NHS
East Midlands

An Independent Investigation into the Care and Treatment of a person using the services of Leicestershire Partnership NHS Trust

Undertaken by Consequence UK Ltd

Ref 2007/9913

January 2010

This independent investigation was commissioned by NHS East Midlands in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd,
- Dr Mark Potter, Consultant Psychiatrist, South West London and St George's Mental Health Trust, and
- Bronwen Williams, Mental Health Training Team Leader, 2gether NHS Foundation Trust.

Acknowledgements

The Investigation Team wishes to thank:

- the mental health service user (MHSU),
- the parents of the MHSU,
- the family of Miss K (the deceased),
- the medium secure forensic service currently caring for the MHSU,
- Leicestershire Partnership Trust and its staff,
- Leicestershire Constabulary,
- Leicestershire County Council, and
- the Local Housing Association that was the landlord to the MHSU,

all of whom assisted in the completion of the investigation conducted.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Incident overview and intention

This report sets out the findings of the independent Investigation Team (IIT) regarding the care and management of the mental health service user, here referred to as the "MHSU", by Leicester Partnership NHS Trust (LPT) between 2002 and August 2007. The MHSU attacked and killed his neighbour in August 2007. He was subsequently sentenced in the Crown Court in Leicester in March 2008. The judge passed a hospital order for an indeterminate length of time with a restriction order (under Section 37 of the Mental Health Act with a section 41 restriction order), so that an application is made to the Ministry of Justice for any future release.

Purpose

The terms of reference for the team were to undertake a systematic review of the care and treatment provided to the MHSU by Leicestershire Partnership NHS Trust (LPT) to identify whether there was any aspect of care and management that could have altered or prevented the events of 15 August 2007.

Outline of the review process

The team conducted:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of LPT's internal investigation report.
- Interviews with staff working in adult mental health in-patient services and the MHSU's community mental health team (CMHT).
- A review of LPT's CPA policy and the operational policy for CMHTs.
- Meetings and telephone contact with other LPT staff.

Main conclusions

The IIT has carefully analysed the MHSU's care and treatment by LPT. As a result it has concluded that although some elements of his care and management could, and should, have been addressed differently, it cannot say that had elements of his care been different that this would have prevented the death of his neighbour (Miss K).

The primary reasons for this are:

- The police investigation suggests that the MHSU had the opportunity to undertake his attack on Miss K any time between 10am and 7pm on 15 August. These were the hours between which the MHSU's whereabouts were unknown on this day.
- The care coordinator and social worker from the South West City Community Mental Health Team (SWC CMHT), who both regularly dealt with the MHSU, visited his flat on 15 August at 11.30-12.00.

The MHSU was not in so they were unable to assess him. However, what could be seen of the flat from outside, plus intelligence from a neighbour, led these professionals to become concerned about the MHSU's mental state. The City Crisis Team and the ward to which the MHSU was normally admitted were notified that the MHSU's mental health professionals (MHPs) believed the MHSU to be unwell.

- The SWC CMHT mental health professionals (MHP's) took appropriate steps to try and locate the MHSU which included contacting his mother who was a reliable informant regarding her son. The MHP's also contacted the in-patient ward where they believed the MHSU's wife to be residing to alert them to what they had found. The MHP's were told that the MHSU's wife had raised no concerns about her husband when she attended the planned ward round to review her care and how things were going at home.[1]
- The SWC CMHT MHP's also tried to contact the MHSU but he did not answer his mobile phone.
- The main concern about the MHSU at this time was the potential risk he might pose to his wife. However this risk was not considered to be one of homicide, but low level domestic violence and reckless behaviour. The MHP's were reassured that the MHSU's wife had been noted to be well and showing no concerns about her husband. There was no reason for staff to consider the MHSU a risk to the general public.
- The MHP's had agreed with the MHSU's mother that she would let them know if she heard from, or saw her son at all. She did contact them the following day having spoken with his wife on the evening of the 15 August (after 7pm). This was the first time that day that anyone knew of the location of the MHSU after 10.45am when he was seen by a witness walking along Avonside Drive in Leicester.
- The MHSU told the IIT that on 15 August he was high on cannabis and that this triggered a psychotic episode. In the week prior to this he recalled being reasonably well.

Although the above actions were reasonable there were some additional actions the MHP's could have taken on 15 August. These were:

- To have contacted the MHSU's wife's assertive outreach team (AOT). This team said that if they had been aware that the MHSU had 'trashed' his flat they would have made an afternoon visit to

[1] Note: Historically the MHSU's wife did raise concern if she felt her husband was becoming very unwell, or was anxious about his behaviours. It is notable that she raised no concerns at all on 15 August even though she had opportunity to do so at her in-patient ward round review.

check on his wife's well being even though she had been seen by the ward that day. Had the AOT done this, and found the MHSU's wife to be at home, this would have provided an opportunity to ask her directly about her husband's behaviour and mental health and to remind her that she could call the crisis team at any time if she was concerned. Had this occurred, and had this revealed concerns, the most probable course of action would have been contact with the MHSU's MHP's and a planned visit to try and see the MHSU the following day at his home[2].

- To have made a repeat visit to the MHSU's flat on the afternoon of the 15 August. Although this could have occurred, the IIT does not believe that the MHP's were wrong not to have attempted a second home visit on this day. The IIT considers that to have planned to visit the MHSU on 16 August would have been acceptable. However the IIT has to acknowledge that the potential for a repeat visit on 15 August would have been enhanced had the MHSU been under the care and management of a CMHT in the east of the city.

With regards to the MHSU's placement with a south west CMHT, looking more broadly at his care and management even had he been discharged from this CMHT and then referred to the appropriate CMHT for where he lived, it is not possible to make a causal link between this and the death of Miss K. However, the IIT does believe that tracking the MHSU during his periods of no contact with mental health services would have been easier, and there is a chance that he may have been seen in and around the community by a more local CMHT between 8 and 15 August. However, even had this happened, and he had been identified as unwell, his past history indicates that a number of measures may have been attempted to achieve recovery in the community before looking at hospital admission on a voluntary or compulsory basis. Therefore, one cannot surmise that had he been with an east city CMHT that he would have had more frequent visits and that these would have resulted in hospital admission prior to 15 August. There is no evidence to support this hypothesis.

In view of the above the IIT do not believe that anyone can say that the SWC CMHT MHP's could have prevented the death of Miss K that day. However, the IIT appreciates that because some elements of the MHP's response could have been more assertive, and because the MHSU was not provided his mental health care by a CMHT that was geographically appropriate, for the family of Miss K, there will always have been a potential missed opportunity to have prevented her death.

---

[2] Note the crisis team had already been alerted to the fact that the MHSU was most likely in relapse. Both the MHSU's parents and his wife had the numbers for the Crisis and the Emergency Duty Team if needed.

With regard to the MHSU's overall care and management, the elements of his care that could have been improved were:

- The clarity of, and documentation of, the MHSU's relapse prevention plans. Risk management plans and contingency plans were not consistently documented and detailed, and there was a lack of involvement of the MHSU's parents in crisis intervention and contingency planning. (This does not mean that the mental health professionals were not risk aware - they were.)
- When the MHSU was married in 2004 and moved into the flat in which his wife was already a tenant, consideration should have been given to transferring his care to the appropriate CMHT for this area. Although continuity of care for service users is generally considered to be good practice, in this case retaining this MHSU was misguided, given the extensive periods of infrequent contact he had with the team and the challenges of making contact with him when he was actively being followed up by SWC CMHT.
- There were a number of occasions where the MHSU was placed on "open contact" by his care team (in other words, it was his responsibility to initiate contact). He was in fact on "open contact" when care coordinator 2 (CC2) took over his case management from care coordinator 1 (CC1) in July 2004. It is not good or safe practice to have an individual on one's case load who is not receiving any planned contact from the CMHT for substantial periods of time. If a service user is well enough to be at work full-time, and have no contact with mental health professionals for periods of greater than 4-6 weeks, then he or she could be considered well enough to be discharged from the caseload.
- There is no firm evidence that the MHSU's care team discussed with the MHSU the benefit of him being on depot medication. The IIT, and the MHSU's parents, consider it to be unlikely that he would have accepted medication by this route but nevertheless it should have been formally considered and the outcome of this documented.
- Although discharge planning was reasonable in the broadest sense, there were missed opportunities for effective contingency planning, given that this MHSU was likely to disengage from the service if well and go back to work. It is fortunate that the MHSU's parents were diligent in their communications with their son's mental health professionals. The lack of formal contingency planning was in many ways mitigated by the quality of communication between the MHSU's family and the mental health professionals.

It may be tempting for the reader of this report, in trying to make sense of the death of an innocent person, to perceive a causal link between the above and the preventability of the incident. However one cannot say that had the above aspects of the MHSU's care been different, the death of Miss K would have been prevented. As stated previously, from what the IIT knows of the week

preceding the incident, there is no information available that suggests any deterioration in the MHSU's mental state. Consequently there is no information that pointed to a need for enhanced contact with the MHSU during this week. The planned visit by the mental health professionals that took place on 15 August was appropriate and the time gap between that and the previous visit reasonable. However, had the MHSU been with an east city CMHT, there would have been greater opportunity for more assertive follow up when he was not available for his planned appointments at the end of July and in early August. However, there are no guarantees that more assertive follow up over this period would have occurred or that signs of deterioration in the MHSU's mental state would have been identifiable prior to 15 August 2007.

In addition to the above issues, the communication with and support provided to the MHSU's parents could have been considerably improved, as follows.

- The MHSU's parents were only offered one Carer's Assessment. This was in 2007. They should have been offered a Carer's Assessment annually in the years preceding this.
- They should have been provided with a carer's information pack. This did not happen. The information pack contained very useful information for any family, or carer, providing substantial support to a loved one with a serious mental illness.
- They should have been provided with support and debriefing by their son's CMHT in the immediate aftermath of the incident. This did not happen.

With regards to the family of the deceased, LPT could have offered to meet with them via the relevant family liaison officer provided to them by Leicestershire Constabulary. The IIT understands that this did not happen.

With regard to the management of service users who use illegal substances such as cannabis, it is important that readers of this report appreciate that the avenues open to the specialist mental health service for dealing with service users who do not take their medication and who engage in the use of illicit substances are very limited. This is especially so where a service user does not accept that using illicit substances has a negative effect on their mental health and can only exacerbate their underlying mental illness. This MHSU did not accept this.

Limitations also apply to the extent to which the specialist mental health service can bring pressure to bear on a service user to take their prescribed medication. Even with the introduction of supervised community treatment in November 2008, a community treatment order (CTO) does not give mental health staff the power to forcibly medicate in the community.

However, for individuals such as this MHSU a CTO may now provide more inducement for medication and treatment compliance. For a service user, compliance with medication may be a more favourable prospect than detention in hospital. Whether regular uninterrupted medication would have made a difference for Miss K is very difficult to say given the MHSU's use of cannabis.

Recommendations
The IIT has six main recommendations for LPT following this investigation. These are as follows.

Recommendation 1: "open contact"
The management team for adult services in LPT needs to establish on a CMHT by CMHT basis, in the city and the county, the number of service users who are on "open contact" and the professionals' rationale for this.

If the dominant reason for "open contact" is to enable rapid re-access to specialist mental health services, as was the case for this MHSU, then LPT must review its systems to enable service users to achieve a fast-track route back into the system without having to be treated as a "new" referral.

If an effective system can be achieved it will enable CMHTs to discharge service users while they are well whilst also having, and giving, confidence that those service users who are likely to relapse will be able to re-access specialist mental health services in a timely manner with a care team they know.

Target audience: LPT's Chief Operating Officer.

Recommendation 2: Care Programme Approach and risk assessment
In many respects it appears that the Care Programme Approach (CPA) and risk assessment (RA) are embedded in community and inpatient practice. However the IIT does have some concern about the quality of the information entered on to the CPA and RA documentation tools. This concern is particularly focused on the risk prevention and contingency plans generated within the community. Therefore, LPT needs to consider how it assesses the quality of content, and the frequency with which CPA and RA plans are critically appraised within the context of management and clinical supervision.

In partnership with frontline staff, LPT needs to continue its work of fine-tuning the design of its documentation tools so that they best promote the standard and quality of documentation to which it aspires.

The following information should be stated clearly in risk assessments and risk prevention and crisis management plans so that they can be as useful as possible.

- Where a professional indicates the presence of current and/or previous risk behaviours these must be described, including the context in which they are displayed and their known consequences. LPT can assist its staff in this when it updates the current RA documentation tool. Consideration could be given to including a free text space after each main section of the actuarial element of the RA tool.

- The action plan must state precisely what is required and not just be a bulleted list. This is not acceptable practice. For example if enhanced visiting is required it would be useful to indicate the minimum frequency for this.
- Contingency plans must be sufficiently detailed so that if no-one is available who knows the service user, then any other professional dealing with the crisis has immediate access to all essential information to enable them to implement the crisis plan. This should include all essential contact numbers, any known haunts and hangouts of the service user, and details of significant others. The crisis plan should also state what core activities and actions must be delivered in the management of crisis, including those professionals who must be notified.

It is expected that LPT will conduct an audit of risk assessment documentation across all of its services to check whether this is being done.
The IIT encourages LPT to utilise a peer review process in addition to more formalised documentary audit tools.
Target audience: LPT's Chief Operating Officer and Medical Director.

Recommendation 3: Risk assessment training
In 2004 a recommendation was made to LPT regarding the provision of clinically focused risk assessment for its staff. The IIT is encouraged that all community staff had accessed risk assessment and CPA training within the Trust and that both CPA and risk assessment were part of the same training workshop. However, the IIT is concerned that not one of the inpatient staff it spoke with had been provided with the same training opportunities or input.

LPT must ensure that clinical risk assessment training, as it relates to the assessment of risk in service users, is provided to inpatient as well as community staff.

The IIT recognises that there may be significant cost implications associated with this, depending on how LPT chooses to address the training deficit. The IIT suggests therefore that LPT must present a proposal of how it will address this essential area of training for all of its staff working within Adult Services in the next financial year (2010/11).

Target audience: LPT's Medical Director

Recommendation 4: Joint working
The IIT is disappointed at the lack of formalised joint working arrangements between the MHSU's CMHT and his wife's AOT. However, it is commendable that LPT has addressed this issue in its current CPA policy document

implemented in 2007 (page 14, section 3.4). Although the principles espoused at section 3.4 appear plainly stated to the IIT, its impression is that LPT's professionals are still not always certain about when one should consider joint working.

The IIT therefore recommends the use of this case, and previous relevant serious untoward incidents where joint working would have enhanced the quality of care to the service users, as case studies within LPT's CPA training workshops.

The IIT also recommends that this case be used to highlight the issue of joint working in the next quarterly issue of its learning from experience bulletin TRAIL[3]. It is incumbent on LPT to ensure that TRAIL is circulated to all CMHTs and inpatient services regardless of whether they are city or county based.

Target audience: LPT's Medical Director

Recommendation 5: Support for the family of a service user and the family of the victim following serious incidents such as homicide
Although the internal investigation team did meet with the family of this MHSU during the course of its investigation, there was no immediate post incident support provided to the family by the MHSU's care team. Neither was any support offered to the family of Miss K.

Today LPT has a "Being open" policy that is in line with the guidance provided by the National Patient Safety Agency. Section 5.1, page 5, of LPT's policy is explicit about the requirement to communicate with families and carers following serious incidents.

However there is a gap in the policy document relating to communication with:

- the family and/or carer(s) of the service user(s) involved in the serious incident, and
- the family of any victim(s), if this is different to the family of the service user, where harm has been caused by a service user,

after the incident has been investigated.

[3] TRAIL is a clinical governance newsletter that has been developed by Adult Services in Leicester City to share learning points with all health and social care professionals working within the service. TRAIL stands for "Talk, Reflect, Act, Improve and Learn".

Section 7, pages 6 and 7, of LPT's policy does not make explicit the requirement for staff to meet with and feed back to the respective families and/or carers the findings and recommendations of the internal investigation process. Sending a family a copy of the Trust's internal investigation report in the post is neither sufficient nor acceptable.

It is therefore recommended that an addendum to the policy is issued as the IIT does not believe that remedy of this can wait until the policy is reviewed in October 2010.

Target audience: LPT's Director of Quality and Innovation.

Recommendation 6: Investigation of serious untoward incidents (SUIs)
LPT's internal investigation report did not evidence that a reflective or analytical approach had been taken to the investigation of the MHSU's care and management. Furthermore the report was written in a rather congratulatory style and this caused offence to Miss K's family and to the family of the service user.

The incident management policies in LPT are now far more robust than they were in 2007. Furthermore a director of LPT is given the responsibility of overseeing the investigation process and for the quality of the end report.

What continues to be absent from LPT's policy documents is any practical guidance for staff who are identified as having the correct skills and aptitude for investigating. The LPT's incident reporting toolkit, which incorporates the guidance on incident investigation, talks of a structured investigation process but does not set this out anywhere in the policy document. Furthermore it does not set out clearly the core competencies that are required of staff who take the operational lead for SUI investigations.
The IIT suggests that the following should be considered as core competencies for anyone asked to lead SUI investigations.

- An understanding of the basic, key components of a robust investigation process.
- Knowledge of how to construct an analytical timeline (e.g. a tabular timeline) and to which types of incidents it should always be applied.
- Knowledge of how to construct a validation and triangulation map once all questions to be asked have been identified.
- Recognising the importance of the lead investigator having 'hands on' involvement at all key stages of the investigation process. (Delegation to uninvolved third parties is not good practice).
- An understanding of investigative interviewing using a cognitive style.
- Knowledge about what constitutes acceptable and unacceptable interviewing practice. For example there should never be just one interviewer who is also the note keeper.

- The need for as full a record as possible of everything discussed within the interview scenario.
- Knowledge of data analysis techniques such as content analysis and affinity mapping. How to use the 'fishbone diagram'.
- Knowledge of how to write a high level report that is likely to be made available to non-professionals such as the family of a service user and the family of a victim.

It is recommended that these competencies are included in LPT's incident reporting and investigation tool kit as an appendix, and that where a staff member does not possess these competencies they are mentored by someone who does until they are considered competent.

LPT is also encouraged to set out in an appendix of this policy document its investigation framework, i.e. the key stages of the investigation process that it expects all SUI investigators to utilise.

Target audience: LPT's Director of Quality and Innovation

Note: The IIT expects that LPT will, when generating its action implementation plans for presentation to East Midlands Strategic Health Authority, include the actions / measures it will take to test out that the recommendations have been implemented and also the impact of implementation on clinical and investigation practice.

1.0 INTRODUCTION

This investigation was commissioned by East Midlands Strategic Health Authority to determine:

- the quality of care and management afforded the MHSU; and
- whether or not the MHSU's attack on Miss K could have been prevented by different management by the specialist mental health services in Leicester.

In August 2007 the MHSU attacked and killed Miss K. He was subsequently sentenced in the Crown Court in Leicester in March 2008. The Judge passed a hospital order for an indeterminate length of time with a restriction order (under Section 37 of the Mental Health Act with a section 41 restriction order), so that an application is made to the Ministry of Justice for any future release.

The investigation undertaken is a statutory requirement under Department of Health guidance HSG(94)27.

1.1 Overview of the MHSU's contacts with specialist mental health services in Leicester

The MHSU first came into contact with mental health services in January 2002. The events leading to this were bizarre behaviours, with the MHSU becoming increasingly withdrawn and isolated. The MHSU's father told mental health services that there had been a serious incident in the family home a number of years previously that seemed to be the precipitating event for the MHSU's ill health. The MHSU was assessed by a specialist registrar (SpR) at home. At the time of the assessment there were no signs of homicidal or suicidal ideation.

The MHSU was again assessed at home in July 2002. Following this assessment he was admitted to hospital under section 2 of the Mental Health Act (MHA). During this admission he was diagnosed with paranoid schizophrenia.

Following his discharge from inpatient services in September 2002, the MHSU was managed in the community by the South West City Community Mental Health Team (SWC CMHT) until August 2003 when he was again admitted to hospital because his community psychiatric nurse (CPN) was concerned about his mental health and that he was in relapse. On this occasion the MHSU agreed to hospital treatment so the admission was on an informal basis. He was subsequently discharged approximately one month later.

Throughout 2004 the MHSU remained well. He went back to work, got married, had a child and had virtually no contact with the specialist mental health services.

This situation prevailed until the middle of 2005 when stressful home circumstances prompted telephone contact with the MHSU. The first face-to-face contact occurred in August 2005 following a number of unsuccessful attempts to meet with the MHSU. At this time the MHSU remained reasonably well. His consultant psychiatrist had no major concerns about him providing that he remained in contact with his care coordinator (CC) and social worker (SW).

