Independent Investigation

into the

Care and Treatment Provided to Mr. X

by

Lancashire Care NHS Foundation Trust

Commissioned by
NHS North West
Strategic Health Authority

Independent Investigation: Health and Social Care Advisory Service

Report Author: Alan Watson

Contents

1. Investigation Team Preface

This Independent Investigation into the care and treatment of Mr. X was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*[1]. The Investigation was asked to examine a set of circumstances associated with the death of Mr. A who was found killed on the 7 April 2008.

Mr. X received care and treatment for his mental health condition from Lancashire Care NHS Foundation Trust. It is the care and treatment that Mr. X received from this organisation that is the subject of this investigation.

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

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

1. Health Service Guidance (94) 27: Guidance on the discharge of mentally disordered people and their continuing care in the community: Department of Health 1994

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

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

It is the sincere hope of the Independent Investigation Team that this investigation process has addressed all of the issues that Mr. A's family have sought to have examined and explained. The Investigation Team Chair would like to thank the widow of Mr. A for her contribution to this process.

3. Incident Description and Consequences

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 (Mr. X) 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 admitted 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.

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

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 *EL(94)27, LASSL(94)4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

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

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

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

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

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

The purpose of an independent investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future, incorporating what can be learnt from a robust analysis of the individual case.

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. Lancashire Care NHS Foundation Trust was consulted regarding the terms of reference and did not wish to make any additions. The Terms of Reference are set out below.

1. To examine:

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

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

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

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

- the exercise of professional judgement and clinical decision making;

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

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

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

2. To identify:

- learning points for improving systems and services;

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

3. To make:

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

4. To report:

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

6. The 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.

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.

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	Capsticks Solicitors.

7. Independent Investigation Methodology

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

Consent and Communication with Mr. X

During the course of this Investigation Mr. X was detained at Ashworth Hospital Merseyside. On the 15 June 2010 a letter was sent to him by NHS North West requesting his consent for the Independent Investigation Team to access his clinical records, a consent form was enclosed.

Following this correspondence liaison was established with the hospital clinical team. Mr. X was offered the opportunity to meet with a Senior Officer from NHS North West and a member of the Investigation Team. On the 29 July 2010 this meeting took place at Ashworth Hospital. The Investigation process and *raison d'etre* were discussed with Mr. X and he gave his consent for his clinical records to be accessed and used. He said that he wanted to play no part in the process of the Investigation and did not wish to be interviewed by the Investigation Team or to offer his views on his care and treatment. The Investigation Team therefore had full access to Mr X's notes held by the Trust.

Communication with the Victim's Family

The Independent Investigation Team was advised that all communication with the family of the victim was being dealt with, at their request, through the family's legal representative. The Chair of the Independent Investigation Team contacted the legal representative to give information about the terms of reference for the work, and invite Mr. A's widow to meet the Team during its two periods of interviews in the Preston area. Mr. A's widow did not wish to meet the Team and her wishes were respected. Later the Chair of the Independent Investigation Team met with her and her legal representative on 12 May 2011 to discuss the findings of the Investigation.

Communication with Lancashire Care NHS Foundation Trust

On 2 August 2010 NHS North West wrote to the Lancashire Care NHS Foundation Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. X. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust.

On the 7 September 2010 a meeting was held with the Senior Management Team at Lancashire Care NHS Foundation Trust. The Investigation process was explained and a liaison person identified by the Trust. An invitation was made by HASCAS for a workshop to take place within the Trust to provide a briefing opportunity for all those who would be involved with the Investigation.

On the 11 November 2010 a Trust workshop was held. Lancashire Care NHS Foundation Trust senior personnel and employees were present. Each workshop attendee was given an information pack that described the HSG (94)27 process, gave witness advice and set out the draft terms of reference. The workshop provided each attendee with the opportunity to learn more about the forthcoming procedure and what would be expected of them.

Between the first meeting and the formal witness interviews, the Independent Investigation Team Chair worked with the Trust liaison person to ensure:

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

Formal interviews were held between 30 November 2010 and 2 December. Further interviews and a visit to the Preston Community Mental Health Team were held on 1 and 2 March 2011.

On 16 March 2011 a meeting was held between the Independent Investigation Team representative (Chief Executive Officer of HASCAS) and representatives of the Trust Senior Management Team

and a representative from Lancashire County Council. The purpose of this meeting was to inform the Trust of the headline findings of the Investigation.

Communication with Primary Care Trust

Lancashire Care NHS Foundation Trust services are commissioned by NHS Central Lancashire Primary Care Trust (PCT) on behalf of a commissioning consortium. Investigation Team Members held a meeting with representatives of the Primary Care Trust on 18 April 2011 to give headline feedback on the findings of the Investigation.

Witnesses Called by the Independent Investigation Team

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

During the period that Mr. X received his care and treatment from Lancashire Care services he was seen by a large number of health and social care professionals. It would not have been either practical or useful to have interviewed them all. The Independent Investigation Team took the decision to interview a sample of the Responsible Medical Officers, Named Nurses and Care Coordinators that provided the principal aspects of Mr. X's care and treatment over this period and who were responsible for the formulation of his care management. We were also able to interview staff from the Preston Supported Tenancy Scheme where the incident took place. The total number of witnesses interviewed by the Independent Investigation Team was 24. The witnesses who attended for interviews are set out in table one below.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
30 November 2010	Trust Chief Executive Trust Director of Nursing Trust Network Manager Trust Assistant Network Manager	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer

	*** Members of the Internal Investigation Team *** Trust Social Inclusion Manager *** Mental Health Support Worker	
1 December 2010	Mental Health Support Worker *** Consultant Psychiatrist *** Care Coordinator *** Residential Care Worker *** Group of Residential Care Workers	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
2 December 2010	Care Coordinator *** Consultant Psychiatrist *** Consultant Psychiatrist *** Trust Chief Executive	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
2 March 2011	Community Mental Health Team Manager *** Present Manager of the Community Mental Health Team *** Assistant Network Manager *** Trust Human Resources Director	Investigation Team Chair Investigation Team Psychiatrist In attendance: Stenographer
20 April 2012	Care Coordinator	Investigation Team Chair Investigation Team Nurse

Salmon and Scott Compliant Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Independent Investigation Team Meetings and Communication

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

Prior to the first meeting taking place each team member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation terms of reference. It was possible for each team member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

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

30 November - 2 December 2010. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose.

Between the 2 December 2010 and 18 January 2011 each Team Member prepared an analytical synopsis of the identified subject headings in readiness to conduct an in-depth Root Cause Analysis process. The Team were also able to read transcriptions of interviews. Transcriptions were sent to interviewees for their further comment or amendment and these amended transcriptions were received back from Lancashire Care NHS Foundation Trust during January 2011.

18 January 2011. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' and 'Five Why' process advocated by the National Patient Safety Agency. This process was facilitated greatly by each Team member having already reflected upon the evidence prior to the meeting and being able to present written, referenced briefings at the meeting.

2 March 2011 and 20 April 2012. Additional Witness interviews were held.

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

The Independent Investigation Team held a further collation meeting on **14 March 2011** to discuss the additional findings from the second round of interviews and to prepare for feedback to the Trust on **16 March 2011.** On that day a meeting was held with the Trust Senior Management Team and also a senior representative from Lancashire County Council.

A feedback meeting with representatives of NHS Central Lancashire and NHS Blackburn-with-Darwen (the lead Primary Care Trust for mental health services in Lancashire) was held on 18 April 2011.

The Chair of the Independent Investigation Team met Mrs. A, the widow of the victim, with her legal representative on 12 May 2011.

Other Meetings and Communications

A member of the Independent Investigation Team met on a regular basis with NHS North West throughout the process. Communications were maintained between meetings by email, letter and telephone.

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

Root Cause Analysis

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

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

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

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Decision Tree and the Fishbone.

4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

8. Information and Evidence Gathered (Documents)

During the course of this investigation clinical records have been read and other documentary evidence was gathered and considered. The following documents were used actively by the independent investigation team to collect evidence and to formulate conclusions.

1. Mr. X's Lancashire Care NHS Foundation Trust records.
2. Mr. X's Ashworth Hospital Forensic records.
3. Mr. X's GP records.
4. The transcription of the Preston Crown Court proceedings.
5. The Lancashire Care NHS Foundation Trust internal investigation report and action plan.
6. Secondary literature of review of the media reporting the death of Mr. A.
7. Independent Investigation witness transcriptions.
8. Preston Supported Tenancy Scheme operational policy and case notes.
9. Partnership agreement between Lancashire Care NHS Trust and Lancashire County Council.
10. Trust management structure charts.
11. Lancashire Care NHS Trust Annual reports.
12. Trust Executive management Team governance terms of reference.
13. Manual for Network Service Core Governance Groups.
14. Trust Quality Improvement Strategy.
15. Trust Care Coordination policy.
16. Trust Clinical Risk policy.
17. Management of Violence and Aggression policy.
18. Lone Worker policy.
19. Supervision policy.
20. Observation policy.
21. Restraint policy.
22. Medication in Social Care settings policy.
23. Safeguarding and Vulnerable Adults policy.
24. Healthcare Commission/Care Quality Commission Reports for Lancashire Care Trust Services.

25. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.

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

9. Profile of the Lancashire Care NHS Trust Services (Past, Present and Transition)

Profile of Lancashire Care NHS Foundation Trust

Lancashire Care NHS Foundation Trust was established in April 2002 and authorised as a Foundation Trust on 1 December 2007. The Trust covers the whole of the county and employs around 3,700 members of staff across more than 100 sites. The 2008/2009 Care Quality Commission's Annual Health Check rated Lancashire Care as 'Excellent' for the use of resources and 'Good' for the quality of services. These results place the Trust joint top within Lancashire and in line with other Mental Health Trusts within the North West.

Mental Health Services in Preston

Lancashire Care NHS Foundation Trust is a specialist Mental Health Trust. It has a budget of over 180 million, and provides services to a population of over 4 million. In 2007 when Mr. X received his care and treatment, the Trust provided the whole range of specialist mental health and substance misuse services. For the purpose of this report the Adult Mental Health Services will be described.

The Trust came into being in April 2002 and brought together a range of mental health services that had been both provided and managed by a number of different organisations including acute, community and specialist providers. Many of these services were characterised by a history of under investment. In the period leading up to 2007/2008 Lancashire saw a significant investment in adult mental health services in line with the implementation of the National Service Framework. As a result, each geographical locality served by the Trust had a whole system of services characterised by the following components:

- Inpatient Services;
- Community Mental Health Teams;
- Crisis and Resolution and Home Treatment Teams;
- Assertive Outreach Services;
- Early Intervention Services.

Prior to 2007 services were managed on a locality basis with an Associate Director responsible and accountable for services in the East, Central, West and Blackpool and Fylde Coast Services. Services

from Lancaster and Morecambe joined the Trust in October 2006. As such there was a specific Associate Director for services in East Lancashire.

In early 2007 the Trust moved to a Network Structure with a Network Director responsible for the whole range of Adult Mental Health Services across Lancashire. This role was supported by Service Managers in each local service area.

Trust Vision and Mission

The vision sets out an image of the future in the North West that the Trust wishes to create:
"21st Century mental health care with well-being at its heart."

The mission sets out what Lancashire Care NHS Foundation Trust will do to make the vision a reality:
"To improve the lives of the people we serve and ensure that mental health matters across the whole community."[2]

Trust Services

Clinical services are currently delivered through four networks:

Adult Mental Health, providing:

- inpatient services (including psychiatric intensive care units);
- community services (including outpatients, community mental health teams):
- specialist teams such as assertive outreach and crisis resolution and day services).

The Adult Network provides integrated health and social care to approximately 8000 adults in Lancashire between 16 and 65 (and in some cases over 65). The network is subdivided into three localities (East, Central and North).
Services provided include:

- Inpatient Care including Psychiatric Intensive Care;
- Community Mental Health Teams;
- Assertive Outreach;

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- Crisis Resolution and Home Treatment services;
- Eating Disorders;
- Specialist Psychological interventions;
- Social Inclusion and Day Services;
- Supported Accommodation and Group Homes;
- Primary Mental Health Care (although in some areas this is provided by Primary Care Trusts) including Counselling and Cognitive Behavioural Therapy.

The network has recently embarked upon a project to restructure its services in line with a stepped care model, integrating Community Mental Health Teams and Assertive Outreach, developing a recovery service for people with long term conditions and providing a single point of entry to mental health services in Primary Care.

Older Adult Mental Health, providing:

- Inpatient Services;
- Community Services (including outpatients, community mental health teams, memory clinics and day services);
- Intermediate Support Services.

Secure Services, which also take admissions from South Cumbria, providing:

- an inpatient medium secure unit and a low secure unit;
- transitional services;
- a range of community mental health services including criminal justice liaison teams and prison mental health in-reach teams.

Child and Adolescent Mental Health (CAMHS), Substance Misuse and Early Intervention Services, providing:

- an inpatient facility for young people in Lancaster (The Junction) and Preston (The Platform);
- specialist CAMHS outpatient community services in Lancaster and Morecambe;
- community drug and alcohol services in Blackpool;
- community early intervention services across Lancashire.

A range of psychological therapy services are provided to other NHS organisations.

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. X and on his care and treatment from mental health services.

Background Information

Mr. X was born in Wigan in 1956. His 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 in clinical interviews 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.

Clinical History with Lancashire Care NHS Foundation Trust

10 July 2002. Mr. X was admitted to hospital after presenting at the Accident and Emergency Department. He had low 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 unit[3]. This was Mr. X's first presentation to mental health services at the age of 46.

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27 July 2002. Mr. X was discharged with a diagnosis of mild depression and anxiety. He was followed up by Care Coordinator 1[4] a discharge letter was written by Senior House Officer 1 to the GP (GP1).

20 August 2002. Mr. X failed to attend his out-patient appointment.[5]

6 September 2002. During a home visit Care Coordinator 1 noted that Mr. X was living with his daughter, her partner and two children, and his youngest son. Mr. X's son was not attending school and Mr. X had been fined as a consequence. The Care Coordinator later contacted the Education Welfare Department and was told that Mr. X's son had been taken off the 'school roll'.[6]

16 September 2002. Mr. X did not attend his out-patient appointment.[7]

15 October 2002. Mr. X attended his out-patient appointment with Specialist Registrar 1. Mr. X reported that he was feeling very anxious and that he was sleeping in the lounge because there were so many people in the house. He was referred to the Crisis Team and medication continued.[8]

2 December 2002. Mr. X attended a further out-patient appointment with Specialist Registrar 1. He complained about poor sleep and appetite, anxiety, feeling scared and like a prisoner.[9]

7 December 2002. Mr. X was treated in the local District General Hospital after a self-inflicted stab wound to his stomach.[10]

9 December 2002. Mr. X was transferred to the psychiatric unit under Section 2 of the Mental Health Act (1983). After the stabbing incident he was treated on a medical ward but had believed staff were trying to poison him with potassium and oxygen and he removed all intravenous lines. He had also absconded and refused to come out of a lift.[11]

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24 December 2002. Mr. X was placed on a Treatment Order, Section 3 Mental Health Act (1983). He was assessed as very paranoid, a high risk of suicide and severely depressed.[12]

22 January 2003. Consultant Psychiatrist 1 noted that Mr. X continued to have a negative outlook on life. had obsessive thoughts about having body odour and that *"some staff feel that he is getting too comfortable in the intensive ward…"*. There is a view that this dependency was preventing progress.[13]

5 February 2003. Mr. X was transferred to another ward in the psychiatric unit and started to attend occupational therapy sessions and was said to be doing well in the kitchen.[14]

2 April 2003. At the ward round with Consultant Psychiatrist 1 it was noted that Care Coordinator 2 would look into the possibility of sheltered accommodation for Mr. X.[15]

23 April 2003. Mr. X was granted unescorted leave to visit the local shops for one hour and escorted leave to attend a football match.[16]

30 April 2003. Mr. X saw Consultant Psychiatrist 2 for a psychotherapy assessment. This assessment concluded that Mr. X presented with moderately severe depressive symptoms, and psychotic symptoms involving paranoid delusional beliefs and self-referential ideas.[17]

21 May 2003. Mr. X had visited a new flat but was not sure whether to take it or not. Senior House Officer 2 decided that he should remain on his section of the Mental Health Act *"to avoid panicking him…."*[18]

4 June 2003. A ward round discussion referred to an improvement since Mr. X had been taking Amisulpride. Mr. X was said to enjoy occupational therapy. His Section expired on 24 June 2003 and Consultant Psychiatrist 1 was of the opinion that it should not be renewed. The plan was for him to move to a flat. He consequently visited the flat with an Occupational Therapist as preparation for

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the move. He continued to express many anxieties about details of the move and obsessively checked details of the taps and pipe work.[19]

6 August 2003. In the ward round it was noted that Mr. X would be having overnight leave.[20]

27 August 2003. After several weeks of overnight leave, Mr. X was asked when he felt he would be ready for discharge. He said that he would be *"gutted"* when he was discharged. He was asked to think whether he needed support from the Home Treatment Team after discharge planned for the following week.[21]

3 September 2003. Mr. X was discharged from the psychiatric unit with support from Care Coordinator 2.[22]

5 September 2003. Mr. X was visited by Care Coordinator 2 and was said to be doing well. He was also being helped by a Support Worker who was encouraging him to do practical things to improve the flat.[23]

17 September 2003. Care Coordinator 2 made a home visit and noted that Mr. X had been out with the Support Worker to buy curtains and the flat looked very clean and tidy. Mr. X was said to be coping well but became easily distressed if problems arose.[24]

10 October 2003. Mr. X was visited by Care Coordinator 2[25] who recorded that Mr. X remained well.

24 October 2003. Mr. X was visited by Care Coordinator 2 and was said to be well and had an appointment with a Welfare Benefits Advisor.[26]

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24 SCN pg 88
25 SCN pg 88
26 SCN pg 88

18 November 2003. Mr. X was admitted under Section 3 Mental Health Act (1983) to the psychiatric unit. 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. The application was completed by Care Coordinator 2 with recommendations from GP1 and Consultant Psychiatrist 1.[27]

19 November 2003. Consultant Psychiatrist 1 noted that after discharge Mr. X would need supported accommodation[28]

24 November 2003. The clinical notes recorded that Mr. X was now sleeping better on the ward and that he thought that his problems were mainly financial and that he would be better off dead.[29]

3 December 2003. Mr. X was referred to the Assertive Outreach Team because he had complex needs and there was a significant risk of suicide.[30]

26 January 2004. After an unsuccessful referral to a supported housing scheme Mr. X was discharged from the psychiatric ward to his flat, to be supported by the Home Treatment Team. The discharge plan was:

- to continue with medication;
- to be visited twice a day by the Home Treatment Team to dispense medication;
- to monitor risk;
- to receive visits from the Care Coordinator to help with financial problems;
- to receive help with domestic chores to establish a daily routine.
- To receive follow up in out-patient clinic.[31]

26 January 2004 to 23 March 2004. During this period Mr. X was supported intensively by the Home Treatment Team (HTT). He was living in a rented flat with two of his children. He remained anxious about his finances and about the day-to-day running of the home. He expressed suicidal ideas. His children were critical of him and were described as rejecting, demanding and bullying.[32]

27 HR Vol 2 pg 35
28 HR Vol 2 pg 39
29 HR Vol 2 pg 39
30 HR Vol 2 pg 40
31 HR Vol 2 pg 44
32 HR Vol 2

May-September 2004. Mr. X remained at home and was visited regularly by Care Coordinator 2 and Support Worker 1 with whom he had a good rapport. His mental state was recorded as variable-sometimes better, but also with chronic anxieties about coping with daily living. His son was also living at the flat.[33]

8 October 2004. Care Coordinator 2 reported that Mr. X was agitated and low in mood. There were problems in relationships with his son and daughter who were reported as demanding and confrontational.[34]

12 October 2004. Mr. X was visited by Support Worker 1 but when the worker tried to leave, Mr. X got into the worker's car and refused to let him go. Mr. X showed signs of acute anxiety, distress and was hyperventilating. Later he was assessed by Senior House Officer 3 and Care Coordinator 2 had a discussion with Consultant Psychiatrist 3 about the next steps.[35]

18 October 2004. Mr. X was admitted to the psychiatric unit after he was found in an agitated state in a public telephone box. The Police had been called to deal with the incident.[36] Mr. X called 999 because he felt low and could not get in touch with his Care Coordinator. He complained about being ill-treated at home by his son and about wanting to walk in front of traffic to end his life.[37]

20 October 2004. Mr. X had to be restrained and detained under Section 5(2) Mental Health Act (1983). He said he would kill himself if he left the ward. He refused medication, would not eat or drink, refused to cooperate with physical examinations and was experiencing panic attacks.[38]

25 October 2004. Mr. X was detained under Section 5(2) because he wanted to leave the ward and was expressing suicidal thoughts. He has paranoid ideas about other people and their beliefs about him.[39]

26 October 2004. Mr. X was detained under Section 2 Mental Health Act (1983) after making repeated attempts to leave the ward.[40]

33 HR Vol 2/SCN pg 44
34 HR Vol 3 pg 353
35 SCN pg 42
36 HR Vol 3 pg 353
37 HR Vol 3 pg 353
38 HR Vol 3 pg 353
39 HR Vol 3 pg 371

17 November 2004. Mr. X was detained under Section 3 Mental Health Act (1983). He remained suspicious of people and had a fixed belief that he emitted an unpleasant smell. At times his behaviour was disturbed and he was subject to seclusion on the ward. He was uncommunicative, stared at people, and was uncooperative with treatment plans.[41]

December 2004. During this month some improvements were noted and Mr. X was granted some unescorted leave. He spent Christmas on the ward and did not receive any visitors. There was some discussion by the clinical team about supported accommodation and the Care Coordinator followed this up. Mr. X's behaviour became gradually more settled.[42]

5 January 2005. The Section 3 Treatment Order came to an end. An application to a mental health voluntary sector provider of supported accommodation was unsuccessful but a further application for a nursing home place was made.[43]

18 January 2005. A ward round discussion noted that Mr. X would not be eligible for nursing home placement because he was *"fully independent and capable".* It was agreed that the Care [44]Coordinator should look at other possibilities, including sheltered housing.[45]

4 February 2005. Mr. X was discharged from the ward to his flat. The care plan included:

- daily visits from the Home Treatment Team (HTT);
- the Care Coordinator was to seek a supported accommodation placement;
- medication was to be provided by the HTT;
- liaison was to be maintained between the HTT and the care coordinator.

