crisis Resolution and Home

Treatment Team. Mr. X's GP was kept informed of care by secondary services through letters from the Consultant Psychiatrist.

There were some shortcomings in the handover process from care coordinator to care coordinator and from doctor to doctor in the out-patient setting. In the latter process the responsibility for continuity fell to the community consultant psychiatrist as Mr. X was seen by a succession of junior doctors (as expected in the system in use). However the Independent Investigation Team found that the Psychiatrist had only a vague knowledge of the case.

The last Care Coordinator had the skills to make a good assessment and care plan but received a poor handover from his predecessor. His work with Mr. X after the incident demonstrated a sound understanding of the CPA process and well developed analytical skills.

- ***Contributory Factor Six: detailed knowledge about Mr. X was not known to all those with responsibility for his care. This was particularly relevant to the out-patient clinic where only part of his clinical notes was available and the doctor reviewing the care had not met him before.***

- ***Service Issue Six: handover of information between care coordinators and from doctor to doctors was variable in practice.***

8. Carer Assessment and Experience

The Trust and Local Authority policies in relation to carer assessment were not highly relevant in the case of Mr. X except in appreciating his role as a carer for his three children and in engaging his children in the later stages of care and treatment when there was evidence that they were both exploiting him and making use of him to provide care for a grandchild. Some of the clinical team tried to engage Mr. X's family in his treatment with no success but it would have been useful to use their knowledge of his family background and behaviour more in their assessment.

9. Service User Involvement in Care Planning and Treatment

Mr. X had limited capacity to engage with care plans and treatment. He was compliant with medication and during the period when he lived at the supported tenancy scheme he was cooperative with social skills programmes devised for him. He was chronically anxious, lacking in motivation and did not express positive plans for the future. His understanding was limited and ability to reason and rationalise probably impaired by his illness. At times he was uncooperative with treatment and could be obdurate in his resistance to interventions by nursing staff. Staff at the supported tenancy scheme made good attempts to engage him in plans to improve daily living skills.

10. Documentation and Professional Communication

The Independent Investigation Team found that the quality of recording in Mr. X's case notes was variable. There were examples of well written summaries of contacts with care coordinators and consultant psychiatrists and some examples that did not meet the Trust standards.

Care programme approach documentation was similarly variable in quality with some documents not completed. Particularly in the early phase of contact with the Trust there would have been value in a comprehensive social history including more information about the extended family.

Professional communication was similarly variable with examples of consistent engagement with some care coordinators and consultant psychiatrists. However, during the period when Mr. X was a tenant at the supported tenancy scheme, care coordination and communication between different elements of the mental heath service was poor, and at times discordant. There were problems in professional relationships which detracted from the quality of care planning for Mr. X and also, because of the implications of new ways of working, a lack of continuity in the delivery of care by a series of responsible clinicians.

- ***Contributory Factor Seven: professional communication between the staff team at the supported tenancy scheme, the community mental health team, and other support workers was limited by a legacy of difficult professional relationships.***

- ***Service Issue Seven: documentation was not used in accordance with trust policy to provide a comprehensive account of Mr. X's mental health problems. Many documents were only partially completed.***

11. Clinical Supervision

The Independent Investigation Team found that both the Trust and the Local Authority had supervision systems in place during the time that Mr. X was a service user. In relation to the performance of one care coordinator, we found that although he had regular supervision meetings with his line manager, his poor performance was not identified. We found that a factor in this failure was that the manager had a wide area of responsibility of control and was supervising and managing a large number of staff in the Community Mental Health Team. There were also some poor relationships between professional staff.

In relation to the clinical supervision of doctors working with Mr. X the Independent Investigation Team found that the Community Psychiatrist, who had responsibility for the case after Mr. X was discharged from hospital for the last time, had little recollection of the case and could not recall discussing Mr. X's care and treatment in supervision with the junior doctors who provided the direct contact with Mr. X.

- ***Contributory Factor Eight: the poor performance of Care Coordinator 6 was not identified through the supervision system in place.***

- ***Contributory Factor Nine: the responsible clinician after Mr. X was discharged to the supported tenancy scheme had little recollection of the case and did not provide informed discussion with junior doctors.***

12. Organisational Change and Professional Leadership

Mr. X's care and treatment were delivered within an organisational and professional framework and staff interviewed by the independent investigation team referred to wider issues as part of the context.