There was little contact between mental health services and the MHSU until the summer of 2006. Contact at this time was again prompted by increasing stressors at home. The MHSU's wife was unwell and required hospital admission.

The MHSU was successfully managed in July when non-compliance with his prescribed medication (olanzapine) and continuing cannabis use, coupled with the stress of looking after his young son, resulted in a relapse of his mental illness.

This admission lasted for approximately five weeks.

The MHSU's next admission to hospital was in December 2006. The precipitating factors were again medication non-compliance and cannabis use. The MHSU's parents had alerted the community mental health services to their increasing concerns about their son's health. Following a period of trying to manage him in the community, his non-engagement with the services offered resulted in a compulsory admission under section 2 of the MHA on 14 December.

This admission was for six weeks with discharge occurring on 25 January 2007.

Admission was again necessary on 4 February 2007. The speed of the MHSU's relapse and the speed of his recovery suggested to the mental health professionals that a high usage of cannabis was the most likely precipitator for admission.

The MHSU was subsequently discharged back home on 9 February 2007.

The next notable incident for this MHSU was on 8 March. On attending for a home visit the CC and SW found the windows of the MHSU's flat boarded up and him not there. The MHSU's mother, a reliable informant, told the professionals that as he had not been able to get into his flat, he had broken the windows to gain access.
The mental health professionals were also advised by the local housing association that the MHSU would be charged with criminal damage for breaking the windows.

On 15 March the SW received a phone call from the MHSU's mother, who stated that he had visited her on 10 March and told her that he had smashed the flat windows because voices had told him to. He came back again on 11 March and was distant and twitching, talking incoherently and mentioned killing himself. The MHSU stayed the night with his mother. The SW notified the Crisis Resolution and Home Treatment Team (CHRT), Emergency Duty Team (EDT) and the inpatient ward. He also tried to contact the MHSU but was unable to do so.

A home visit was achieved on 16 March when the MHSU presented with some odd content in conversation. He stated that he was compliant with medication. Following this meeting the SW accompanied the MHSU into town to address some identified social needs and to pick up his medication. With the MHSU's consent, the SW also delivered some medication to the MHSU's mother so that she could assist him with taking it. The CPN and SW placed the MHSU on amber alert with the CHRT.

Between 19 March and 24 June 2007, the MHSU was stable in the community and appeared to be managing well. Positive reports were received from his mother during this period.

On 25 June an incident occurred on the psychiatric ward where his wife was an inpatient. The MHSU had taken his son to visit her. An argument had occurred and the MHSU had abandoned his son on the ward. Child care services and the MHSU's mother were contacted.

Following this incident the MHSU avoided contact with his parents and his community team. It transpired that the main reason for this was embarrassment.

On the 20 July 2007 there was a child care family meeting. The MHSU was due to attend along with his CC and SW. He did not attend. He subsequently said that he forgot.

On 25 July the CC and SW achieved a face-to-face meeting with the MHSU at his home. The clinical records say: "MHSU appearing mentally well and informing us that he [is] compliant with medication". It is also noted that the MHSU said he forgot about the family meeting.

The SW records note that he spoke with the allocated child care worker for the MHSU's son at Social Services. The plan was for the SW and this professional to do a joint home visit to meet with the MHSU, so that he could be taken through a behaviour contract regarding future contact with his wife and child.

There was another home visit on 1 August by the SW to explain what was happening to the MHSU.

The joint visit with the child care worker occurred on 8 August. However the MHSU either was not in or would not answer the door. The behaviour contract was left with the SW to obtain the MHSU's signature on another occasion. The SW contacted the MHSU's mother to find out how he was. She told the SW that she had seen her son over the weekend. She said he was OK. He did not mention the planned home visit. The MHSU's mother is noted to have suggested that he might be being "avoidant". She agreed to ask her son to contact the SW.

On 13 August the MHSU's situation was discussed at the SWC CMHT weekly meeting. The plan was to revisit him on 15 August.

The CC and SW visited as planned on 15 August. They raised no response from the MHSU. The clinical records and interviews undertaken reveal that they looked through the windows, but a clear view was not obtained due to the net curtain. However, they could see that the flat had been "trashed" and the sofa appeared to have been slashed with a knife, plus there were pieces of wood on the floor. The notes say that the neighbour from the flat above informed them that the MHSU had been making a lot of noise the night before, and that at about 04.30hrs, he had been on the phone shouting at somebody for a couple of hours. Following this information the SW contacted the MHSU's mother and his wife's inpatient ward. The MHSU's mother had not seen him and the ward informed the SW that the MHSU's wife had not raised any concerns about the MHSU that morning. (She had been on home leave and had returned to the ward for the ward round).

On 16 August the SW spoke with the MHSU's mother. His mother said she had spoken with the MHSU's wife the previous evening. His mother said her son was 'ranting' in the background and saying that other than his knee being busted and his head messed up he was OK.

The SW also called the assertive outreach team supporting the MHSU's wife in the community. They agreed to visit her and also to ask her to encourage the MHSU with his medication.

On the same day the MHSU's wife also contacted the SW and left a message asking him to contact her on Friday.

On 17 August the SW and CC were informed that the MHSU had been arrested on suspicion of murder.

Please go to Appendix 1, page 92, for a more detailed chronology of the MHSU's contacts with the statutory mental health service in Leicester.

2.0 TERMS OF REFERENCE

The terms of reference for this Independent Investigation, set by East Midlands Strategic Health Authority (the SHA) were as follows.

To undertake a systematic review of the care and treatment provided to the MHSU by Leicestershire Partnership NHS Trust (LPT) to identify whether there was any aspect of care and management that could have altered or prevented the events of 15 August 2007.

The IIT is asked to pay particular attention to the following:

- The quality of the health and social care provided by the Trust to the MHSU and whether this adhered to Trust policy and procedure, including:
  - to identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to the MHSU;
  - to identify whether the risk assessments of the MHSU were timely, appropriate and followed by appropriate action, including consideration of children's safeguarding arrangements;
  - to examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
  - the Mental Health Act assessment process (if appropriate); and
  - to examine the appropriateness of actions taken on 15 August 2007 following the unsuccessful visit to the MHSU's flat and the concerns raised by neighbours.
- To consider whether the housing he was placed in was appropriate
- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.
- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority.

3.0 CONTACT WITH THE FAMILY OF MISS K, THE FAMILY OF THE MHSU AND THE MHSU,

East Midlands Strategic Health Authority first met with the family of Miss K on 21 January 2009. Following telephone and email communications in April and early May, the IIT subsequently met with the family of Miss K on 14 May 2009. The purpose of the meeting was to hear their concerns and questions and to inform them about the investigation process. Present at the meeting were:

- Miss K's mother;
- Miss K's and brother; and
- Miss K's uncle and aunt.

The IIT also met with the family of the MHSU. This meeting occurred on 24 June. The purpose of this meeting was also to hear the recollections of the MHSU's parents, listen to their questions and advise them of the investigation process.

Following the investigation process arrangements were made to meet again with both families to take them through the findings and recommendations of the IIT.

The meeting with the family of Miss K took place on 11 September to take them through the findings and recommendations of the IIT. The meeting with the family of the MHSU took place on 25 September.

Initially it was agreed that the investigation lead would meet with the sister of Miss K for a supervised reading of the full report. However, subsequent to this decision she and her uncle decided that they would wait until the publication of the report to read it in full.

The MP for Miss K's uncle was provided with an embargoed copy of the full report on 12 October 2009.

Both the family of Miss K and the family of the MHSU had a range of questions that they hoped the independent investigation would address. These are set out in Appendix 2, page 119.

Meeting with the MHSU

The IIT met with the MHSU on the 17 November towards the end of the investigation process. This timing was agreed between the IIT and the MHSU. At this meeting the MHSU told the IIT that he was satisfied with the contact he had with his care coordinator and social worker. He also advised the IIT that he did not believe that there was anything either of them could have done to have prevented his attack on Miss K. The MHSU told the IIT that at the time he had been smoking cannabis very heavily and that this triggered a psychotic episode for him. In the days preceding this he recalls being reasonably well.

The MHSU told the IIT that he deeply regretted his attack on his neighbour and that he never realised that using cannabis could have made him so unwell as to have committed such an act. He acknowledged the efforts of his care coordinator to counsel him against its use but he just didn't believe it would lead to such an awful incident.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the independent Investigation Team's (IIT's) findings in relation to the following questions. The findings of the IIT in relation to each of these is presented in sections 4.1 – 4.5, pages 25 to 74. The questions are:

1. Was the overall care and management of the MHSU reasonable in relation to:
    - his diagnosis and the overall understanding of his psychosis;
    - the overall direction of his care plan (including discharge planning);
    - medicines management;
    - frequency of contact with the MHSU;
    - management of his substance misuse;
    - use of the Mental Health Act; and
    - out of hours care
    - non-referral to assertive outreach services (AOT).
2. Was there an acceptable level of appreciation of the MHSU's risk factors, and were risk assessments undertaken appropriately? Furthermore were any risk management and relapse prevention plans appropriately formulated?
3. Was there effective communication between:
    - Professionals within the MHSU's care team?
    - The MHSU's care team and in-patient services and the crisis team?
    - The MHSU's care team and the AOT responsible for the care and management of the MHSU's wife?
    - The MHSU's care team and the MHSU's parents, and his wife?
4. Was the housing situation for the MHSU appropriate?
5. On 15 August 2007, when the MHSU's flat was discovered to be in a state of disarray, were the actions of his care coordinator and nominated social worker appropriate given that it was almost certain that he had relapsed and was again unwell?

As a result of its investigation in relation to the above questions the IIT has identified a number of areas in the MHSU's management that could have been improved. These are:

- A lack of relapse prevention planning and the absence of consistently documented and detailed risk management plans or contingency plans.
- When the MHSU was married in 2004 and moved into the flat where his wife was also a tenant, consideration should have been given to transferring his care to the local CMHT for this area. Although the IIT appreciates that the consultant psychiatrist for the MHSU believed

that it was good practice to maintain continuity of care for the MHSU in this case, the IIT believes SWC CMHT was misguided not to have transferred his care.

- There were a number of occasions where the MHSU was placed on "open contact" (in other words, it was his responsibility to initiate contact) by his care team. He was in fact on "open contact" when care coordinator 2 (CC2) took over his case management from CC1. It is not good or safe practice to have an individual on one's case load who is not receiving any planned contact from the CMHT. If the service user was well enough to be at work, and have no contact for periods greater than 4-6 weeks with the CMHT, then he could be considered well enough to be discharged from the caseload.

- There is no firm evidence that the MHSU's care team discussed with the MHSU the benefit of him being on depot medication. The IIT considers it to be unlikely that he would have accepted medication by this route but nevertheless it should have been formally considered and the outcome of this documented.

- Although discharge planning was reasonable in the broadest sense, there were missed opportunities for effective contingency planning, given that this service user was likely to disengage from the service if well and go back to work.

In addition to the above direct care concerns, the MHSU's parents were only offered a Carer's Assessment in 2007. The MHSU was on enhanced CPA and therefore at the annual CPA reviews there should have been contact with his parents to i) gather information from them with the consent of their son and ii) to offer them a Carer's Assessment. In addition to this contact the MHSU's parents should have been provided with the information pack entitled "Information for relatives and friends who look after someone with a mental health problem". This pack was intended for any family member with a close relationship to a service user regardless of whether they accepted the offer of a Carer's Assessment. (See section 4.3.3, pages 68 - 71 for further information about why this pack was not provided).

As the above shows, there were aspects of the MHSU's care and management that could have been improved. However, the IIT identified no aspect of his care and management that if changed would have prevented the untimely death of Miss K. There was nothing in the MHSU's behaviours or history that could have alerted his mental health team to his homicide risk. Furthermore there was nothing in his past history or behaviour that suggested that he would plan such a violent act.

The remainder of this section sets out in detail the IIT's findings in relation to the five questions stated above.

4.1 Was the overall care and management of the MHSU reasonable in relation to:

- **4.1.1 the MHSU's diagnosis and staff's understanding of his psychosis;**
- **4.1.2 the overall direction and adequacy of the MHSU's care management plan, including the Care Programme Approach (CPA);**
- **4.1.3 frequency and quality of contacts with the MHSU;**
- **4.1.4 medicines management;**
- **4.1.5 management of the MHSU's substance misuse;**
- **4.1.6 the usage of the Mental Health Act;**
- **4.1.7 out of hours care; and**
- **4.1.8 the non-referral of the MHSU to assertive outreach services?**

4.1.1 The MHSU's diagnosis and staff's understanding of his psychosis

The MHSU had a diagnosis of paranoid schizophrenia. This was a correct diagnosis and was understood by all staff involved in his care and management.

There was a reasonable exploration of his psychosis. The effort undertaken by the involved mental health professionals was no more, or less, than one would expect from any other group of mental health professionals.

A review of his records reveals that he was reported to be hearing voices from as early as July 2002. However when asked about these he would deny the presence of auditory or visual hallucinations. The staff on the psychiatric intensive care ward, in 2002, believed that the MHSU was psychotic but they had no clear evidence of this. It is noted in his clinical records that the MHSU did make odd responses and show behaviour indicating that he was masking his symptoms.

In August 2002 a second opinion was sought regarding the MHSU's diagnosis from a professor in psychiatry. This individual determined that the MHSU was most probably suffering from a schizophrenic illness. The professor identified some changes in the MHSU's social function that led him to this conclusion. The MHSU continued to deny any auditory hallucinations but did eventually acknowledge some auditory experiences and visual hallucinations. Olanzapine 10mg was recommended as the medication of choice for the MHSU. He was commenced on this medication on 2 August 2002. Because of challenges in achieving a firm insight into the MHSU's illness and his erratic behaviours, his detention under Section 2 of the Mental Health Act 1983 was reviewed and regraded to a Section 3 on 7 August 2002. The MHSU's mother was informed and was advised that the staff were not "seeing much in terms of *mental* illness, other than the MHSU laughing to himself or shouting out things". The MHSU's mother is noted to have said that the MHSU "presented

like this at home, laughing, talking [and] shouting when he was alone with no obvious stimulation".
Following a further informal admission in August 2003, the MHSU was noted to have admitted to having a "dream" where he was turned into a sixteen year old. He thought this dream would go away with more medication. He was also noted to have reported that he has "lost jobs because of these thoughts". This was the only time such a phenomenon was reported.

Towards the end of this admission a KVG[4] PSI (psychological and social intervention) assessment was undertaken. Although it is noted in the nursing progress notes that the MHSU scored zero for hallucinations and scored zero for delusions during this assessment, it is not clear how these scores were formulated as there is insufficient narrative. However the records state that the MHSU "is quite adamant he had never experienced any paranoia, delusions or thought interference". With regard to hallucinations the MHSU said that he did hear music in his head that was not actually there. This was "inside his head" and he said it was usually a song that had got "stuck in his head". With regard to his previous ill health the MHSU attributed this to an over-involvement in trying to work out what life and the universe was about. He at this stage felt much calmer and less interested in these things. He was reported to have reflected that his calmness was probably down to the medication.

During 2004 and until the middle of 2005 the MHSU was well for long periods and there appear to have been no notable episodes of him behaving oddly. This changed in August 2005 when he again began to act bizarrely. A home visit by members of SWC CMHT on 10 August revealed that "there was an element of irritability about his person and that at times he presented quite paranoid, he also spoke in riddles". The MHSU "spoke about an invention – a tape measure, plans of which were in the back of his car and it was going to make him a millionaire." Between 10 and 19 August, although the MHSU's behaviour was erratic, there were no other expressed paranoid ideas. By 19 August the clinical records note that his mental state had noticeably improved. To all intents and purposes the MHSU remained relatively stable throughout the remainder of 2005 and until May 2006 where at a home visit it was noted that his thought content was "slightly distorted". There were no significant displays of relapse during this time. Relapse did not happen again until July

[4] The purpose of the KGV(M) is to enable the user to elicit, and to measure the severity of the psychiatric symptoms that are most commonly experienced by people who have psychotic illnesses such as schizophrenia and bi polar affective disorder. (http://www.mentalhealthnurse.co.uk/images/Assessment%20Tools/KGV%20Master.pdf)

2006 when a period of medication non-compliance resulted in the MHSU's informal[5] admission to a psychiatric in-patient ward. During this admission he admitted to hearing voices "like parrots telling him to do things" (there is no elucidation as to what the voices were telling him to do). During the remainder of this admission there is nothing to show that the MHSU admitted to any visual or auditory hallucinations. His behaviour, as recorded in the clinical records, was very similar to his previous admissions in 2002 and 2003. That is, he was hostile and showed some unacceptable behaviour, using obscene language and pushing boundaries. The main issue during the latter part of this admission was hostility between the MHSU and his wife as they were in the process of separating. There were also issues of the MHSU presenting as well on the ward but not so well to his parents when on home leave. The MHSU discharged himself from hospital on 11 August 2006 when his benefits came through.

The MHSU next became unwell in December 2006 where a compulsory admission under Section 3 of the MHA was required. This admission revealed no new behaviour or thoughts. The issue of his tape measure design prevailed.

It became apparent to the IIT that throughout the MHSU's contact with the mental health services in Leicester, a complicating factor for the staff was his unwillingness to share detailed information about his thought disorder and experiences (i.e. what was going on inside his head). As the information extracted from the clinical records shows, supplemented by corroboration at interview, the consistent information shared by the MHSU with his care coordinator and social worker related to the measuring device and a logo that he believed would be worth millions of pounds. Furthermore the MHSU did not admit to any command hallucinations between 2004 and the incident in 2007.

[5] Informal means that the MHSU was a voluntary patient and had not been compulsorily admitted via the Mental Health Act.

4.1.2 The overall direction and adequacy of the MHSU's care management plan, including the Care Programme Approach (CPA)

This MHSU was on enhanced CPA which was appropriate. The Trust's "Care Programme Approach Policy and Practice" document, dated August 2003, states that a service user on CPA must have a care plan to address the service user's assessed needs, that will be documented on the Trust's standardised care plan. This document also states that "each care coordinator will set review dates on an individual basis according to need and at a time of any major change in care. For people on enhanced CPA the minimum will be 6 months, but reviews must be done according to need."

A review of the MHSU's clinical records revealed that CPA reviews are documented to have occurred on:

- 5 September 2002;
- 4 November 2002;
- 03 February 2003;
- 24 November 2003 – noted that neither the MHSU nor his parents would be able to attend;
- 5 January 2004 – the MHSU's mother could not attend as husband ill;
- 23 February 2004 (first note of planned open contact for a time limited period of 1-3 months);
- 28 June 2004;
- 21 January 2007; and
- 30 May 2007.

The dates of the CPA reviews show that in all years except 2005 and 2006 reviews were delivered in line with the Trust policy. The IIT was provided with copies of the CPA reviews that occurred in 2002, 2004, and 2007. The Trust was not able to locate the CPA review paperwork for 2003. This was not an impediment to the IIT.
The care plan tool provided to staff, by the Trust, was comprehensive with set areas to record information relating to a range of issues including a summary of a service user's needs, the objectives of the care plan and the medical and nursing plans.

In 2002 the medical plan was for regular outpatient appointments as part of the CPA process and the prescription of an anti-psychotic medication, olanzapine. The nursing care plan was to visit the MHSU every four weeks, to work with the MHSU on his medication compliance, to provide education and support to the MHSU's parents about their son's illness, to work therapeutically with the MHSU so that he could reach and maintain optimal levels of functioning and to use the collective knowledge of the multi-disciplinary team where necessary to deliver the most effective care. The

clinical records maintained by CC1[6] evidence that this plan of care was delivered to the MHSU as far as was possible. However, the plan was curtailed from time to time by the MHSU's inability to meet with CC1 because of his working hours.

The "Patient Review Plan" (PRP) report of June 2004 does not detail any specific plan of care as the MHSU was on "open contact" with SWC CMHT by this time (see section 4.1.3, pages 30-49 for further commentary regarding open contact).

The PRP of January 2007 detailed the following:

- CPA in six weeks to discuss transfer – consultant psychiatrist 1 (CP1) to begin this process;
- CMHT to visit 31 January 2007;
- taken off Section 3 of MHA;
- outpatient appointment (OPA) six weeks post discharge; and
- CMHT input once a week for three weeks and thereafter every two weeks.

The PRP of May 2007 stated:

- CMHT to visit weekly/fortnightly; and
- medication 10mg olanzapine.

The summary care plans detailed above were reasonable as far as they went. However the IIT would have expected to have seen a more detailed care plan setting out:

- How SWC CMHT intended to work with the MHSU regarding his medication compliance.
- Measures agreed between SWC CMHT and the MHSU's family, including communication strategies.
- Specific issues the MHSU's family was advised to be on the alert for and notify SWC CMHT of.
- A contact strategy with the MHSU as he was often unavailable due to work commitments.
- Joint working arrangements with the mental health team caring for the MHSU's wife, given the ongoing close contact between the two because of their son.