February-March 2005. Mr. X was visited regularly by a Support Worker 1. At first support workers visited in pairs because of an earlier incident when Mr. X refused to leave a support worker's car. Sometimes Mr. X did not let the support workers into the flat. An entry in the case notes on 2 March 2005 noted that Care Coordinator 1 and Support Worker 1 attended a ward round and noted that Mr. X was in the process of being referred back to the Community Mental Health Team. Support Worker

40 HR Vol 3 pg 374
41 HR Vol 3
42 HR Vol 3 pg 440
43 HR Vol 3 pg 446
44 HR Vol 3 pg 390
45 HR Vol 3 pg 453

1 raised the issue of risk when visiting Mr. X alone however Consultant Psychiatrist 3 and the Home Treatment Team believed that the risk was reduced.[46]

29 April 2005. There was a visit to Mr. X from Care Coordinator 3 who had taken over the role from Care Coordinator 2. Support Worker 1 continued to work with Mr. X. There was a discussion about Mr. X moving to a supported tenancy scheme in the Preston area and in particular to the Harewood Road facility. Mr. X was undecided about moving there. Mr. X's son was living at the flat with him and Mr. X was worried that if he gave up his flat his son would be made homeless.[47]

16 May 2005. There was a CPA review attended by Care Coordinator 3, Support Worker 1 and Consultant Psychiatrist 3. There were concerns that Mr. X was being exploited by his son financially and that the son (aged 17) was living at the flat with his girlfriend (aged 16) and that at weekends they had care of Mr. X's grandchild who was three moths old.[48] It was agreed that it was not appropriate, in view of Mr. X's mental state, that he should have care of a child of this age.

15 June 2005. Discussion was recorded on file between Care Coordinator 3, Support Worker 1 and Consultant Psychiatrist 3. Mr. X was not engaging with the Support Worker and would often not let him into the flat. It was agreed that Support Worker 1 would continue to visit once a week to monitor and report any signs of relapse.[49]

15 July 2005. Care Coordinator 3 accompanied Mr. X to an out-patient appointment with Consultant Psychiatrist 3. It was noted that Mr. X was experiencing low mood, lack of sleep and did not wish to engage in any of the activities offered to him e.g. attendance at a day centre.[50]

16 September 2005. A new Care Coordinator was allocated to Mr. X, Care Coordinator 4, had visited Mr. X but was told by Mr. X's son that he (Mr. X) was at his daughter's flat in another part of Preston.[51]

30 November 2005. The note of a CPA review with Consultant Psychiatrist 3 recorded that:

46 SCN pg 77
47 SCN pg 69
48 SCN pg 67
49 SCN pg 65
50 SCN pg 63
51 SCN pg 61

- the case was to be closed to the Community Support Team (of which Support Worker 1 was a member) and referred to the Community mental health Team for *" care coordination only";*
- Mr. X's situation remained unchanged with his son living at the flat and taking money from him;
- Mr. X's mood remained flat;
- Mr. X was not making use of the Support Worker.

It was agreed that if Mr. X wanted to move to supported housing he would have to ask his son to leave the property. Mr. X was reluctant to take this step.[52]

16 February 2006. The next CPA review was attended by Consultant Psychiatrist 3, Care Coordinator 4 and a Housing Officer from a local housing association. The Consultant Psychiatrist wrote to the GP (GP2) with the view that Mr. X would benefit from a referral to supported accommodation, but that he was reluctant to agree to this because his son, presently living with him, would not be able to take over the tenancy and would therefore be homeless. However concerns were raised that it was reported that the son had damaged the property and exploited Mr. X financially. It was agreed to allow the housing association to find warden supported accommodation and that they would review the plan at the next CPA meeting in May 2006. [53]

16 March 2006. An entry in the case notes recorded that Care Coordinator 5 had now taken over from Care Coordinator 4.[54]

16 May 2006. It was noted by Approved Social Worker 1 for the Emergency Duty Team, that Mr. X presented himself at the psychiatric unit on 15 May 2006 and had deteriorated both physically and mentally. There were obvious signs of self-neglect. Mr. X 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 psychiatric unit in Blackpool. Mr. X refused to sit down in the ambulance transferring him. The Police were called and there was

52 SCN pg 58
53 SCN pg 55
54 SCN pg 54

some delay while the Police and ambulance staff considered the protocol for transfer. Eventually Mr. X was admitted to the hospital in Blackpool at 10:40 pm.[55]

26 May 2006. Mr. X was transferred to the psychiatric unit in Preston and care coordination was resumed by Care Coordinator 4.

27 June 2006. A CPA risk assessment was completed by Nurse 1. Historical risks identified included use of weapons and intimidating behaviour but there was no current risk to others identified in the plan.[56]

2 August 2006. Case recording by Care Coordinator 4 noted that Mr. X had been offered a place at the supported tenancy scheme in Preston, subject to being supervised under Section 25 Mental Health Act. Care Coordinator 4 took Mr. X to his flat to pick up belongings and noted that the flat was a mess.[57]

8 August 2006. Mr. X moved to the supported tenancy scheme and care coordination was transferred to Care Coordinator 6. There was a two-page care plan on file at the supported tenancy scheme recording Mr. X's status as being on enhanced CPA, subject to Section 117 aftercare, and supervision under Section 25 Mental Health Act (1983). The notes also contained an Individual Care Programme which was the scheme's own care plan concentrating on daily activities and living skills.[58] Mr. X was on leave from the psychiatric unit under Section 17 Mental Health Act (1983). His consultant psychiatrist was now Consultant Psychiatrist 6, who had taken over from Consultant Psychiatrist 3.

5 September 2006. Lancashire Care NHS Trust formally accepted the Section 25 Supervised Discharge Order and the supervisor was named as Care Coordinator 6.[59]

13 September 2006. Mr. X was formally discharged from the psychiatric unit. He was then formally under the care of Consultant Psychiatrist 4. He was seen as an out-patient by Senior House Officer 4

55 SCN pg 54
56 PSTS pg 52
57 SCN pg 52
58 SCN pg 45/PSTS pg 2
59 MHAF pg 140

and Specialist Registrar 2, with Care Coordinator 6 and Residential Support Worker 1 from the supported tenancy scheme. It was recorded that *"he has been doing well"*.[60]

16 October 2006. Mr. X attended an out-patient appointment with Senior House Officer 4, accompanied by his Key Worker at Glebe Close (the supported tenancy scheme), Residential Support Worker 2. It was noted that he was attending classes at a local day centre and otherwise his mood was variable, but he denied having any thoughts about harming himself or others.[61]

7 November 2006. Mr. X's family, his son, daughter and son's girlfriend, came to visit him at the supported tenancy scheme because it was his birthday.[62]

7 December 2006. Care Coordinator 6 noted that he had visited Mr, X at the supported tenancy scheme and that Mr. X was *"sullen in presentation".* He was attending college for cookery classes and a local day centre for computer skills and said he was enjoying both.[63]

5 January 2007. Care Coordinator 6 noted that Mr. X's family visited on Christmas day. Mr. X remained unchanged and continued to have a negative outlook on life. He sought constant reassurance from staff and tended to repeat the same questions.[64]

22 January 2007. Mr. X attended an out-patient appointment with Senior House Officer 4 accompanied by Residential Support Worker 3. No major changes were noted.[65]

26 February 2007. The Section 25 Supervised Discharge Order was ended formally.[66]

7 March 2007. Mr. X was visited by Care Coordinator 6 at the supported tenancy scheme. It was noted that he was anxious and not enjoying anything at present, but was still attending daily activity sessions and was fully compliant with his treatment plans. Mr. X was happy to stay at Glebe Close and had no plans to move.[67]

60 HR Vol 5 pg 7
61 HR Vol 5 pg7/SCN pg 44
62 IIR pg 32
63 SCN pg 44
64 SCN pg 44
65 HR Vol 5 pg 8
66 MHSF pg 142
67 SCN pg 43

8 March 2007. Mr. X was seen by Senior House Officer 5 at out-patients accompanied by Residential Support Worker 3. He felt everything was against him and was nervous all the time. He had had less contact with his family. It was noted that he was low in mood. There was reference to a referral for cognitive behavioural therapy.[68]

20 March 2007. Care Coordinator 6 visited Mr. X and recorded that he was still suffering from low mood, was following staff around and staring at them for long periods.[69]

23 March 2007. A further home visit was made by Care Coordinator 6 who noted that Mr. X's eating had improved.[70]

30 April 2007. The supported tenancy scheme notes included a Generic Risk Assessment which identified the key workers for Mr. X as Residential Support Worker 2 and Residential Support Worker 3, the case manager as Residential Manager 1 and the deputy case manager as Residential Manager 2. The plan referred to risk areas for suicide, self-neglect, diet and medication but did not include an assessment of risk to others (i.e. there was not a category for this kind of assessment).[71]

14 June 2007. Mr. X attended an out-patient appointment with Senior House Officer 5, accompanied by Residential Support Worker 2. He was said to be *"always anxious and anhedonic"* Residential Support Worker 2 reported that he had come on in leaps and bounds. The medication dosage was increased and it was noted that a referral for Cognitive Behavioural Therapy was in place.[72]

22 June 2007. Care Coordinator 6 visited and recorded that Mr. X presented as settled in mood and with no behaviour problems. He was more occupied and more able to cope with difficulties and compliant with medication.[73]

21 August 2007. Mr. X was visited by Care Coordinator 6. He presented as a little anxious because he thought that the Care Coordinator was going to *"move him on"*. Staff said that he was continuing with his rehabilitation programme.[74]

68 HR Vol 5 pg 8
69 SCN pg 43
70 SCN pg 43
71 PSTS pg 5 et seq
72 HR Vol 9 pg 5
73 SCN pg 42

17 September 2007. Mr. X was seen at the tenancy scheme by Care Coordinator 5 and at out-patients by Senior House Officer 7 accompanied by Residential Support worker 2. A degree of paranoia about staff talking about him was noted. He was prescribed Risperidone. The Care Coordinator noted that he was still having fleeting paranoid ideas but that these were "*easily diswayed (sic) by staff*".[75]

15 October 2007. The tenancy scheme case notes recorded that Mr. X had a signed tenancy agreement with the Housing Association administering the scheme. There were no references to the time limit of the tenancy in the agreement.[76]

15 November 2007. As a result of the implementation of changes in Trust organisation, formal responsibility for psychiatric oversight passed from Consultant Psychiatrist 4 to Consultant Psychiatrist 5 who supervised the junior doctors who saw Mr X as an out-patient.

11 December 2007. Mr. X attended an out-patient appointment with Senior House Officer 6, who was working as a junior doctor to Consultant Psychiatrist 5, accompanied by Residential Support Worker 3. Consultant Psychiatrists 4 (and then 5) had had case responsibility for Mr. X since his discharge from the psychiatric unit but delegated the patient contact to senior house officer graded doctors working under their supervision. Mr. X was said to have low mood and motivation, and was still feeling paranoid that the staff were talking about him.[77]

18 December 2007. Senior House Officer 6 completed a review of Mr. X's case notes.[78]

10 January 2008. Mr. X attended an out-patient appointment with Senior House Officer 6, accompanied by Residential Support Worker 2. The Doctor noted that Mr. X had made progress since living at the supported tenancy scheme and had improved his daily living skills. However, his moods fluctuated and he had thoughts about harming himself. However Mr. X did not think he would act on these thoughts and would discuss his feelings with staff.[79]

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74 SCN pg 42
75 SCN pg 41/HR Vol 5 pg 10
76 PSTS pg 46
77 HR Vol 5 pg 11
78 HR Vol 5 pg 13
79 HR Vol 5 pg14

12 February 2008. Mr. X was allocated to a new care coordinator, Care Coordinator 7, who made an unsuccessful attempt to contact Mr. X by telephone.[80]

20 February 2008. Care Coordinator 7 recorded a further unsuccessful attempt to contact Mr. X by telephone.[81]

4 March 2008. Care Coordinator 7 visited Mr. X at the supported tenancy scheme to complete a health and social care needs assessment. Care Coordinator 7 noted that:

- Mr. X's mood was Dysthymic (depressed);
- Mr. X had not made plans for suicide but believed that people would be better off without him;
- Mr. X believed that people discuss him in a negative way;
- his activity levels were low but staff did a good job of encouraging involvement, he was going to photography and cookery courses, but said he got no enjoyment from these;
- he said he was happy with his placement;
- cognitive behavioural therapy was discussed with him.

Care Coordinator 7 noted that during his discussion with staff at the scheme no concerns were expressed about increased aggression or violent posturing towards them or other tenants.[82]

31 March 2008. Mr. X had an out-patient appointment with Senior House Officer 8, Care Coordinator 7 and Residential Support Worker 2. The record of this discussion by Care Coordinator 7 recorded the information set out below.

- Residential Support Worker 2 said that based on the supported tenancy scheme remit, Mr. X was now due to move on to a more independent setting such as a supported tenancy.
- It was noted that Mr. X presented as anxious, with limited expression and poverty of content to his conversation.
- His responses were substantially negative and hopeless.
- Mr. X appeared to obsess about other people talking about him and thinking about him.

80 SCN pg 40
81 SCN pg 40
82 SCN pg 103

- It was suggested that Cognitive Behavioural Therapy might be helpful but Care Coordinator 7's view was that *"his age, length of time with the condition and service and his presentation indicate an entrenched and pervasive negative/nihilistic perspective"*.
- It was agreed that Care Coordinator 7 would do some preliminary work on the Cognitive Behavioural Therapy.

Care Coordinator 7 recorded that the supported tenancy scheme would *"begin to look at alternative tenures."*[83]

7 April 2008. Mr. A, working as a residential support worker at the supported tenancy scheme**,** requested Care Coordinator 7 to come to see Mr. X because he (Mr. X) was anxious. A later call recorded that Mr. X had become more paranoid and thought that people wanted to get rid of him. Care Coordinator 7 recorded that staff were possibly being more assertive in trying to achieve greater independence for Mr. X and that this was the cause of his anxiety.[84]

7 April 2008. Mr. X attacked Mr. A with a knife in the office of the supported tenancy scheme and killed him.[85]

83 HR Vol 5 pg 15/SCN pg 104
84 CPA electronic record pg 33
85 CPA electronic record pg 32

11. Timeline and Identification of the Thematic Issues

Root Cause Analysis (RCA) Second Stage

11.1. Timeline

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

11.2. Issues Arising from the Review of other Data

The Independent Investigation Team found 13 issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the key headings of the Independent Investigation Terms of Reference.

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, for example 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 Independent Investigation Team 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.

2. Medication and Treatment

Mr. X was treated with anti-depressant and anti-psychotic medication when in hospital. This was appropriate and followed on from the diagnosis. He was also prescribed antidepressants and antipsychotics long term while in the community. The need for the latter was insufficiently clearly accounted for in the notes and should have been reviewed more critically during his period of follow-up. He was adherent to medication and after leaving hospital and was trusted to take the medication unsupervised. He was reviewed regularly through out-patient appointments. The focus of out-patient review in the latter years of his contact with service was on medication adherence 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).

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 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 Consultant Psychiatrists 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.

4. Mental Health Act (1983 & 2007)

Mr. X was detained under Sections 2 and 3 of the Mental Health Act (1983) and at times under the emergency 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, both unnecessary and ineffective because:

- he was compliant with residence and medication requirements;
- the Care Coordinator did not fulfil his role as supervisor under the Act.

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 Independent 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 after-care 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, and in face to face review by a consultant psychiatrist. In fact the contact with the Care Coordinator was superficial and managed poorly, and he did not see a consultant. 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 junior doctors rotated to different roles on a regular basis. 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.

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[86] and were the subject of an inter-agency agreement and policy guidance[87]. The Independent Investigation Team found that there were shortcomings in the appreciation of safeguarding issues as an element of the risk assessment.

- 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.

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

- 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.

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 Care Coordinator 7 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

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 it was reported that 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.

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, the Independent Investigation found that although he had regular supervision meetings with his line manager, his poor performance was not identified. The Independent Investigation found that a factor in this failure was that the manager had a wide span of

responsibility and was supervising and managing a large number of staff in the community mental heath team. This was also in a context of some poor relationships between professional staff.

In relation to the clinical supervision of doctors working with Mr. X The Independent Investigation Team found that after Mr. X was discharged from hospital for the last time, the Community Consultants in charge of his case were initially locums who did not meet him. A substantive Consultant later took over responsibility for the case and discussed Mr. X's care and treatment in supervision with the junior doctor who provided the direct contact with Mr. X. He asked for Mr. X to be booked into his clinic but this did not take place, and Mr. X was not reviewed by a consultant for the final 18 months of his community care. Continuity of his medical care was limited as a result.

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 sought assurances from the Trust that it 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 commitment to implement 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 Coordinator 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 the Independent Investigation Team about a culture in the Trust that made problem-solving more difficult.

The Independent Investigation Team found that currently there was now more confidence in the present leadership of both the Supported Tenancy Scheme and the CMHT. However some clinical witnesses retained concerns about the implementation of change within the organisation

At Individual Level:

At the level of individual practice, care coordination for Mr. X was variable in quality until the last Care Coordinator took over. The supervision system did not pick up poor practice on the part of some care coordinators. 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 understood that this was not a policy at the scheme and that movement would normally be at the pace of the individual service user. Nevertheless Mr. X believed he was being *"thrown out"* and this contributed to his anxious mental state at the time of the incident. His anxieties were known to some of his fellow residents who commented on Mr X's mental state in their witness statements following 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.

13. Clinical Governance and Performance

In the relevant chapter of this report the Independent Investigation Team describes the governance arrangements now in place within the Trust. These are different to those in 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 Team found that both organisations had governance and accountability systems in place, differing in style, but consistent with models in operation at the time. The 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 Team 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.

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 been present on the day of Mr. A's death. The Trust commissioned an internal investigation that was chaired by an independent person. The Independent Investigation Team found that few witnesses had seen the report, or knew what the recommendations had been. Similarly in relation to the Independent Investigation, relatively few staff took advantage of the workshop offered as preparation for interview by HASCAS. The Independent Investigation Team 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.

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

RCA Third Stage

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

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

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the significant deterioration of Mr. X's mental health and how it impacted upon the death of Mr. A. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. X's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the

death of Mr. A need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

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. An Investigation Team then has to consider whether the care and treatment provided was in accordance with the patient's presentation and national best practice guidance.

The standard of care and treatment that Mr. X received over a seven-year period was of a generally good standard. In the days prior to the incident the issue of Mr. X moving on from his place at the supported tenancy scheme was being discussed. This transition was likely to cause anxiety to Mr. X although in fact it was not imminent. The attack on Mr. A was neither predictable nor preventable. Mr X gave no warning as to his actions and had not previously been assessed as likely to behave in such a manner.

12.1. Lancashire Care NHS Foundation Trust Findings

12.1.1. Diagnosis

12.1.1.1. Context

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

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

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to address some care, treatment and risk management issues.

12.1.1.2. Findings

The following diagnoses were recorded in case notes at different points during Mr. X's care.