At Corporate Level:

There was a lack of understanding by Trust staff at all levels of the accountability and governance systems in place at the time of the incident and subsequently, when the internal investigation and related disciplinary procedures were being completed. Staff were not clear about the appropriate action to take when they were concerned about service user and workforce issues. Some of these problems arose from the complexity of the working arrangements in the joint service. That is, many staff working in the Community Mental Health Team, for example, were employed by the County Council but managed by the Mental Health Trust. In relation to the disciplinary and whistle-blowing procedures of each organisation, The Independent Investigation Team found that their working was cumbersome and time consuming. From its analysis of the handling of staffing and service delivery issues associated with the incident, the Independent Investigation Team was not confident that the Trust was now able to deliver changes to working systems in a way that was understood by staff at all levels of the organisation and had their commitment e.g. the move to the 'stepped' system of care being introduced in 2011.

At Team Level:

There were dysfunctional elements in both the teams delivering care to Mr. X in 2007 and 2008. The Supported Tenancy Scheme's Manager had been suspended and the Deputy Manager was also not at work. There was a lack of leadership in the scheme. In the Community Mental Health Team (CMHT) there were professional relationship problems and the Team Manager was the subject of a whistle-blowing allegation. The Care Manager for Mr. X was later dismissed from the Trust. One of the allegations found against him was that he falsified records. There was also a difficult relationship between some care coordinators and some support staff. Many staff spoke to us about a culture in the Trust that made problem-solving more difficult.

The Independent Investigation Team found that there was now more confidence in the leadership of both the Supported Tenancy Scheme and the CMHT but there remained concerns about the implementation of change in the organisation.

At Individual Level:

At the level of individual practice, care coordination for Mr. X was poor until the last care coordinator took over. The supervision system did not pick up the poor practice. Although

there were a number of staff involved with Mr. X the lack of an active and clearly directed care plan contributed to the uncertainty about the future that Mr. X reacted to. Within the tenancy scheme the notion that Mr. X would have to move on gained currency although the Independent Investigation Team understand that this was not a policy at the scheme and that movement should be at the pace of the individual service user. Nevertheless Mr. X believed he was being "thrown out" and this contributed to his mental state at the time of the incident.

There was no apparent trigger for Mr. X's behaviour and Mr. A had been making every effort to deal with Mr X's anxieties on the day of the incident.

- ***Contributory Factor Ten: the supported tenancy scheme was not effectively managed at the time of the incident. This had an impact on the preparation of Mr. A for his role in the supported tenancy where Mr. X lived.***

- ***Contributor Factor Eleven: the relationship between care coordinator 6, the staff at the supported tenancy and other mental health support staff was poor. It contributed to an inadequate formulation of Mr. X's needs and an ill-informed plan for his future.***

13. Clinical Governance and Performance

In the relevant chapter of this report we describe the governance arrangements now in place in the Trust. These are different to those on place at the time of the incident and reflect changes in the organisation of the Trust in the intervening years.

At the time of the incident the mental health service was delivered by staff who were employed by either the Local Authority or the Mental Health Trust. The supported tenancy scheme was managed by the Trust. The Independent Investigation found that both organisations had governance and accountability systems in place, differing in style, but consistent with models in operation at the time. Our conclusion was that staff who were at the 'front line' of service delivery were often not clear about accountability in the system. This was demonstrated most clearly when there were difficulties in professional relationships and disciplinary problems. There were examples of confusion in the handling of disciplinary

procedures that added to the problems of operational delivery of the service. The Independent Investigation also found that some of these issues were still relevant for staff some years after the incident, despite changes to the accountability arrangements in the service. Front line staff were not clear about the outcomes of investigations and disciplinary actions and were wary of future changes to the organisation of services being implemented by the Trust.