It would not have been self evident to anyone picking up the CPA care plans what the substance of this MHSU's plan was. This therefore cannot constitute a good standard of documentation.

The lack of detailed care plans the IIT considers to be particularly significant in 2007 where it was very evident that the mental health professionals working with the MHSU placed a significant degree of reliance on the parents of the MHSU, making them essential components of the care plan. Nowhere is the

[6] The MHSU's care coordinator until mid 2004.

parents' place in the care plan documented. Neither are any of the social care needs for the MHSU.
The IIT's independent consultant psychiatrist, who is an associate medical director in a busy inner city mental health service, suggested that although the care planning element of CPA forms is of utmost importance, placing this element at the end of a lengthy documentation tool does tend to adversely affect the quality of documentation in his experience.

The IIT discussed the quality of the documented plans at length and felt that the progress notes and interview data evidenced some very good care provided to the MHSU, especially in relation to the social support he received from SW2.
It is the opinion of the IIT that in spite of a lack of formalised and detailed care plans, there is a significant amount of information confirming that the care plan and its delivery to the MHSU were of a reasonable standard.

The following section 4.1.3, pages 30-49, addresses the frequency of contact with the MHSU by the mental health services in Leicester and provides reflective comment.

4.1.3 The frequency and quality of contacts with the MHSU

Because the MHSU was placed on "open contact" in 2004, the IIT focused the analysis of his contacts with the mental health services in Leicester on the two year period preceding the incident in August 2007. This is what the IIT considers to be the critical period leading to the incident.
For clarity, an overview of the contacts between the mental health professionals and the MHSU is presented below in a chronological format with commentary from the IIT as required.

Date	Nature of contact
04 January 2005	The clinical records note that the MHSU was to remain on open contact. His care coordinator was to remain the same (i.e. CC2). Note: The MHSU was last seen on the acute inpatient ward for an outpatient appointment on 22 November 2004. He was noted to be well at this stage. Prior to this the last contact with the MHSU was on 21 July 2004 when the MHSU had self presented, stressed following the premature birth of his son.
Comment by Investigation Team In 2004 the Trust's CPA policy document did not address the issue of change of care coordinator within the same team. This is an issue that one would have expected an operational policy to have addressed, but the only operational policy provided to the IIT is one that has been in draft for some period of time and this does not address this issue either. The 2003 CPA policy document did address transfers of care between teams and logically one would expect the same principles to apply for transfer of care coordinator within a team. The Trust's revised policy document for 2007 states this explicitly. Had the MHSU been in active contact with SWC CMHT at the time CC2 took over his care and management in April 2004, it is probable that a face-to-face meeting between CC2, the MHSU and CC1 would have occurred. Because this was not possible and because the MHSU's parents were an integral component of the MHSU's support network and his care plan it would, the IIT suggests, have been ideal if CC2 had made contact with them when she took over care coordination responsibility for the MHSU.	
6 June – 6 July 2005	Contact at this time was wholly via the telephone, except for 6 July when the MHSU was seen at home by his care coordinator and then social worker (SW1). He was also seen on 7 July by his consultant psychiatrist in outpatients. The MHSU requested to remain on open contact at this time.
Comment by Investigation Team The MHSU had no face-to- face contact with his community mental health team and was on open contact during this period. To have agreed open contact for an unspecified period of time was not appropriate. In February 2004 when open contact was agreed, there was a time limit established of one to three months. In June 2004 there is no information to show that there was any real consideration of what might be a reasonable time period for open contact, or how some element of formal contact with the MHSU could have been achieved. It is the assertion of the IIT that if the mental health professionals were content for the MHSU to have no contact with the mental health service then he should have been discharged from the CMHT caseload and a plan put in place to enable him to re-access the mental health service if he became unwell again.	
Date	**Nature of contact**

1 August 2005	The MHSU was becoming unwell. The MHSU's wife reported that he was non-compliant with his medication and that he was becoming irritable with her and his son. These concerns are validated in the chronology provided to the IIT by the City AOT which was providing care and treatment to the MHSU's wife. As a result of the concerns raised, CC2 contacted the MHSU's consultant psychiatrist seeking his advice and direction.
Comment by Investigation Team To have contacted the consultant psychiatrist was a reasonable course of action. However in the presenting circumstances, proactive contact between the MHSU's wife's AOT and the SWC CMHT would have been prudent, as would an attempted home visit by one of the MHSU's mental health professionals, since he had not had any contact with the service since 6 July 2005 and this contact had been by telephone. The purpose of proactive communication with the City AOT would have been to i) agree a joint strategy for assisting the MHSU and his wife, ii) to agree a strategy for achieving a mental health assessment of the MHSU and iii) to ensure that both the City AOT and SWC CMHT had an accurate understanding of what was happening with both service users given their living circumstances and that they had a young baby at home.	
8 August 2005	SWC CMHT received further information about the MHSU. His wife contacted them to advise of his behaviour over the previous weekend. He was reported to be smoking cannabis, not taking his medications and to have left their flat naked and gone driving in their car. He was also reported to be acting in a paranoid way. The MHSU's wife told CC2 that she had contacted their GP and that as a result a home visit had occurred and the MHSU had been administered diazepam. On 8 August the MHSU's father had also taken him back to the GP and a prescription of olanzapine had been provided. The clinical records note therefore that the MHSU had recommenced olanzapine.
9 August 2005	The MHSU's mental health professionals attempted to meet with the MHSU at home. However, he was not at home. CC2 and SW1 waited for 45 minutes but he did not return. The plan was to return to the MHSU's home on 10 August.

Date	Nature of contact
10 August 2005	A successful home visit occurred. The MHSU was noted to be "flat in his presentation with some irritability and at times presented as quite paranoid". The MHSU was also speaking of his invention "a tape measure plans of which were in the back of his car and it was going to make him a millionaire". Following liaison with the senior nurse for SWC CMHT, a referral was made to the CHRT and an up to date care plan faxed to them. The consultant psychiatrist (CP2) was also informed. Further contact with CP2 occurred on 12 August when a home visit was planned. In the event, the MHSU's wife contacted SWC CMHT to advise that this was no longer required.
Comment by Investigation Team 8 -10 August: it is the opinion of the IIT that the contacts and actions of the MHSU's mental health professionals were appropriate. It is notable that the CHRT was already aware of the MHSU when SW1 contacted it, as the MHSU's wife's care team had already notified the CHRT of the home situation and the MHSU's behaviour. Although the MHSU's wife did not subsequently believe that a home visit was necessary, the IIT considers that more assertive follow up by CC2, via liaison with the MHSU's GP, community pharmacist, parents and so on may have been sensible as the MHSU was largely an unknown service user to CC2 at this time. 12 August 2005: the planned domiciliary visit with CP2 was very appropriate in view of the MHSU's non-availability for assessment when the CHRT visited, as were the joint communications and working with the City AOT.	
15 – 18 August 2005	There was attempted telephone contact with the MHSU following a report from his wife that he stopped his car in the middle of the road enroute to taking her and their son to nursery.
19 August 2005	A joint visit to assess the MHSU was conducted by SW1 and SW2. The MHSU was noted to be more settled and less agitated. He agreed to consider asking his mother to look after his son if he and his wife needed a break. He also revealed that he had been offered a job at a reasonable hourly rate. The MHSU's wife was also noted to have confirmed that things were better at home. The assessing professionals noted that they had no concerns about the MHSU's mental state.
Date	**Nature of contact**
15 September 2005	The MHSU attended for his OPA with CP1. His mental state was noted to be relatively stable. CP1 was noted to have no concerns providing that the MHSU remains in contact with the

	service.
16 September 2005 – 26 March 2006	There was no contact with the MHSU.

Comment by Investigation Team

Between early August to mid-August 2005 the MHSU had experienced an unsettled period with erratic and irritable behaviour. His mental state had appeared to settle by 19 August, and this was confirmed by CP1 on 15 September at his outpatient appointment, where CP1 noted that he had "no concerns providing that the MHSU remains in contact with the services".

There then followed a period of six months where the MHSU had no real contact with the services at all. (His next face-to-face contact was in May 2006, a period of eight months). In March his contact with CC2 was on a telephone basis only. One of the telephone contacts was made by the MHSU's wife on 27 March and the other by the MHSU on 8 May when he left a message for CC2 to make contact, and again on 15 May advising CC2 that his wife was not well.

Reflecting on the lack of contact with this MHSU, the IIT again questions why he was not discharged from the CMHT caseload in 2005. The social work records of 4 November 2005 show that he had been discharged from the social work caseload because he did not require any social work input at that time.

The IIT tried to find out why the MHSU was not discharged from the care coordinator's case load back to the care of his general practitioner (GP). All interviewees advised that they used a system of open contact so that when a service user known to relapse periodically does so, he or she can re-access the service without having to go through the new referral route. The only professional who did not say this was the team leader for SWC CMHT[7] who advised that there was "no such thing as open contact".

[7] This was the CMHT to which CC2 was attached.

Date	Nature of contact
Comment by Investigation Team (continued) Discussions with a range of staff suggests that the usage of open contact was not unique to this case, furthermore it is inconceivable that the team leader could not have been aware of this, especially as CC2 inherited the MHSU on open contact. This MHSU remained on the SWC CMHT caseload without any planned contacts between September 2005 through to May 2006. He remained subject to the Trust's CPA policy which required six monthly reviews, but these did not happen from the end of 2005 through to January 2007. It is the perspective of the IIT that the community mental health professionals working for LPT, and the managers of community services, need to reflect on the unquantified risks and responsibilities they are carrying when a service user is on open contact. It is insufficient for these professionals to cite continuity of care as a reason for not discharging a service user appropriately, especially when there are effective procedures in place to effect a safe transfer of care.	
27 March 2006	The SWC CMHT was contacted by the MHSU's wife. She expressed concerns regarding the medication compliance of her husband. It was also noted that he had increased his usage of cannabis again.CC2 was informed that the MHSU had crashed his car and that he "wasn't pleasant". CC2 advised the MHSU's wife that she would make an outpatient appointment for him. CC2 also offered a home visit. CC2 was advised by the MHSU's wife that although not well the MHSU continued to work full-time, a home visit would therefore be difficult An OPA was made for 30 September. The MHSU's wife was advised of the date.
8 May 2006	The next contact information about the MHSU was generated when he made contact with SWC CMHT asking that CC2 make contact with him. Return calls were made on 8, 9 and 10 May but with no response elicited.
15 May 2006	The MHSU made contact with CC2 and advised that "things are not going so well". He reported being compliant with his medication but that he was smoking cannabis. He also revealed that his wife was unwell at this time.

Date	Nature of contact
15 May cont....	The City AOT notes confirm that the MHSU's wife was not well and that on 23 May she was admitted to an acute psychiatric in-patient ward. CC2 advised the MHSU that she would visit at home on 17 May at 13.00hrs. This had to be rearranged for the 23 May.
23 May 2006	The home visit occurred. The MHSU was noted to be agitated and friction was noted between him and his wife. It was also noted that "his thought content was slightly distorted". The MHSU told CC2 that he had money problems that needed sorting out. SW2 was advised of the re-emergence of the MHSU's social care needs. SW2 undertook to inform the City AOT of his and CC2's concerns regarding the MHSU's wife. There were no concerns for the MHSU's son at this time. The outcome of the visit was that an OPA was made for the MHSU the following week (1 June 2006). CC2 and SW2 also arranged with the MHSU to visit him on 30 May. This was good practice.
30 May – 5 June 2006	CC2 contacted the MHSU's parents to ascertain his whereabouts. She was informed by the MHSU's father that the MHSU and his son were staying with him and his wife. The MHSU's father reported no major concerns. The MHSU's father was advised about his son's OPA on Thursday. He said that he would take his son to this. The next contact from the MHSU's parents was from his mother on 2 June. She advised CC2 that the MHSU wanted to make a further appointment to address his financial issues. The MHSU's mother was advised that SW2 would make contact with her or her son about this. SW2 did this on the same day.
6 June 2006	SW2 attended at the MHSU's home. SW2's records state that the MHSU "appeared well". As a consequence of the home visit SW2 requested an application for housing benefit for the MHSU, who said he would be able to complete this himself. SW2 also made contact with the ward caring for the MHSU's wife, and asked them to refer her to the in-reach team so that her benefits could also be sorted out. This was good practice.

Date	Nature of contact
3 July 2006	The MHSU was admitted to an acute psychiatric inpatient ward for five weeks. He was an informal patient for this time. On admission the MHSU was clearly thought-disordered, looking unkempt and his concentration was poor. He was taken to hospital by his brother and his father. Following admission the MHSU's mother made contact with her son's mental health professionals to advise that she had found her son's flat "in a state". There were burnt photos, "he had placed loads of stuff in the bath" and there were also "pots in the washing machine".
7 July - 14 July 2006	CC2 and SW2 made two joint visits to see the MHSU on the ward. He was noticeably improved by 15 July and wanting to be discharged. CC2 and SW2 advised him that he needed to remain in hospital longer and he did so.
11 August 2006	The MHSU was discharged back into the community.
24 August 2006	A home visit was attempted by the MHSU's mental health professionals. The MHSU was not in. A note was left for him.
25 August 2006	The MHSU made telephone contact with his mental health team.

Comment by Investigation Team

The contact and communications between the MHSU's care team, the MHSU's family and the MHSU were very reasonable. The mental health professionals were responsive to information provided to them by the MHSU's parents and by the professionals working in Social Services in relation to child support . SW2 was also appropriately attentive to the MHSU's social care needs. On 30 June the MHSU was given fair advice when he informed his care coordinator that he did not want to go back home having fallen out with his wife.

Furthermore when the MHSU was an inpatient between 3 July and 11 August, CC2 and SW2 made a number of visits to meet with him. This represents very good practice.

The only omission over this period was the lack of a seven-day discharge visit. LPT's "Care Programme Approach (CPA) Policy and Practice" document 2003 states, in section 9 "Reviews" 19.9 page 16:

Comment by Investigation Team (continued)
"At the pre-discharge review the professional who will be visiting within 7 days post discharge (for those service users who meet the criteria) must be identified, with their knowledge and consent." The policy also states at 9.17 that: "Service users who discharge themselves against medical advice should be followed up no later than 7 days post discharge". In this case the MHSU self-discharged on 11 August. On notification of this SWC CMHT should have ensured that the seven-day visit occurred[8].

The expectations of the Trust policy are underpinned by the Primary Care Trust's local delivery plans for financial year 2006/7, which stated that the "percentage of people on enhanced CPA receiving follow-up (by phone or face-to-face) within 7 days of discharge from hospital – 100%"[9] There has been no reasonable explanation for the lack of seven-day follow up for this MHSU on this occasion. One influencing factor may have been that the MHSU self discharged on a Friday evening after 7pm. The CHRT was notified but advised that they could not follow him up because he had self-discharged. Information sought from the team leader for the city CRHT revealed "we do not offer 7 day follow up as routine. This is not within the remit of CRHTs. It happens by default when we accept a patient for early discharge but this is a planned assessment with everyone, including the patient,in agreement. We would visit the next day thereby fulfilling the 7 day follow up. We do not offer to do this with all discharges as it is the responsibility of the CMHTs" to undertake this activity.

Date	Nature of contact
30 August -21 November 2006	The MHSU was placed on open contact.
5 September 2006	The MHSU left a message for SW2 advising that he had received a letter from the housing association saying he was going to be evicted because of rent arrears. He was to phone again to speak with SW2 at 9.15am on Wednesday.
6 November	CP1 left a message for CC2 and a message for SW2 to advise that he could see no contact with the MHSU since his last discharge. He was querying whether CC2 or SW2 had seen him.
13	Child and family services left a message for SW2 asking for an

[8] The 2006 audit of seven day discharge visits showed that missed visits very extremely rare and once full validation via case notes review had occurred there was only one occasion in 2006 where a seven day visit did not occur in the Directorate of Working Age Adults.
[9] "7-DFUP Guidance on 7 Day Follow-up procedures and practice". Care Services Partnership National Institute for Mental Health in England, August 2006. The figure of 100% refers to what is expected not what was achieved.

November 2006	update on the MHSU. Full contact details for the relevant social worker were noted.

Comment by Investigation Team

Following a telephone call from the MHSU to his care team on 30 August advising that he was again working full-time, and that he would not be able to meet with the team, he was again placed on "open contact".

Although the IIT appreciates that some service users can be challenging to maintain contact with, we do not feel that open contact was appropriate at this time. The MHSU had only recently been discharged from in-patient services. The IIT accepts that it was unlikely that the MHSU would relapse within a short period of time; the IIT also accepts that the social support network for the MHSU was very good, especially with regard to parental support. Nevertheless it is our opinion that a more assertive approach should have been taken with the MHSU at this time. For example although a CMHT usually provides a Monday to Friday 9am – 5.30pm service the MHSU could have attended the in-patient unit for assessment, or the CHRT could have been asked to undertake home assessments over agreed weekends. Even if the contact period was agreed for once every three to four weeks this would have been far preferable to open contact.

Date	Nature of contact
21 November 2006	The MHSU's father made contact with SWC CMHT advising that his son had lost his job. Furthermore his parents did not believe that he was taking his medication. The MHSU's father was advised by SW2 that he and the care coordinator would make contact with the MHSU and make arrangements to see him. SW2 also advised the MHSU's father to re-contact him if he had any further concerns about his son.
28 November 2006	SW2 and CC2 attended at the MHSU's flat but he was not in. It was not possible to leave a note as the access door was shut.
1 December 2006 (a Friday)	The MHSU's mother made contact with SWC CMHT raising further concerns about her son's mental health state. She was advised about their attempted visit to see him. The MHSU's mother advised that he had been at her home. It was agreed that SW2 and CC2 would visit her son on 5 December.

Date	Nature of contact
5 December 2006	The MHSU was seen at home by CC2 and SW2. He was noted to be thought-disordered and unkempt in his appearance. He was talking a lot about electrical matters and "the idea" that had been stolen from him. The MHSU was advised to restart his medication and he was also advised that SW2 and CC2 would visit him again that week.
7 December 2006	On 6 December SW2 discussed the MHSU's presentation with CP1. Consequently SW2, CC2 and the specialist registrar (SpR) to CP1 visited the MHSU at home. The MHSU remained thought-disordered and was unable to give an account of what had been happening for him over the past few days. He remained pre-occupied with his invention. The MHSU was offered admission to hospital which he declined. He did however agree to work with the CHRT and to take his medication. The CHRT "agreed to take the MHSU on". The SpR also wrote a prescription for him. The CHRT advised that it would try and make contact with the MHSU later that same day.
8 December 2006	The CHRT made contact with SWC CMHT to advise that the MHSU was not in when team members attended at his home on 7 December. They advised that they would make another visit that day, and if he was not there they would take his medication to his parents as suggested by SW2. SW2 was going to make contact with the MHSU's mother to advise her of the plan, which he did. On this same day CC2 liaised with SW2 regarding arranging a Mental Health Act assessment for the MHSU if he did not engage with the CHRT. CC2 was to be on annual leave the following week. The CHRT did make successful contact with the MHSU and he accepted his medication. He then told the CHRT to "fuck off". Therefore it was not able to engage him or assess him[10].

[10] Although CHRT staff are trained to manage more difficult to engage service users, they do not have right of access to someone's home. Neither do they have the right to force a service user to have an assessment. In the absence of any identifiable risk of harm to self or others at this time, an appropriate action for the CHRT would have been to refer the MHSU back to his 'home team'.

Date	Nature of contact
11 December 2006	The case management for the MHSU was passed back to SW2 from the CHRT. Case management was discussed with the SpR. The resulting plan was to i) phone the MHSU's local pharmacy to find out if had collected his prescription and ii) to attend at his home on 14 December with the MHSU's GP, to assess him under the Mental Health Act with a view to admission to hospital.
12 December	SW2 contacted the pharmacy; the MHSU had not collected his medication. The SpR was advised. The need for a Mental Health Act assessment was therefore confirmed. On this same day the MHSU's mother contacted SW2. The MHSU had attended at their home and was, she reported, "kicking off". His father asked him to leave and he did. The MHSU then tried to smash up his father's car. The MHSU's parents told SW2 that they believed that their son needed to be in hospital. They were advised of the plan for a MHA assessment in two days' time. The MHSU's father was also advised to call the police if his son turned up at their house again. This was important both for their welfare and the welfare of their son.
14 December 2006	The MHSU was detained in hospital under the Mental Health Act.