- Mild depression with anxiety (discharge summary, admission of 10 July 2002-22 July 2002 and subsequent outpatient correspondence).
- Recurrent depressive disorder, current episode severe depression (Discharge summary second admission 9 December 2002-3 September 2003).
- Moderately severe depression with psychotic symptomatology involving paranoid delusional ideas and self referential ideas (psychotherapeutically oriented opinion by Consultant Psychiatrist in psychotherapy Consultant Psychiatrist 2 , 12 May 2003).
- Recurrent depressive disorder- severe without psychotic symptoms (discharge summary, home treatment 26 January 2004-23 March 2004 following third admission).
- Severe depression with psychotic symptoms (discharge summary, home treatment team 4 February 2005-4 March 2005 following fourth admission).
- Depression with psychotic features, significant personality characteristics which affect his presentation (Consultant letter to GP, November 2005).

- Not stated (discharge summary fifth admission of 27 June 2006-16 August 2006).
- Mixed anxiety and depression (outpatient clinic 14 June 2007).
- Treatment resistant depression with psychotic symptoms (impression formed by Consultant Psychiatrist 5 at supervision of outpatient consultation by trainee, 18 December 2007).

These are diagnoses recorded in discharge summaries or made by Consultant Psychiatrists, and are presumed to reflect expert opinion or discussion by a clinical team, or are diagnoses which had a demonstrable impact on management. Diagnoses included in differential lists which were not supported by subsequent Consultant notes are generally disregarded in the following discussion, as these are often included in notes for completeness even where they are evidently considered of low likelihood. However, some speculative references to diagnoses or other uses of diagnostic terminology are discussed below where relevant.

Most of the diagnostic terms used are approximately those of the ICD-10 , though the specific codes are not given, and there are minor departures from the formal classification. For example, 'mild depressive episode', code F32.0, can encompass anxiety symptoms but they are not included in the diagnosis. 'F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms' is the closest approximation to the diagnosis used for the second episode. The diagnosis used in the third episode does not correspond exactly to an ICD-10 code, and it is arguable that all diagnoses following the second episode should be under the heading 'F33 Recurrent depressive disorder', though 'mixed anxiety and depression' is an ICD-10 term (code 41.2). However, these are minor points, and the terms used would be generally well understood within mental health services.

The diagnoses given above appear broadly consistent with the symptoms recorded in the notes, with one possible exception. That is that a diagnosis of 'mild depression', as given after the first episode, appears to understate the severity of the symptoms and behaviour. 'Mild depression' would be commonly understood to imply that management should be possible entirely within primary care (for example, see the NICE Guideline on Depression, CG23, which was issued in 2004[88] or more recently, the Map of Medicine[89]).

88 http://www.nccmh.org.uk/downloads/Depression/cg023fullguideline.pdf,
89 http://eng.mapofmedicine.com/evidence/map/depression_in_adults2.html

Though the mental state examinations recorded in the clinical notes for this first episode are not very detailed, sufficient symptoms (low mood, poor sleep, poor appetite, reduced concentration, suicidal ideation), intensity and duration are noted to justify a diagnosis of at least a moderate depressive episode. The treatment offered after this episode (medication, and follow-up by both a Community Psychiatric Nurse and a Psychiatrist) was in fact consistent with a diagnosis of a moderate episode, so the diagnosis given had no adverse consequences.

Though the diagnoses described above, with the exception described, appear generally well founded and appropriate, three further issues in relation to diagnosis merit discussion.

The first is that of personality. There are a number of references throughout the clinical record to a history of disrupted parenting, difficulties in relationships throughout life, and (from the second admission onwards), comments about Mr. X's dependence on services. These were set out most clearly by Consultant Psychiatrist 2, Consultant Psychiatrist in Psychotherapy, who noted in his assessment letter of 12 May 2003 that Mr. X had stabbed himself in the abdomen shortly after his daughter, with whom he had been staying following the loss of his own home, had told him he could not continue to live with her. He described Mr. X's personality more in terms of a dynamic formulation than a diagnosis, as follows: *"…there is probably quite a psychotic part of (his) personality….(which)…might be linked to serious failures in attachment routine and containment in early infant life with what we might speculate to have been quite disturbed parents…his status as an in-patient has encouraged and engaged a regressed part of him who has enjoyed feeling safe, secure, and looked after in the ward environment but who might find it very difficult to take up a position of more responsibility again in living in the community. He can acknowledge that discharge might be a particular danger point for him'.*

Apart from this prescient formulation, there seems to have been little attempt to make a diagnosis of personality disorder. A Care Coordinator noted in 2003 having heard a Consultant describe Mr. X as having *"a narcissistic personality with self-destructive tendencies".*[90] Narcissistic personality disorder is a term from the Diagnostic and Statistical Manual (DSM) IV diagnostic system, the published criteria for which would appear to have limited relevance to Mr. X.[91]

90 HR vol7 pg 109
91 (http://www.behavenet.com/capsules/disorders/narcissisticpd.htm).

A brief note from Consultant Psychiatrist 1's ward round dated 28 May 2003 refers to Consultant Psychiatrist 2's assessment as *"…paranoid personality with schizoid tendencies"*, but these terms (which may refer to ICD-10 diagnostic categories of paranoid (60.0) and schizoid (60.1) personality disorders) are not used in Consultant Psychiatrist 2's letter, nor would either diagnosis appear to be justified fully by reference to the symptoms described, by Consultant Psychiatrist 2 or elsewhere in the clinical record.

The failure to make a diagnosis of personality disorder could be justified on a number of grounds. For example, that Mr. X would not appear to fit precisely into diagnostic categories (whether those described above, or others such as the ICD-10 categories of anxious (avoidant) (60.6) or dependent (60.7) personality disorder); that any diagnosis of personality disorder may be stigmatising and exacerbate rejection by services rather than lead to more careful consideration of its consequences; that a diagnosis may not help to predict treatment or outcome; or that it can be hard to establish in the absence of a good developmental history and informant or collateral information. However, it is not clear from the clinical record that the issue was considered in sufficient detail, with the exception of Consultant Psychiatrist 2's assessment. Wider awareness of his formulation of Mr. X's difficulties, or a structured diagnostic assessment of personality, and perhaps further involvement of Consultant psychiatrist 2 or another psychotherapist in later discussions about Mr. X's management (in a supervisory capacity, given his apparent unsuitability for individual therapy) might have assisted risk assessment and management over time.

The second issue requiring further consideration is the nature of Mr. X's apparent psychotic ideas. These are first described by his GP in October 2002, but in terms which make it difficult to be certain that they were in fact psychotic. By the time they were assessed by a Psychiatrist three weeks later, they did not seem to be of delusional intensity, though this might have been a consequence of the antipsychotic medication he had been prescribed.

In the initial period of the second, fourth and fifth admissions, there is clear evidence of paranoid thinking associated with abnormal behaviour, at a time when Mr. X's depressive symptoms were also severe. He expressed a range of ideas of persecution, and also other ideas suggestive of a depressive psychosis (such as *"convinced he is dead and in the morgue"*, May 2006). Though the precise phenomenology of his beliefs is not well described, and may in any case not have been possible to obtain, it seems clear that a diagnosis of depressive psychosis (or in the ICD-10

terminology, 'recurrent depressive disorder, current episode severe with psychotic symptoms') was justified. However, these symptoms seem to have reduced markedly, on each occasion, over a period of a month or less, associated with a reduction in depressive symptoms.

The evidence that he had enduring psychotic symptoms, which would not be expected in someone with this diagnosis once depressive symptoms had resolved, is far less clear. There appears to be an enduring uncertainty in the clinical record about the nature of his persistent preoccupation with the belief that he smelt, which was particularly frequently noted during his second and fourth admissions. Delusions of body odour, and olfactory hallucinations, are known to be associated with depressive psychosis, and this may have led to a tendency to make that association in his case. However, they would normally be associated with severe psychotic symptoms rather than emerge, or persist, at phases of the illness when depressive symptoms are not severe.

The description in the case notes of his persistent seeking of reassurance about his odour would possibly be consistent with anxiety, or with intrusive thoughts associated with obsessive compulsive disorder (OCD), as would observations that at times he scrubbed himself vigorously or cleaned his teeth excessively. This appears to have been the view of nursing staff working with him during his second admission, supported by his own belief that he had this condition. This anxious seeking of reassurance might be exacerbated by the fact that at some points in his illness he did not wash, did have body odour, and poor dental hygiene, and was told this by nursing staff who were prompting him to wash or to clean his teeth.

It was also not clear that he did in fact have olfactory hallucinations, and references to this are not supported by phenomenological description, although in one detailed description during his fourth admission it was stated that, when seeking reassurance about his smell, he did *not* himself notice a smell but believed others did. This would be consistent with Obsessive Compulsive Disorder (OCD) or a delusion but would not be consistent with olfactory hallucinations. In summary, while there is evidence of brief periods of psychosis associated with his severe depression, the evidence for enduring psychotic symptoms prior to April 2008, which would be suggestive of other diagnoses such as schizophrenia, is not convincing.

The third diagnostic issue to be considered is whether Mr. X had Obsessive Compulsive Disorder (OCD). There are a few references to symptoms suggestive of this, such as a comment in an

outpatient clinic letter dated 24 October 2002 by Specialist Registrar 1 that *"…he (Mr. X) talked about some intrusive thoughts coming into his mind like 'what is this' and 'what is it made of' and he keeps pondering. He also talked about his counting ritual"*. Unfortunately, no detail is given about this counting ritual, nor is an adequate diagnostic assessment of OCD made. There are a number of references to obsessional thinking, 'traits' and OCD in the case notes, particularly during his second admission. One of these, in March 2003, records that *"obsessive compulsive disorder is still evident……he spoke about how the focus of his OCD moves, from his body smell to his weight and ….his beard….these thoughts…do bother him, especially when he feels he has to check things repeatedly (sic).… (he) said that he has always had OCD, but in the past it has not bothered him"*. There is no evidence in the clinical record of an adequate history or diagnostic assessment of OCD being carried out. This is regrettable given that, as described above, his beliefs about his smell were taken at times to be indicative of psychotic illness, and may in turn have contributed to long term treatment with antipsychotic medication in substantial doses, and a diagnostic assessment should have been carried out to clarify their nature. The traditional distinction is that in OCD, the patient is able to acknowledge the beliefs as false, despite being distressed by them, while in psychosis they are firmly held to be real; this basic distinction does not appear to have been adequately investigated.

12.1.1.3. Conclusions

The diagnoses used in relation to Mr. X's depression were generally well founded and appropriate. However, Mr. X's possible psychotic symptoms were insufficiently assessed and recorded, and this was a recurrent problem throughout the clinical record. There are strong grounds for diagnosing psychotic symptoms of depressive illness for relatively brief periods at the onset of his second, fourth and fifth inpatient admissions. However, though there were suggestions that he might have had enduring delusional beliefs there was a failure to clarify the phenomenology and identify whether they were consistent with anxiety, or obsessive compulsive disorder (OCD), or of some other origin.

Despite his reported belief that he had long standing OCD, and some descriptions of symptoms which would be consistent with this, no formal assessment of OCD was carried out and the diagnosis was not clarified.

After the incident of 8 April 2008, the nature and intensity of paranoid ideation elicited at that point naturally raises the question of whether an alternative diagnosis, such as paranoid schizophrenia, should have been given more weight at an earlier stage. However, taking the clinical record as a

whole, together with the evidence obtained at our interviews, we conclude that the evidence of schizophrenic symptoms was weak, and the diagnosis would likely not have been made even if the available evidence had been reviewed in detail prior to April 2008.

Insufficient consideration was given to making a structured assessment of his personality. Taking the record as a whole, it does not appear probable that a formal diagnosis of a personality disorder according to the ICD-10 classification should have been made. However, a psychodynamic formulation of Mr. X was made which accurately described some of the difficulties in his management and provided an understanding of them which might have informed future management and psychological and psychosocial treatments. This appears to have been insufficiently well understood by the teams which provided treatment subsequently.

No collateral or informant history is recorded, which would have helped to clarify a number of issues in relation to diagnosis, whether of personality, his self-reported OCD, or the nature or impact of his paranoid symptoms. Though contact with the family appears to have been very difficult at some points in his treatment, and we were told (by Consultant Psychiatrist 3, who was his consultant from his 2004 admission to mid-2006) that several unsuccessful attempts had been made to engage them, at other points there was some contact with his children, and there may have been missed opportunities to obtain a history.

- ***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. A broader formulation of his mental illness and his personality during his first two admissions would have better informed his subsequent treatment.***

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have an approach which may include psychological treatments (for example, cognitive behaviour therapy, supportive counselling), psychosocial

therapies (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

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

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

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

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

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

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to

take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals for example, weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

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

12.1.2.2. Findings

The principal forms of medication of relevance to Mr. X's mental health care throughout the period 2002-2008 were antidepressants and antipsychotics and these are considered in detail below. In addition, Mr. X was identified as having high blood pressure during his first admission to hospital in 2002 and treated with Atenolol, and later with Lacidipine. Lacidipine is noted as having mood disturbance as a rare side effect (British National Formulary 2.6.2) but Mr. X's mood disturbance predates the use of this drug and it seems unlikely to be a relevant concern. There are also references in the clinical record to the occasional uses of painkillers (such as Paracetomol and Diclofenac) or antibiotics (such as Ciprofloxacin) for short term physical health problems. These do not have significant psychiatric side effects or interactions with the prescribed psychiatric medication and are not considered further.

Antidepressants

Mr. X's depression was treated initially with Mirtazapine. This is a pre-synaptic alpha 2 adrenoceptor antagonist. According to the Maudsley Prescribing Guidelines[92], a selective serotonin reuptake inhibitor would be a more usual selection as a first line treatment for depression. However, the choice of anti-depressant in clinical practice is often a pragmatic one and Mirtazapine was not contra-indicated by published evidence or guidelines. It could be argued that had Mr. X's depression

92 MPG 10th Edition, London: informa healthcare

been correctly diagnosed as 'mild depression' during his first admission then an antidepressant might not be needed at all, as the evidence suggests that antidepressants are relatively ineffective in mild depression, and psychological treatments are recommended in preference.[93] However, for reasons discussed above, a diagnosis of moderate, rather than mild, depression could more appropriately have been applied during the first admission. On this basis (and taking into account the difficulty of giving effective psychological treatments to Mr. X, discussed elsewhere) the prescription of Mirtazapine was justified and appropriate. The dose, 15mg within 5 days of hospital admission, increased to 30mg on discharge from the ward a week later, was also in line with guidelines.[94]

Mr. X appears to have continued to take this after discharge, complaining to the allocated support worker from the primary care mental health team on 6 September 2002 that it was making him bloated. By October his GP was referring to the dose of Mirtazapine as 45mg (the highest recommended dose, British National Formulary 4.3.4).

The Mirtazapine 45mg continued to be prescribed throughout his second admission and after discharge, though it was noted he requested a review on 6 February 2004 at which time he was complaining of upper limb tremor. This was considered by his Consultant on 17 February 2004, but Propranolol (10mg three times daily, increased to 20mg three times daily on 2.3.03) was recommended as a treatment for his tremor, and Mirtazapine continued until he was admitted to hospital for the third time on 18 October 2004. At that point it was noted that he had not taken his medication for one week, and he also refused it after admission.

Trazodone was substituted during this admission, being started on 3 November 2004 and increased stepwise to 300mg by 23 November 2004. This is an antidepressant described by the British National Formulary as of the 'tricyclic related' class, indicated for depressive illness, 'particularly where sedation is required' (relevant at that point as Mr. X had been agitated and required restraint on the ward in the days before and after the Trazodone was started), and for anxiety (British National Formulary March 2010 page 213). The dose of 300mg was within the recommended range.

The prescription of Trazodone was continued until March 2007, though the dose was reduced over time (to 225mg by August 2006 and 150mg by March 2007). In March 2007 the Trainee Doctor

93 MPG pg 55
94 (British National Formulary (BNF) 2010 section 4.3.4).

seeing Mr. X in outpatients suggested a change of antidepressant to Venlafaxine (a serotonin and noradrenalin reuptake inhibitor, SNRI, British National Formulary 4.3.4) on advice of the Consultant Psychiatrist, and this was initiated (by the GP, on advice from the Outpatient Doctor) at a dose of 37.5mg, to be increased to 37.5 mg bd (twice a day, i.e. 75mg in total) after a week. This was increased further to 75mg twice a day (150mg) in June 2006, and to 225mg daily (150mg in the morning, 75mg at night) in January 2008 on the advice of the consultant. All these doses are within the recommended range for Venlafaxine (British National Formulary 4.3.4).

The Independent Investigation Team considered whether the continuous prescription of antidepressants over a six-year period was justified. The National Institute for Health and Clinical Excellence guidelines recommend that patients who have had *"two or more episodes of depression…and who have experienced significant functional impairment"* should continue antidepressants for at least two years, and this would appear to apply to Mr. X and justify the continuous prescribing of antidepressants.

However, such prolonged prescription of antidepressants is only justified when they are effective. This cannot be established with any certainty in this case. It is a clear theme throughout the clinical record that Mr. X's depressive episodes were triggered by social stressors, such as the threat of losing his accommodation or by isolation, and that he found the inpatient environment supportive. **It is entirely possible that the principal factor in his recovery from depression following each relapse was the change in the social environment which resulted from admission, and antidepressants were of marginal significance**. Though the importance of the social environment in affecting his mood was clearly apparent to services and was noted at a number of points in the record, this does not seem to have been reflected in reviews of medication which took place in outpatient clinics by junior doctors who did not have access to the full clinical picture. As a result, it may be that the antidepressants described above were prescribed for prolonged periods with no evidence of effect, and when they were changed it was equally on the basis of weak evidence.

Antipsychotics

Antipsychotic medications are medications which are believed to have a specific effect on psychotic experiences. Mr. X was not prescribed an antipsychotic medication during his first admission to hospital in July 2002.

He was first prescribed an antipsychotic medication by his general practitioner in October 2002. He was prescribed Stelazine (trifluoperazine) 2mg once, then twice daily, a phenothiazine antipsychotic (BNF 4.2.1). This dose was relatively low, and at a level which is recommended as a short term adjunctive management of severe anxiety (British National Formulary March 2010 page 199) in adults. Given the possibility of significant extrapyramidal side effects (muscle stiffness and spasms, which can be severe) in someone who has never been treated with antipsychotic drugs, starting at this dose may be regarded as showing appropriate caution, but it is below the usual recommended dose for psychotic illness (10mg). It appears to have been increased to 6mg by the time of the outpatient appointment of 24 October 2002, despite the fact that the diagnosis had not been established and the presenting symptoms were not regarded as of psychotic intensity at that point.

During his second admission in December 2002, Mr. X showed clearer evidence of psychosis at presentation. He was prescribed Olanzapine, an 'atypical antipsychotic' (BNF 4.2.1), initially in a dose of 10mg. He continued to be prescribed Olanzapine from December 2002 to April 2008, at an initial dose of 10mg, increased later in the second admission to 15mg, and to 20mg during his fourth admission. A dose of between 10mg-20mg is the recommended range for effective treatment of psychotic symptoms.

Olanzapine is a widely used medication of a class, atypical antipsychotics, which is recommended by NICE guidelines for first line treatment of schizophrenia and is appropriate for the treatment of psychotic symptoms arising in other conditions. It has a wide range of possible side effects, among the more commonly reported of which are drowsiness and weight gain.

From May 2003, an additional atypical antipsychotic, Amisulpride (BNF 4.2.1) was added, at a dose of 50mg, and this was continued up to April 2008 in combination with Olanzapine. The rationale for this combination was not stated in the ward round note of 28 May 2003, though the note states that it was suggested by Consultant Psychiatrist 2 following his assessment of 12 May 2003, and his observations about psychotic symptoms. However, while Amisulpride is believed to be of some effect in the treatment of negative symptoms of schizophrenia (not diagnosed in this case), it is not proven to be more effective than Olanzapine and this does not provide a rationale for their use in combination. The use of antipsychotics in combination, while a widespread practice in the treatment of schizophrenia, is not well supported by evidence and is advised against by the Maudsley Prescribing Guidelines. Notwithstanding that Mr. X was reported the following week to have

"…noted an improvement since Amisulpride was introduced. Feels calm", this does not appear to be a rational prescription. On the other hand, the dose of Amisulpride prescribed is at the bottom of the recommended range of doses and may have had little effect for good or ill.

Risperidone, a further antipsychotic, was added to his treatment in September 2007 for reasons which are not clear from the records, and with uncertain effect.