- ***Service Issue Eight: the mental health service was subject to a partnership agreement between the local authority and the Mental Health Trust. However, when there were problems, staff were not clear about accountability in the service. Whistle blowing and disciplinary procedures were cumbersome and staff were not clear about the outcome of action under them. Many of these issues remained a concern for staff.***

14. The Trust Response to the Incident

Trust and Local Authority Managers responded to the incident and supported staff in the immediate aftermath. Staff from the Trust also supported service users from the Supported Tenancy Scheme who had witnessed the tragic events of the day. The Trust commissioned an internal investigation that was chaired by an independent person. The Independent Investigation Team found that the internal investigation concentrated on the chronology of Mr X's care but that few witnesses had seen the report or knew what the recommendations had been. Similarly in relation to our independent investigation, relatively few staff took advantage of the workshop offered as preparation for interview by the Health and Social Care Advisory Service. We were inevitably struck by the numbers of Trust staff who were very distressed about the incident and the handling of organisational and team discipline issues. The concern of staff about their management by the Trust extended to present efforts to introduce *New Ways of Working* and new operational structures while maintaining safety.

- ***Service Issue Nine: staff who took part in the Trust internal review were unaware of the outcome of the review, its recommendations or actions flowing from them.***

- ***Service Issue Ten: despite the action to support staff taken immediately after the incident, some years later many staff were concerned about the management of their day to day work and proposals for further change in the mental health service.***

Conclusions

The Independent Investigation Team reviewed the history of care and treatment for Mr. X provided by the Trust and partner agencies. From his first presentation to mental health services in 2002, Mr X was provided with help in many forms. He received in-patient treatment on several occasions, sometimes under the provisions of the Mental Health Act. The care he received was of a good standard, sometimes delivered in difficult circumstances when his mental illness made him uncooperative and resistant to treatment. He had good continuity of care from the clinical team treating him and consistency in his relationship with the Consultant Psychiatrist who acted as his Responsible Medical Officer. When he left hospital he was supported in the community by a range of services, including the Community Mental Health Team and mental health support workers. The success of interventions by care coordinators was variable, and at times he was uncooperative with attempts to help him to achieve greater independence.

Mr. X's difficulties were made worse by the pressures he was under from his own family. Concerns were raised that at times he may be being exploited by the family and subject to financial and emotional abuse. He should have been seen as a vulnerable adult at this time and therefore appropriate for protection under the multi-agency Safeguarding Policy. The situation at home did not help his recovery and he required periodic treatment in hospital.

Over a period of years the realisation grew that Mr. X required support to live outside hospital and could not manage to live independently. He was allocated a place in a supported tenancy scheme in Preston in 2006. The view of the independent investigation team was that this was a good decision based on an assessment of his capabilities at the time. At the point of his admission to the scheme, he was well supported by a combination of the residential care staff at the scheme, his care coordinator, mental health support staff and his responsible clinician. He was also subject to the formal requirements of the Mental Health Act under Section 25 and Section 117 and was on the enhanced level of the Care Programme Approach. This provided a legislative framework for the work with him.

However, over the next eighteen months, the delivery of this care package was variable. The residential support staff at the scheme worked consistently with Mr. X to improve his social skills and used the recovery model to good effect. They encouraged him to attend day services and acquire skills in daily living. They were undermined by poor management of the

service and a series of absences of key managers. Similarly, the Care Coordinator (Care Coordinator 6) allocated to Mr. X performed poorly and did not fulfil his obligations under Trust policies. He did not take an active role in care planning and his attitude to working with Mr. X was an obstacle to progress. He was subsequently dismissed by the Trust for poor performance across a number of areas. Mr X saw a series of junior doctors in regular out-patient appointments. At these reviews there were discussions of progress and medication. The overall supervision of these doctors was the responsibility of a Consultant Psychiatrist who had not met Mr. X.

At the final review meeting on 31 March 2008 there was discussion about Mr. X moving on from the supported housing scheme because he was thought to have made as much progress as he could. There was evidence that Mr. X found this idea threatening and it was the view of the Internal Investigation Team appointed by the Trust that, in fact, Mr. X should have been considered for a more rather then less supportive setting.

Mr. A had worked at the supported tenancy scheme for some months but did not usually work with Mr. X or at Mr. X's residence. He had some contact with Mr. X on the day of the incident which led him to remain with him to reassure him and deal with his anxieties rather than attend a staff meeting. Mr. X attacked Mr. A without warning and fatally injured him.