Comment by Investigation Team

By and large the contacts over this period of time were reasonable. The care coordinator and SW2 communicated appropriately with the MHSU's consultant psychiatrists and worked effectively with the SpR to CP1, attending to undertake a home assessment and having a clear plan of action following this. To have tried to manage the MHSU in the community with the support of the CHRT was a reasonable course of action. When it was clear that the MHSU was not going to engage with this, contrary to his initial agreement to do so, the plan was escalated to conduct a Mental Health Act assessment. The aspect of this episode that could have been managed better was the information provided to the MHSU's parents. They did not feel that their concerns regarding their son had been listened to; when they told SW2 on 12 December that they believed that their son needed to be in hospital. However what had not been explained to them was the benefit of undertaking the MHA with a team of professionals known to their son. To have conducted the assessment on 12 December would have meant using professionals unknown to their son. On balance the mental health professionals believed that to wait until 14 December was preferable for him. The IIT has discussed this with the MHSU's parents and they can now appreciate the short delay in undertaking the assessment.

The IIT believes that the decision by the mental health professionals to delay the MHA until 14 December was reasonable. It is generally considered preferable that where possible professionals known to a service user should undertake the MHA. It is possibly less stressful for the service user, and also the professionals have a much greater insight as to the service user's presentation when well and at the various stages of relapse.
Although SW2 did advise the MHSU's parents of the actions to take if he were to re-attend at their home, and the family also had all of the emergency contact numbers should the situation deteriorate further requiring an urgent MHA assessment rather than a planned one, it would have assisted them greatly to have understood better the rationale for the delay.

Date	Nature of contact
25 January 2007	The MHSU was discharged from hospital.
31 January 2007	The MHSU was assessed at home within seven days of discharge. He was noted to be mentally well. It was also noted that he had rent arrears and was due in Court about this on 6 February. A check was made on his medication and it appeared that the MHSU was taking it.
4 February 2007	The MHSU was readmitted to hospital on an informal basis. All the indications were that his psychosis at this time was directly linked to the cannabis he was smoking. (The indications were the speed of his relapse and the speed of his subsequent recovery).
9 February 2007	The MHSU went on leave from the in-patient ward on 8 February but did not return as planned because it had snowed. Consequently he returned to the ward on 9 February. He was then discharged home the same day.

Comment by Investigation Team
Initially the IIT was concerned at the very short period of time for which the MHSU had been admitted prior to discharge on 9 February. However, having interviewed the SpR who discharged him on 9 February and the MHSU's consultant psychiatrist, CC2 and SW2 we are satisfied that this admission was precipitated by cannabis usage rather than by deterioration in his mental health. The speed of his recovery following admission also suggests that medication non-compliance was not an issue on this occasion.

Date	Nature of contact
15 Feb – 27 March 2007	Attempts were made to meet with the MHSU at home on six occasions. On four of these face-to-face contact with the MHSU occurred. The only date of note was 8 March. This was one of the occasions that the MHSU was not in when his care team visited. The windows of his flat were boarded up. The MHSU's mother advised that her son had lost his keys and tried to gain access to his flat with a crowbar, and when this failed he had smashed his windows to get in. That was the explanation he had provided to her. The MHSU's mother also advised the mental health professionals that she was concerned about her son's personal hygiene. She also advised that she had provided her son with money to buy food as he had none. Following this information exchange contact was made with the local housing association, the City AOT and the police by SW2. 9 March: The MHSU's mother advised that she had spoken with her son and asked him to contact SWC CMHT. 12 March: Concerns about the MHSU were highlighted at the SWC CMHT multidisciplinary team meeting. The plan made was for another home visit that day. This was attempted but not successful as the MHSU was not in.
15 March 2007	The MHSU's mother again made contact and advised that she had seen her son on 10 March and he had been twitching, talking incoherently and also mentioned something about killing himself. He also told his mother that "the voices" had told him to smash the windows in his flat. He stayed with his parents overnight and then left returning on the Tuesday asking for money. He was agitated and mumbling to himself. The MHSU's mother also provided CC2 and SW2 with the new contact numbers for her son. SW2 ensured that the MHSU's mother had the contact numbers for CHRT and the EDT. SW2 attempted to contact the MHSU on his new telephone numbers. There was no response so messages were left for him. The CHRT was also contacted and requested to place the MHSU on alert for assessment and admission. The inpatient ward was also alerted.

Date	Nature of contact
16 March 2007	The MHSU was at home when SW2 and CC2 attended. He was noted to present with some “odd thought content” but to be pleasant in his manner. The MHSU also reported compliance with his medication and took medication in the presence of SW2 and CC2. SW2 stayed with the MHSU and escorted him into town to address his social needs. They also collected supplies of his medication while they were out.
19 March 2007	The MHSU was again visited at home and was noted to be mentally well. He was asked why he did not answer the phone when the CHRT called over the weekend. No answer was forthcoming. He again took medication in front of his care team.
27 March 20072007	The MHSU received a home visit from his care team. Again he was noted to be mentally well.
11 April – 24 June 2007	There were five attempts to meet with the MHSU at home. On four of these occasions face-to-face contact occurred. There was also contact from the MHSU’s mother on 16 April advising that her son “seemed well”. She also reported that he took his medication when she gave it to him. There were no observed or reported concerns over this period.
Comment by Investigation Team The care and management of the MHSU was reasonable between 15 February and 24 June 2007.	
26 and 27 June 2007	There were two attempts to meet with, and assess, the MHSU at home following an incident where he left his son on the ward where his wife was an inpatient, following an argument with her on 25 June. Essentially the MHSU abandoned his son on the ward. SW2 made contact with the MHSU’s mother to elicit information but she had not seen, or had contact with, her son. A “safe and well check” was made by the police on 29 June following his mother reporting him missing. He was found at home, “safe and well”.
29 June 2007	SW2 attended at the MHSU’s flat. He was not in. Information about the incident was fed back at the SWC CMHT meeting.

Date	Nature of contact
2 July 2007	SW2 attended at the home of the MHSU. It transpired that he was rather embarrassed about his behaviour following his row with his wife on 25 June. That was why he had not gone home. The MHSU was advised to make contact with the Child Care Worker at social servcies as it was important. The records note that the MHSU had collected his medication but that it did not appear as though he was taking it regularly because not enough tablets were missing.
6 July 2007	SW2 made a home visit to meet the MHSU. He appeared well but did not want to discuss the incident with his son. Neither had he made contact with his mother or the Child Care Worker. An arrangement was made to meet with him again in a week.
11 July 2009	The MHSU was not at home when SW2 attended for their meeting.
25 July 2007	The MHSU was at home when SW2 and his care coordinator attended. He appeared to be well. When asked why he had not attended the child care meeting on 20 July, he said he had forgotten. Mentally he was noted to be well. He also stated that he was taking his medication.

Comment by Investigation Team

The abandonment of the MHSU's son on an in-patient ward was very concerning. The MHSU's social worker responded appropriately to the level of concern and made concerted attempts to meet with him so that he could ascertain whether the MHSU was unwell. This perseverance paid off with a successful contact on 2 July. The plan to meet with the MHSU in one week's time following this contact was also reasonable.

The IIT suggests that in light of the unpredictability of the MHSU, and the rashness of his abandonment of his child in June, it may have been prudent to have made contact with the MSHU's mother when he was not available for the planned contact on 11 June. Provision could also have been made for further face-to-face, or telephone, follow up within a further seven days. However, the IIT understands that the expectation of SWC CMHT was that the MHSU was to attend a family meeting on 20 July where one of his care team would be in attendance. In light of this, not arranging further face-to-face contact in advance of the meeting planned for 25 July was not unreasonable.

Date	Nature of contact
1 August 2007	SW2 visited the MHSU at home. He was advised of the planned visit with the Child Care Worker on 8 August. The MHSU revealed that he had been to his parents over the weekend to see his son and it went OK. He was noted to be mentally well but not doing much other than lounging around the house.
8 August 2007	SW2 and the Child Care Worker attended at the MHSU's flat. There was no answer. It was noted by SW2 that he was not sure whether the MHSU was in or not as the windows were ajar. This was unusual for the MHSU who was notably security conscious. The Child Care Worker gave SW2 the contract for the MHSU to sign at a later date. SW2 made a telephone call to the MHSU's mother. She advised that she had seen her son over the weekend and that he was OK. She advised that her son had not mentioned the planned visit with SW2 and that she thought he (her son) might be being avoidant. She agreed to ask her son to contact SW2.
15 August 2007	The MHSU's care coordinator and social worker attended the MHSU's flat for a pre-scheduled visit between 11.30am and 12pm. He was not in. His flat was noted to be "trashed". SW2 called the MHSU's mother and also the in-patient ward where his wife was an inpatient. to advise them that he and CC2 were concerned about the MHSU's mental state. A plan was also made to make contact with the AOT responsible for the community management of the MHSU's wife. This was the last home visit attempt made as the MHSU was arrested on 17 August on suspicion of murder.
Comment by Investigation Team The contact and attempted contact by the MHSU's care team with him in August was reasonable. When he was not available as planned on 8 August information was sought from his mother. There was nothing in the information exchange between the mother and the mental health professionals that suggested in any way that the MHSU was relapsing, or behaving oddly. The MHSU's non-availability on 8 August is not wholly surprising given his embarrassment about his previous unacceptable behaviour in relation to his son.	

Comment by the Investigation Team (continued)
SW2 and CC2 correctly raised the MHSU's situation at their team meeting on 13 August and the resulting plan was that they would go again to visit him on 15 August with the dominant purpose of getting him to sign the behavioural contract provided by the Child Care Worker. The attending professionals were not expecting to find the MHSU's flat in the state that it was. (For detailed analysis of the appropriateness of actions taken by the professionals after their arrival at the MHSU's flat please go to section 4.5, page 74).

Overall comment by the Investigation Team
On the whole the contacts the mental health professionals had with the MHSU were of a reasonable standard. Furthermore there is good evidence from July 2006 showing that the team proactively sought information from his parents if he was not available as planned. Similarly the MHSU's parents contacted the SWC CMHT if they were concerned. The MHSU's contact with the SWC CMHT was however punctuated with a number of periods of "open contact".

On the subject of open contact the IIT has a firm viewpoint. This is, if a service user is well enough to receive no care or contact from the mental health team assigned to him or her, and is well enough to be working, then the service user is well enough to be discharged from the CMHT case load with a clearly documented and agreed plan for how they can re-engage should they become ill again. If a service user is kept dormant on a caseload the mental health team have continuing responsibility for the individual. Furthermore it means that other individuals requiring the input from community mental health services may be denied this because caseloads are full. The use of open contact does not constitute good or safe practice.

In 2004 the MHSU moved in with his wife in the east of Leicester. When this happened he moved out of the geographical catchment area for SWC CMHT. Following the planned initial time-limited period of open contact of one to three months, when it became clear that the MHSU was not going to be having any meaningful contact with SWC CMHT, arrangements to transfer him to a CMHT in the east of the city, or to discharge him in the normal way should have been made.

The impact of maintaining the MHSU on the SWC CMHT caseload was:

- It was difficult for his care team to make more than one attempt to meet with him during the day if he was not at home for the scheduled contact. The MHSU's home was approximately a 25 minute drive each way from the SWC CMHT base.
- There was no opportunity for the care team to "bump into" the MHSU during the process of visiting other service users in the area.
- There was no opportunity for informal intelligence. It is not uncommon for service users to know of each other and to provide

information on an informal basis to the mental health professionals. For example :“ Jane, have you seen Janet recently?”, “ Yes, I saw her in the corner shop on Friday, she was looking well.” Or “Yes. She’s not looking so good.”

Although the above are not expected components of a reasonable care package, such ad hoc meetings and information gathering can enable mental health professionals working in the community to “keep tabs” on service users such as this MHSU. That is, those service users who are not unwilling to engage with mental health services but whose lifestyle means that often they will not be available for pre-arranged meetings.

Although one cannot say that the distances concerned caused significant impediment to the care delivered to the MHSU, both CC2 and SW2 advised that there were times where they would ordinarily have made more than one attempt in a day to make contact. This just was not possible for this MHSU. They had other service users on their case loads that also needed their time. The day when this is of most significance was 15 August 2007.

The IIT enquired as to why the MHSU had not been transferred to a team in the east of the city. The consistent message received from all interviewees was that CP1 did not like to transfer his patients. This consultant was challenged on this point and he refuted this, saying that transfer of the MHSU was on his mind in 2007, and he was planning for it at the CPA review after the one in June 2007. The IIT, with the benefit of having retrospectively reviewed the MHSU’s clinical records, suggests there were a number of earlier periods where transfer could have been safely undertaken following the MHSU’s move to the east side of the city in 2004.

LPT’s “Care Programme Approach Policy and Practice” document does address the issue of transferring a service user “between services”. The policy document is a little ambiguous as it does not make explicit that the principles espoused apply to transfers between teams within the same service, and also between care coordinators within the same teams. Unfortunately the “CMHT Operational Policy for Adult Services” contains little in it that constitutes an operational policy. This is disappointing, as in January 2005 following a serious incident investigation, the Trust was recommended to develop an operational policy for CMHTs across adult services that addressed and contained:

- clear definition of the clinical and managerial leadership;
- clear definition of the roles and responsibilities of individual team members (to include clarity of differentiation between the grades of community psychiatric nurses);
- case load allocation and case mix (e.g. 70% on enhanced CPA, 30% on standard CPA);
- collective CMHT caseload size, and the maximum case load for each member type;

- CMHTs' relationship with general practitioners (e.g. on a quarterly basis one or more of the CMHT members will meet with the GP practice to look at issues of concern, referral patterns etc); and
- systems for preceptorship and induction of new staff (to include how different grades of staff are managed and supported).

The IIT suggests that before the current draft operational policy document is ratified that the authors reflect on the above and also ensure that caseload management is referred to.

4.1.4 Medicines management

The medicines management for the MHSU was reasonable. He was prescribed olanzapine[11] which was an appropriate choice of medication for his diagnosis.

The following represents the range of activities undertaken by the MHSU's care team to determine whether or not the MHSU was medication compliant.

- The usage of "dosette" boxes. These were introduced in November 2003. They enabled the care coordinator or social worker visiting the MHSU at home to check and see if he was taking his tablets. It was relatively easy to see if the MHSU was missing continuous or sporadic doses of his medication because the boxes had dated compartments for tablets.
- Working in partnership with the MHSU's parents and his wife so that the community mental health team could be alerted if either thought that he was non-compliant. There are a number of entries in the MHSU's clinical records between 2002 and 2007, and in his wife's records, that show that his parents and wife did advise one of his mental health professionals if they believed him to be medication non-compliant.
- Engaging the support of the MHSU's parents and his wife. In 2006 supplies of medication were taken to the MHSU's parents and also to his wife's flat. The purpose of doing this was that both parties could give the MHSU his tablets if they suspected that he was not taking his medication regularly. This was a sensible and pragmatic plan. The IIT knows from the MHSU's parents that they did ask him to take his tablets if he was in their house when they had doubts about compliance. His parents advised that usually he would take his medication if it was offered to him.
- Asking the MHSU directly about his medicines. There is sufficient information in the clinical records coupled with the information from the MHSU's family to suggest that the MHSU would generally be honest about whether or not he was taking his medications. Furthermore the clinical records also show occasions where the MHSU would proactively contact his care team when becoming unwell due to medication non-compliance.
- Obtaining relevant prescriptions for the MHSU and going with him to the pharmacy to collect the medication if he did not do this himself.
- Working flexibly with the MHSU. In July 2006 the MHSU said that the main reason for stopping his medication was that it made it difficult for him to get up for work in the mornings. He normally took his

[11] Olanzapine is an antipsychotic drug.

medication at night. To try and combat this, SW2 advised him to take his medication earlier in the evening, so that this side effect would have worn off by time he got up for work in the morning.

In addition to the above the MHSU's care coordinator (CC2) told the IIT that she tried to enhance the MHSU's understanding about his medication and the linkage between medication compliance and being well. At interview she reflected that although the MHSU "had a level of understanding about how his medication kept him well and that they kept his thoughts away", she was not sure how much he really understood. CC2 also told the IIT that she tried to do reflective work with the MHSU but that he would still find it difficult to associate ill health and his thoughts pre-medication to his better thoughts with medication. She was not sure he ever really saw the link.

His social worker revealed the MHSU to be reasonably reliable with his medication. When asked, SW2 reported that the MHSU would admit to missing doses if this was the case. When SW2 was asked about the frequency of missed doses he told the IIT that he thought the MHSU would miss a couple of doses over a period of a couple of weeks. His overall impression was that the MHSU was not against taking his medication per se.

If the MHSU did miss doses of his medication, SW2 advised the IIT that there would be early signs of this. The quality of the MHSU's sleep would suffer and there might be indications of self neglect. If he missed more than a couple of doses he would begin to mention his "invention". Generally the experience of SW2 was that the MHSU would gradually deteriorate over a period of weeks when medication non-compliant. He did not tend to decline quickly. This perspective is shared by his family and other members of his care team. (The exception to this was February 2007 where all believed his admission to hospital was precipitated by excessive cannabis use.)

CC2 said that if one had contact with the MHSU when he was starting to talk about his invention a full relapse could be avoided if he was re-medicated in the community. Her experience was that they could get him stable and reasonably well again quite quickly. However if this was not possible hospital treatment was required more often than not.
All of the MHSU's care team said that when unwell he lost sight of the benefits of his medication, and therefore the level of non-compliance with medication would be exacerbated. The MHSU, it is reported, would assign responsibility for his ill health to other things such as stress, or his wife. He would not attribute the fact that he was not taking his medication to a decline in his mental health. Neither would he attribute his health decline to an increase in alcohol consumption or to his cannabis usage.

Comment by Investigation Team
The only omission the IIT found in the MHSU's medicines management was in relation to the use or non-use of depot medication. There is no evidence in the clinical records that the team considered the benefit of depot medication for

the MHSU. Furthermore the interviews with his consultant psychiatrist, CC2 and SW2 did not convince the IIT that there had been discussions about this that had not been recorded.

There should have been a formal discussion with the MHSU about the benefit to him of having his anti-psychotic medication via depot injection, and the optimal time for this was following his admission in July or December 2007. Prior to these admissions that MHSU had managed to live in the community without relapse since 2004.

That depot medication should have been formally considered does not mean that the MHSU would have accepted this, or that he would have complied with its use on a medium to long term basis if it had been accepted. Based on the information with the IIT has been provided from:

- the MHSU's family,
- his consultant psychiatrist,
- his care coordinator and social worker, and
- staff working on the acute adult psychiatric in-patient ward where the MHSU was cared for,

the IIT does not believe that the MHSU would have agreed to have depot medication. Furthermore his pattern of going back to work when well and not wanting, or needing, to meet with the CMHT means that any agreement to accept depot would in all likelihood have been short lived. The MHSU's parents agree with the assessment of the IIT.

It is also important to note that even if the MHSU's care team believed that depot would have been the correct medication route for him, they would not have been able to enforce this in the community. Even with the introduction of supervised community treatment in November 2008, a community treatment order (CTO) would not have given mental health staff the power to forcibly medicate in the community. However for individuals such as this MHSU a CTO may now provide more inducement for medication and treatment compliance. (see glossary page 124 for an explanation of CTOs).

Apart from having formally discussed the merits of depot medication it is difficult to see how his care team could have managed his medication differently. The mental health professionals undertook all of the activities one would usually expect and also had the consistent support of the MHSU's family in maximising the opportunities for him to be given medication. The IIT believes that the strategy of keeping a supply of medication at the MHSU's parents and also at his wife's flat was a very good one. It is a good example of collaborative working between the MHSU, his family and mental health services.

4.1.5 The management of the MHSU's substance misuse

The MHSU was a regular user of cannabis, admitting to spending between £20.00 and £40.00 per week on it. This suggests that he was a moderate to heavy user of this substance. The information provided by his parents, SW2 and CC2 suggests that when he was well, and in full time work, his usage was reduced. However, when out of work his usage increased. SW2 advised the IIT that there was a marked increase in the frequency of his cannabis usage following his separation from his wife. The MHSU took his marital and fatherly duties seriously and these gave him a measure of stability and focus. The removal of these from the day-to-day aspect of his life left a vacuum that he seemed to fill in part with cannabis when not working. SW2 and CC2 also advised the IIT that it was sometimes difficult to determine what was at the root of the MHSU's issues, his schizophrenia or his cannabis use.

The IIT's discussions with the in-patient staff who knew the MHSU suggests that staff were divided on which was the dominant problem for this MHSU.

The question for the IIT was, were the measures taken by his care team to assist the MHSU in addressing his illicit substance misuse reasonable? In exploring this, the IIT is very mindful that it is almost impossible to work effectively with an individual with a substance misuse problem if they are not prepared to accept that the substance misuse makes their life unmanageable. Unfortunately this was the position for this MHSU. Even when there is such acceptance, sometimes the compulsion to use that substance continues to be overwhelming for the individual.