While the prescription of an antipsychotic was clearly justified during the periods of acute illness at the start of his second, fourth and fifth admissions, it is less clear that such a high dose of Olanzapine over such a long period was adequately justified. Olanzapine has significant side effects including appetite stimulation and weight gain, and drowsiness, all of which Mr. X expressed concerns about at times. In addition, it may cause sedation which can exacerbate problems of poor motivation, which was a pervasive and important problem in Mr. X's case. It may be that the confusion about whether his persistent and prolonged concerns about smell were psychotic or related to anxiety led to an assumption that long term prescription of antipsychotics, at such a high level, was needed to control this symptom. In fact, it does not seem to have been very effective at doing so, and although the paranoid symptoms present when he was acutely unwell reduced over a matter of weeks once treated, his preoccupations about smell persisted for long periods despite being treated with olanzapine, raising the question of whether it had any effect on these. A further justification for prolonged antipsychotic prescription would be for prevention of relapse of psychotic symptoms. This may have been reasonable, though it may not have been necessary to continue at the dose of 20mg to achieve this, and dose reduction after discharge from hospital does not appear to have been sufficiently considered.

Was Mr. X Adherent to Medication?

The term 'medication adherence' is used here in preference to the term medication compliance. Adherence to medication is generally defined as the extent to which patients take medications as prescribed. The word 'adherence' is preferred here as 'compliance' is often understood to imply that medication is taken under compulsion, whereas in the community (and often in hospital, even when detained), it is necessary that medication is taken as a consequence of a therapeutic alliance or

relationship of trust between patient and doctor. However, both terms are imperfect descriptions of the actual complexities of medication-taking behaviour.[95]

Absolute assurance that medications taken by mouth (oral medication) are adhered to can only be obtained by demonstrating the presence of the drug in the blood, urine or other tissue samples. This is seldom practical or justified, and would not have been usual practice in the case of the oral antidepressants and antipsychotics prescribed to Mr. X. In the case of antipsychotic drugs, adherence is often assured by the use of long acting injectable preparations ('depots'), but not used in Mr. X's case. Adherence is usually assessed, as it was in this case, by direct observation of medication taking behaviour when it is administered in a hospital, or supervised, for example by staff of a home treatment team or residential care setting. The patient's attitude to medication generally, or to particular medications, should be established and will contribute to the assessment of adherence. In community settings where direct supervision of medication is not feasible, adherence is assessed by:

- observations of the process of obtaining medication (does the service user appear to be collecting prescriptions from a GP surgery and taking them to a pharmacy);
- evidence of medication in the service users possession (and whether it appears to have been removed from the packaging at the rate expected);
- direct reports from the service user of their experience of taking medication.

These methods cannot give absolute assurance of adherence, and as described above, are effective only if there is a trusting therapeutic alliance in which the service user is confident that reluctance to take medication, or difficulty tolerating side effects, can be openly expressed and sympathetically responded to. This skilled task is a key aspect of the role of a care coordinator, working closely together with the psychiatrist (and with the prescriber, if this is someone other than the Psychiatrist, such as the GP).

In Mr. X's case, it appears that during his first admission to hospital he was willing to take the prescribed antidepressant, and later expressed concerns about it to his care co-ordinator which suggest he was taking it. There are numerous comments in the record subsequently which suggest that, when well, he had a trusting and non-confrontational relationship with staff around medication,

95 Osterberg L, Blaschke T (2005) Adherence to medication, N Engl J Med 353: 487-497.

and at times he described concerns about side effects, or the ineffectiveness of the medication (which seem well founded), and also reported the occasions when he had not taken it.

The Independent Investigation found no reason to assume sustained and covert non-adherence, and it therefore seems appropriate that the prescriptions were oral (as opposed to by depot injection) throughout. There were clearly periods when Mr. X did not take medication which are well described in the records, such as those preceding his fourth and fifth admissions. On the latter occasion, it seems possible that his failure to take medication may have been prolonged and was not apparent because he was engaging poorly with services.

The staff at the supported tenancy scheme reported that Mr. X took his medication regularly and that they had no concerns in this respect.

12.1.2.3. Conclusions

Mr. X was prescribed antidepressants throughout the period 2002-2008. The medications chosen were appropriate considering available guidance, and were prescribed within recommended dose limits. At times his mood improved, and this was attributed to the effects of medication; at other points his mood remained low while apparently taking antidepressants. It is not possible to say with confidence that antidepressant medication was effective in treating Mr. X, as he appears to have been very sensitive to changes in his social environment and relationships, and these, rather than changes in medication, may have been responsible for much of the observed changes in his mood. He discontinued medication on at least two occasions prior to (or simultaneous with) deterioration in his mental state and subsequent admission, though this in itself is no proof that it was effective. It is also possible that sudden discontinuation of medication may have worsened his mental state prior to these admissions, and contributed to the confused and psychotic presentation observed.

Mr. X was prescribed antipsychotic medication continuously between October 2002 and April 2008. For reasons discussed above, it is insufficiently clear that this was justified on the basis of his diagnosis, and antipsychotics were prescribed pragmatically to treat self-referential thinking which was presumed to be psychotic in origin but may not in fact have been so. With this caveat, the principal medication used, Olanzapine, was appropriate, given relevant guidelines, and given in doses within the recommended range, though the dose of 20mg, while appropriate for hospital treatment, may have been more than necessary during his periods in the community and may have

exacerbated problems of low motivation. Two other antipsychotics given, in small doses, at different times in combination with Olanzapine were not clearly justified on the basis of the clinical evidence or published guidelines.

As with antidepressants, the evidence that antipsychotic treatment was effective in Mr. X's case is equivocal. While it seems probable that it was helpful in the resolution of the psychotic symptoms associated with his acute episodes of depressive psychosis, its contribution to his longer term improvement in mood is in doubt given that he was also treated with antidepressants, and that he was responsive to environmental factors. Similarly, deterioration at times when he was not taking Olanzapine might have been related to other factors, though as with antidepressants, rapid cessation of Olanzapine may have worsened his mental state.

- ***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. The emphasis on treatment with medication, which may in fact have been of limited effect other than during periods of acute admission to hospital, may have limited consideration of other forms of treatment.***

12.1.3. Overall Management of the Clinical Care and Treatment of Mr. X

12.1.3.1. Context

The delivery of patient care and treatment in secondary mental health services is usually provided within a team context. People with mental health problems often require a high degree of case management in order to ensure that effective liaison between agencies takes place and that long-term treatment strategies are effective.

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

On the 17 October 2007 the Department of Health Published *New Ways of Working*[96]. This document advocated a change to traditional working practice. Historically the Psychiatrist was seen as the senior professional leader of any clinical team. *New Ways of Working* set out a revised model of management. This revised model promoted the concept of the 'democratisation of power'. A Team Manager would provide management, team leadership and service coordination. In addition professional leads were to be appointed on a patient-by-patient basis according to the individual needs of the person requiring the care and treatment. The professional lead role would no longer be allocated to a Psychiatrist as a default position as had been done previously. The purpose of introducing *New Ways of Working* was to provide a patient-centered ethos that provided a more bespoke model of care and treatment.

12.1.3.2. Findings

Management of the Clinical Care and Treatment of Mr. X

When Mr. X first presented acutely to services, he was admitted to hospital promptly, treated, and discharged to follow-up in outpatients and with a Social Worker from the Primary Care Mental Health Team. Outpatient appointments were not attended, possibly because they were sent to an old address, but there was appropriate communication between the Doctor and the Social Worker, and subsequently between the GP and the mental health service. A request from the GP for a prompt appointment when he was concerned about deterioration was responded to after a 23 day interval. The Outpatient Doctor sought to refer to a different outpatient clinic on the basis of the change of address but no change in outpatient doctor took place before the next admission.

Following the second admission, Mr. X came under the care of his (new) Catchment Area Psychiatrist, and remained under the care of the same psychiatrist throughout his second admission and the following period of community care. He was then care coordinated by the Community Mental Health Team (CMHT). He came under the care of his Catchment Area Psychiatrist again during his third admission, and the same consultant, and his junior doctor reviewed him after discharge when he came under the care of the Home Treatment Team before again being followed up by the CMHT.

96 Mental health: New ways of working for everyone, Department of Health May 2007

At the point of his fourth admission, he came under the care of a new Catchment Area Psychiatrist, who remained responsible for his psychiatric care over the following 18 months during periods when he was under the care of the Home Treatment Team and the CMHT, and when he was admitted for the fifth time. Within his CMHT care, he was seen for substantial periods both by a Support Worker and by a Care Coordinator.

At the end of his fifth admission the services were in transition, and he first came under the care of a Locum Consultant as an inpatient, then following this, another Locum Community Consultant he did not meet, then following this, a substantive Community Consultant he did not meet, encountering a number of Junior Doctors in the outpatient clinic in the process. In addition Mr. X received care coordination from the CMHT, input from a Support Worker from the CMHT, and he also received care from Support Workers at his supported housing scheme.

There were therefore six distinct parallel strands distinguishable in Mr. X's care; his GP, consultant psychiatric care, outpatient medical appointments with staff grade or trainee doctors, care coordination from the CMHT, a support worker from the CMHT, and support work from his housing provider. (Care from the Home Treatment Team did not appear to be added in parallel to all the other strands, but was substituted for routine care coordination and outpatient medical follow up when needed).

All six strands were involved only for a brief transitional period after his discharge from hospital in August 2006, but there were a number of points at which all other strands could be identified as working in parallel.

Considering communication between these parallel strands of care, communication with the GP seems generally to have been good, with evidence in the notes of outpatient letters and direct contact between CMHT staff and GPs. However, when prescribing is managed in primary care while the patient is seen by the CMHT, the possibility of confusion is always present, and this might have led, for example, to the recommendation of risperidone in 2007 by an outpatient doctor who was unaware that olanzapine was being prescribed.

When Mr. X was an inpatient, communication between the consultant and care co-ordinator took place by attendance at inpatient ward rounds and there is evidence in the records that this took place

when appropriate. It was also apparent that when Mr. X was in the community, at times of crisis, such as in May 2006, direct communication between the Care Coordinator and Consultant could take place as needed.

In the community, communication between outpatient medical staff and care coordinators or support staff could take place by joint attendance at outpatient clinics, and there is evidence in the record of this occurring routinely, though not always with all staff simultaneously.

Communication between the Care Coordinator and the Support Workers was (the Independent Investigation Team was told during interviews) unsystematic but relatively uncomplicated, with the relevant staff having separate offices in the same building, and being able to communicate as needed face to face or by telephone. However, there was no evidence of detailed case discussion involving both the Care Coordinator and the Support Workers with the Consultant. The Independent Investigation Team also heard evidence of problems which arose between Care Coordinators and Support Workers about the care of Mr. X which were not resolved by discussion in wider fora.

The most significant areas in which the parallel strands of care appear to have operated with insufficient communication between them relate to the role of the consultant psychiatrist while Mr. X was in the community. There was evidence in the record during the periods December 2002 to March 2004 (Consultant Psychiatrist 1) and October 2004 to August 2006 (Consultant Psychiatrist 3) that the Consultants appeared to have acquired a good knowledge of Mr. X in the inpatient setting, and were able to use this to communicate an overview of the case to the Care Coordinator. However, the level of communication between Consultants and Outpatient Doctors may have been insufficient to support high quality care, and Junior Doctors (trainees or staff grade doctors) were relatively isolated in their management of cases. This may explain, for example, why medication was changed relatively seldom, and why a high level of antipsychotic prescribing was sustained over such a long period. The Independent Investigation was told that consultant job plans prior to the introduction of *New Ways of Working* (2007) contributed to this, with high workload and responsibilities for inpatient and outpatient care precluding close oversight of large numbers of outpatients. The Independent Investigation Team was told that this concern underlaid the decision to change consultant job plans in mid-2006. It was as a result of these changes that Mr. X's Consultant changed prior to his discharge to the community in September 2006.

Paradoxically, the effect of the change in Mr. X's case was a negative one, in that from his discharge in 2006 until April 2008 he was nominally under the care of consultants (Consultant Psychiatrist 4 and Consultant Psychiatrist 5) who had no direct knowledge of him and did not meet him. This problem was clearly apparent to the Community Consultant (Consultant Psychiatrist 5), who started a process of oversight during his supervision of his Trainee Doctor in December 2007, hearing the case presented, asking for a summary of the notes to be prepared, which was done, and giving advice. He also appears to have made plans to see Mr. X, though this did not take place.

Psychological Treatment

Mr. X was assessed for psychodynamic treatment in some detail in May 2003, and it was concluded that he would be unlikely to engage with this. References were also made to him being offered Cognitive Behavioural Therapy at points in the notes, for example in 2007 and 2008, but this does not appear to have happened. It appears that this treatment was not available within the CMHT but would have required engagement with another service, which might in any case have proved a significant barrier to Mr. X, who declined a number of other offers of care. However, an opportunity might have existed to offer him treatment during inpatient admissions, and it appears that this was done during his second admission, when there is a reference to him attending anxiety management classes whilst an inpatient. In this respect it is unfortunate that his possible obsessive compulsive disorder was not more fully assessed, as this might have provided an avenue for effective psychological treatment to be provided.

Psychosocial Treatment

The importance of social and environmental factors in Mr. X's presentation was a recurring theme throughout the clinical record and it is clear considerable effort went into considering and addressing this. He was helped to obtain a new tenancy in 2003 and supported accommodation in 2006, which followed sustained effort by the whole care team. There is also much evidence of attempts to involve and support Mr. X's children with a view to helping Mr. X himself. Long periods of relatively intensive support worker input were provided with a view to improving his social functioning and supports. In addition, it was clear that on several occasions over a long period of time attendance at day centres and supported work schemes was offered, to the extent of interviews being arranged, but Mr. X always declined.

12.1.3.3. Conclusions

Continuity of Care

Continuity of care allows for consistent decision making in relation to an individual's care, made within a context of therapeutic relationships developed over time. Continuity of care has two elements; longitudinal continuity, defined as continuity of care over a period of time, and cross-sectional continuity, defined as effective communication between all members of a care team involved in an individual's care at a point in time. Care can never be fully continuous, and transfers between services or professional care givers over time, and the involvement of multiple professionals and services at a point in time, are unavoidable. Attempts to mitigate discontinuities are therefore necessary. These consist of effective information recording and sharing, shared decision making, and attempts to minimise transfers between services when possible.

Continuity of care in all its aspects was markedly lacking in Mr. X's case. This appears to result from a number of factors. These are set out directly below.

The recording of information was of limited quality. With some exceptions noted above, the written record shows limited evidence of detailed history taking, the consideration of the phenomenology of symptoms, or formulation of problems. The rationale for decision making is not clearly set out in contemporaneous notes or discharge summaries. As a result, the various services and individuals Mr. X encountered over the period of six years appear to be providing treatment on the basis of assumptions about diagnosis, or the effectiveness of previous treatments, which are not adequately based on written evidence. Multiple records exist: the written inpatient notes; the ISSIS electronic record used by Lancashire County Council social care staff within the CMHT (and, commendably, by other staff of the CMHT); and later the electronic CPA record; and written notes by the supported tenancy scheme staff. It is not clear to what extent parallel records were available contemporaneously to professionals involved in providing care and treatment.

A large number of different services and treating individuals were involved over a period of time, with up to five different professionals being involved simultaneously for some periods. Problems resulting from limited communication inevitably arose at times. The complexity of services involved is common within United Kingdom mental health services and is not therefore to be regarded as a criticism of this service in particular, but it emphasises the need for effective information recording, awareness of the previous history by care co-ordinators, and ideally oversight by a limited number of

senior clinicians, all of which were also lacking for significant periods of care. The role of consultant psychiatrists in this service was clearly a point of weakness within this service, and although this was recognised by the service it was not mitigated during the period of care considered here.

Considering cross-sectional continuity, there was some evidence of effective routine communication by letter between primary and secondary care, particularly important during those periods of care in the community when prescribing was done in general practice while follow-up was provided in secondary care. However, errors did result.

Though parallel, discontinuous care is of particular significance at the period immediately prior to the incident, such as the outpatient review of 31 March 2008 at which a doctor was present who had never met Mr. X, it is a feature of his care throughout the record.

- ***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.***

12.1.4. Use of the Mental Health Act (1983 and 2007)

12.1.4.1. Context

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

Act has been significantly amended by the Mental Health Act 2007. Mr. X was subject Sections of the Act during his time with the Trust. They are set out below.

Section 2 of the Mental Health Act (1983 & 2007) allows for a 28-day period of compulsory detention in hospital for assessment purposes only. A patient has the right to appeal within 14 days of the section being ordered. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 3 of the Mental Health Act (1983 & 2007) is an admission for treatment order for a period of up to six months. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 5 (2) of the Mental Health Act (1983 & 2007) allows the compulsory detention of a patient already receiving inpatient treatment for a duration of up to 72 hours by the doctor in charge of the case.

Section 117 of the Mental Health Act 1983 provides free aftercare services to people who have been detained under Sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

Section 25 of the Mental Health Act provided for supervised discharge in the community. The 1983 Act was previously amended in 1995 by the Mental Health (Patients in the Community) Act which created "supervised discharge" or "after-care under supervision", and this has been important for people receiving "Section 25 aftercare". This 1995 Act was replaced by the 2007 Mental Health Act, and "Section 25 aftercare" has ended. It was replaced by Supervised Community Treatment.

12.1.4.2. Findings

The Independent Investigation Team examined Mr. X's case notes and records of actions taken by the Trust under the Mental Health Act. Mr. X was first detained in hospital under Section 2 Mental Health Act (1983) on 9 December 2002. There was consultation with Mr. X's nearest relative (his daughter) and the medical recommendations were completed by two doctors who knew him, one being his General Practitioner. Mr. X's rights under the Mental Health Act (1983) were explained to him and he was given a written copy of these, including his right to appeal against the order. Following a period of assessment, Mr. X was then detained under a Treatment Order, Section 3, on 24 December 2004. Again both Medical Practitioners had previous knowledge of him and there was consultation through the Approved Social Worker making the application with Mr. X's next of kin.

During the period that Mr. X was detained there was a consent to treatment certificate under Section 58(3) (a) completed appropriately. The Section 3 was allowed to lapse on 24 June 2003 because Mr. X's mental state had improved and he was cooperative with treatment. Mr. X was detained for treatment again on 18 November 2003. Medical recommendations were completed by his GP and the Consultant Psychiatrist who had been his Responsible Medical Officer for some time. Mr. X's nearest relative was informed of the detention. This period of compulsory treatment ended on 7 January 2004 when Mr. X remained in hospital as an informal patient.

Later in 2004 Mr. X was detained under Section 2 Mental Health Act (1983) on 26 October following the use of section 5(2) to prevent him discharging himself from the ward where he was an in-patient. The assessment order was then followed by a Treatment Order under Section 3 Mental Health Act (1983) on 18 November 2004. The Order continued until 5 January 2005 when Mr. X became an informal patient. Later that year he was admitted to a psychiatric unit in Blackpool because there were no beds available in Preston, under Section 3 Mental Heath Act (1983) on 15 May 2006. He transferred to Preston to complete his treatment and was allocated a place at the Supported Tenancy Scheme in Preston. A condition of acceptance on the scheme was that he was subject to supervision under Section 25 Mental Health Act (1983). The conditions of his supervision were that:

- he lived at the supported tenancy scheme;
- he was to meet regularly with his Support Worker and his Care Coordinator;
- he was to engage in rehabilitative activities;

- he had an identified responsible medical officer.

The Supervision Order remained in place until 26 December 2007 after which it was not thought to be necessary because Mr. X was compliant with the terms of the order.

12.1.4.3. Conclusions

The Independent Investigation Team concluded that the Trust met fully its obligations under the Mental Health Act in relation to Mr. X's care and treatment. Procedures were well documented and carried out in accordance with the Mental Health Act Code of Practice. The use of the assessment and treatment provisions of the Act were justified and Mr. X and his next of kin were fully informed about their rights under the Act.

In relation to the decision to use the powers of Section 25 after his last discharge from hospital, with hindsight this was not necessary since Mr. X was compliant with the conditions of the order and eventually it was ceased. The named Care Coordinator failed to carry out the duties of care coordination and that is discussed more fully in other sections of this report.

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

12.1.5. The Care Programme Approach

12.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[97]. Since its

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

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

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

introduction it has been reviewed twice by the Department of Health: in 1999 (Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach) to incorporate lessons learned about its use since its introduction and again in 2008 (Refocusing the Care Programme Approach)[98].

'*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services*[99].' (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

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

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

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a key worker whose job is:
  - to keep in close contact with the patient;

  - to monitor that the agreed programme of care remains relevant; and
  - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

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

The Trust operational guidance of the CPA was set out in their policy document.[100] This included the expectations of care coordinators and clearly defined their role.

12.1.5.2. Findings

The Independent Investigation Team found that Mr. X was allocated to a total of seven Care Coordinators during his period of contact with secondary mental health services. The Care Coordinators came from professional backgrounds in either nursing or social work. The first allocation was to Care Coordinator 1 after Mr. X was discharged from hospital on 27 July 2002 after his first hospital admission. She noted that Mr. X's living arrangements were problematic. At this time he was living with his daughter, her partner and two children, and also his youngest child, a son. The son was not attending school and Mr. X had been fined as a result. There was some liaison between Care Coordinator 1 and the local Education Welfare Department and it was noted that Mr. X's son had been taken off the school roll. One consequence of the over-crowded living arrangements was that Mr. X was sleeping in the lounge.