This Investigation found no direct causal links between any act or omission on the part of the Lancashire Care NHS Foundation Trust and the death of Mr. A. Whilst it was evident that some of the decisions made by the Trust had a detrimental effect on the maintenance of Mr. X's mental health, these on their own could not be seen as causal factors. When assessing causality an Investigation Team has to take into account what was both known, and what should have been known, about a patient during the time care and treatment was being given. The Team then has to consider whether the care and treatment provided was in accordance with the patient's presentation and national best practice guidance.

While there were shortcomings in the organisation and delivery of services at the time of the incident, The Independent Investigation Team found that Mr. X's actions had not been predicted by any staff who worked with him. None of them saw him as a threat nor was there any indication of an assault or aggression to others. The attack on Mr A was not one that could be predicted at that time.

The recommendations of this report are designed to help the Trust to learn lessons from this tragic incident and to improve services in the future.

1.6. Lessons Learned

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Trust to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice has been identified and that the recommendations set below have not been made simply because recommendations are required, but in order to ensure that they can further improve services and consolidate the learning from this process.

The Independent Investigation Team found that Lancashire Care NHS Foundation Trust through the internal investigation process and the independent investigation had learned several lessons from the examination of the care and treatment that Mr. X received. These lessons will have a resonance for all mental health Trusts across the country faced with similar issues. The principal lessons are summarised below.

Staff Supervision and Management Practice

The findings of this independent investigation included shortcomings in the implementation and quality of staff supervision in a number of settings. The Trust has taken steps to strengthen the systems in place and provide quality assurance of their efficacy. In the current system Assistant Network Directors have 1:1 supervision arrangements for their senior reportees and clinical leads. Team leaders have regular supervision and are responsible for line management supervision of team members. Community teams across the network including these, report compliance levels of between 85-100% clinical and management supervision (1 hour) per month. Since the incident the Team Managers in the Supported Tenancy Scheme and the Community Mental Health Team have changed.

Care Coordination

The role and responsibilities of care coordinators are set out in the Trust policy. The care and treatment of Mr. X illustrates that care coordination is an active process, and not simply a nominal or administrative function. In a system where service users are likely to have contact with a wide range of professional staff, there should be additional emphasis on the provision of assertive and well-informed care coordination. The role of the Care Coordinator is not; therefore, to provide a commentary on the service user's mental health but rather to engage the service user actively and fully in the complex arrangements of health and social care that should support them. The revised Trust policy sets out the requirements of care coordination. Recommendations agreed with the Trust support the implementation of the revised policy and measures for regular audit and review.

Continuity of Care

The Trust internal investigation commented on the number of different health and social care professionals responsible for delivering a service to Mr. X over the period of his contact with services. Although there were examples of consistent relationships with professional workers, there were also dislocations in care. Some of these were caused by the inevitable movement of staff within a large organisation, but there was also a sense that the knowledge accumulated about Mr. X was not communicated fully and successfully when changes took place. There were also changes in response to new policy guidance, for example the Trust response to *New Ways of Working*. There is now a greater recognition in the Trust of the importance of transition planning, both for staff and service users. There is greater recognition of the importance of ensuring that for every 'event' on the care pathway there is a corresponding reference in the various operational policies clearly outlining the standards and responsibilities associated with that event.

Standards of Clinical Record Keeping, Audit and Review

Through the process of examination of case records for this investigation, the Trust now has a better understanding of the need for good quality record keeping as a contribution to improving information flow and exchange. There is renewed emphasis on audit and staff training programmes in place to promote a better understanding of the requirements of good record keeping for all staff.

Organisational Change and Staff Support

The Independent Investigation Team had several discussions with the most senior Trust managers about the significance of organisational change for staff at all levels of the organisation. These were prompted by concerns about the gap between the managerial assumptions about change and the experience of "front line" staff. This was also relevant to the Trust because it continued to implement changes to the organisation of services- for example the introduction of the stepped care model. The Trust is now more aware of the challenges of introducing new methods of working and new structures and has invested considerably in a programme of support to managers and staff central to the changes.

1.7. Recommendations

Diagnosis

1. The Trust should ensure that initial assessment of people with mental health problems takes full account of social care factors: this is particularly relevant when the service user has responsibilities as a carer and there are known child care difficulties. Initial assessments should include thorough analysis of social care factors in mental health presentations.