When asked about the MHSU's cannabis usage, CC2 told the IIT that it was his vice and that he struggled to see the connection between cannabis and any instability in his mental health. It was her impression that when he was medication compliant he did not use cannabis very much, but when non-compliant and becoming unwell he would use cannabis to "self-medicate". Her experience of his cannabis usage was that he was not a particularly heavy user, however she could tell the difference when he was using and not using. When he was not using he was much more coherent. He was essentially an intelligent man who could and wanted to work. However when he was using cannabis "it was difficult for him to put two sentences together". It was also difficult to have a rational conversation with him as his perspective of reality when using cannabis was quite different to her sense of reality or that of SW2. She described his thinking as "way off base". The perspective of the CC2 is shared by SW2. This individual found it notable that when the MHSU had the responsibility of caring for his son that he did put his child first and did not smoke cannabis around him. This showed that he did have awareness about the effects of the drug.

With regard to the efforts made to help the MHSU gain a perspective of the harm cannabis was doing to him, CC2 tried to take a holistic and educational approach. She also tried to encourage the MHSU to behave differently to

achieve harm minimisation. For example she encouraged him to have a shandy instead of a beer, and to have a cigarette instead of a joint. In light of his unwillingness to accept that he had a problem, her strategy with him could not focus purely on ceasing to use cannabis. Furthermore because the MSHU did not accept that his cannabis use was problematic, any strategy was unlikely to have any measure of success.

CC2 was asked if the MHSU was ever referred to the drug and alcohol services. She advised the IIT that he was not. The reasons for this were that i) the statutory drug services are mainly focused on users of class A drugs such as heroin and cocaine and ii) that the MHSU did not want to participate in any activity aimed at reducing his drug usage. This included opportunities with the statutory and non-statutory agencies.

The IIT also asked staff working in inpatient services what approach they took to encourage and enable service users to address their illicit drug habits. The response was very similar to that of CC2. The predominant approach was health promotion. The then acting ward manager (AWM) recalled that because the MHSU continued to smoke cannabis, they tried to advise him on the different strengths of the drug and how to reduce his risks. This staff member does not believe that the MHSU ever had any commitment to changing his habits and believed that he brought cannabis onto the ward on more than one occasion. Ideally they should have undertaken urine screening for drugs but this MHSU would get angry when challenged so achieving this was difficult. On the occasion they did succeed the drug screen came back as negative. It was the AWM recalls, difficult to prove his drug usage on the ward. Room searches, as far as she can recall, did not result in the location of cannabis. However, the AWM advised that there were many places where a service user could “hide a stash”. As to his motivation for smoking cannabis, it was her perspective that it was a social habit he had picked up.

CP1 told the IIT that cannabis use for the MHSU was very damaging. He said: “You could see him go from simmering to very unwell in a matter of days. He would have a spiralling loss of insight – he would start not to take his meds.”

Comment by Investigation Team

It is difficult to see what other measures the MHSU's care team could have instituted in relation to his illicit drug usage. Motivational interviewing (see glossary page 124) may have been an option but for this to have any measure of success the service user has to have a level of engagement and this was not the situation with this MHSU. The evidence base for motivational interviewing suggests that it is an intervention that can be used in the pre-contemplation as well as the contemplation stages of change[12,13]. Consequently the IIT believes that the mental health professionals did the best they could to try and educate the MHSU about the inherent dangers in his drug habit. The only area of potential improvement the IIT identified was in relation to the educational input provided to the dual diagnosis link workers, of which CC2 was one. The educational programme did draw on the insights and expertise of addicts in recovery; however the IIT understands that there were no seminars or workshops on the underpinning theory of addictive behaviours. The Trust's specialist dual diagnosis worker may wish to consider the inclusion of addictive behaviour theory in future training packages for those working with service users with substance misuse issues.

---

[12] Rollnick, S. & Miller, R. (2002), Motivational Interviewing: preparing people for change. Guilford Press, New York, USA.

[13] Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992), "In search of how people change: applications to the addictive behaviours", *American Psychologist* 47 (9) 1102-14.

4.1.6 The usage of the Mental Health Act (MHA)

Admissions under section 2 and 3 of the MHA
This MHSU had a total of five admissions to hospital between 2002 and 2007. Of these two were under the auspices of the MHA, one in 2002 and the other in December 2006. Section 4.1.3, page 41 already addresses the decision to maintain the planned date of the 14 December 2006 for a MHA assessment rather than bring this forward in response to the restated concerns of his parents on 12 December 2006. These situations often require fine judgment and to have waited until 14 December was not unreasonable for this MHSU. There is no controversy surrounding any of the other admissions.

Section 135 of the MHA
The parents of the MHSU wanted to know why the mental health professionals, and/or the CHRT, could not forcibly enter their son's home on the occasions they and his family believed him to be unwell. The only way the staff could have undertaken such an act was via Section 135 of the MHA. This has to be provided by the court. However before approaching the court the usual course of action would be to make a number of attempts to achieve a face-to-face assessment with a service user. Only after a number of attempts have failed, and only if there were significant concerns about the deterioration in the mental health state of a service user, would a section 135 be applied for.

In the case of this MHSU, there was not an occasion where the staff could have justified an application for access under section 135 of the MHA. If at home, the MHSU usually allowed the mental health professionals to come in. On the occasions where he was repeatedly not at home, more often than not he would present at his parents' home. They were able to update the mental health professionals regarding his presentation and persuade the MHSU to make contact with his team even if this was only on the telephone. There was only one occasion where the MHSU's social worker (SW2) thought that the MHSU may have been at home and would not open the door. This was when he attended with the Child Care Worker with the behavioural contract for him to sign in relation to his son. There were no concerns about the MHSU's mental health state at this time.

The clinical records also show that there was at least one occasion where the MHSU asked the CHRT to leave and would not invite them into his home, and one occasion where it is inferred that the CHRT knew he was at home but that he did not respond to their call. On neither of these occasions was the level of concern about the MHSU such that there would have been consideration of utilising a section 135 to gain entry.

4.1.7 Out of hours care

With regard to the interface between the SWC CMHT and the CHRT and the out of hours emergency duty team (EDT), this was appropriate. The clinical notes and the interviews evidence that CC2 and SW2 contacted the CHRT if the MHSU's behaviour suggested a need for heightened surveillance and contact with him. Similarly if it was anticipated that an out of hours response might be required, the EDT was notified. All contact details for the CHRT and the EDT were also provided to the parents of the MHSU and they have confirmed that they had these.

The above being said, the parents of the MHSU, and his younger brother, had at least one experience when they had taken the MHSU to the inpatient unit (where he was known) because they felt he needed to be in hospital. This was in July 2006. On this occasion they were asked to take the MHSU to A&E for assessment which was in a different hospital. They continue to feel aggrieved about this. Consequently the IIT asked staff why this had happened. The then acting ward manager told the IIT that "we have a policy in place where every individual is seen by their GP or goes to A&E to be assessed for the service available. We cannot admit directly to the ward. There was a time where we could admit via our duty doctor who was on site if out of hours and the patient was known to be on a fast track system which cut out the need for a service user to go to A&E. With the firm foundation of CHRT services this is no longer the case. Every admission must go through CHRT."

The IIT appreciates the current situation in all mental health services where CHRT is the gatekeeper for admissions. However the IIT can see no reason why the CHRT cannot attend on the ward to undertake this assessment if the service user is known to the ward and a family member has brought the service user in because they are concerned about their mental health. If LPT is designing its services for the benefit of the service user and not for the benefit of the professionals, then there should be no impediment to such assessments taking place on the ward. The additional stress caused to the family of this MHSU, and the lack of care and concern communicated by being asked to take him to A&E, cannot be underestimated.

4.1.8 The non-referral of the MHSU to assertive outreach services

Following the IIT's initial analysis of the MHSU's clinical records, a key question with regard to his care planning was whether or not the mental health professionals had considered referral to an assertive outreach team.

In exploring the mental health team's consideration of this, the IIT was advised that the criteria for referral to the assertive outreach service in Leicester at the time was:

- "Has been admitted to a mental health in-patient unit on at least two occasions or over a six month duration over the last two years with a severe and enduring mental health problem."
- "Is on enhanced CPA level".

In addition to these criterion a service user also had to fulfil three or more of the following criteria:

- Failure to engage with the service: has this person failed to engage with the service?
- History of violence or of persistent offending: does the person have a recorded and persistent history of violence or persistent offending?
- At risk of persistent self-harm or neglect: does the person persistently neglect or self harm?
- Failure to respond to treatment: has this person failed to respond to treatment?
- Combined substance misuse with serious and enduring mental illness: does this person have a dual diagnosis?
- Has this person been detained under the Mental Health Act 1983 on at least one occasion?

This MHSU only met the last two criteria (dual diagnosis and MHA detention) and so he did not fulfil the criteria for referral to assertive outreach.

Having now analysed all of his care contacts, and interviewed the staff involved and the MHSU's parents, the IIT does not believe that this MHSU needed the input of assertive outreach services. What would have been most ideal was for him to have been on the caseload of a local CMHT in the east of the city, where there would have been greater opportunity for return visits to his home and ad hoc contact, rather than with the SWC CMHT where opportunities for this were reduced.

4.2 Was there an acceptable level of appreciation of the MHSU's risk factors, and were risk assessments undertaken appropriately? Furthermore were any risk management and relapse prevention plans appropriately formulated?

The seriousness of the incident that occurred on 15 August 2007 demands that the IIT paid particular attention to the understanding of the MHSU's risks by the LPT staff involved in his care and management, and the adequacy of the risk management and contingency plans devised.

4.2.1 Understanding of the MHSU's risk factors

All staff interviewed were asked about their perception of the MHSU's risk factors. The following represents the aggregated collection of perceived risks. Community staff made the following points.

- Poor sleep when not taking medication (a few doses missed).
- Talking about his "invention" if he missed more than a couple of doses of medication – he could be preoccupied with his invention.
- Self neglect was an early risk sign that the MHSU was not taking his medication.
- Unreliable with his medication.
- "Yes there was a risk of harm to others in a fight sort of way but not a planned attack".
- He was a risk to women – "he was hostile to his mother and his behaviours to his wife were sometimes poor".
- Main risk of harm was in relation to his wife – this escalated when they were both unwell as they were unable to contain each other's behaviour. There is some evidence to suggest that both husband and wife were abusive towards each other.
- Preoccupied with electrical things generally.
- Pre-morbid jealousy. He believed his wife was having affairs.
- Substance misuse - the MHSU could not see the connection between his substance misuse and any deterioration in his mental health state.
- "The issue of knives did come out latterly – February 2007. However whether he was actually ever carrying a knife is another matter entirely." (CP1).
- With the MHSU there was a general element of risk rather than a specific focus of risk. He would damage property, get into a fight, be erratic in his driving.
- There was a risk with the MHSU but did not see a risk of homicide.

In-patient staff said:

- He could be very aggressive – staff were anxious about him.

- If he wanted to leave the ward you might not stand in his way.
- "Batten down the hatches" – you would wonder how he was going to be, if advised he was to be admitted.
- He could hit 100% with his anger and then come down again very quickly. He certainly was not in a league of his own. There were others like him.
- Did not "clock" him as someone who would kill someone. They did have service users about whom harm to others was a concern but not this MHSU.
- Intimidating and manipulative.
- He was physically abusive to his wife and her to him. They had a mutually volatile relationship when unwell.
- Disrespectful towards females. However he took his frustration out on both sexes equally.
- In February 2007 he was saying that he had weapons and had harmed people (subsequently believed not to be true and spoken in a cannabis-induced state).
- Said he was carrying a knife in his flat as he thought someone would break in. However he was tightening the security in his flat so felt better about this.
- He would fight when unwell. If he needed to be transferred to psychiatric intensive care a police escort might sometimes be required.
- The MHSU was not a service user who could reflect on and be honest and/or reflect on his behaviours. He would deny them.
- Unpredictable in his actions – not someone who would plan.
- He was a service user who "always had an edge to him" he would "strut about in his work boots" when admitted on the ward.
- When unwell the MHGSU did not like being in hospital. He did not like being treated, he would be confused with irritable undertones. He would make menacing comments but then retract them.
- He could be aggressive on admission – challenging to the team.
- There were a variety of attacks on staff and fellow patients. He would smash things up. For example: "There was a lass he had a kiss with in the kitchen. It went sour and the lady threw a cup of tea over him. He stood up and punched the lady. He couldn't see past his own frustration."
- "When he got angry he could be very intimidating. Loud shouting, loss of control. It didn't matter who you were – male, female, member of staff, visitor etc. No recognition of boundaries." The nurse recalled feeling quite frightened of him. She felt he didn't recognise her at all when he was in an anger state.

- On one occasion he set fire to items in his bath at home as he wanted to test the flammability of his son's toys.

In addition to the above there were two references made to knives from staff. One was by the SpR who attended at the MHSU's home in 2006 to conduct the MHA assessment. She recalled the MHSU "had a knife in his hand but he was standing behind the kitchen counter. He never made any threats with the knife at all. There was no intentional intimidation. He was preoccupied with stroking the knife – it was as though he was preoccupied with the design of it and was stroking the knife absent mindedly during this. There were a number of tools and gadgets near to him."

The other reference was found in the in-patient records in February 2007, following the sudden admission of the MHSU. This admission was generally agreed to have been prompted by excessive cannabis use rather than non-compliance with his prescribed medication. This reference says: "Contacted A&E with an update. They informed me that the MHSU had a knife and said he had thoughts to kill women. Contacted the police – incident number 707 and informed them of all of the above." Subsequently the MHSU was admitted to the acute psychiatric in-patient unit. Within 24 hours of admission the MHSU was more orderly in his thinking and denied wanting to harm anyone, or that he had been carrying a knife. At this time CP1 believed the MHSU because his previous claims were made while he was in a mind-altered state.

There is also one reference in the CHRT records to homicidal intent towards his wife when the MHSU was relapsing in July 2006. As a result he was admitted to hospital. His presentation at this time was that he was clearly psychotic with auditory hallucinations and ideas of reference[14].

---

[14] Ideas of reference and delusions of reference involve people having a belief or perception that irrelevant, unrelated or innocuous phenomena in the world refer to them directly or have special personal significance. In psychiatry, delusions of reference form part of the diagnostic criteria for psychotic illnesses such as schizophrenia, delusional disorder, or bipolar disorder during the elevated stages of mania.
Persons with ideas of reference may experience:

- A feeling that people on television or radio are talking about or talking directly to them.
- Believing that headlines or stories in newspapers are written especially for them.
- Having the experience that people (often strangers) drop hints or say things about them behind their back.
- Believing that events (even world events) have been deliberately contrived for them, or have special personal significance for them.
- Seeing objects or events as being set up deliberately to convey a special or particular meaning.
- Thinking persons or groups of persons are plotting against them and that precautions must be taken to avert the threat.
- Many religious propositions, particularly that God created the universe with them in mind.

With regards to staff's level of concern about the MHSU and risk, his consultant psychiatrist told the IIT that the MHSU would be in his most worrying 10% or so of service users. Although the MHSU's consultant had other young men who were as chaotic, the reason why he saw the MHSU in his top 10% was because he had required compulsory admission, including time on a psychiatric intensive care unit (PICU) due to irritable and threatening behaviour when unwell. Most people they see don't present at this level. The MHSU had also been associated with "more unpredictable events in the community than we normally see also". It is important for readers of this report to understand, however, that a service user giving cause for concern is not equivalent to their presenting a homicide risk or a danger to the public.

Leicestershire Police were also approached to further research the MHSU's risk taking or "bad character" evidence. The information gathered for the trial following the manslaughter of Miss K showed that the MHSU had a total of 24 convictions logged between 1990 and 2008, and 64 offences. The vast majority of these related to "theft and kindred offences" and "miscellaneous offences". There were only three occasions where the MHSU is recorded as having committed offences against another person. One of these was towards Miss K and the other two were towards his wife. On neither of the assaults to his wife were weapons of any kind used. On one occasion he punched her and on the other the problem was one of harassment. There was only one firearms/shotgun/offensive weapons offence and this was in 1996, eleven years before the death of Miss K.

Investigation Team comment
It is clear from the above, and the testimony of the MHSU's parents, that the MHSU could be chaotic, intimidating, manipulative, threatening and unpredictable. However no one ever considered that he might pose a risk of harm to anyone other than himself or his wife.

His physical acts of harm to others, pre-dating August 2007, were contained to punching and pushing. On one occasion he used a crowbar to break into his own flat. There are two occasions where he is noted to have expressed homicidal intent, one in July 2006 and the other in February 2007. The first was when he was relapsing due to non-compliance with medication and was making threats towards his wife, and the other was when he was under the influence of cannabis and was making a threat to women generally. In both instances he was assessed and admitted to hospital for fuller assessment and stabilisation. It is important to understand that one cannot assume that just because a service user experiences bad thoughts that they are going to act on them. The documentation in the MHSU's records strongly suggests that he would not carry out his bad thoughts. Furthermore there was no historical evidence to suggest differently to this. It is reassuring that the murder investigation undertaken by Leicestershire Constabulary collated information that, in the opinion of the IIT, further confirmed staff's perspective of this MHSU. Nothing was revealed in the murder investigation that could have enabled anyone to have predicted that this MHSU was a potential homicide

risk, any more than any person who displays unpredictable behaviour and takes mind-altering drugs. Finally the IIT sought the perspective of the MHSU's current forensic care team. The forensic consultant psychiatrist does not believe that the act of violence committed against Miss K was predictable by the community mental health service.

4.2.2 The quality of the risk management, relapse and prevention and contingency plans for the MHSU

Although the MHSU's actions in August 2007 may not have been predictable, and the range of his risks was understood, the IIT did assess the quality of risk documentation between 2005 and 2007. This assessment identified the following:

- A risk assessment tool completed by CHRT on 3 July 2006.
- An initial risk screening tool also completed on 3 July 2006 by inpatient services.
- The inpatient assessment tool/interagency Care Programme Approach assessment completed 2 July 2006.
- Interagency Care Programme Approach Assessment Adult Services, which includes risk assessment, completed on 14 December 2006.
- Interagency Care Programme Approach Assessment Adult Services which includes risk assessment, completed on 4 February 2007.
- Interagency Care Programme Approach Assessment Adult Services, completed on 25 February 2007.
- The Adult Mental Health Risk Assessment Tool completed on 29 June 2007.
- A further interagency Care Programme Approach care plan risk management form that was undated and unsigned.

Comment

Overall the IIT is disappointed in the frequency with which formalised risk assessments were undertaken for this MHSU. Even without any significant issues occurring for him, risk assessment should be revisited on at least an annual basis, consequently there should have been a detailed risk plan with clear review dates for 2005, 2006 and 2007.

In addition to the basic requirement for annual review, it is considered good practice for a service user's risk assessment to be reviewed whenever there is any significant change in life circumstances, or incidents or admissions occur.

2005

Although there were no admissions in 2005, there were incidents including the occasion where the MHSU left his home naked in May and went out driving in his car. The period between May and September of this year was quite unsettled for him. There should therefore have been a risk assessment

completed during this period with a corresponding risk management and contingency plan.

2006 - 2007
Risk screening was undertaken in July 2006 following the MHSU's admission to hospital. However, no full risk assessment or risk management plan was undertaken and devised as a consequence of this. This should have been done.

Following the MHSU's admissions in December 2006 and early February 2007, a full risk assessment was undertaken. The full risk assessment however was undertaken some four months after the initial risk screening, which was too long a period of time given the circumstances of the admissions. However the documentation when it was completed was of a reasonable standard. The risk profile provided a comprehensive overview of key events in the MHSU's life, to the extent that one had a clear sense that the MHSU could be chaotic and unpredictable. The profile could have been enhanced with some clear headings that set out the context of the MHSU's known risky behaviours and some of the consequences of these. Although the chronology provided is helpful, if professionals referring to the plan did not know the MHSU they would need to refer back to his records to get more depth of detail and contextual insights. Ideally one should not need to do this with a well-formulated risk assessment.

The other aspects of this assessment that could have been enhanced were details of those factors that help reduce and contain risk. For example "enhanced contact with the care team". Ideally the plan should have set out clearly how this would be achieved. Furthermore the crisis plan should have detailed how to contact the MHSU's mother. This is also an expectation of the Trust's own "CPA Policy and Practice" document 2007 (section 4.3.2, Crisis Planning, page 17). The IIT understands that the mental health professionals involved with the MHSU expected to be undertaking all interventions themselves, and that they therefore would have had all of this information. However, the bottom line is that the risk assessment, risk reduction plan and crisis and contingency plans are meant to work for any mental health professional who has to deal with a crisis. This means providing extra information.