There is evidence that the dysfunctionality of family life was a precipitating factor in Mr. X's depression and the Independent Investigation Team found that the description and analysis of social circumstances was under represented in the case formulation at this time. Mr. X, who had cared for his three children for some years as they grew up, was now, as they reached adolescence and young adulthood, living in overcrowded conditions. It was reported that he was also subject to a degree of exploitation by family members and was sleeping in the lounge. He was in effect a victim of their behaviour and unlikely to achieve full recovery from his illness in a context of financial and social

100 Effective Care Coordination Policy CL012: revised 2008

exploitation. There was evidence of Mr. X's vulnerability in the case notes from this period but despite a growing awareness in health and social care of the needs of vulnerable adults, Mr. X was not seen as requiring support to assert his rights to an independent life free from family exploitation.

After Mr. X was admitted to hospital again in December 2002, the idea that he should move to supported accommodation was discussed by the clinical team. This was thought to be in his best interests but it was difficult to engage Mr. X in this plan because he felt that he should be providing a home for his son, the youngest child. In the event Mr. X moved to a flat with his son after leaving hospital in September 2003. Care Coordinator 2 now took over the care coordination role.

Care Coordinator 2 visited Mr. X at home and worked with Support Worker 1 to provide practical help to Mr X including welfare benefits advice and help with domestic tasks. However after only a few months Mr. X was re-admitted to the psychiatric unit under Section 3 Mental Health Act (1983) in November 2003. Again, the need for supported accommodation was discussed at ward round meetings but a referral to a supported housing scheme was unsuccessful and Mr. X was discharged to his flat on 26 January 2004. Mr. X was also supported by the Crisis Resolution and Home Treatment Team which provided daily visits. The role of the Care Coordinator was mainly to monitor Mr. X's mental health. It was noted that the living arrangements were still problematic and that Mr X was exploited by his children. Mr. X had anxieties about coping with everyday life and sometimes (for example in October 2004) he was acutely anxious, not allowing the support worker to leave. Shortly after this incident Mr. X admitted to hospital and was detained under the Mental Health Act (1983) because he said he would kill himself.

It was the finding of the Independent Investigation Team that Mr. X's social circumstances were not given sufficiently high profile in the formulation of his needs at this time. It was well known that Mr. X was subject to abuse from his children and he should have been regarded as a vulnerable adult.[101] One consequence of such a referral would have been that there could have been a vulnerable adult strategy meeting where all agencies involved with the family would pool their knowledge and agree a joint approach. The Care Coordinator was not assertive in engaging with the family and merely provided a running record of the impact of their behaviour on Mr. X's mental health. It is likely that

101 No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse; Department of Health March 2000

there were a number of social care issues in relation to child protection and vulnerable adult procedures that could have been investigated more rigorously.

As at the point of first contact with mental health services (in 2002) there would have been value in a full social history being available to the clinical team.

In April 2005 Care Coordinator 3 took over from Care Coordinator 2. In the preceding months Mr. X had been at home after discharge in February 2005 and support from the Home Treatment Team. At a CPA meeting on 16 May 2005 it was noted that Mr. X remained vulnerable to exploitation by his son. Care Coordinator 3 discussed the possibility of Mr. X moving to the Supported Tenancy Scheme but Mr. X was concerned that this would result in his son being made homeless because he would not be allowed to take over the tenancy of the flat. Reviews were held at the psychiatric out-patient clinic and Consultant Psychiatrist 3 continued to provide medical oversight of the case. Care Coordinator 3 and the Support Worker continued to support Mr. X through home visits and encouragement to attend day centre activities. They also helped with practical issues to do with his welfare benefits. Sometimes contact was difficult because Mr. X would not be at home at agreed times.

In September 2005 Care Coordinator 4 took over the case because Care Coordinator 3 left the employment of the Trust in August 2005.

Care Coordinator 4 continued to work with Support Worker 1 to engage Mr. X in social activities and resolve his accommodation problems. There were CPA reviews in November 2005 and February 2006. The clinical team agreed that it would be best for Mr. X to be referred for a supported tenancy but noted that his son and his associates continued to exploit him and had damaged the property. There was a brief period in March 2006 when Care Coordinator 5 was allocated to the case but by May 2006 when Mr. X was admitted to hospital, Care Coordinator 4 made an application to the supported tenancy scheme in Preston which was successful. Care Coordinator 4 facilitated the move to the scheme and Mr X moved in on 8 August 2006. Care Coordination was now taken over by Care Coordinator 6.

The Independent Investigation Team considered that Care Coordinator 4 had worked hard to achieve movement in the case and encourage Mr. X to accept a supported tenancy and escape the difficult

family situation and periodic exploitation by his son. He had also made contact with both of Mr. X's daughters to discuss the move to the tenancy scheme and enlist their support. He also showed an appreciation of the concerns that had been raised about the reportedly exploitative relationship between Mr. X, his son and his son's associates. Care Coordinator 4 also wrote to all three of Mr. X's children to explain the move and give contact details.

Care Coordinator 6 had responsibility for case management from August 2006 to January 2008. The independent investigation team found that:

- Care Coordinator 6 recorded a total of 14 contacts with Mr. X during this period;
- the contacts were at the supported tenancy scheme but the notes of the scheme do not corroborate any contacts during the period;
- Care Coordinator 6's recording was brief and limited in content;
- Care Coordinator 6 failed to fulfil any of the responsibilities of care coordination as described in the Trust policy;
- although Mr. X was subject to Section 25 supervision under the Mental Health Act and Section 117 after-care, Care Coordinator 6 did not make appropriate contact with other members of the clinical team or follow up the work of Care Coordinator 4 with Mr. X's family;
- Care Coordinator 6 had a poor relationship with other staff, either at the scheme or as part of the visiting support arrangements and did not include them in a care plan;
- Care Coordinator 6 failed to complete full CPA documentation including risk assessments;
- Mr. X continued to have reviews in out-patient clinics during this period. Although under the care of Consultant Psychiatrist 4, Mr. X saw a number of junior doctors. There was therefore a premium on the detailed knowledge and continuity that care coordination should provide. Care Coordinator 6 failed in this respect.
- Care Coordinator 6 was supervised by Team Manager 1 throughout this period but supervision failed to indentify the inadequacies in Care Coordinator 6's professional practice.

Care Coordinator 7 took over in February 2008 and remained the care coordinator until the time of the incident in April 2008. There was no evidence of a satisfactory handover of the case from Care Coordinator 6 to Care Coordinator 7. Care Coordinator 7 attended a CPA review meeting with Mr. X, Senior House Officer 8, and Residential Support Worker 2 on 31 March 2008. At this meeting the idea of Mr. X moving from the tenancy scheme to a more independent setting had been discussed.

Care Coordinator 7 received a telephone call from Mr. A on the day of the incident, 7 April 2008, in which Mr. A discussed his recent contact with Mr. X and the anxieties that Mr. X had expressed about being asked to move to a more independent setting. Care Coordinator 7 gave advice to Mr. A about the presentation of this plan to Mr. X, given his anxiety about change and transition and the perception that he was being *"thrown out"*. Care Coordinator 7 agreed with Mr. A that it was not necessary to bring forward his next planned contact with Mr. X which would have been on 15 April 2008.

12.1.5.3. Conclusions

The Independent Investigation Team found that performance in relation to the practical application of the Care Programme Approach was variable. There were examples of thorough and well-timed interventions that flowed from an agreed care plan. There were also examples of poor practice. The most positive aspects of engagement with Mr. X were in relation to his move to the supported tenancy scheme and the liaison with his wider family that was achieved at this point. In particular Care Coordinator 4 made efforts to visit Mr. X's children to explain the background to the move to supported accommodation and tried to enlist their support for the plan. There were also examples of joint work between Care Coordinators and Support Workers who helped Mr. X with practical tasks. However, following the move to the supported tenancy scheme and the change of care coordinator to Care Coordinator 6, there were serious shortcomings in the approach. These included:

- a failure to use the procedures for CPA as set down in the Trust policy;
- a failure to assess risk and vulnerability as part of the care planning;
- a failure to use documentation fully to support the staff at the supported tenancy scheme;
- a failure to engage Mr X in discussion about the future;
- a failure to apply an analytic and professional approach to working with colleagues in the scheme and medical colleagues;
- a lack of active involvement in the care and treatment of Mr. X.

The approach of Care Coordinator 6 and to some extent of other care coordinators was limited and their contact performed mainly a monitoring function. While this may be a part of the activities of care coordination, the role should extend further to include active engagement with the service user and family. A number of care coordinators did not give sufficient weight to Mr. X's status as a vulnerable adult who was being exploited by members of his family.

After the admission to the supported tenancy scheme care coordination activity was reduced to:

- out-patient appointments with a series of junior doctors. Mr. X did not meet the consultant psychiatrist responsible for his care, Consultant Psychiatrist 4;
- visits where Mr. X's mental state was briefly described but not tested;
- a reliance on the residential care staff at the supported tenancy scheme to identify any problems.

In particular the idea that Mr. X should be moving on from the scheme (discussed at the last meeting on 31 March 2008) was not part of a care plan that had been agreed by all parties, including Mr. X, with an agreed strategy for its implementation.

Care Coordinator 6 did not adhere to Trust CPA policy in either working with Mr. X or handing over responsibility to the next care coordinator. This was a proven gross misconduct issue and Care Coordinator 6 was later dismissed. The performance of the team manager and senior manager were also reviewed at this time and found to be weak. Enhanced supervision was put in place. These issues are discussed more fully in a later section of this report.

- ***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.***

12.1.6. Risk Assessment

12.1.6.1. Context

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

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

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety and the safety of others. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

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

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

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

- *it conforms with relevant guidelines;*

- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed.'*[102].

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

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

12.1.6.2. Findings

The Independent Investigation Team found that the Trust risk assessment documentation had been used at various points in the care and treatment of Mr. X. Before discharge from his last in-patient episode of treatment the CPA assessment of needs/risk form had been completed.[103] This included domains for the assessment of suicide and self-harm, harm to others, treatment and illness related risks, substance misuse and social circumstances. No risks were identified in relation to harm to others, the main risk being identified as self-harm in view of Mr. X's past behaviour and intentions when unwell, for example, he had spoken about walking into traffic and had injured himself with a knife.

After discharge from the psychiatric unit the risk assessment was not updated by the Care Coordinator. The supported tenancy scheme had its own 'Individual Risk Assessment' document which had been completed when Mr. X took up his tenancy[104]. This contained brief assessments in the domains of suicide/self-harm, self neglect and diet. It did not include a domain for harm to others. In the assessment carried out at the scheme the emphasis was on daily living skills and social interaction.

102 Best Practice in Managing Risk; DoH; 2007
103 HR Vol 4 pg 47 et seq
104 PSTS pg 9

Earlier in the history of the case there were missed opportunities to complete a thorough social history of Mr. X and his family. There was evidence that Mr. X was having difficulties in caring for his three children as they entered their teenage and early adult lives. Mr. X's son had not attended school and the education welfare department had been involved. He was eventually removed from the school roll. Later there was clear evidence that Mr. X was a vulnerable adult under the terms of the local multi-agency policy and that action under the joint safeguarding protocols could have been justified. This would have had the benefit of bringing together all agencies involved with the wider family, pooling information, and agreeing a strategy for intervention. The Independent Investigation Team could find no evidence that this had been considered and that staff were not generally well informed about safeguarding issues.

12.1.6.3. Conclusion

The Independent Investigation Team found that the Trust had risk assessment tools in place in its operational procedures and in the Care Programme Approach documentation. These were completed for Mr. X periodically. The last record was in September 2006 when Mr. X moved from hospital to the supported tenancy scheme. This had not been updated regularly by the care coordinator and was only partially completed. The Independent Investigation Team concluded that the supported tenancy scheme risk assessment proforma was limited in scope because it did not include an assessment of 'risk to others'. There were also limitations on the knowledge of the risk factors in Mr. X's case because the professional staff working with him at the time of the incident were relatively new to the case and did not have the benefit of a longitudinal view.

The Independent Investigation Team also concluded that earlier in the care and treatment of Mr. X there should have been active consideration of the safeguarding issues in his case and that he could have been seen as a vulnerable adult under the protection of vulnerable adult procedures. Against that background, the staff who worked closely with Mr. X every day did not regard him as a risk to them or to other people and in that sense the attack on Mr. A could not have been predicted.

- ***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 and develop a strategy for working with them.***
- ***Service Issue Five: the development of policies and practice in relation to vulnerable adults and safeguarding was not well understood by Trust staff.***

12.1.7. Referral, Transfer and Discharge

12.1.7.1. Context

Lancashire Care NHS Foundation Trust policies in relation to referral, transfer and discharge were contained within the Care Programme Approach (CPA) policy. The policy included sections on:

- access to specialist mental health services;
- assessment;
- care planning and coordination;
- discharge;
- transfer of CPA responsibility.

Trust policies were compliant with the requirements of the Department of Health.

12.1.7.2. Findings

The Independent Investigation Team found that transitions in the care and treatment of Mr. X were generally managed well by staff. For example, when Mr. X first presented to services he was assessed by a Psychiatrist and his admission to the psychiatric unit arranged in a timely way. His general practitioner was kept informed by letter about the progress of his treatment and was involved in assessments under the Mental Health Act at points of crisis.

When Mr. X was discharged from the psychiatric unit this was after periods of home leave and with the support of the Home Treatment Team during the first stages of his return to the community. He was granted Section 17 leave to move to the supported tenancy scheme in August 2006, returning to

the in-patient unit for reviews for a period of several weeks before being formally discharged in September 2006.

The most notable problem in referral was in May 2005 when Mr. X presented himself at the psychiatric unit in Preston at midday with clear signs of self-neglect.[105] He refused to accept treatment at the unit and an assessment under the Mental Health Act resulted in a Section 3 treatment order. However, there was not a bed available at the local unit in Preston and after a protracted negotiation; Mr. X was admitted to a psychiatric unit on Blackpool at 10:40 pm. The Approved Mental Health Practitioner (Approved Social Worker 1) organising the admission had difficulty in negotiating the method of transport to Blackpool and the police and senior officers had to be involved to resolve the impasse. This demonstrated a need for clear operational protocols between the agencies concerned to prevent delay and misunderstanding at a time of acute need.

The Independent Investigation Team found that the transition from the psychiatric unit to the supported tenancy scheme in Preston was well managed and Care Coordinator 4 in particular was assiduous in contacting members of Mr. X's family to inform them of the plan and engage them in the process. This was against a background of difficult relationships and suggestions of exploitation by some family members.

There was clear evidence from Mr. X's case history that he experienced change and transition as negative events. In his contacts with professional care workers a constant theme was anxiety about change and his perception that people were rejecting him, sometimes at a level of paranoid intensity. On occasions he had tried to prevent visiting support workers from leaving him at home on his own. Later, he had worried a great deal about the impact of his move to the supported tenancy scheme on his son and this had delayed decision-making. Reports from staff at the supported tenancy scheme were that Mr. X ruminated about his future and was concerned that he was being *"thrown out"* of the scheme. The record of his last CPA review meeting on 31 March 2008 included the observation that the member of staff from the supported tenancy scheme who accompanied Mr. X to the meeting commented that it was the view of the scheme that Mr X should move to more independent living. There were no firm plans for this move but the idea of change was not welcomed by him.

105 SCN pg 54

The Independent Investigation Team found that the issue of movement from his placement at the supported tenancy scheme was one of great concern to Mr. X. There was no documentary evidence of a case discussion at the scheme where this conclusion was recorded. It should have formed part of the CPA planning process, led by the Care Coordinator but the Independent Investigation Team could find no record in the case notes to support the plan, other than the record of the discussion between those present at the out-patient appointment on 31 March 2008.

From the Independent Investigation interviews with staff at the supported tenancy scheme, and reading of the operational policy for the scheme, the Independent Investigation Team concluded that there was not, in fact, a two-year limit on residence at the scheme and that there were tenants who had remained there longer. The conclusion that Mr. X should move to more independent living was not supported by the progress he had made at the scheme where he remained very anxious about change and independence. It was clear from the case history that Mr. X was a person who reacted badly to change and experienced change as stressful.

This aspect of transition was not handled well by the mental health service and was a contributory factor to deterioration in Mr. X's mental health.

12.1.7.3. Conclusions

The Independent Investigation Team concluded that the processes of referral, transfer and discharge were generally handled well by the Trust. When Mr. X required hospital admission this was organised in a timely way. The Mental Health Act was used appropriately to facilitate this process. Discharge from hospital was preceded by periods of leave where Mr. X's capacity to live independently was tested. He was supported by the Crisis Resolution and Home Treatment Team and by Support Time and Recovery workers who monitored his progress and assisted with practical tasks.

Secondary mental health services linked with primary care services through letters to the GP from the Consultant Psychiatrist. The GP was involved when assessments under the Mental Health Act were required.

The move to the supported tenancy scheme was well planned. Staff at the scheme worked well with Mr. X to achieve greater independence but he remained anxious about moving on and the planned transition to more independent living required careful consideration and preparation. This was

primarily the role of the care coordinator, working in tandem with other professional staff, and the performance of Care Coordinator 6, who was responsible during most of the time Mr. X stayed at the scheme, was poor in not helping Mr. X to prepare for the next transition, whatever that might have been.

- ***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 doctor was variable in practice.***

12.1.8. Carer Assessment and Carer Experience

12.1.8.1. Context

Carer involvement

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

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

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

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

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

12.1.8.2. Findings

The Independent Investigation Team found that although Mr. X lived with family members before his admission to the supported tenancy scheme, in the case records they were seldom portrayed in a caring role. Mr. X had three children from his second marriage and had been the main carer as his children grew up. At the point of his first admission to hospital in 2002 he was living with his daughter, her partner and two children, and his youngest child, a son. The son was not attending school, the Education Welfare Department had been involved and Mr. X had been fined. His son had been removed from the school roll.

The accounts of family life recorded by successive Care Coordinators during Mr. X's history of contact with mental health services portray a picture of disorganisation and lack of cohesion. Although Mr. X clearly worried about his children, there were reports that his son, in particular, was abusive towards him. Mr. X lived in a flat and was sleeping in the lounge. It was reported that his son exploited him financially and in company with his friend used the property for drug taking. Visitors to the property noted damage to its fabric and had difficulty communicating with family members.

There was evidence that Mr. X was a vulnerable adult within the meaning of legislation and guidance on the safeguarding of vulnerable adults, and that some action to protect him from the family would have been justified. Against this background it is difficult to see how Mr. X's family could have been engaged as carers in the role described in legislation and guidance.

The efforts of Care Coordinator 4 to inform and include Mr. X's three children in his move to the supported tenancy scheme were commendable. After his admission their contact was intermittent and they were not part of the reviewing and planning for the future as Mr. X. Staff at the tenancy scheme

told the Independent Investigation Team that Mr. X remained concerned about his children and on the occasions when they visited him was able to give them sound advice. He had previously had sole responsibility for their care as they grew into adulthood.

12.1.8.3. Conclusions

The Independent Investigation Team concluded that although Mr. X's family were significant to him it was difficult to engage them in a caring role. Most descriptions of family life portrayed them as a source of anxiety and potential abuse. Mr. X was concerned about the impact of moving to the supported tenancy scheme on his son, who would not be able to take over the tenancy of his flat. After Mr. X moved to the tenancy scheme, family contact was limited and the wider family did not figure in plans for Mr. X's next potential move to greater independence. There would have been value in a more detailed description and analysis of the family context in the formulations of Mr. X's mental health problems and a full social history in the early stages of intervention would have been helpful in providing a context to later problems of family relationships.

- ***Contributory Factor five: a study of Mr. X's case demonstrates a lack of carer assessment and involvement. Whilst it was evident that the family were difficult to engage and potentially abusive, Mr. X's care and treatment package should have been formulated with the family dynamic more explicitly in mind.***

12.1.9. Service User Involvement in Care Planning

12.1.9. 1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

'*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'.

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that '*people with mental health problems can expect that services will involve service*

users and their carers in planning and delivery of care'. It also stated that it will '*deliver continuity of care for a long as this is needed*', 'offer choices which promote independence' and 'be accessible so that help can be obtained when and where it is needed.

12.1.9.2. Findings

The Independent Investigation Team found that Mr. X had limited capacity to engage with mental health staff. Typically he demanded a great deal of reassurance about any change to his living conditions. He was at times obdurate in refusing to engage with staff who wished to work with him. In some of the recording in the case notes there was a sense that his personality predisposed him to being negative and resistant to new behaviour. He seldom expressed positive views about his future and usually expected to be looked after by staff.