Medication and Treatment

2. The Trust should complete an annual audit of compliance with medication standards at residential and supported accommodation schemes for which it has management responsibility.

3. The Trust should ensure that a full range of therapeutic interventions are available to clinical teams including behavioural approaches (for example Cognitive Behavioural Therapy).

Management of Clinical Care and Treatment

4. The Trust should take action to ensure that all patients on enhanced CPA will be seen by the Consultant Psychiatrist at least once a year in accordance with the Trust CPA policy.

5. The Trust should complete the work on a detailed care pathway for the whole of the stepped care model. This should include:

- arrangements for stepping up and stepping down based on clinical need:

- testing the current operational policies against this pathway and ensure that for every 'event' on the care pathway there is a corresponding reference in the various operational policies clearly outlining the standards and responsibilities associated with that event;

- identifying throughout the care pathway each administrative action required to support the pathway and identify performance standards to achieve this; this could include identifying all communication events and the development of standard templates for communication;

- developing a service user and carer version of the care pathway that clearly describes how the service works and establishes a series of customer care outcomes for various stages of the pathway; and

- developing a stakeholder version for General Practitioners and other organisations with appropriate service standards and contact details for various stages of the pathway.

Mental Health Act

6. The Trust should ensure that statutory duties under the Act are met: this is particularly relevant to community treatment and supervision and to meeting obligations to provide aftercare under Section 117 Mental Health Act. There should be systems in place to ensure that staff carrying out these responsibilities meet Trust standards.

Care Programme Approach

7. The Trust should ensure that the revised Care Programme Approach policy has been fully implemented, including procedures for effective handover and transfer of patients. The trust should monitor implementation through regular audit of the effectiveness of the policy and procedure. This must take place at least annually.

8. The Trust should review its systems for ensuring that all care coordinators receive regular supervision and that this supervision includes monitoring of caseloads to ensure that both Lancashire Care NHS Foundation Trust and national professional guidance and standards are met.

Risk Assessment

9. The Trust must implement a system to ensure that adequate risk assessments are being completed and that regular care planning and multidisciplinary reviews are taking place for people resident in the supported tenancy schemes and similar accommodation where the trust and partner agencies provide services.

10. The Trust should take action to raise the profile of issues associated with vulnerable adults and safeguarding. In particular the Trust should ensure that staff are aware of the inter-agency Safeguarding Policy and their obligations under it.

Referral, Discharge and Handover

11. The Trust should ensure that there is full information exchange between care coordinators when case responsibility is transferred. There should be a system in place to ensure continuity of care when service users are seen by junior doctors under the supervision of a Consultant Psychiatrist .

Documentation and Professional Communication

12. The Trust should complete regular audits of case documentation to ensure compliance with standards.

13. The Trust should ensure that there are systems in place to identify and manage professional communication difficulties. When there are problems the relevant senior manager should be informed and assume responsibility for resolving difficulties.

Clinical Supervision

14. The Trust should implement its clinical supervision policies to ensure that all activity is carried out to the required standards and is accurately recorded. Where there are issues of poor performance the clinical supervision structure should be used to address these issues. All staff should be clear about the supervision arrangements and their role within them.

Organisational Change and Professional Leadership

15. The Trust must develop a communications strategy to improve the level of understanding by staff at all grades of the Trust and Lancashire County Council governance and managerial systems. Particular attention must be given to raising concerns and whistle blowing within the partnership.

16. The Trust should use the findings of this Independent Investigation to inform its work on developing a more open and supportive culture to support high quality clinical practice. Proposed changes to the organisation and delivery of services should be fully discussed with partner agencies.

Governance and Performance

17. The Trust should monitor the application of the disciplinary and whistleblowing policies and report regular summary information to the Trust Board.

18. The Trust should ensure that staff involved in disciplinary or whistleblowing allegations are given timely feedback on the outcome of investigations and are fully supported through the process

Trust Internal Investigation

19. The Trust should ensure that when an internal investigation is completed, it leads to an action plan that can be monitored and that the outcomes are communicated to participants and others with a need to know in a timely way.