The most poorly completed risk form was that completed by the CHRT in July 2006 prior to the MHSU's admission to the inpatient ward. The form the CHRT uses is designed to allow for a good amount of detail to be recorded. In this case the information recorded was sparse. The IIT appreciates that the MHSU may not have been a forthcoming informant at the time of his assessment. However the CHRT should have been able to access previous history known about the service user and ensured that this was detailed on the form. No historical information however is detailed at all. It is the perspective of the IIT that the document completed by the CHRT would not have been a particularly useful document for the receiving inpatient staff.

4.2.3 Involvement of the MHSU in the formulation of his risk management relapse prevention plan

The MHSU did not want to be involved in his care planning or the development of his risk relapse prevention plans.

4.3 Was there effective communication between;

- **The MHSU's care team, the CHRT and inpatient services?**
- **The MHSU's care team and the care team for his wife?**
- **The MHSU's care team and the MHSU's parents, notably his mother?**
- **The MHSU's care team and the MHSU's wife?**

The effectiveness of mental health care often relies heavily on the quality of communications between the mental health professionals, the mental health services and the family of the service user, and between the mental health service and other agencies.
Therefore, the IIT considered it important that the effectiveness of communications in relation to this MHSU were considered. Each of the above bullet points will be taken in turn.

4.3.1 Communications between the MHSU's care team, the CHRT and inpatient services

The communication between the mental health professionals involved with the MHSU in the community and on the ward was of a very good standard. There is a good amount of information in the clinical records that shows that CC2 communicated appropriately with the MHSU's consultant psychiatrist if she was at all unsure as to the direction to take with the MHSU.

The SWC CMHT's system of weekly meetings also provided a good opportunity for the staff involved with this MHSU to raise any concerns they had and to seek the input of their colleagues, including the consultant psychiatrist. SWC CMHT had a system by which any service user who was considered to be of concern took priority for discussion and consideration at the weekly meetings. A review of the minutes of these discussions revealed that this MHSU was discussed regularly in 2007.

Interviews with the community and in-patient staff also revealed a healthy attitude towards communicating with each other and the need for good quality information sharing.

The following are a selection of extracts from these interviews:
"The consultant psychiatrist for the MHSU would always communicate with the team, and the matter of risk would be discussed on a weekly basis with

the consultant and daily with the nursing team. This would be in the form of verbal handover – nurses handing over behaviours and symptoms - and from written document." Acting ward manager, inpatient services.

CC2 and SW2 were "hard working and down to earth. The care coordinator would definitely come for advice. In my opinion the care coordinator highlighted issues appropriately". The SpR to CP1.

"They (the care coordinator and SW2) came to the ward on many occasions. I have no concerns about the communications." Acting ward manager, inpatient services.

"CP1 was an active player in team meetings. He would give direction rather than taking responsibility for the team. I feel we were all on the same page re. the MHSU." SW2.

"[At team meetings] a key feature was the at risk register – it had a number of purposes. It, in my view, meant that:

- Team members can acknowledge to self that things are not going well and they need to think about what is happening.
- It is done publicly so that feedback can be achieved from other team members.
- It is also a public speaking out of actions planned. You know what is not going well, you say it is not going well, and the meeting is a place to say what you are doing about the issues.

The MDT [multidisciplinary team] highlights the problem globally and enables joint decision making and the identification of whether any other involved person can/should do something". CP2.

[In working with medical staff] "Good relationship. Good consistency. CP1 was with the team for a long time. Good relationship also with SpR. CP1 was accessible and approachable." Team leader, SWC CMHT.

"Easy to contact CP1 – he had brilliant secretaries. They would know exactly where he was and get hold of him." She would also establish at what point he might get her messages. If she needed immediate contact it would happen. CC2.

CC2 and SW2 did highlight a potential impediment with being well informed and this related to their lack of access to inpatient records. To access these they had to go to the ward. LPT is aware that it needs to move towards electronic record keeping and has the IIT is informed a strategy in place for this. However this issue was not an impediment in the care and management of this MHSU.

The IIT also identified a further potential communication challenge for SWC CMHT. CP1 was not based with the team, his office was at one of the Trust's hospital sites. This meant that there was little opportunity for informal

communication in situations where one might not actively seek the input of medical staff. Although the location of a CMHT consultant away from the team base is in keeping with "New Ways of Working" (Department of Health, October 2007), where case management responsibility is invested in the team and not in the nominated lead professional, the IIT did ask CP1 whether he had experienced any problems in not being based in the CMHT. He told the IIT that "whilst missing some informal contact, the advantages of being on the same site as the ward, and being able to network/cross cover with other consultant colleagues in other neighbouring patches more easily" balanced this. He also advised that he met with the community staff at team meetings and there was also a regular communication route via the weekly inpatient ward rounds, as a social worker from SWC CMHT always attended these. This was very good practice. The SpR to this consultant also confirmed that she did not feel that the geographical placement of the medical staff was a problem, and that it was not a problem in the case of this MHSU.

4.3.2 Communications between the MHSU's care team and City AOT, the team responsible for the care and management of the MHSU's wife

Both the MHSU's clinical records and the chronology provided by the City AOT to the IIT show that there were communications between the two teams, especially if there were any concerns about the MHSU's behaviour and risk to the MHSU's wife, or concerns about the MHSU's ability to care for his son if his wife was hospitalised. However the IIT believes that the communications between the SWC CMHT and the City AOT could have been significantly enhanced to the benefit of both service users had they held a joint professionals' meeting. Although there was no guidance available within the Trust that promoted such meetings at the time, the IIT believes that to have considered their merits when assessing and managing risk in a complex social situation would have been prudent. That this was not considered does raise a question about the effectiveness of the clinical supervision and caseload supervision for both teams. The 2007 Trust CPA policy states: "Regardless of CPA levels, when it is identified that there is more than one care coordinator within a family, or household (e.g. one service user receiving a service from MHSOP and another family or household member receiving a service from AMH), the care coordinators for each service area should ensure good joint working. They **must** meet together formally at least on a quarterly basis, to overview the total package of care." (LPT CPA policy section 3.4, page 14).

Even though the living circumstances for the MHSU and his wife did not always wholly meet the precise wording of this policy, their personal circumstances were clearly within the spirit of this section of the policy.

It is difficult to say what difference joint meetings would have made to the actual care and management of either service user. However what would have been different is that CC2 and SW2 would have had a much better insight and understanding into some of the MHSU's behaviour in his marital home towards his wife. It would also have enabled his wife's team and the

SWC CMHT to have agreed a formal communication strategy between them which would have been very useful for both teams.

With regard to the MHSU's wife the IIT, having met with the team leader for the City AOT and the care coordinator for the MHSU's wife, is in no doubt that had the AOT staff had any concerns about the MHSU and his interactions and behaviour around his wife, then they would have alerted the SWC CMHT of this.

With regard to the events of 15 August 2007, there is no evidence to support any assertion that had the teams had a formalised joint working relationship, that there would have been the opportunity to alter the events of this day. Section 4.5 page 74 sets out in detail the IIT's analysis of the actions taken by professionals on 15 August 2007.

4.3.3 Communication between the MHSU's care team and the MHSU's parents and wife

There are a number of key mechanisms for communicating with the family of a service user. These are via:

- CPA reviews;
- Carer's Assessments;
- the care coordinator for a service user with his/her consent; and/or
- proactive communication from the family to the service user's care team.

There is evidence in the MHSU's clinical records, supplemented by the information provided by the MHSU's parents and the chronology provided by his wife's AOT, which shows that both the MHSU's parents and his wife made contact with the MHSU's care coordinator and/or SW2 if they were concerned about him. These contacts occurred predominantly between August 2005 and December 2006. The records also show that following these communications there was always a response made. An analysis of the message books for CC2 and SW2 also showed that all messages left were collected by the relevant professional and responded to.

The clinical records also show that SW2 in particular made proactive contact with the MHSU's parents if he needed to seek information regarding the MHSU's whereabouts and state of mental health. Almost all of these contacts occurred in 2006 and 2007.

Both CC2 and SW2 told the IIT that the MHSU's parents were effective and valuable informants for the mental health team. They were sensible and were able to make sensible judgments about the state of their son's mental health state.

The IIT asked CC2 why most contacts were made by SW2. This professional believed that this was because he developed a natural rapport with the MHSU's parents and also because the MHSU himself engaged better with SW2. The main influencing factor to this was the fact that SW2 assisted the MHSU with all of his social issues such as housing benefit, whilst CC2 took

responsibility for trying to engage him therapeutically on issues such as his cannabis use. Unsurprisingly the MHSU was less willing to engage with CC2.

In relation to the above, one can say that there was good communication between the MHSU's care coordinator and SW2 and his parents and wife. This is in some measure endorsed by the MHSU's parents who felt they had a good relationship with SW2 with whom they had most contact.

However, the MHSU's parents also had some disappointment in the communications between them and their son's community care team. This disappointment stemmed largely from frustrations caused, in their view, by a lack of manned telephones after 3.30pm. The team manager has assured the IIT that the CMHT office phones are covered until 5pm each evening, Monday to Friday. The IIT were also advised that there was an effective message book system[15] should service users or carers call to speak with a member of staff while they were out.
The MHSU's parents also experienced frustration that their son's care team could not just gain entry to his flat when they knew him to be becoming unwell, or why he could not have been assessed under the Mental Health Act on 12 December 2006. These issues have been addressed in section 4.1.6, page 56 of this report. In retrospect it is clear that what was missing from optimising communications with the MHSU's parents was any planned face-to-face communication with them. The MHSU's care coordinator and SW2 both agree that they relied on the information the MHSU's parents could and did provide to them, and that they found them invaluable in assisting them in maintaining contact with the MHSU. However both also have spontaneously reflected and suggested that in addition to the crisis type telephone contact, more planned discussions with his parents would have been beneficial for both parties. In particular it would have enabled SW2 and CC2 to have tested the MHSU's parents' understanding of issues such as their rights as nearest relative under the MHA (1983).[16] It is clear from the clinical records that SW2 did speak to the MHSU's parents about such issues over the phone, and consistently provided them with the CHRT contact numbers and the numbers for the EDT and the ward. However, this really is not sufficient when one is placing such reliance on family members for information exchange.

---

[15] The Investigation Team reviewed the message books for CC2 and SW2 between 1 January 2006 and August 2007. There was a clear system of recording the messages and the quality of message taking was of a good standard. Once dealt with messages were ticked or scored through by the relevant professional.

[16] As nearest relative the MHSU's parents had the right to ask for a Mental Health Act assessment for their son if they believed he was sufficiently unwell and it was not already planned by the mental health services.

A significant disappointment in the communications with the MHSU's parents was that they did not receive the information folder entitled "For relatives and friends who look after someone with a mental health problem."

The information folder has the following information in it:

- "In a crisis". It tells families what to do and who to call giving helpful contact numbers.
- "I look after someone with a mental health problem: am I a carer?"
- Carer's Advocacy Service.
- Taking care of yourself.
- Who's who in mental health.
- What does it mean? (a glossary of terms).
- The Care Programme Approach.
- Where to get help: local services.
- Dealing with difficult behaviour.
- Mental Health problems – common symptoms and treatments.
- Therapies – non-drug based treatments for mental health problems.
- The Mental Health Act (1983) (includes information on nearest relative).
- The Mental Health Act Commission.
- Getting a second opinion.

It is comprehensive and had the input of a range of carers in developing it. It is a very good resource.

The IIT asked SW2 why it was not provided. He advised that they used to have packs at the CMHT base but that the Trust had stopped producing it and they were expected to photocopy the leaflets and they had run out. The IIT also asked the service manager for the South West City Adult Services who advised that the booklets were available from the carer's assessors, one of whom was based in the MHSU's CMHT. He asserted that all carers/families should receive a booklet regardless of whether they accept a carer's assessment or not.

The IIT also spoke with a carer's assessor who was very helpful and very passionate about her work with carers. She advised the IIT that the information provided by SW2 was correct. She had not been provided with any copies of the booklet for a number of years, and had been asking for further supplies for a very long time. It was only in recent times that she had been re-provided with a booklet to photocopy at the CMHT base for the carers she was having contact with. She did not have the time resource to make copies for all of her colleagues. The IIT understands that a new resource pack is currently being developed.
Because of the absolute importance of the provision of information to families and carers of mental health service users, the IIT approached the Service

Development Officer (MH) in Strategic Commissioning & Service Development at Leicestershire County Council.

She communicated the following to the Investigation Team:
"The Carer's Information Pack was commissioned by the local multi-agency NSF Standard 6 group, and was first produced in 2003, for use by all the partners involved in providing care and support for carers of people with mental health difficulties. It was then redesigned to be more user-friendly and the new version was first printed in 2005, and a reprint was produced in 2006. During this time, translated versions (Punjabi, Urdu, Gujarati, Bengali) had also been produced and were made available on our local community mental health site, LAMP Direct (www.lampdirect.org). Throughout this, the English version (always the most recently updated) was also available on the LAMP website. The print run quantities were dictated by the budget made available each time, however information was sent to statutory and voluntary sector organisations providing services to carers about the availability of the information on the LAMP website, with a request that if ready-printed copies were not available they should download and print out the information leaflets. The hard copies were distributed to carers' workers/assessors including our voluntary sector partners (LAMP, Rethink, Crossroads, CLASP), Community Mental Health Team staff, the PALS co-ordinator, assertive outreach teams and hospital day units.
Stocks of the printed booklet remained available up to March 2007, and at this stage the pack was updated but no hard copy versions were produced due to the reorganisation and split of the Local Implementation Team, which resulted in the NSF Standard 6 group being disconvened until decisions were made about future structures. The 2007 updated version was published on the LAMP website and any staff who made contact regarding the pack were given that information. The pack is currently being reviewed to update the contents and reflect legislative changes (the Mental Health Act, the Mental Capacity Act) and is expected to be reprinted by the end of the year."
This professional was able to confirm that a total of 1500 copies were printed in 2004/5 and 1000 copies in 2005/6. This number does not seem wholly sufficient to meet the demand.

Comment by Investigation Team
Having seen the information pack it neither seems reasonable nor realistic to expect individual CMHTs to print off the contents of this from the internet to give to carers or families when supplies of the hard copies have run out. The Trust really should identify the shelf life of the new information booklet and scope how many booklets are likely to be required on an annual basis. Then it can ensure that it orders sufficient readymade packs so that adequate supplies can be issued to all inpatient wards and community teams.

4.4 Was the housing situation for the MHSU appropriate?

A key question for the family of Miss K was the appropriateness of the local housing association flat that the MHSU was residing in at the time of her death. The results of the Investigation Team's enquiries suggest that there was no good reason for the MHSU not to have been placed as a joint tenant with his wife in 2004. That he had a mental health disorder is not an acceptable reason for denying an individual tenancy in "general needs" housing, i.e. the general housing stock.

The IIT met with the housing officer who was responsible for the flat the MHSU lived in, to find out how he was allocated the flat, and what assessments were undertaken in determining his suitability.

These enquires revealed that the MHSU had never applied for a tenancy in his own right. His application was to be added to the existing tenancy held by his wife. Therefore no assessments were performed. The flat was a general needs home and there is no requirement to perform assessments on an individual added to an existing tenancy arrangement. The process for adding individuals onto existing tenancy agreements is that an individual can move their partner into their home, providing that they advise the housing association. After a period of six months, if there have been no complaints during this time, the new individual can be added to the existing tenancy agreement. This is standard practice. There were no complaints in the six month trial period about the MHSU so there was no reason not to add him to his wife's tenancy agreement.

The MHSU was added to his wife's tenancy in May 2004. When he and his wife split up, she moved elsewhere. The first complaint was received about him in November 2006.

In total there were two formal complaints against the MHSU, both were made in November 2006. One was received on 22 and the other on 23 November. Both related to noise and music. Both complainants were asked by the local housing association to maintain a diary of noise nuisance so that formal action could be taken with environmental health if necessary. No further information was received by the housing association from the complainants. The housing officer told the IIT that he did meet with the MHSU on a number of occasions during his tenancy. On no occasion was he awkward or difficult.

In addition to the two formal complaints, the police investigation revealed that in the 18 months preceding the incident, the two complainants had been into the housing authority officer's office three times. However the visits were informal and no official complaints were made. The housing officer is noted to have advised the police that "it was evident that there were issues between the neighbours".

There were two other issues that were problematic for the MHSU regarding his tenancy. One was his rent arrears and the other was the time where his flat sustained damage in March 2007. This was reported by a neighbour and the broken windows were boarded up. Both issues were subsequently resolved.

With regard to damage the MHSU created in his flat when unwell, the damage appears to have been largely to his personal property. In July 2006, after he had set fire to toys in the bath, his parents came and cleaned and redecorated his flat. In December 2006 there was no damage to the flat. The flat was in a state of disarray and the MHSU had taken the back off his television and other electrical items were noted to have been taken apart. None of these issues would have threatened the MHSU's tenancy. The issue that did potentially jeopardise it were the broken windows in March 2007[17].

The IIT also sought the perspective of his care team regarding the MHSU's living circumstances. Collectively they do not believe that this MHSU would have benefited from more supported accommodation. SW2 advised that the MHSU was essentially self caring, and when he was well worked full-time and independently paid his rent on the flat without claiming benefits. When ill his income dropped to zero and he then needed to claim benefit for the duration of this period. It was notable to his care coordinator and SW2 that when the MHSU was well the flat was maintained in good order. When he was not well the order of his flat was not so good, but not remarkably bad either.

[17] Note the fire setting would have been of concern to the housing association but would not have threatened the MHSU's tenancy at this stage. The housing officer advised the Investigation Team that the emphasis now is on maintaining tenancies where possible, and working in partnership with mental health teams to achieve this, where an individual has diagnosed mental health issues.

4.5 On 15 August 2007, when the MHSU's flat was discovered to be in a state of disarray, were the actions of his care coordinator and nominated social worker appropriate given that it was almost certain that the MHSU had relapsed and was again unwell?

On 15 August SW2 and CC2 made a planned visit to the MHSU's flat. When they arrived there was no response to the buzzer. They therefore went around the back of the flat and knocked on the window. This also elicited no response.

A neighbour "stuck his head out of the window" and told them that the MHSU has been making a lot of noise the night before. "He said it sounded like things were smashing and breaking." SW2 and CC2 went to look through the window and it was evident that "the flat had been trashed". There were "slash marks on the sofa" and bits of wood and glass all over the place.

The neighbour also told SW2 and CC2 that the MHSU "was on the phone to his girlfriend at 04.30 in the morning shouting and swearing, using obscenities". SW2 and CC2 believed the "girlfriend" to be the MHSU's estranged wife.[18]

The records note "we were concerned about his mental state". They were also concerned about the wellbeing of the MHSU's wife and his son.

The following actions then occurred:

- Contact was made with the wife's in-patient ward.
- Contact was made with the MHSU's mother for "an update as he is likely to have visited over the weekend".
- Attempted to contact the MHSU on his telephone. However it went to answerphone.

The result of these actions were:

- The in-patient ward advised that the MHSU's wife had been seen on the ward that morning. She did not mention the MHSU, or having any difficulties with him (she usually would if there had been issues). The ward was advised of the concerns held by SW2 and CC2. The inpatient ward was asked to monitor the situation with his wife. However SW2 was advised that this might be difficult as the MHSU's wife was on home leave until the following Wednesday. SW2 agreed to keep them updated with developments.
- The MHSU's mother advised that she had seen her son on Sunday. She said he seemed to be "in and out" meaning he had periods of

[18] In fact the MHSU and his wife were never divorced. They had separate living arrangements but remained in close contact because of their son. The MHSU and his wife divorced after the incident of 15 August 2007.

being lucid and periods where he was not so lucid. However, she felt he was quite in control of his behaviour. He was being "off" with her, however, when she challenged him he was then "OK" with her. SW2 informed the MHSU's mother of their concerns and what they had witnessed. The records note that "she was obviously quite concerned and she suggested we contact [his wife]". It is also noted that the MHSU's mother agreed to keep SW2 updated on any contact she had with her son. SW2 agreed to contact the MHSU's wife's AOT and keep her (the mother) informed.

The following day – 16 August 2007

The MHSU's mother contacted SW2. She advised him that she had spoken to her son the previous day. He was at his wife's flat. Her main conversation was with his wife who stated that the MHSU seemed fine. She also told SW2 that she asked her son "who was ranting in the background" if he was OK. He is reported to have replied "I'm fine, my knee's busted and my head is messed up, but otherwise OK". SW2 advised that he would call the AOT today to highlight concerns, and would encourage the MHSU's wife to prompt the MHSU to contact SW2 or CC2 and take his medication.

The records show that SW2 did contact the AOT and informed one of the workers about their current concerns. The records clearly state that SW2 informed this worker of his conversation with the MHSU's mother. It was jointly agreed that the main concern was the welfare of the MHSU's son. The AOT worker was clear that the MHSU's wife was very aware of the boundaries around the MHSU's contact with her and her son, and she would do nothing to jeopardise these. The AOT worker agreed to address the situation with the MHSU's wife and encourage the MHSU to engage with his care team and take his medication.