At the supported tenancy scheme, he was encouraged to engage with a range of daily living tasks that would help to prepare him for greater independence. He was, in fact, quite able to perform a range of social tasks but required prompting from staff to do this. If not prompted he tended to remain isolated in his room and not engage in activities.

The Independent Investigation found that staff at the supported tenancy scheme attempted to work closely with Mr. X to achieve the goals in his care plan and he had consistency in key worker relationships over the time he was there. During interview the Independent Investigation Team found that staff from the scheme had a good understanding of the recovery model of care and tried hard to put Mr. X at the centre of activities and build on his strengths.

In relation to care planning with the care coordinators allocated to his case, Mr. X showed limited insight into his difficulties and was not able to form plans for the future other than expressing a desire to be looked after. Care coordinators tried to keep in touch with him regularly to monitor his mental state and social functioning. Care Coordinator 4 in particular tried to engage Mr. X's children in the planning processes. The decision that he should begin to think about moving on from the supported tenancy scheme was a challenge to Mr. X and would have required careful presentation to him for a successful partnership to work. This had not been provided by Care Coordinator 6 and the following Care Coordinator (Care Coordinator 7) had only recently assumed responsibility for the case at the time of the incident.

12.1.9.3. Conclusions

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. His capacity to engage in planning for the future was limited and he viewed change as a threat. Without prompting from staff he had little motivation to live independently and take the initiative in looking after himself.

12.1.10. Documentation and Professional Communication

Documentation and use of records

12.1.10.1Context

"The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.
The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*

- *Not transferred to other countries without adequate protection"*[106]

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Act. All records should be archived in such a way that they can be retrieved and not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further treatment was considered necessary; or eight years after the patient's death if the patient died while still receiving treatment.

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professional have adopted similar guidance.

The GMC states that:
"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off". [107]

Pullen and Loudon writing for the Royal College of Psychiatry state that:
"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised".[108]

12.1.10.2 Findings

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.

106 Information Commissioner's Office Website 2009

107 http://www.medicalprotection.org/uk/factsheets/records

108Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP. 280-286

In particular there would have been value in a thorough social history at the point of Mr. X's early contacts with the Trust to establish the nature of family life and the history of relationships. There was evidence that Mr. X's children, who were by then teenagers or in early adulthood, were experiencing a range of problems that impinged on his mental health. At a later stage there were clear concerns that Mr. X may be being exploited by one or more of his children and their associates and that he met the criteria for being seen as a vulnerable adult within the meaning of legislation and guidance. Had he been assessed as a vulnerable adult, this could have led to a strategy meting to bring together all agencies involved with the family and informed Mr. X's future care and treatment. The Trust was a signatory to the local safeguarding agreements, but there was no evidence from case notes that this possibility had been considered and pursued. [109]

The recordings at the supported tenancy scheme were made regularly but were mainly brief and domestic in style- that is they were a daily record of Mr. X's activities and did not include reflective analysis of his mental state and its relationship to his behaviour.

A further limitation of documentation was after the allocation of Care Coordinator 6 to the case. He failed to complete assessment and review documentation satisfactorily. His recordings were brief and gave no overview of the case and the goals and performance against the goals. They lacked a professional and analytic insight into Mr. X's problems and future care. His poor performance was not identified through the supervision arrangements in place at the time.

Professional Communication

12.1.10.4 Context

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[110]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme approach when used effectively should ensure that both interagency communication and working takes place in a service user centric manner.

109 Lancashire Safeguarding adults Multi-Agency Policy: March 2010
110 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P.121

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone[111]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994), criticises agencies for not sharing information and not liaising effectively.[112] The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. This level of expectation was firmly in place during the time that Mr. X first came to the attention of mental health services.

12.1.10.5 Findings

The chronology of Mr. X's care and treatment demonstrates that he had contact with a wide range of professionals during his years of contact with services. The Independent Investigation Team found that communication within and between teams working with him were generally effective. The case notes show that successive care coordinators and responsible clinicians met regularly to discuss the progress of Mr. X's care and treatment. He was involved with some staff who knew him very well- for example Consultant Psychiatrist 3 who was assiduous in keeping Mr. X's General Practitioner informed about the progress of treatment. Similarly, the support staff at the supported tenancy scheme, worked very closely with each other to support him and were a cohesive and experienced staff group.

In forming conclusions about professional communication to inform service development and improved practice, the Independent Investigation Team found that after Mr. X was discharged from hospital for the last time, and moved to the supported tenancy scheme, he was seen by a number of junior doctors at out-patient clinics. This was in contrast to the preceding years when he had a consistent relationship with his responsible clinician, Consultant Psychiatrist 3. This was consistent with the system in place at the time, but placed a greater onus on Consultant Psychiatrist 4 who supervised the work of the junior doctors to provide continuity and an over view of care and treatment.

While Consultant Psychiatrist 4 had supervised Junior Doctor 6 (who had conducted a commendably thorough review of the case notes) on the case, he had never met Mr. X and his supervision therefore

111 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). P.144.

112 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

concentrated on issues of medication; he was not in a position to take a broader view of the case or to provide the necessary continuity. He told us he had asked for an appointment to be made for him to meet Mr. X but for unclear reasons this did not take place and Mr. X was in fact seen by his Staff Grade doctor instead. The Trust Internal Investigation commented on the fact that Mr. X had had contact with a large number of professionals during his years of treatment.

Mr. X's last out-patient review was on 31 March 2008 with a Junior Doctor who had not met him before and a relatively new Care Coordinator.

A further learning point in relation to professional communication was that, as previously stated, Care Coordinator 6 did not fulfil his role satisfactorily against the standards described in the Trust care programme approach operational policy. In view of the fact that the medical input to care and treatment would inevitably be provided by a series of junior doctors, this placed a greater premium on the depth of knowledge and continuity provided by the care coordinator. The Independent Investigation Team found that the Care Coordinator should have taken a more active and assertive role in inter-professional meetings to give the necessary longitudinal view of the case to inform good decision-making.

There were also examples of difficulties in professional communication between Support Workers who were from the Support Time and Recovery Team (STAR) and a care coordinator. This centred on the failure of the Care Coordinator to visit as planned, and in some cases on the perceived attitude of the Care Coordinator to working with Mr. X. It was also found through disciplinary processes initiated by the Trust that the care coordinator asked other staff to falsify case records of visits. The Trust dealt with this issue through its disciplinary processes and the care co-ordinator was dismissed from Trust employment.

12.1.10.6. Conclusion

The Independent Investigation Team concluded that there were examples of good professional contact between Mr. X and some mental health professionals and that some care coordinators and responsible clinicians were able to demonstrate consistency in their contact with him over a period of months or years. Professional documentation was variable in quality and particularly poor during the period when Mr. X was a tenant at the supported tenancy scheme. It did not meet the professional standards of the Trust.

Communication between professionals was also variable with some periods of support by a settled team providing good continuity. There were also periods when care was lacking in continuity and Mr. X was seen by a series of clinicians who had not had long term involvement in the case. This placed a premium on the quality of care coordination to provide that input. There were also examples of hostility between team members that acted against the delivery of coordinated care. There were staffing issues in the mental health team and the supported tenancy scheme that made it difficult to deliver a service that could meet the service standards expected.

- ***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.***

12.1.11. Clinical Supervision

12.1.11.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations [113] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:

113 Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses.

"….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations".[114]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

12.1.11.2. Findings

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 care coordinator 6, 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 span of control and was supervising and managing a large number of staff in the community mental health team. This was also in a context of some poor relationships between professional staff.

In relation to the clinical supervision of doctors working with Mr. X we found that after Mr. X was discharged from hospital for the last time, the community consultants in charge of his case were initially locums who did not meet him. A substantive Consultant later took over responsibility for the case and discussed Mr. X's care and treatment in supervision with the Junior Doctor who provided the direct contact with Mr. X. He asked for him to be booked into his clinic but this did not take place, and Mr. X was not reviewed by a consultant for the final 18 months of his community care. Continuity of his medical care was limited as a result.

12.1.11.3. Conclusion

We found that the Trust had supervision policies in place at the time of the incident but that their effectiveness was limited in two critical examples:

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

- The supervision of the penultimate Care Coordinator did not identify his poor performance in the role. There was evidence of poor relationships between that Care Coordinator and other colleagues that was not identified. He failed to fulfil his professional responsibilities.

- The clinical care offered after Mr. X's last discharge from hospital was consistent with Trust policy at the time. However it was delivered by series of junior doctors who saw Mr. X as an out-patient and did not, from their recording, have a long term view of his care. Therefore, the significance of planning a change in the care setting and a move away from the supported tenancy scheme was not fully appreciated in the case discussion on record.

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

- ***Contributory Factor Nine: the community responsible medical officers (consultant psychiatrists) overseeing his care in the community after Mr. X was discharged to the supported tenancy scheme did not meet with him and care was provided by a number of junior doctors working under supervision, an approach which resulted in limited continuity of care.***

12.1.13. Organisational Management and Professional Leadership

12.1.13.1. Context

In October 2007 *New Ways of Working for Everyone* was published. This document set out the national implementation guide for policy change that had been in development over a period of four years previously. The Department of Health stated that *New Ways of Working "promotes a model where distributed responsibility is shared amongst team members and no longer delegated by a single professional such as the consultant".*

The Department of Health also stated that *"this cultural shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs. More experienced staff will then support other staff to take on less complex or more routine work. All*

qualified staff will be able to extend the boundaries of what they do (i.e. non medical prescription) and there will be more chances for new roles such as support time and recovery workers (STR), primary care mental health workers and assistant practitioners to take their places within teams".[115]

Lancashire Care NHS Foundation Trust implemented the changes required from the Department of Health during 2008. They had an impact on the organisation of services and the care delivered to Mr. X.

12.1.13.2. Findings

The Independent Investigation Team took the view that apart from looking at the practice of individual members of staff in relation to the care and treatment of Mr. X, it was also important to examine the organisational context that they operated in. In reviewing the documentary evidence and talking to witnesses it became clear that there were two important teams within the Trust closely involved with Mr. X. These were the Community Mental Health Team in Preston and the Preston Supported Tenancy Scheme. The former was the team from which Care Coordinators and support workers were drawn, the latter was responsible for the day to day living arrangements and support to Mr. X from August 2006 to the time of the incident in April 2008. The impact of the incident on both sets of staff was also clearly evident to the Investigation Team.

Community Mental Health Team

Organisational Structure

In 2008 the Central Lancashire Adult Mental Health Service was split into three localities- West Lancashire, Chorley, and South Ribble and Preston. The Central Lancashire locality had seven Community Mental Health Teams (CMHTs) and two Assertive Outreach Teams. In West Lancashire there were three Community Mental Health Teams and the Chorley and Ribble locality also had three Community Mental Health Teams. In Preston there was one CMHT and one Assertive Outreach Team which also covered the South Ribble locality. The CMHTs each had a permanent full time Team Manager from a social care or nursing background, as well as a Deputy Manager. The Preston CMHT had responsibility for Mr. X and had a Team Manager from a social care background with two Deputy Managers from a nursing background. The team was made up of a number of social workers, community psychiatric nurses, a psychiatrist, occupational therapists, psychology and

115 http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_074106

support time and recovery workers. The Preston Support Time and Recovery (STR) workers were part of two attached STR Teams each with their own team leader who in turn reported to the CMHT manager. Medical input to the CMHT was from a consultant psychiatrist and junior doctors saw patients under the supervision of the consultant.

All new referrals to the mental health services in Preston were received by the Preston Primary Care Mental Health Team (PCMHT) which has acted as the single point of access for this locality since 2001. Following an initial screening assessment the PCMHT would refer cases on to CMHT and AOT as appropriate, some cases were retained and care and treatment provided and coordinated by the PCMHT.

In relation to the care and treatment of Mr. X there was input from a range of team members including care coordinators from the CMHT, the Support Time and Recovery Team and from the occupational therapy staff, as well as medical supervision. These contributions were appropriate and provided resources to help Mr X remain in the community.

There was also input to Mr. X's care from the Crisis Resolution and Home Treatment Team at times when his mental health was in a state of crisis.

The Independent Investigation Team comments in another section of this report on the performance of care coordinators in relation to the operation of the Care Programme Approach. This Investigation found that performance was variable with one particularly poor example. Poor performance was not identified through the management system. One factor was that the Team Manager had a very wide span of control, being responsible for about 70 staff from a variety of professional backgrounds and experience. Though supervision occurred, the quality of Care Coordinator 6's work was not identified as a problem at the time. Care Coordinator 6 was also the subject of a whistle blowing allegation that we examine in greater detail in another section of this report.

Another factor in the management of the service was that there were poor relationships between some team members and between teams. This led, for example, to allegations from some support workers that care coordinators were not fulfilling their obligations. The Team Manager was undermined by these allegations and by some historic difficulties in the team. In relation to the care and treatment received by Mr. X this led to a poor quality of care coordination in the last eighteen

months of his contact with the CMHT which was not detected at the time. There was an assumption that because Mr. X was living in a supported living setting, there was not a need for active care management. In fact it was the role of the care coordinator that was critical in providing continuity and in planning for the future and managing changes to the care plan.

A further reason for the role of care coordination being critical to the care and treatment was the impact of the implementation of *New Ways of Working*[116] by the Trust. This meant that medical oversight transferred from Consultant Psychiatrist 4, to Consultant Psychiatrist 5 in November 2007. Neither Consultant met Mr X. They did not have the direct and detailed knowledge of his case that the previous Consultant (Consultant Psychiatrist 3) had achieved. Instead, a number of junior doctors had contact with Mr. X in the outpatient clinic. This was consistent with the system in operation at the time but placed a greater importance on the role of the care coordinator in providing continuity, detailed face to face contact, and a longitudinal view of the case. When the issue of change in Mr. X's placement was discussed in March 2008, there was a need for a strong care coordinating role to manage this process successfully.

The Preston Supported Tenancy Scheme

The supported tenancy scheme was established in 1995 to resettle people who had been long stay patients at Whittingham Hospital. In September 1995 twelve patients moved to the scheme which was then in three properties owned by a Housing Association. In April 1998, following a review the scheme changed its purpose to provide short and medium term rehabilitation. The scheme acquired another property in 2003 for the provision of a satellite service to promote a gradual move to independent living.

According to the operational policy for the scheme its mission statement was for tenants to:

- live in a safe and secure environment to work towards their rehabilitation;
- become partners in their own care;
- have control and direction in their own lives and in the running of the unit;
- participate in the maintenance of their domestic environment to the best of their ability. With the aim of maximising potential in this are;
- have access to resources for work, education and leisure; and

116 See: Mental Health Review Journal Vol 12 issue 3 October 2007: Supporting Change: Implementing new Ways of Working in East lancashire

- be able to take acceptable risks and to make mistakes within a safe supported environment, enabling a learning experience leading to growth, recovery and independence.

The scheme was made up of:

- a house divided into three self-contained flats for a total of six tenants;
- a second 'Core House' for four tenants with their own private bathrooms and communal areas;
- two 'satellite' houses accommodating two or three tenants.

The core houses provided 24-hour staffing while the two satellite houses provided minimal support and supervision according to individual need.

The model of intervention described in the operational policy was one based on the recovery model. The primary focus of intervention was to support each individual to achieve their full potential and lead a fulfilling life. *"Each individual tenant is supported by identifying and working towards short-term, medium term goals, devised to meet their needs under their CPA (care plans)."* Each tenant was allocated a named key-worker who worked with them closely to access necessary resources and agencies to meet their needs i.e. social skills training, colleges and employment.

The scheme relied on the Trust to provide care coordination for the tenants and medical oversight through out-patient appointments. At the point when Mr. X was accepted by the scheme, he was subject to Section 25 supervision under the Mental Health Act and Section 117 aftercare, having been detained under Section 3 Mental Health Act. It was stated in the case notes that Section 25 supervision was a condition of the scheme offering a place to Mr. X, although it was not clear to the Independent Investigation Team why this additional power was required as Mr. X was compliant with the plan to live at the scheme and was, in fact, reluctant to consider moving on. From the point of Mr. X's introduction to the scheme on 8 August 2006 to his formal discharge from the psychiatric unit on 13 September 2006 he was on Section 17 leave and being supervised by Consultant Psychiatrist 6 who had assumed responsibility for the in-patient ward from Consultant Psychiatrist 3.

The supported tenancy scheme kept its own records which the Independent Investigation Team reviewed alongside the Trust case records.

The records included an Individual Care Programme and Individual Risk Assessment. The records also included a two page care programme approach extract completed by Care Coordinator 6. The tenancy scheme care plan was brief and emphasised daily living skills and competencies. The risk plan included sections on the risk of suicide or self-harm, self neglect, diet and medication. It did not include a section on risk to others.

The running daily record at the supported tenancy scheme was completed for Mr. X and contained brief recording of daily events- what he had to eat and the activities he was involved in. It referred to some behavioural characteristics- for example, whether he enjoyed the activities or whether he was anxious about something. The notes largely reflected the domestic life of the scheme and Mr. X's participation in it.

The Independent Investigation Team asked the staff who worked with Mr. X about their impressions of him and the following comment summarises their view of him:

"He was very frustrating to work with. He could have been very easy to work with but all the time we were prompting him to do normal things, because he would stay in his room most of the day otherwise and just come out for cigarettes and appointments and things, so it was difficult working with him; but in some ways it was not, because he was easy to be around and everything. You never felt threatened or anything by him, nothing at all."[117]

Mr. X lived in a house with 24-hour staff support. He was encouraged to attend sessions at a local day centre to take part in computer and photography courses and to go to local facilities like the sports centre. Although Mr. X was said to enjoy these activities there remained misgivings about his motivation and desire to become more independent, which was the aim of the scheme. he was also lacking in confidence to do things and sometimes *"paranoid"* about staff writing about him although they explained the need to keep notes of their work and offered to let him read their notes. There was also a sense in the notes that Mr. X would not always make an effort to do things that he could manage - whether through illness or unwillingness.

117 Witness Interview Transcriptions

In 2008 the issue of moving on to greater independence was raised. Although there was not a hard and fast rule about tenants moving after a certain time, there was a view that Mr. X needed to make some progress towards greater independence as a reasonable goal consistent with the purpose of the scheme and his care plan.

During interviews with the Independent Investigation Team staff members commented on this issue:

Q.*"One of the key events was on 31 March (2008) when Mr. X had a CPA review, and the person we have just seen, Care Coordinator 7, was there who was the new care co-ordinator, and Senior House Officer 8. The substance of that was that Mr. X was really to be moved on, if you like. I don't know where that decision came from, but that was recorded in the notes of the meeting as something that was important. Can you help us to know a bit more about that and how that decision was made?*
A. *From what I understand the (supported tenancy scheme) staff worked closer to Mr. X than I did, but I know for definite that yes, it was being made aware to people that he was ready to move on. I am not sure whether that was his decision or whether that was the staff decision, that he would not work any further towards any more skills or take any more stepping stones. I think Mr. X had withdrawn himself a little bit, and from seeing him it seemed that maybe he was not ready to move on, that it was kind of a fear for him. This needed to happen because I think he liked living at (the supported tenancy scheme) and he saw that as maybe being his home for the rest of his life."*[118]

The Independent Investigation Team findings are set out below.

- The idea of Mr. X moving to greater independence had been discussed at the out-patient appointment on 31 March 2008.
- There were no firm plans for the achievement of this goal.
- Within the tenancy scheme there were individual differences in relation to tenants' length of stay- there was not a fixed period that would be enforced.
- The most likely move for Mr. X was to a satellite house within the same scheme which would have provided a less intense level of staff support but within a familiar setting. This would have been contingent on his demonstrating a capacity for more independent living.
- The pace of change was not being forced by the staff at the scheme who worked most closely with Mr. X.

118 Witness Interview Transcriptions

- Mr. X commonly expressed anxiety about change despite reassurances from staff that he would be included in decision-making.
- Staff at the scheme were not well supported by Care Coordinator 6 who did not provide detailed updates of the care plan and whose approach to care management was poor.

In relation to the management and leadership at the scheme, the Independent Investigation Team found that the staff group were experienced and had a good practical understanding of the challenges in working with people with mental health problems. The approach of the staff team was based on the recovery model and was appropriate to the service user group. In relation to Mr. X their work was based on sound principles and their encouragement to acquire and use social skills was consistent with the care plan.

At the time of the incident there were problems with the management of the scheme and the manager was suspended. We also found that there were some misunderstandings amongst staff about the governance of the scheme and this is explored in more detail in a later section of this report. The staff at the scheme were employed by Lancashire County Council but management was through the Trust under partnership arrangements in place at the time.[119] In relation to Mr. A's employment at the scheme, we found that the absence of key managers would have contributed to an induction process that was less than complete, that Mr. A did not usually work at the house where Mr. X lived, but that the risk posed by Mr. X was judged to be low by colleagues of Mr. A who had worked with him for some time.

12.1.13.3. Conclusions

The Independent Investigation Team concluded that the delivery of mental health services to Mr. X depended on joint arrangements between the Mental Health Trust and the Local Authority. This was underpinned by a formal partnership agreement. There were operational policies in place for both the Community Mental Health Team and the supported tenancy scheme. Both teams had operational problems at the time of the incident. The community mental health team had a history of difficult working relationships between some managers and frontline staff. In particular the poor performance of Care Coordinator 6 was not detected through the supervision system in place. There were also whistle blowing allegations that had a bearing on the day-to-day running of the team. The supported

119 Partnership agreement for the provision of integrated mental health services in Lancashire: 2007

tenancy scheme manager was suspended and the deputy mangers were also subject to sickness absences. Individual team members were therefore operating within a context of disrupted management.

In relation to the direct care that Mr. X received, the Independent Investigation Team's view was that the closest staff to him, the residential support staff at the supported tenancy scheme, continued to work effectively despite these difficulties and provided a good level of service to him. The Independent Investigation Team took up these issues of organisation and leadership with the Mental Health Trust in order to be assured that these difficulties had been addressed. We therefore conclude that there were service delivery problems in the service at this time but that they did not have a direct causal link to the death of Mr. A.

- ***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.***

12.1.14. Clinical Governance and Performance

12.1.14.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[120]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS

120 Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation.

12.1.14.2 Findings

The Independent Investigation Team looked at the broader context of how mental health services were delivered at the time of the incident. The rationale for this approach is that individuals working in mental health services do so in a context of team working and as a part of a larger organisation. The working of the team and the organisation has an impact on the capacity of individuals to deliver components of the service and the quality of decision-making and accountability.

We found that the care provided to Mr. X by the supported tenancy scheme was of good quality within the terms of reference for the scheme and its operational policies. The staff providing care were experienced and well motivated and in interview we were impressed by their understanding of the recovery model of care and their practical application of it. They also showed a degree of cohesion as a staff group that had faced difficult challenges in the aftermath of the incident and its consequences for their professional roles within the scheme.

The staff providing direct care were, however, hampered by two factors concerning organisational management and accountability.

First: at the time of the incident the Scheme Manager was suspended and the Deputy Managers were also not available. This left a management vacuum at the scheme and did not help the front line workers to deal with problems of care coordination due to the poor performance of Care Coordinator 6. It would have been the role of the scheme manager to take up issues that were impinging on the ability of residential staff to plan for the future of Mr. X.

Second: issues of poor performance by the Care Coordinator were not identified by the CMHT manager. There were also issues of accountability in relation to whistle blowing allegations at the

CMHT. While these did not have a direct bearing on the care and treatment of Mr. X, they formed part of the context for his care and were a contributory factor to care delivery problems.

This Investigation interviewed staff who, apart from their role in providing care to Mr. X, had been participants in two whistle blowing actions and also disciplinary processes within the Trust. Although these staffing issues were not directly part of the remit of the investigation, the Investigation Team found that they added important contextual information to the care and treatment of Mr. X. The Investigation Team also found that several members of staff interviewed were very concerned about the way these issues had been handled by the Trust and were distressed at their treatment as employees of the Trust or the County Council.

In relation to these processes it was found that:

- staff were not clear whether they had taken action under the procedures agreed by the County Council or the Trust;
- staff were not clear about the lines of accountability in the Trust;
- there were vestigial reporting lines to the county council on some matters;
- the differentiation between the Trust and the County Council procedures was still not clear to staff at various levels of the organisation;
- disciplinary processes were complex and took too long;
- some staff had been interviewed several times as part of the processes of whistle blowing and disciplinary proceedings and had not received feedback to close off the processes;
- the Preston CMHT had a relatively large proportion of staff who were on Lancashire County Council contracts.

Because of these concerns, the Independent Investigation Team asked the Trust to describe the governance arrangements in place at the time of the incident.

The mental health service was delivered through the Adult Network, part of the Lancashire Care Trust services and was set up in 2007 following a section 75 agreement[121] with Lancashire County Council. Network Directors in the localities served by the Trust were supported by operational

121 Section 75 agreement: An agreement made under section 75 of National Health Services Act 2006 between a local authority and trusts or NHS foundation trusts, which can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised. The powers originated in the Health Act 1999 and agreements made under section 31 of that Act remain in force.

managers and clinical leads. The Trust governance structure included a monthly Adult Network Senior Management Team meeting. This meeting included all Adult Network Directors and Network Professional leads. This meeting is still in place and focuses on operational management, service delivery and development issues. There was also an Adult Network Governance Group that met monthly to review clinical governance, safety and quality issues. Every two months the Adult Network Senior Management Group included all senior managers and professional leads and focused on cross-cutting work streams and service development issues.

These structures remained in place until an operational management and clinical leadership review in 2010. The Trust view was that there were a number of operational challenges and clinical leadership deficits:

- there were inconsistent practices across teams and localities;
- performance of Senior Managers with a diverse "silo" type of service structure;
- there was Insufficient focus on group homes and rehabilitation services;
- social care leadership review and capacity; and
- there was a need for a nursing lead in the Network.

Present arrangements in the Trust

In early 2010 a new structure was agreed after consultation in the network with partners in Lancashire County Council and the Trust's Executive Management Team. The structure reflected a move towards service line reporting and enabled a cross-network approach to the development of services such as Community Mental Health Teams and Crisis Intervention and Community Treatment Teams.

The structure adopted and finally implemented in December 2010 is described below. The Network has an Adult Network Director supported by four Assistant Network Directors. One is responsible for step 2/3 primary mental health services[122] and teams across Lancashire. Assistant Network Directors also cover specialist psychological services and clinical networks such as eating disorders and personality disorders. The Step 4 Assistant Network Director covers all community (secondary care) services such as Community Mental Health Teams, Assertive Outreach Teams and the new

122 The step model of care is described in appendix X

CCTTs. The Step 5 Assistant Network Director is responsible for all inpatient services, crisis resolution and home treatment services, and Accident and Emergency liaison services for the Adult Network. The Assistant Network Director for Rehabilitation and Wellbeing Services is responsible for county wide rehabilitation, recovery, wellbeing and restart services, managing the supported accommodation services. This was a new post along with an 8b senior manager and this recognised the need to provide clearer oversight and accountability of these services. The Network appointed senior managers to each post to continue to cover specific step care services for each locality.

Each step care Assistant Network Director has a monthly governance meeting attended by Operational Senior Managers, Step Care Professional Leads and on a rolling basis the Network Professional Leads for Nursing, Social Care and user/carers.

Every two months the Assistant Network Directors hold a whole locality meeting with managers and leads from other step care services. This is designed to hold both a Trust wide imprint for services but also to look at unique issues in each geographical area and to ensure the Assistant Network Directors and other locality managers are kept fully aware of all services and developments across the whole mental health system in the locality. It is not planned to consider changing these arrangements until after a review in autumn 2011.

Line Management and Supervision

The Network Director meets members of the management team for one-to-one supervision and line management for more than one hour at least once a month. This time allows for more in-depth discussions on operational issues and service development and innovation. The Assistant Network Directors in turn have individual 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 (one hour) per month. The Network has a briefing communications document which updates the Network on developments.

Leadership and management development.

One of the Trust's key priorities is to develop the leadership capability of current and future leaders at all levels within the organisation including Lancashire County Council employees as part of the Partnership Agreement. The Trust is in the process of rolling out a new 'Appreciative Leadership'

programme, to approximately 600 managers across the Trust over the next two years. The programme is one of a number of organisational development initiatives that have been introduced to achieve the desired culture change.

The programme is based on the 'appreciative inquiry' approach and the principles of engagement and conversational based change. It is also underpinned by the Trust's values which are now becoming more visible in the behaviours of its leaders.

In addition, the Trust is developing a Leadership Framework to underpin the Appreciative Leadership programme covering the following three dimensions of leadership:

- strategic leadership: setting the direction;
- operational/tactical leadership: delivering the service;
- personal leadership skills: qualities and attributes.

This will be a blended learning approach providing opportunities for learning and development in a range of areas and including skills aimed at improving service quality and performance including, for example:

- managing change;
- managing conflict;
- Clinical Supervision;
- Risk Assessment/Assurance/Management;
- Customer Care.

12.1.14.3. Conclusions

The Independent Investigation Team found that the Trust had invested considerable time in developing the operation models described above and the senior management team felt that there was a clear governance structure in place. While we acknowledge the progress of the Trust in this area we also concluded that the communication of changes to staff on the front line of operational delivery was variable and that some staff interviewed were very cautious about the benefits of introducing further changes to systems that were not fully understood. For example the closure of the local psychiatric in-patient unit in Preston, although justified by senior managers, was seen by some staff as an inevitable reduction in service. Similarly the introduction of the 'stepped care' model was

viewed with concern as it had negative consequences on caseloads for many staff. We also received equivocal evidence about the degree to which changes had been discussed and agreed with partner agencies, notably the Primary Care Trust and the Local Authority.

- ***Service Issue Eight: the mental health service was subject to a partnership agreement between the Mental Health Trust and Lancashire County Council. However, when there were problems, staff were not clear about accountability in the service. Whistleblowing 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.***

13. Findings and Conclusions

Lancashire Care NHS Trust

The following findings, Contributory Factors and Service Issues were identified:

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[123] and were the subject of an inter-agency agreement and policy guidance.[124] The Independent Investigation Team found that there were shortcomings in the appreciation of safeguarding issues as an element of the risk assessment.

- 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.***

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

- ***Contributory Factor Five: successive care coordinators failed to assess Mr. X as a vulnerable adult and use the inert-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 were 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 it was reported that there was evidence that they may be 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 sought assurances from the Trust that it 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 variable until the last care coordinator took over. The supervision system did not pick up 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 in 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. Whistleblowing 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.***

15. 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. It was reported that at times he was 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 support 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.

14. Lancashire Care Trust's Response to the Incident and Internal Investigation

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 independent 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 the independent investigation, relatively few staff took advantage of the workshop offered as preparation for interview by Hascas. The Independent Investigation was 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.

14.1 The Trust Internal Investigation

The Internal Investigation Panel comprised the following personnel

Seven people were involved in the development of the Trust internal investigation report. These individuals comprised medical, nursing, pharmacy, safeguarding, social services and general management staff.

The Terms of Reference were as follows:

- *"To inquire into the circumstances leading up to and surrounding Mr. X becoming the tenant of a supported accommodation service for people with mental health problems; and the incident of 7 April 2008 in which he fatally assaulted Mr A, and to consider the ;lessons and implications for Lancashire Care Foundation Trust and Lancashire County Council with a view to making recommendations;*
- *To examine the care and treatment provided to Mr. X, including multi-disciplinary decision-making , risk assessments and risk management;*

- *To identify legal matters of relevance to the review;*
- *To identify workforce matters of relevance to the review;*
- *To examine the policies and protocols in operation at the time of the incident;*
- *To gather from documentation, interviews with key staff and written reports from staff a chronology of events leading up to the fatal assault;*
- *To identify the acre and service delivery issues and the factors associated with these;*
- *To identify any underlying root causes;*
- *To ensure that the conclusions are evidenced;*
- *To make recommendations that can be implemented by Lancashire Care Foundation Trust and Lancashire County Council."*

Methodology

The post incident review process began with the collection of relevant clinical records, policies and documentation associated with the supported tenancy scheme. Information was compiled into a timeline narrative by the consultant forensic psychiatrist and used to inform discussions within seven post incident review meetings between April and November 2008.

Additional reports were prepared by the adult network lead for social care, the Deputy Director of Nursing, the chief pharmacist and the chair of the review, all information arising from six interviews was analysed and agreement was sought on the strengths and weaknesses of systems. Interviews were held in September 2008. Where service delivery problems were identified these were subject to further detailed analysis using the National Patient Safety Agency's contributory factor taxonomy to explore and identify possible root causes. The review report was submitted to Lancashire County Council and Lancashire Care Foundation Trust in January 2009.

Recommendations

The internal review made nine recommendations as follows:

Recommendation 1: (a) The focus of care coordination should align with the care programme approach.

1: (b) The transfer of care coordination responsibility should be premised on multi-disciplinary expertise.

Recommendation 2: The supported tenancy scheme requires conspicuous and visible management and leadership.

Recommendation 3: The supported tenancy scheme must be compliant with the Foundation Trust's policy and procedures regarding mediation management and administration.

Recommendation 4: (a) Mental Health services and the supported tenancy scheme should be familiar with, and adhere to, safeguarding procedures for children and adults.
4 (b) The circumstances of other tenants of the scheme should be reviewed with a view to determining whether or not they are subject to abuse.

Recommendation 5: What integration means for the supported tenancy scheme, Lancashire County Council and |Lancashire Care Foundation Trust must be specified in a shared vision, governance, management and leadership, arrangements for working together, policies and procedure and service delivery.

Recommendation 6: Review whether or not the supported tenancy scheme properties are fit for purpose in 2008-2009.

Recommendation 7: The role and function of the supported tenancy scheme should be reviewed and consideration should be given to registration.

Recommendation 8: The poor care coordination between professional and agencies requires attention.

Recommendation 9: Greater attention is given to clinical and care coordinator continuity for individuals who cease to engage in their day to day circumstances.

14.2 Findings of the Independent Investigation Team

The Independent Investigation Team found that the internal review carried out by the Trust was completed by a team of appropriately qualified and experienced staff. The team had identified four care delivery problems[125] which were confirmed by the work of the independent review. These are set out directly below.

Care coordination practice: the internal review found that some care coordination did not reflect the aims of the care plan and did not reflect multi-disciplinary and multi-agency decision-making. In particular care coordinators did not identify Mr. X as the victim of abuse and therefore an appropriate referral to the safeguarding team.

Unclear decision making on 31 March 2008: the internal investigation team found that the decision that Mr. X should leave the supported tenancy scheme was not the outcome of a multi-agency care planning process. The evidence to support the idea of Mr. X moving to greater independence was not clear and indeed the internal review took the view that Mr. X's dependence supported the view that he should *not* move on. The status of the meeting on 31 March was also not clear, was this an out-patient appointment or a CPA review meeting? The decision that Mr. X should leave the supported tenancy scheme is recorded as a statement from the Residential Support Worker present at the meeting. The Care Coordinator who was new to the case had not had time to form a view about the next steps in Mr. X's care and the doctor was meeting him for the first time. The internal review also concluded that the two year length of stay at the supported tenancy scheme was a "rule of thumb" and that in fact there was no prescribed time limit on tenancy. This was linked to a lack of clarity at the scheme about the role of managers.

Compliance with medication: the internal review noted that non-compliance with medication was pervasive across all records. It was not clear who took responsibility in the supported tenancy scheme for ensuring that Mr. X took his medication. The case record at the scheme recorded that Mr. X was self medicating. There were inadequate safeguards to ensure that this was the case.

Failure to invoke safeguarding procedures: when Mr. X was living with family members there was sufficient evidence to justify a referral to the safeguarding team. Mr. X was being financially

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abused and there was evidence of neglect. The internal review found that staff acting as care coordinators managed this aspect of the case poorly, and that the contact between Mr. X and his family did not receive sufficiently high profile status in the care plan.

The internal review process also identified five service delivery problems. These are set out directly below.

- Lines of accountability and levels of responsibility in the supported tenancy scheme. At the time of the incident the Manager of the scheme was suspended and at interview staff were not clear about the accountability in an integrated service. That is, they were not clear whether the County Council or the Trust had responsibility for staffing issues in the team. They also found that Mr. A was employed during a period of operational difficulty and there were no records of Mr. A's induction to the scheme. In relation to supervision there were two incomplete supervision notes and a recording that Mr. A had had a lack of line management due to the sickness of the Manager.

- The supported tenancy scheme fell short of being either a safe working environment or a home for tenants. Sometimes staff had to ask tenants to leave their living room so that staff could have a meeting as the office was not big enough. The internal review noted that the office/sleep-in room at the house was too small and the siting of the desk meant that staff had their back to the door and could not see people coming into the room. It was not known whether Mr. A knew where the alarm was in the office or whether he had been briefed about its use.

- The role of the supported tenancy scheme was not clear to the internal review team and they concluded that by virtue of his chronic anxiety and lack of motivation, Mr. X was not suitably placed there. The origins of the scheme were as a psycho-social rehabilitation unit for people recovering from mental illness. It aimed to promote greater independence and movement towards independent living. The scheme was not registered with an external regulator- for example the Commission for Social Care Inspection or the Healthcare Commission and the internal review concluded that it lacked a sense of scrutiny and a clear operational model. The internal review found that "*Mr. X did not meet the criteria of the scheme. his anxieties about*

living independently were evident throughout is contact with mental health services and he had shown no progress in attaining the necessary skills".[126]

- There was a lack of professional involvement in the supported tenancy scheme. The staff were not helped by the wider community of mental health professionals to develop a range of strategies for helping Mr. X. The case recording noted everyday routines and was minimal in style. It was known that Care Coordinator 6 in particular, did not fulfil the requirements of the care programme approach in relation to the quality of work with Mr. X.

- There was discontinuity of professional contact. The internal review process also pointed out that Mr. X had contact with 23 key mental health service professionals within a six year time frame. It noted that his final five medical contacts were with different junior doctors.

14.3 Conclusion

The Independent Investigation Team found that the internal investigation process had detailed the chronology of Mr. X's care and treatment and identified some important professional and organisational issues that our findings confirmed in relation to the operation of the Care Programme Approach, safeguarding issues and the operation of the supported tenancy scheme.

The internal review process had also emphasised the importance of governance and accountability in an integrated service and a need to define **what integration means for the supported tenancy scheme, Lancashire County Council and Lancashire Care Foundation Trust (which) must be specified in a shared vision, governance, management and leadership, arrangements for working together, policies and procedure and service delivery.**

The Independent Investigation, interviewing staff some time after the completion of the internal report, found that the conclusions and actions from it were not generally known and understood by staff and that there had not been effective action in relation to their implementation. There remained problems in relation to all the areas of concern that the internal review had identified as the Trust moved forward with the implementation of further organisational change.

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- ***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.***

15. Notable Practice

No specific notable practice of a kind that would offer points of positive learning was found when examining the care and treatment of Mr. X. However the Independent Investigation Team noted that the practice of Care Coordinator 7 was sound and that he provided a robust level of clinical care and treatment to Mr. X in the weeks leading up to the death of Mr. A.

16. 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.

17. Recommendations

Lancashire Care NHS Foundation Trust

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 whistleblowing 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.

Glossary

Approved Social Worker	A Social Worker who has extensive knowledge and experience of working with people with mental disorders.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Case management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Delusional Disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental disorder that is characterized by holding one or more non-bizarre delusions in the absence of any other significant psychopathology. Non-bizarre delusions are fixed beliefs that are certainly and definitely false, but that could possibly be plausible, for example, someone who thinks he or she is under police surveillance.
Depot Injection	This is an intramuscular injection (an injection into the muscle) by which certain antipsychotic medication is administered, e.g. Clopixol.
DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up.
Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support.

Extrapyramidal	Extrapyramidal symptoms include extreme restlessness, involuntary movements, and uncontrollable speech.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Schizophrenia	Schizophrenia is a mental disorder characterised by a disintegration of the process of thinking and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction.

Schizoaffective Disorder

Schizoaffective disorder most commonly affects cognition and emotion. Auditory hallucinations, paranoia, bizarre delusions, or disorganised speech and thinking with significant social and occupational dysfunction are typical. The division into depressive and bipolar types is based on whether the individual has ever had a manic, hypomanic or mixed episode. Symptoms usually begin in early adulthood, which makes diagnosis prior to age 13 rare. Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder. There has been a controversy about whether schizoaffective disorder is a type of schizophrenia or a type of mood disorder. Today, most clinicians and researchers agree that it is primarily a form of schizophrenia.

Schizoid/Schizotypal Personality Traits

Individuals with *schizoid personality* are characteristically detached from social relationships and show a restricted range of expressed emotions. Their social skills, as would be expected, are weak, and they do not typically express a need for attention or approval. They may be perceived by others as sombre and aloof, and often are referred to as "loners." *Schizotypal personalities* are characterised by odd forms of thought, perception and beliefs. They may have bizarre mannerisms, an eccentric appearance, and speech that is excessively elaborate and difficult to follow. However, these cognitive distortions and eccentricities are only considered to be a disorder when the behaviours become persistent and very disabling or distressing.

Section 2 Mental Health Act (83)

Section 2 of the Mental Health Act (83) allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days.

Section 3 Mental Health Act (83)

Section 3 of the Mental Health Act (83) is a treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year. It is instituted in the same manner as Section 2, following an assessment by two doctors and an Approved Social Worker. Most treatments for mental disorder can be given under Section 3 treatment orders, including injections of psychotropic medication such antipsychotics. However, after three months of detention, either the person has to consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person's best interests.