The plan at this time was to encourage the MHSU's support network, to prompt medication and for SW2 and/or CC2 to be alerted to any concerns of deterioration in his mental health. The plan was also to discuss the MHSU at the CMHT meeting on 19 August.

Comment by Investigation Team

It is the task of the IIT to make objective comments about the actions taken by SW2 and the care coordinator on 15 August. It is also our task to avoid hindsight bias whilst doing so.

The initial actions taken by SW2 and CC2 on 15 August 2007 were reasonable. That is, making immediate contact with the inpatient ward caring for the MHSU's wife and his mother. However we do not feel that the actions taken were assertive enough given the MHSU's previous history of relapse.

In July 2006 and December 2006, when in relapse, the MHSU required hospital admission. In both instances his pre-admission behaviours included

disruption to his flat. The scene that greeted SW2 and CC2 on 15 August was therefore very suggestive of full relapse for the MHSU.

The MHSU's mother gave a clear indication that she thought her son would be with his wife. She suggested that SW2 make contact with her.
This suggestion was not followed through. Neither was any contact made with the AOT responsible for the care and management of the MHSU's wife until 16 August. This should have occurred on 15 August.

It is somewhat surprising that SW2 and CC2 were not more assertive in their efforts to track a service user who was showing clear signs of relapse. It would not have been reasonable to have expected them to traipse around Leicester looking for the MHSU. However, they could have explored the possibility of a joint visit to the MHSU's wife's flat with her care team later on in the afternoon of 15 August.

Furthermore to have alerted the CHRT, the MHSU's in-patient ward, and CP2[19] that he might be in relapse in the community would also have been prudent.

The lack of optimal assertiveness does open up the question of whether the incident could have been prevented, and the IIT can appreciate how the family of Miss K believe that any potential for prevention was lost because of this. However owing to what is known about that day the IIT cannot see how it could have been prevented.

The four actions that SW2 and CC2 could have taken would have been:

- Making contact with the MHSU's wife on 15 August, in line with the suggestion of the MHSU's mother.
- Contacting the MHSU's wife's AOT on 15 August.
- Exploring the possibility of a joint visit to his wife's flat with her AOT.
- Alerting the CHRT, inpatient services and the CMHT's consultant psychiatrist to the possibility that he had relapsed.

However, given that the MHSU was not at his wife's flat between 10am and 7pm on 15 August – the period during which the police information provided to the IIT shows that Miss K could have been killed – SW2 and CC2 would still not have found him in order to assess his mental state even had they attended with AOT at his wife's flat.

The IIT cannot therefore see, even with an appropriately assertive response to their findings when visiting the MHSU's flat on 15 August, how the mental

[19] CP1, the consultant psychiatrist to the MHSU, was on annual leave at the time.

health services could have acted to save Miss K. However it appreciates how for Miss K's family any loss of opportunity represents a lost opportunity for the prevention of her death.

Note: The MHSU's wife, who had the closest contact with the MHSU on 15 August, did not raise any concern about his behaviour to staff when she attended her ward for a planned assessment on the ward round. In the past she had done this where she was concerned. It is also noteworthy that on 16 August she left a message for SW2 to call her on 17 August. This message conveys no urgent need or concern about her husband. It is therefore possible that at this time he remained able to mask the degree to which he had relapsed. The fact that he was not unwell enough to warrant compulsory detention under the Mental Health Act (1983) when assessed for fitness to interview on 17 August and that he was in prison for at least two weeks before being transferred to a medium secure mental health unit also suggests that he would not have come across as requiring a compulsory hospital admission around the time of the offence.

ACTIONS TAKEN BY LECEISTERSHIRE PARTNERSHIP TRUST FOLLOWING ITS OWN RECOMMENDATIONS IN 2008

The following details the action plan...

Recommendation	Action Agreed: (Against the Recommendation)	Progress to date
1. The Trust risk assessment tool should prompt the recording of whether a depot has been considered for patients who have been identified to be at risk of non-concordance with anti-psychotic medication.	Review of the Trust risk assessment tool and raising awareness amongst clinicians. Raise awareness of the importance of recording of rationale behind decisions made Qualitative audit of record keeping **(linked rec)**	The LPT risk assessment tool has been reviewed and the policy revised and updated. It was agreed that it was not appropriate that the risk assessment tool should prompt the consideration of depot medication for people at risk of non compliance but that if this risk was identified, like all risks, there should be an accompanying plan of care. This issue is audited as part of the annual CPA audit programme Reminders about the importance of the recording regarding the rationale informing clinical decisions are included in the LPT record keeping guidance. Additionally training focusing on the requirements of good record keeping from a legal perspective is planned. This action is being led by the Medical Director and is scheduled for completion by end December 2009. A Record Keeping audit has taken place and an improvement plan is being actioned.

Recommendation	Action Agreed: (Against the Recommendation)	Progress to date
2. The Trust should consider the systems and resources required to ensure that clinical summaries are completed and updated for key patients.	A multi-professional group, including representatives of IT, to be convened to check new files and guidance and make recommendations (see T&R interagency CPA assessment)	This work is ongoing. Clinical summaries are currently compiled for service users with the most extensive and complicated histories but there is not currently the capacity to do this for all service users as yet. LPT is planning to make better use of its electronic clinical record management system to facilitate more comprehensive information being easily available to appropriate clinicians when needed but this is part of a longer term work programme. LPT is not yet fully electronic in terms of clinical records. A recruitment process is in place to attempt to build capacity to provide leadership for the ongoing progression of this.
3. Consultant psychiatrists should be offered feedback about the above, and asked to consider if junior doctors could undertake longitudinal case studies for key clients or complex cases as part of their training.	Medical Education Lead to consider if this could be incorporated into the role of trainee and junior doctors	This work is ongoing. Clinical summaries are currently compiled for service users with the most extensive and complicated histories but there is not currently the capacity to do this for all as yet. LPT is planning to make better use of its electronic clinical record management system to facilitate more comprehensive information being easily available to appropriate clinicians when needed but this is part of a longer term work programme.

Recommendation	Action Agreed: (Against the Recommendation)	Progress to date
4. The importance of recording the rationale around clinical decision making should be reiterated to all staff as part of the process of learning lessons from this investigation.	To feed this learning in via the Healthcare Records Project To disseminate learning through the Clinical Governance Committee and Trail To undertake an audit project to evaluate compliance.	This action is completed
5. Issue a reminder and guidance on the management of risk relating to informal inpatients, clearly stating that the use of the abbreviation 'NTLW' should not be used.	A statement should be included in the Trust record keeping standards. Statement to be added to junior doctors Handbook and to the observation policy	Guidance is now included in the 'Safe and Therapeutic Observation for Inpatients Policy' and the Junior Doctors Handbook and is included in clinical induction.
6 The Trust should consider how it can develop practice in accordance with 'Think Family' guidance.	Consider the need for a 'Think Family' awareness raising or training event Consider the need for guidance for staff	A 'Think Family' awareness raising event has taken place in 2008 and the concepts are reiterated on an ongoing basis within mandatory safeguarding training

Recommendation	Action Agreed: (Against the Recommendation)	Progress to date
7 All CMHTs and other relevant clinical teams should consider the robustness of their local practice.	Through the Clinical Governance structures, team managers will be asked to benchmark their practise and identify and implement any improvements needed.	This recommendation was not accepted or adopted as it is so vague. (The IIT concurs with this).
8 The Trust should remind clinicians that services are encouraged to contact the forensic service to discuss a possible referral if there is a lack of clarity as to where the patient fits into the criteria.	Raise awareness amongst medical staff Disseminate learning through the Clinical Governance Committee and Trail To disseminate learning through medical staff news letter (CLAP)	The service information and criteria was updated and re circulated in response to this incident. Information was also circulated to Consultant Psychiatrists about the availability of forensic advice from the specialist team, even regarding those who would not necessarily meet the criteria for forensic team acceptance. This will be reiterated again in a future Trust publication.

6.0 CONCLUSIONS

The death of Miss K was a tragic incident and one that her family must always live with. For her mother, who found her daughter's body on the morning of 17 August, it is an experience she may never recover from.

The incident was also tragic for the MHSU and his family. They too have lost a son and he has lost his liberty and freedom of choice in how he lives his life. The family of Miss K do not hold the MHSU responsible for her death as they accept that he was ill. They, and the family of the MHSU, do however wonder whether better, or different, mental health care by Leicestershire Partnership NHS Trust would have prevented the tragedy.

Main conclusions
The IIT has carefully analysed the MHSU's care and treatment by LPT. As a result it has concluded that although some elements of his care and management could, and should, have been addressed differently, it cannot say that had elements of his care been different that this would have prevented the death of his neighbour (Miss K).

The primary reasons for this are:

- The police investigation suggests that the MHSU had the opportunity to undertake his attack on Miss K any time between 10am and 7pm on 15 August. These were the hours between which the MHSU's whereabouts were unknown on this day.
- The care coordinator and social worker from the South West City Community Mental Health Team (SWC CMHT), who both regularly dealt with the MHSU, visited his flat on 15 August at 11.30-12.00. The MHSU was not in so they were unable to assess him. However, what could be seen of the flat from outside, plus intelligence from a neighbour, led these professionals to become concerned about the MHSU's mental state. The City Crisis Team and the ward to which the MHSU was normally admitted were notified that the MHSU's mental health professionals (MHPs) believed the MHSU to be unwell.
- The SWC CMHT mental health professionals (MHP's) took appropriate steps to try and locate the MHSU which included contacting his mother who was a reliable informant regarding her son. The MHP's also contacted the in-patient ward where they believed the MHSU's wife to be residing to alert them to what they had found. The MHP's were told that the MHSU's wife had raised no concerns about her husband when she attended the planned ward round to review her care and how things were going at home.[20]

[20] Note: Historically the MHSU's wife did raise concern if she felt her husband was becoming very unwell, or was anxious about his behaviours. It is notable that she raised no concerns at

- The SWC CMHT MHP's also tried to contact the MHSU but he did not answer his mobile phone.
- The main concern about the MHSU at this time was the potential risk he might pose to his wife. However this risk was not considered to be one of homicide, but low level domestic violence and reckless behaviour. The MHP's were reassured that the MHSU's wife had been noted to be well and showing no concerns about her husband. There was no reason for staff to consider the MHSU a risk to the general public.
- The MHP's had agreed with the MHSU's mother that she would let them know if she heard from, or saw her son at all. She did contact them the following day having spoken with his wife on the evening of the 15 August (after 7pm). This was the first time that day that anyone knew of the location of the MHSU after 10.45am when he was seen by a witness walking along Avonside Drive in Leicester.
- The MHSU told the IIT that on 15 August he was high on cannabis and that this triggered a psychotic episode. In the week prior to this he recalled being reasonably well.

Although the above actions were reasonable there were some additional actions the MHP's could have taken on 15 August. These were:

- To have contacted the MHSU's wife's assertive outreach team (AOT). This team said that if they had been aware that the MHSU had 'trashed' his flat they would have made an afternoon visit to check on his wife's well being even though she had been seen by the ward that day. Had the AOT done this, and found the MHSU's wife to be at home, this would have provided an opportunity to ask her directly about her husband's behaviour and mental health and to remind her that she could call the crisis team at any time if she was concerned. Had this occurred, and had this revealed concerns, the most probable course of action would have been contact with the MHSU's MHP's and a planned visit to try and see the MHSU the following day at his home[21].
- To have made a repeat visit to the MHSU's flat on the afternoon of the 15 August. Although this could have occurred, the IIT does not believe that the MHP's were wrong not to have attempted a second home visit on this day. The IIT considers that to have planned to visit the MHSU on 16 August would have been acceptable. However the

---

all on 15 August even though she had opportunity to do so at her in-patient ward round review.

[21] Note the crisis team had already been alerted to the fact that the MHSU was most likely in relapse. Both the MHSU's parents and his wife had the numbers for the Crisis and the Emergency Duty Team if needed.

IIT has to acknowledge that the potential for a repeat visit on 15 August would have been enhanced had the MHSU been under the care and management of a CMHT in the east of the city.

With regards to the MHSU's placement with a south west CMHT, looking more broadly at his care and management even had he been discharged from this CMHT and then referred to the appropriate CMHT for where he lived, it is not possible to make a causal link between this and the death of Miss K. However, the IIT does believe that tracking the MHSU during his periods of no contact with mental health services would have been easier, and there is a chance that he may have been seen in and around the community by a more local CMHT between 8 and 15 August. However, even had this happened, and he had been identified as unwell, his past history indicates that a number of measures may have been attempted to achieve recovery in the community before looking at hospital admission on a voluntary or compulsory basis. Therefore, one cannot surmise that had he been with an east city CMHT that he would have had more frequent visits and that these would have resulted in hospital admission prior to 15 August. There is no evidence to support this hypothesis.

In view of the above the IIT do not believe that anyone can say that the SWC CMHT MHP's could have prevented the death of Miss K that day. However, the IIT appreciates that because some elements of the MHP's response could have been more assertive, and because the MHSU was not provided his mental health care by a CMHT that was geographically appropriate, for the family of Miss K, there will always have been a potential missed opportunity to have prevented her death.

With regard to the MHSU's overall care and management, the elements of his care that could have been improved were:

- The clarity of, and documentation of, the MHSU's relapse prevention plans. Risk management plans and contingency plans were not consistently documented and detailed, and there was a lack of involvement of the MHSU's parents in crisis intervention and contingency planning. (This does not mean that the mental health professionals were not risk aware - they were.)
- When the MHSU was married in 2004 and moved into the flat in which his wife was already a tenant, consideration should have been given to transferring his care to the appropriate CMHT for this area. Although continuity of care for service users is generally considered to be good practice, in this case retaining this MHSU was misguided, given the extensive periods of infrequent contact he had with the team and the challenges of making contact with him when he was actively being followed up by SWC CMHT.
- There were a number of occasions where the MHSU was placed on "open contact" by his care team (in other words, it was his responsibility to initiate contact). He was in fact on "open contact" when care

coordinator 2 (CC2) took over his case management from care coordinator 1 (CC1) in July 2004. It is not good or safe practice to have an individual on one's case load who is not receiving any planned contact from the CMHT for substantial periods of time. If a service user is well enough to be at work full-time, and have no contact with mental health professionals for periods of greater than 4-6 weeks, then he or she could be considered well enough to be discharged from the caseload.

- There is no firm evidence that the MHSU's care team discussed with the MHSU the benefit of him being on depot medication. The IIT, and the MHSU's parents, consider it to be unlikely that he would have accepted medication by this route but nevertheless it should have been formally considered and the outcome of this documented.
- Although discharge planning was reasonable in the broadest sense, there were missed opportunities for effective contingency planning, given that this MHSU was likely to disengage from the service if well and go back to work. It is fortunate that the MHSU's parents were diligent in their communications with their son's mental health professionals. The lack of formal contingency planning was in many ways mitigated by the quality of communication between the MHSU's family and the mental health professionals.

It may be tempting for the reader of this report, in trying to make sense of the death of an innocent person, to perceive a causal link between the above and the preventability of the incident. However one cannot say that had the above aspects of the MHSU's care been different, the death of Miss K would have been prevented. As stated previously, from what the IIT knows of the week preceding the incident, there is no information available that suggests any deterioration in the MHSU's mental state. Consequently there is no information that pointed to a need for enhanced contact with the MHSU during this week. The planned visit by the mental health professionals that took place on 15 August was appropriate and the time gap between that and the previous visit reasonable. However, had the MHSU been with an east city CMHT, there would have been greater opportunity for more assertive follow up when he was not available for his planned appointments at the end of July and in early August. However, there are no guarantees that more assertive follow up over this period would have occurred or that signs of deterioration in the MHSU's mental state would have been identifiable prior to 15 August 2007.

In addition to the above issues, the communication with and support provided to the MHSU's parents could have been considerably improved, as follows.

- The MHSU's parents were only offered one Carer's Assessment. This was in 2007. They should have been offered a Carer's Assessment annually in the years preceding this.

- They should have been provided with a carer's information pack. This did not happen. The information pack contained very useful information for any family, or carer, providing substantial support to a loved one with a serious mental illness.
- They should have been provided with support and debriefing by their son's CMHT in the immediate aftermath of the incident. This did not happen.

With regards to the family of the deceased, LPT could have offered to meet with them via the relevant family liaison officer provided to them by Leicestershire Constabulary. The IIT understands that this did not happen.

With regard to the management of service users who use illegal substances such as cannabis, it is important that readers of this report appreciate that the avenues open to the specialist mental health service for dealing with service users who do not take their medication and who engage in the use of illicit substances are very limited. This is especially so where a service user does not accept that using illicit substances has a negative effect on their mental health and can only exacerbate their underlying mental illness. This MHSU did not accept this.

Limitations also apply to the extent to which the specialist mental health service can bring pressure to bear on a service user to take their prescribed medication. Even with the introduction of supervised community treatment in November 2008, a community treatment order (CTO) does not give mental health staff the power to forcibly medicate in the community.

However, for individuals such as this MHSU a CTO may now provide more inducement for medication and treatment compliance. For a service user, compliance with medication may be a more favourable prospect than detention in hospital. Whether regular uninterrupted medication would have made a difference for Miss K is very difficult to say given the MHSU's use of cannabis.

7.0 RECOMMENDATIONS

Recommendations
The IIT has six main recommendations for LPT following this investigation. These are as follows.

Recommendation 1: "open contact"
The management team for adult services in LPT needs to establish on a CMHT by CMHT basis, in the city and the county, the number of service users who are on "open contact" and the professionals' rationale for this.

If the dominant reason for "open contact" is to enable rapid re-access to specialist mental health services, as was the case for this MHSU, then LPT must review its systems to enable service users to achieve a fast-track route back into the system without having to be treated as a "new" referral.

If an effective system can be achieved it will enable CMHTs to discharge service users while they are well whilst also having, and giving, confidence that those service users who are likely to relapse will be able to re-access specialist mental health services in a timely manner with a care team they know.

Target audience: LPT's Chief Operating Officer.

Recommendation 2: Care Programme Approach and risk assessment
In many respects it appears that the Care Programme Approach (CPA) and risk assessment (RA) are embedded in community and inpatient practice. However the IIT does have some concern about the quality of the information entered on to the CPA and RA documentation tools. This concern is particularly focused on the risk prevention and contingency plans generated within the community. Therefore, LPT needs to consider how it assesses the quality of content, and the frequency with which CPA and RA plans are critically appraised within the context of management and clinical supervision.

In partnership with frontline staff, LPT needs to continue its work of fine-tuning the design of its documentation tools so that they best promote the standard and quality of documentation to which it aspires.

The following information should be stated clearly in risk assessments and risk prevention and crisis management plans so that they can be as useful as possible.

- Where a professional indicates the presence of current and/or previous risk behaviours these must be described, including the context in which they are displayed and their known consequences. LPT can assist its staff in this when it updates the current RA documentation tool. Consideration could be given to including a free

text space after each main section of the actuarial element of the RA tool.

- The action plan must state precisely what is required and not just be a bulleted list. This is not acceptable practice. For example if enhanced visiting is required it would be useful to indicate the minimum frequency for this.
- Contingency plans must be sufficiently detailed so that if no-one is available who knows the service user, then any other professional dealing with the crisis has immediate access to all essential information to enable them to implement the crisis plan. This should include all essential contact numbers, any known haunts and hangouts of the service user, and details of significant others. The crisis plan should also state what core activities and actions must be delivered in the management of crisis, including those professionals who must be notified.

It is expected that LPT will conduct an audit of risk assessment documentation across all of its services to check whether this is being done.
The IIT encourages LPT to utilise a peer review process in addition to more formalised documentary audit tools.
Target audience: LPT's Chief Operating Officer and Medical Director.

Recommendation 3: Risk assessment training
In 2004 a recommendation was made to LPT regarding the provision of clinically focused risk assessment for its staff. The IIT is encouraged that all community staff had accessed risk assessment and CPA training within the Trust and that both CPA and risk assessment were part of the same training workshop. However, the IIT is concerned that not one of the inpatient staff it spoke with had been provided with the same training opportunities or input.

LPT must ensure that clinical risk assessment training, as it relates to the assessment of risk in service users, is provided to inpatient as well as community staff.

The IIT recognises that there may be significant cost implications associated with this, depending on how LPT chooses to address the training deficit. The IIT suggests therefore that LPT must present a proposal of how it will address this essential area of training for all of its staff working within Adult Services in the next financial year (2010/11).