Section 12 Approved Doctors A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.

Section 17 Leave Section 17 of the Mental Health Act 1983 allows the responsible medical officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These can include a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO can require a patient to take medication while on Section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of Section 17 leave provided the original authority to detain remains in force. Section 17 leave is not required within the grounds of the hospital. (Code of Practice 20.1). However, the decision to allow the patient to leave the ward area should only be made at the formal multi-disciplinary review and/or following consultation with all involved in the patient's care and following a comprehensive risk assessment. It must be part of a plan and not a response to a patient's request, although the patient should be fully involved in the decision to grant leave.

Section 117 Aftercare Section 117 of the Mental Health Act 1983 (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and local social services authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

Service User The term of choice of individuals who receive mental health services when describing themselves.

SHO (Senior House Officer) A grade of junior doctor between House officer and Specialist registrar in the United Kingdom.

Specialist Registrar A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order

	eventually to become a consultant.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other.

APPENDIX ONE: MR. X TIMELINE

DATE	EVENT
15 November 1956	Mr. X was born in Wigan. His family life was characterised by parental discord, separations and physical punishment. He had two sisters. 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.
10 July 2002	Mr. X was admitted to hospital after presenting at the Accident and Emergency Department. He had low 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 Avondale Unit.
27 July 2002	Mr. X was discharged with a diagnosis of mild depression and anxiety. Follow up was by Care Coordinator 1, a social worker.
20 August 2002	Mr. X failed to attend his out-patient appointment.
6 September 2002	During a home visit the Care Coordinator noted that Mr. X was living with his daughter, her partner and two children, and his son. Mr. X's son was not attending school and Mr. X had been fined. The Care Coordinator later contacted the Education Welfare Department and was told that Mr. X's son had been taken off the school roll.
16 September 2002	Mr. X did not attend his next out-patient appointment.
15 October 2002	Mr. X attended his out-patient appointment with Specialist Registrar 1. He reported that he was feeling very anxious and that he was sleeping in the lounge because there were so many people in the house. He was referred to the Crisis Team and medication continued.
2 December 2002	Mr. X attended a further out-patient appointment with Specialist Registrar 1. He complained about poor sleep and appetite, anxiety, feeling scared and like a prisoner.
7 December 2002	Mr. X was treated at Ward 12 Preston General Hospital after a self-inflicted stab wound to the stomach.
9 December 2002	Mr. X was transferred to the Psychiatric Unit under Section 2 Mental Health Act He reported that he had stabbed himself with a breadknife. When on the medical ward he had believed staff were trying to poison him with potassium and oxygen and he removed all intravenous lines. He had also absconded and refused to come out of a lift.
24 December 2002	Mr. X was placed on treatment order, Section 3 Mental health Act. He was said to be very paranoid, a high risk of suicide and severely depressed.

22 January 2003	Consultant Psychiatrist 1 noted that Mr. X continued to have a negative outlook on life, had obsessive thoughts about having body odour, and that some staff felt that he was *"getting too comfortable in intensive ward*". There was a view that his dependency was preventing progress.
5 February 2003	Mr. X was transferred to the Psychiatric Unit. His mental state remained the same but he started to attend Occupational Therapy sessions and was said to do well in the kitchen.
2 April 2003	At a ward round it was noted that the Care Coordinator was going to look at the possibility of supported accommodation.
23 April 2003	Mr. X was granted unescorted leave to the local shops for one hour and escorted leave to attend a football match.
30 April 2003	Mr. X saw Consultant psychiatrist 2 for a psychotherapy assessment. This assessment concluded that Mr. X presented with moderately severe depressive symptoms, and psychotic symptoms involving paranoid delusional beliefs and self-referential ideas.
21 May 2003	Mr .X had been to see a new flat but was not sure whether to take it or not. The consultant psychiatrist decided to leave him on his section of the Mental Health Act *"to avoid panicking him".*
4 June 2003	A ward round discussion referred to an improvement since Mr. X had been taking Amisulpride. He enjoyed Occupational Therapy. It was noted that his section expired on 24 June 2003 and was not to be renewed. The plan was for him to move to a flat and he visited the flat with an Occupational Therapist as preparation for the move. He continued to express many anxieties about details of the move and obsessively checked details of the taps and pipe work.
24 June 2003	Consultant Psychiatrist 1 agreed to let the treatment order under the Mental Health Act to lapse.
6 August 2003	The ward round noted that Mr. X would have overnight leave.
27 August 2003	After several weeks of overnight leave, Mr. X was asked when he felt he would be ready for discharge. He said that he will be *"gutted"* when he is discharged. He was asked to think whether he needs support from the Home Treatment Team after discharge planned for the following week.
3 September 2003	Mr. X was discharged to his flat and Care Coordinator 2.
5 September 2003	Mr. X was visited by Care Coordinator 2 who noted that he was doing well. Mr. X was also being visited by support worker and encouraged to do practical things to improve the flat.
17 September 2003	Care Coordinator 2 made a home visit and noted that Mr. X had been out with the support worker to purchase curtains and the flat was very clean and tidy. Mr. X seemed to be coping well but became easily distressed if problems arose.
10 October 2003	Car Coordinator 2 visited Mr. X at home and noted that he remained well.
24 October 2003	A further visit by Care Coordinator 2 noted that he remained well and had an appointment to see a welfare benefits advisor.
18 November 2003	Mr. X was admitted to the psychiatric unit under Section 3 Mental Health Act. 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. The application for admission was completed by Care Coordinator 2 with

	recommendations from the GP 1 and Consultant Psychiatrist 2.
19 November 2003	At the ward round it was noted that Mr. X would need supported accommodation.
24 November 2003	Mr. X was now sleeping better on the ward, he said that his problems were mainly financial, but that he would be better off dead.
3 December 2003	Mr. X was referred to the Assertive Outreach Team because he had complex needs and there was a significant risk of suicide.
26 January 2004	After an unsuccessful referral to a supported housing scheme Mr. X was discharged from the psychiatric unit to his flat, to be supported by the Home Treatment Team. The discharge plan was: • to continue with medication; • to be visited twice a day by the Home Treatment Team to dispense medication; • to monitor risk; • visits from the Care Coordinator to help with financial problems; • help with domestic chores to establish a daily routine; • follow up in out-patient clinic.
26 January 2004-23 March 2004	During this period Mr. X was supported intensively by the Home Treatment Team (HTT). He was living in a rented flat with two of his children. He remained anxious about his finances and about the day-to-day running of the home, and he expressed suicidal ideas. His children were critical of him and were described as rejecting, demanding and bullying.
16 April 2004	Mr. X continued to be supported by Care Coordinator 2 and a new support worker.
May-September 2004	Mr. X remained at home and was visited regularly by his Care Coordinator and a support worker with whom he had a good rapport. His mental state was recorded as variable- sometimes better but also with chronic anxieties about coping with daily living. His son was also living at the flat.
8 October 2004	Care Coordinator 2 reported that Mr. X was agitated and low in mood. There were problems in relationships with his son and daughter who were demanding and confrontational.
12 October 2004	Mr. X refused to leave Support Worker 1's car and showed signs of acute anxiety, distress, and was hyperventilating.
18 October 2004	Mr. X was admitted to the Psychiatric Unit after he was found in an agitated state in a public phone box- the police armed response unit had been called. It was not clear from the case notes why an armed unit had been thought necessary. Mr. X said that he had phoned the police because he could not contact his Care Coordinator.
20 October 2004	Mr. X had to be restrained and was detained under Section 5(2) Mental Health Act He said he would kill himself. He refused medication, would not eat or drink, refused to cooperate with physical examinations and was experiencing panic attacks.
25 October 2004	Mr. X was again detained under Section 5(2) because he wanted to leave the ward and was expressing suicidal thoughts. He had paranoid ideas about other people and their beliefs about him.
26 October	Mr. X was detained under Section 2 Mental Health Act after making repeated

2004	attempts to leave the ward.
17 November 2004	Mr. X was detained under Section 3 Mental Health Act. He remained suspicious of people and had a fixed belief that he smelt. At times he was disturbed and subject to seclusion on the ward. He stared at people and was uncooperative with treatment plans.
December 2004	Some improvements were noted and Mr. X was granted some unescorted leave. He spent Christmas on the ward and did not receive any visitors. There was some discussion on the clinical team about supported accommodation and Care Coordinator 2 followed this up. His behaviour was gradually more settled.
5 January 2005	Mr. X's period of treatment under Section 3 Mental Health Act was ended. An application to Making Space (supported accommodation) was unsuccessful but a further application to a nursing home was made.
18 January 2005	At a ward round discussion it was noted that Mr. X would not be eligible for nursing home placement because he was "*fully independent and capable*". It was agreed that Care Coordinator 2 should look at other possibilities, including sheltered housing.
4 February 2005	Mr. X was discharged from the ward to live at his flat. The care plan included: • daily visits from the Home Treatment Team (HTT); • an agreement that the care coordinator would seek a supported accommodation placement; • medication provided by the Home Treatment Team; • liaison between the Home Treatment Team and the Care Coordinator.
February-March 2005	Mr. X was visited regularly by a Support Worker 1. At first support workers visited together because of an earlier incident when Mr. X refused to leave a support worker's car. Sometimes Mr. X would not let the Support Worker into the flat. An entry in the case notes on 2.03.05 said that Care Coordinator 2 and Support Worker 1 attended a ward round and noted that Mr. X was in the process of being referred back to the Community Mental Health Team i.e. discharged from the clinical care of the in-patient team. . Support Worker 1 raised the issues of risk in visiting Mr. X alone however Consultant psychiatrist 3 who had now taken over as the responsible clinician and the Home Treatment Team representative thought that the risk was reduced.
29 April 2005	Mr. X was visited by Care Coordinator 3 who had now taken over from Care Coordinator 2. She was working with Support Worker 1. There was discussion about Mr. X moving to the Preston Supported Tenancy Scheme (PSTS) and in particular to the Harewood Road facility. Mr. X said that he was undecided about moving there. Mr. X's son was living at the flat with him. Mr. X was said to be baby sitting for a grandchild at the weekends.
15 June 2005	The case notes recorded a discussion between care Coordinator 3, Support worker 1 and consultant psychiatrist 3. Mr. X was not engaging with the support worker and would often not let him into the flat. It was agreed that the Support Worker would continue to visit once a week to monitor and report any signs of relapse.
15 July 2005	Care Coordinator 3 accompanied Mr. X to an out-patient appointment with Consultant psychiatrist 3. Mr. X still had low mood, lack of sleep and did not wish to engage in any of the activities offered to him e.g. attendance at a day centre.
16 September 2005	An entry in the notes by a new care coordinator, Care Coordinator 4, said that he had visited Mr. X but been told by his son , that Mr. X was at his daughters flat in another part of Preston.

30 November 2005	The note of a CPA review with Consultant Psychiatrist 3 recorded that: • the case was to be closed to the Community Support Team (of which Support Worker 1 was a member) and referred to the Community Mental Health Team for *" care coordination only";* • Mr. X's situation remained unchanged with his son living at the flat and reportedly taking money from him; • Mr. X's mood remained flat; • Mr. X was not able to use the support worker; • it was agreed that if Mr X wanted to move to supported housing he would have to ask his son to leave the property - Mr X was reluctant to take this step.
16 February 2006	The next CPA review was attended by Consultant Psychiatrist 3, Care Coordinator 4 and a housing officer from Gateway Housing. Consultant Psychiatrist 3 wrote to GP 1 to say that Mr. X would benefit from a referral to supported accommodation but that he was reluctant to agree to this because his son, presently living with him, would not be able to take over the tenancy and would therefore be homeless. However it was noted that the son had reportedly damaged the property and exploited Mr. X financially. It was agreed to allow Gateway to find warden supported accommodation and that they would review the plan at the next CPA meeting in May 2006.
16 March 2006	Care Coordinator 4 recorded in the notes that a new care coordinator would be taking over the case, Care Coordinator 5.
16 May 2006	It was noted by an Approved Social Worker on the Emergency Duty Team (Approved Social Worker 1) that Mr. X had presented himself at the psychiatric unit in Preston on 15.05.06 and had deteriorated physically and mentally. There were obvious signs of self-neglect. Mr. X appeared thought disordered and refused to sit down. Recommendations were completed for Section 3 Mental Health Act but there was no bed available on the unit. After a long delay a bed was found at a psychiatric unit in Blackpool. Mr. X refused to sit down in the ambulance transferring him. The Police were called and there was some delay while the police and ambulance staff considered the protocol for transfer. Eventually Mr. X was admitted to the unit in Blackpool at 10:40 pm.
26 May 2006	Mr. X was transferred to the psychiatric unit in Preston and care coordination was resumed by Care Coordinator 4.
27 June 2006	A Care programme Approach risk assessment was completed by Nurse 1 on the in-patient unit. She identified historical risks including use of weapons and intimidating behaviour but there was no current risk to others identified in the plan.
2 August 2006	Care Coordinator 4 noted that Mr. X had been offered a place at a supported housing scheme in Preston subject to being supervised under Section 25 Mental Health Act Care Coordinator 4 took Mr. X to his flat to pick up belongings and noted that the flat was a mess.
8 August 2006	Mr. X moved to the supported tenancy scheme and care coordination was transferred to Care Coordinator 6. There was a two page care plan on file at the supported tenancy scheme recording Mr. X's status as on the enhanced level of the care programme Approach and subject to section 117 after care and supervision under Section 25 Mental Health Act. The notes also contained an Individual Care Programme which was the scheme's own care plan concentrating on daily activities and living skills.

5 September 2006	The supervision under Section 25 Mental Health Act was formally accepted. The supervisor was named as Care Coordinator 6.
13 September 2006	Mr. X was formally discharged from the psychiatric unit and his consultant care transferred to a community psychiatrist, Consultant Psychiatrist 4. Senior House Officer 4 saw Mr. X with Care Coordinator 6 and a residential support worker from the supported tenancy scheme as a new referral from Consultant Psychiatrist 6 who had recorded that Mr. X *"has been doing well."*
16 October 2006	Mr. X attended an out-patient appointment with Senior House Officer 4 accompanied by his key worker at the supported tenancy scheme, Residential Support Worker 2. It was noted that Mr. X was attending classes at the Bridge and otherwise his mood was variable, but he denied having any thoughts about harming himself or others.
7 November 2006	It was noted that Mr. X's family - son, daughter and son's girlfriend came to the supported tenancy scheme on an arranged visit. The family requested a small buffet because it was Mr. X's 50th birthday.
7 December 2006	Care Coordinator 6 noted that he visited Mr. X at the supported tenancy and that Mr. X was *"sullen in presentation".* He was attending college for cookery and the Bridge for computer skills and said he is enjoying both.
5 January 2007	Care Coordinator 6 noted that Mr. X's family visited on Christmas day. Mr. X remained unchanged and continued to have a negative outlook on life. He sought constant reassurance from staff and tended to repeat the same questions.
22 January 2007	Mr. X attended an out-patient appointment with Senior House Officer 4, accompanied by Residential Support Worker 3. The doctor noted no major changes.
26 February 2007	After-care under supervision (Section 25 Mental Health Act) was formally ended.
7 March 2007	Mr. X was visited by Care Coordinator 6 at the supported tenancy scheme. it was noted that he was anxious and not enjoying anything at present, but was still attending daily activity sessions and is fully compliant with his treatment plans. Mr. X was happy to stay at the supported tenancy scheme and had no plans to move.
8 March 2007	Mr. X was seen by Senior House Officer 4 at out-patients accompanied by Residential Support Worker 3. Mr. X said that he felt everything was against him and was nervous all the time. He had had less contact with family. It was noted that his mood was low. There was reference in the clinical note to making a referral for cognitive behavioural therapy.
20 March 2007	Care Coordinator 6 recorded a visit to Mr. X in which he noted low mood. Mr. X's behaviour included following staff around and staring at them for long periods.
23 March 2007	Care Coordinator 6 recorded visiting Mr. X and noted that his eating had improved.
30 April 2007	The supported tenancy scheme care notes included a Generic Risk Assessment which identified the key workers for Mr. X as residential Support workers 3 and 4, the case manager as Residential Manager 1 and the Deputy Case Manager as Residential Manager 2. The plan referred to risk areas for suicide, self-neglect, diet and medication but did not include an assessment of risk to others (i.e. there was not a category for this kind of assessment).
14 June 2007	Mr. X attended an out-patient appointment with Senior House Officer 5 , accompanied by Residential Support Worker 2. He was said to be *"always anxious*

	and anhedonic". The Residential Support Worker reported that he has come on in *"leaps and bounds".* Medication dosage was increased and it was noted that a referral for CBT had been made.
22 June 2007	Care Coordinator 6 recorded a visit and noted that Mr. X presented as settled in mood and with no behaviour problems- he was more occupied and more able to cope with difficulties and compliant with medication.
21 August 2007	At his next visit Care Coordinator 6 noted that Mr. X presented as a little anxious because he thought that care Coordinator 6 was going to "*move him on".* The supported tenancy staff said that he was continuing with his rehabilitation programme.
17 September 2007	Mr. X was seen at the tenancy scheme by Care Coordinator 6 and at out-patients by Senior House officer 7 accompanied by Residential Support Worker 2. Some paranoia about staff talking about him was noted. He was prescribed Risperidone. Care Coordinator 6 noted that he was still having fleeting paranoid ideas but that these are *"easily diswayed (sic) by staff".*
3 October 2007	Care Coordinator 6 visited and recorded no changes.
15 October 2007	Mr. X signed a tenancy agreement with the Housing Association responsible for the supported tenancy scheme setting out the terms and conditions of his tenancy. There was no reference to the time limits of the tenancy.
29 November 2007	As a result of the implementation of *New Ways of Working* consultant oversight of the case passed from Consultant Psychiatrist 4 to Consultant Psychiatrist 5 on 15 November 2007. Care Coordinator 6 visited and recorded no further concerns and that Mr. X was continuing with his rehabilitation programme.
11 December 2007	Mr. X had an out-patient appointment with Senior House Officer 6, Senior House Officer to Consultant Psychiatrist 5, accompanied by Residential Support Worker 3. Mr. X was said to have low mood and motivation, still feeling paranoid that the staff are talking about him.
18 December 2007	Senior House Officer 6 completed a review of the case notes. She discussed the management of the case with Consultant Psychiatrist 5.
8 January 2008	Care Coordinator 6 recorded an unsuccessful visit - Mr. X was out.
10 January 2008	Mr. X attended an out-patient appointment with Senior House Officer 6 accompanied by Residential Support Worker 2.
12 February 2008	Care Coordinator 7 took over the case and recorded an attempt to speak to Mr. X by telephone.
20 February 2008	Care Coordinator 7 recorded a further attempt to make contact by telephone.
4 March 08	Care Coordinator 7 visited Mr. X at the supported tenancy scheme to complete a health and social care needs assessment. Care Coordinator 7 noted that: • Mr. X's mood was Dysthymic; • Mr. X had not made plans for suicide but believed that people would be better off without him; • he believed that people discuss him in a negative way; • his activity levels were low but staff did a good job of encouraging involvement- he goes to photography, cookery, but says he gets no enjoyment from these; • he said he was happy with his placement;

	• Cognitive Behavioural Therapy was discussed with him. Care Coordinator 7 noted that during his discussion with staff at the supported tenancy scheme no concerns were expressed about increased aggression or violent posturing towards them or other tenants.
31 March 2008	Mr. X attended an out-patient review with Care Coordinator 7, Residential Support Worker 2 and Senior House Officer 8, who was now the senior house officer to Consultant Psychiatrist 5. The record of this discussion by Care Coordinator 7 noted that: • Residential Support Worker 2 said that based on the supported tenancy scheme's remit, Mr X was now due to move on to a more independent setting such as a supported tenancy without such intensive staff support ; • It was noted that Mr X presented as anxious, with limited expression and poverty of content to his conversation; • his responses were substantially negative and hopeless; • Mr. X appeared to obsess about other people talking about him and thinking about him; • it was suggested that Cognitive Behaviour Therapy (CBT) might be helpful but Care Coordinator 7 suggested that *"his age, length of time with the condition and service and his presentation indicate an entrenched and pervasive negative/nihilistic perspective";* • it was agreed that care Coordinator 7 would do some preliminary work on the CBT; • Care Coordinator 7 recorded that that "(the supported tenancy scheme) will begin to look at alternative tenures….".
7 April 2008	Mr. A, who was working as a Residential Support Worker at the supported tenancy scheme, requested that Care Coordinator 7 might come to see Mr. X because he was anxious. A later call recorded that Mr. X had become more paranoid and thought that people wanted to get rid of him. Care Coordinator 7 recorded that staff were possibly being more assertive in trying to achieve greater independence for Mr. X.
7 April 2008	Mr. X attacked Mr. A with a knife at the supported tenancy scheme and killed him.