Target audience: LPT's Medical Director

Recommendation 4: Joint working
The IIT is disappointed at the lack of formalised joint working arrangements between the MHSU's CMHT and his wife's AOT. However, it is commendable that LPT has addressed this issue in its current CPA policy document implemented in 2007 (page 14, section 3.4). Although the principles espoused at section 3.4 appear plainly stated to the IIT, its impression is that LPT's professionals are still not always certain about when one should consider joint working.

The IIT therefore recommends the use of this case, and previous relevant serious untoward incidents where joint working would have enhanced the quality of care to the service users, as case studies within LPT's CPA training workshops.

The IIT also recommends that this case be used to highlight the issue of joint working in the next quarterly issue of its learning from experience bulletin TRAIL[22]. It is incumbent on LPT to ensure that TRAIL is circulated to all CMHTs and inpatient services regardless of whether they are city or county based.

Target audience: LPT's Medical Director

Recommendation 5: Support for the family of a service user and the family of the victim following serious incidents such as homicide
Although the internal investigation team did meet with the family of this MHSU during the course of its investigation, there was no immediate post incident support provided to the family by the MHSU's care team. Neither was any support offered to the family of Miss K.

Today LPT has a "Being open" policy that is in line with the guidance provided by the National Patient Safety Agency. Section 5.1, page 5, of LPT's policy is explicit about the requirement to communicate with families and carers following serious incidents.

However there is a gap in the policy document relating to communication with:

[22] TRAIL is a clinical governance newsletter that has been developed by Adult Services in Leicester City to share learning points with all health and social care professionals working within the service. TRAIL stands for "Talk, Reflect, Act, Improve and Learn".

- the family and/or carer(s) of the service user(s) involved in the serious incident, and
- the family of any victim(s), if this is different to the family of the service user, where harm has been caused by a service user,

after the incident has been investigated.
Section 7, pages 6 and 7, of LPT's policy does not make explicit the requirement for staff to meet with and feed back to the respective families and/or carers the findings and recommendations of the internal investigation process. Sending a family a copy of the Trust's internal investigation report in the post is neither sufficient not acceptable.

It is therefore recommended that an addendum to the policy is issued as the IIT does not believe that remedy of this can wait until the policy is reviewed in October 2010.

Target audience: LPT's Director of Quality and Innovation.

Recommendation 6: Investigation of serious untoward incidents (SUIs)
LPT's internal investigation report did not evidence that a reflective or analytical approach had been taken to the investigation of the MHSU's care and management. Furthermore the report was written in a rather congratulatory style and this caused offence to Miss K's family and to the family of the service user.

The incident management policies in LPT are now far more robust than they were in 2007. Furthermore a director of LPT is given the responsibility of overseeing the investigation process and for the quality of the end report.

What continues to be absent from LPT's policy documents is any practical guidance for staff who are identified as having the correct skills and aptitude for investigating. The LPT's incident reporting toolkit, which incorporates the guidance on incident investigation, talks of a structured investigation process but does not set this out anywhere in the policy document. Furthermore it does not set out clearly the core competencies that are required of staff who take the operational lead for SUI investigations.
The IIT suggests that the following should be considered as core competencies for anyone asked to lead SUI investigations.

- An understanding of the basic, key components of a robust investigation process.
- Knowledge of how to construct an analytical timeline (e.g. a tabular timeline) and to which types of incidents it should always be applied.
- Knowledge of how to construct a validation and triangulation map once all questions to be asked have been identified.
- Recognising the importance of the lead investigator having 'hands on' involvement at all key stages of the investigation process. (Delegation to uninvolved third parties is not good practice).

- An understanding of investigative interviewing using a cognitive style.
- Knowledge about what constitutes acceptable and unacceptable interviewing practice. For example there should never be just one interviewer who is also the note keeper.
- The need for as full a record as possible of everything discussed within the interview scenario.
- Knowledge of data analysis techniques such as content analysis and affinity mapping. How to use the 'fishbone diagram'.
- Knowledge of how to write a high level report that is likely to be made available to non-professionals such as the family of a service user and the family of a victim.

It is recommended that these competencies are included in LPT's incident reporting and investigation tool kit as an appendix, and that where a staff member does not possess these competencies they are mentored by someone who does until they are considered competent.

LPT is also encouraged to set out in an appendix of this policy document its investigation framework, i.e. the key stages of the investigation process that it expects all SUI investigators to utilise.

Target audience: LPT's Director of Quality and Innovation

Note: The IIT expects that LPT will, when generating its action implementation plans for presentation to East Midlands Strategic Health Authority, include the actions / measures it will take to test out that the recommendations have been implemented and also the impact of implementation on clinical and investigation practice.

APPENDIX 1: DETAILED CHRONOLOGY OF CONTACTS BETWEEN THE MHSU AND LPT

Date	Contextual Information
18/01/02	First seen at home by a specialist registrar (SpR), following a GP referral. The MHSU was not forthcoming. His father was present. Information provided revealed problems over the last year with exacerbation over the last few months. Bizarre behaviour was the main concern coupled with the MHSU being increasingly withdrawn and isolated. The father identified that the problem had started 3 years ago when the MHSU's older brother had stabbed his younger brother. The MHSU was saying things like he wanted to get a gun and shoot people to see what it looks like. At the time of the assessment there were no signs of homicidal or suicidal ideation. The SpR also spoke with the MHSU's mother. She told the SpR that "he said that Eve and women in general were snakes and they squeezed the life out of men". The MHSU was able to give a rationalisation for this – that he had become too involved with the Bible.
10/06/02	The MHSU was assessed by the occupational therapist and offered a place in the woodwork group and declined the offer.
11/07/02	The MHSU was seen at home by CP1. The MHSU's presentation was very different. His sleep pattern was reversed. There was also some evidence of impulsivity. The family reported that he shouted and chatted to himself. That he was constantly hostile, there were no periods of light relief. The situation at home was constantly fraught. The consultant noted a possible diagnosis of atypical depressive illness with adjustment disorder and possible psychotic illness. The recommendation was for the MHSU to be admitted to hospital under Section 2 of the Mental Health Act (1983).

Date	Contextual Information
22/09/02	The MHSU was discharged from inpatient services. The MHSU's detention under the MHA had been regraded to section 3 three weeks after his admission. He was placed on enhanced CPA. Medication was Zyprexa Velotab (olanzapine)4mg. Because of his behaviour, his threats to attack nursing staff and increasing hostility early on in his admission he had been admitted to the psychiatric intensive care unit (PICU). The notes show that he had improved on olanzapine. He was more appropriate in his behaviour. Diagnosis at this time was undifferentiated psychosis.
November 2002 – August 2003	The MHSU was reasonably stable in the community. He was holding down a job.
28/08/03	Social work records note that MHSU had been disorientated and getting ideas from the TV. Also he had talked about rejuvenation.
25/09/03	Medical discharge from inpatient services following admission on 8 August because of increased concerns by his care coordinator (CC1). Relapse of schizophrenia/harmful cannabis use. Cannabis use had gone from not very often to harmful levels. Records suggest that the MHSU was now on standard CPA. The plan was for CC1 to maintain contact with the MHSU following discharge. Risk indicators were cannabis use. He was expressing bizarre ideas that he was a young boy who had been rejuvenated.

Date	Contextual Information
Mid-November 2003 – early February 2004	Following discharge from hospital the MHSU recovered quickly and did not attend for his outpatient appointments. He worked long hours and was often not available between the hours of 9am and 5pm to meet with members of the South West City Community Mental Health Team (SWC CMHT). By February 2004 the plan was for the MHSU to be on “open contact” for a period of one to three months.
13/07/04	The CMHT received a telephone call from the MHSU’s mother. The records note that he was reported to be doing well. His son had been born at 28 weeks gestation and the baby was due home on 14 July. The community psychiatric nurse (CPN) explained to the MHSU’s mother the difficulty in meeting with her son due to his work commitments. His mother was informed that he would remain on open contact so that he could get back in touch with the CMHT if he needed anything or became unwell.
20/07/04	A new care coordinator (CC2) was appointed to the MHSU. By this time the working diagnosis was paranoid schizophrenia exacerbated by cannabis misuse. There was an emergency outpatient appointment (OPA) for the MHSU. He had made contact with the inpatient ward. He reported a recent stressful event on 9 May. His son had been born 12 weeks prematurely and had been on the neonatal unit. Now his son was healthy. It is noted that the MHSU’s wife also had mental health issues and was in the care of the assertive outreach team. There was also social services involvement for childcare issues, in relation to the ability of the mother to care for the child properly. It was noted that he was compliant with medication and that he had been in full time work for the last 15 weeks. Note: the CPN’s record says reported “slightly non-compliant with meds", over the last few weeks but placed this down to stress. Asked for support with a meeting he had to attend with his son.

Date	Contextual Information
21/07/04 - 22/11/04	Following CC2's contact with the MHSU on 20 July there was no further contact for four months. He remained on open contact and did not attend for his OPA on 31 August.
22/11/04	The MHSU attended for his OPA. Mentally he was noted to be well although he did talk about reducing his medication. He was advised by CC2 that a maintenance dose for two years was generally advised and now was not the time to think of reducing his intake of olanzapine. It was noted that he seemed accepting of this. A further OPA on one of the adult services inpatient wards was arranged for three months' time.
04/01/05	The clinical records note that the CC2 would continue with the MHSU on open contact as she could not meet with him during normal CMHT hours Monday - Friday.
06/06/05	The MHSU made telephone contact with CC2 and advised her that his wife had been admitted to one of the acute psychiatric inpatient wards. He told CC2 that had to give up work to look after his son and he wanted to know what benefits he could claim. CC2 advised she would contact him with these details (actioned 7/06/05).
17/06/05	CC2 was contacted by the ward where the MHSU's wife was. Staff told her that they were concerned that the MHSU was having difficulties in dealing with his wife being ill. CC2 advised she would make contact with the MHSU by phone.
22/06/05	Unsuccessful attempt to make telephone contact with MHSU.

Date	Contextual Information
28/06/05	Unsuccessful attempt to make telephone contact with MHSU.
05/07/05	Cp1 made contact with CC2 and the social worker (SW2) involved with the MHSU and enquired as to what contact they had had with the MHSU. He advised them of an OPA booked for two days' time. He also requested that they try to make contact with the MHSU.
06/07/05	CC2 and SW1 attended at the MHSU's home and made successful contact with him. The MHSU was noted to be mentally well. He was also noted to be compliant with his medication but stressed due to wife's admission to hospital. It is noted that he was coping OK with looking after his son. He was being supported by his parents. The MHSU requested to remain on open contact.
07/07/05	The MHSU attended his OPA with his CP1 It was noted that the MHSU's wife remained in hospital and that the MHSU wished to reduce his olanzapine. He was advised to reduce his cannabis use.
01/08/05	The inpatient ward caring for the MHSU's wife contacted SWC CMHT. There were again concerns about the MHSU's mental state. His wife reported that he was non-compliant with medication and that he was becoming very irritable with her and their son. It is noted in the records that CC2 left a message for the CP1 asking for guidance on how to manage the situation.

Date	Contextual Information
08/08/05	The mother of the MHSU contacted CC2 and advised her that she had had a terrible weekend with her son. He had been more compliant with his medication but he had also been smoking cannabis. The mother told CC2 that her son left the flat naked on Saturday and drove around undressed. He was opening and shutting windows and was acting paranoid. The GP had been contacted and a home visit had taken place. The GP had given the MHSU diazepam. The CPN advised that she would visit the MHSU the next day.
09/08/05	CC2 and SW1 attempted to visit the MHSU at home. However he was not at home. They waited for 45 minutes but he did not return. CC2 told the MHSU's wife that they would return the next day at 11.30am.
10/08/05	CC2 and SW1 re-attended at the MHSU's home and this time he was at home. Both CC2 and the SW noted that he looked quite flat in his presentation. There was also an element of irritability/hostility about his person. At times he presented as quite paranoid. It is noted that he spoke in riddles at times. He spoke about an "invention" - a tape measure, the plans for which were in his car. He said it was going to make him a millionaire. The MHSU admitted to smoking cannabis. It was also established that he had not taken his medication for two weeks but claimed to have now recommenced medication. Towards the end of the visit he was becoming quite irritable and he asked CC2 and the SW to leave. A CHRT referral was discussed and the MHSU said yes and no. Advice was sought from the G-grade nurse for the CMHT and it was agreed that CHRT referral would be made. An up to date care plan was faxed to the team. The duty consultant psychiatrist (CP2) was also advised.

Date	Contextual Information
11/08/05	The CHRT contacted SW1 and advised that they had tried to make contact with the MHSU as arranged but had been unable to achieve this.
11/08/05 - 18/08/2005	The wife of the MHSU contacted SW1 and advised that she had concerns. She reported that the MHSU had not been sleeping. He had been up at 3am and gone to his father's who was in bed, so he had gone again at 5am. He had been up and down all night. The care coordinator for the MHSU's wife also contacted SWC CMHT. She reported that the MHSU was calm at the time of her visit to see his wife, but in his boxer shorts. She also reported that the MHSU's wife was fragile re. mental state and that the MHSU would not engage with her (the care coordinator). The records note that there was some professional discussion regarding the need for CHRT input or hospital admission for the MHSU's wife. Her team would be visiting again on 12 August and would feed back to the MHSU's care team after this.
19/08/05	Child and family services advised SWC CMHT that the MHSU's son was no longer on the child protection register. He had been deregistered.
19/08/05	SW1 managed to achieve contact with the MHSU at home. Her notes say that the MHSU was more settled, less agitated and that he was taking his medication. The MHSU had been offered a job for £8.00 per hour and that while the visiting professionals were present he was offered another for £9.00 per hour. The MHSU's wife confirmed that things were better and that her husband was taking them to the nursery. The MHSU said that he was sleeping and feeling OK. The SW spoke with the professional care coordinator for the MHSU's wife. This individual advised that the MHSU had been irritable and swearing at the family centre that day. It seems he didn't understand why he could not just leave his son there and collect him later. (His son was being orientated to the centre and therefore parental presence was advised for first few visits). The MHSU was taken off alert and CHRT advised.

Date	Contextual Information
14/09/05	CC2 wrote to a charity requesting funds to enable the MHSU and his wife and child to go on holiday.
15/09/05	The MHSU attended for his OPA with his CP1 The MHSU's mental health was noted to be relatively stable. It was also noted that he was unable to hold down a job and seemed convinced that he could make money from his invention of a "self-centring rule". The MHSU said he was using cannabis less. He also said that he is taking olanzapine 20mg. CP1 noted that he had no concerns providing the MHSU remained in contact with services.
15/09/2005 – 27/03/06	There was no contact with the MHSU by the specialist mental health services between 15 September 2005 and 27 March 2006.
27/03/06	The MHSU's wife telephoned CC2 and advised that her husband was non-compliant with medication and had increased his use of cannabis. She also informed CC2 that he had crashed his car on the Sunday morning. She also said he "wasn't pleasant at the moment". An OPA was made for the MHSU for Thursday 30 March. The MHSU's wife was advised of this. She was also asked if she wanted a home visit. She advised that although not well her husband was still working full-time.
27/03/06 - 08/05/06	There was no contact between specialist mental health services and the MHSU for approximately six weeks.
08/05/06 - 10/05/06	There was some attempted telephone contact with the MHSU but this was not successful. Messages were left for him.
15/05/06	The MHSU contacted CC2 and advised that things were not going so well. He said he was compliant with medication, although he continued to use cannabis. The plan was for a home visit on 17 May.
17/05/06	The home visit was cancelled due to CC2 being off sick.
Date	**Contextual Information**

22/05/06	The home visit was rescheduled for 23 May. The MHSU was contacted by phone and advised of this.
22/05/06	SW2 noted in the records that the MHSU had been referred for joint visiting. The MHSU's case required a SW team review due to ongoing S117 responsibilities.
23/05/06	CC2 and SW2 undertook a home visit to see the MHSU. He was at home and was noted to be agitated and there was clear friction between him and his wife. His thought content was also noted to be "slightly? bizarre". An OPA was made for him for 1 June at 14.30hrs. The SW records say: "The house is noted to be chaotic with toys all-round the place. The MHSU's son appears well and happy. The main concern was the MHSU's wife who was pacing around and around agitated and displaying signs of mania. The MHSU was evidently agitated and frustrated with his wife. The MHSU revealed that there were money problems and I (the SW) agreed another visit to discuss these."
26/05/06	Child and family support services contacted the CMHT to advise that the MHSU's wife had been admitted to hospital. The MHSU's parents were providing support to their son in the care of their grandchild.
30/05/06	There was another unsuccessful attempt to meet with the MHSU at home.
30/05/06	The CMHT contacted the MHSU's parents to seek information about him. The parents advised CC2 that the MHSU and his wife were living with them but that there were no significant issues.
02/06/06	The MHSU's mother made telephone contact with CC2. She advised that her son wanted an appointment to talk about money issues. CC2 informed the MHSU's mother that SW2 would meet with her son to discuss this.
02/06/06	SW2 contacted the MHSU and arranged to meet with him on 6 June.
Date	**Contextual Information**

06/06/06	SW2 successfully met with the MHSU. The records note that he appeared well. He was looking after his son. The MHSU advised SW2 that he needed to apply for benefits as he was not working. He also said he would be able to complete the forms himself and did not need help with these. The MHSU also asked about his wife's benefits and was told that her care team needed to support her with these.
30/06/06	The MHSU made contact with CC2. He told her that he had fallen out with his wife and did not want to go back to their flat. CC2 advised him to spend the weekend with his parents. If this wasn't possible he could to go to the homeless unit. CC2 noted that he did not appear to be paranoid on the phone and said he had not been taking illicit substances.
03/07/06	The MHSU was admitted as an informal patient to inpatient psychiatric services. He was escorted to the ward by his brother. On admission he denied using alcohol recently. He also said that he had not used any other drugs for many months. SW2 records imply non-compliance with olanzapine. The reason for admission was a relapse in the MHSU's psychotic symptoms. The MHSU remained as an inpatient for five weeks.
3/07/06 - 14/08/06	On the day after admission the MHSU's mother contacted CC2. She told CC2 that she had been to her son's flat and found it to be in "a state". He had burnt lots of photos, and he had placed a lot of stuff in the bath, she also found pots in the washing machine. On 20 July it is noted that the MHSU had split up with his wife. Note: he was to stay in the flat, she was moving elsewhere.

Date	Contextual Information
26/07/06	The MHSU was to be discharged on enhanced CPA. He wanted a transfer of accommodation and wanted support with it. He had rent arrears. His signs of relapse were noted to be: psychotic symptoms, thought disorder, hallucinations, bizarre behaviour, agitation/aggression, paranoid beliefs. Discharge medication was 15mg olanzapine.
2/08/06	No seven-day discharge visit occurred.
24/08/06	CC2 and SW2 visited the MHSU at home. He was not in. Therefore a note was left for him to advise that they had visited.
25/08/06	The MHSU made telephone contact with CC2 and informed her that he was well and had been collecting his medication. He was however having difficulty with housing benefit. CC2 asked him to get details of this but said that they would also make a telephone call about his benefits. The SW2 record of the 30 August says "he stated he was working 12 hour days so he would be unable to see us". The CP1 Was advised.
30/08/06	CC2 made phone contact with the MHSU to arrange a home visit. He advised that as he was working full-time he was unable to see them. He advised that he would call if there were problems.
Autumn 2006	There was a further period of no contact with the MHSU.
21/11/06	The MHSU's parents made telephone contact with CC2. They advised that her son had lost his job. It was noted that his mother did not feel her son was compliant with his medication. She advised that he had no money and that they (his parents) had to feed him over the weekend. SW2 advised that they would make contact with the MHSU. SW2 also advised the MHSU's mother to call again if she was concerned. The number for the inpatient ward was given for out of hours support and the MHSU's parents advised to call SW2 again if he was concerned.
Date	**Contextual Information**

28/11/06	CC2 and SW2 tried to visit the MHSU at home. He was not in. No note was left as there was nowhere to leave one.
01/12/06	The MHSU's mother contacted the CMHT again. She was concerned about her son's mental health. She was informed that CC2 and SW2 had called round to see her son but he was not there. She advised that on Tuesday he was at her home. The MHSU's mother was advised to call the GP if her concerns increased and that CC2 and SW2 would visit again next week.
05/12/06	CC2 and SW2 managed to meet with the MHSU at his home. The records note that the MHSU appeared much thought-disordered. He was also unkempt in his appearance.. He spoke about electrical matters and the "idea" that had been stolen from him. His flat was also unkempt and the back was removed from the TV as "something was wrong". He said he was not eating and that he was not taking his medication and did not have any. He did admit to smoking some cannabis over the weekend. When asked if he thought he needed to be in hospital he said "no, I'm fine". He was advised to recommence his medication and to stop using cannabis. After the visit CC2 contacted the consultant psychiatrist and arrangements were made for an SpR to accompany them on the next visit on Thursday 7 December.
07/12/06	The SpR attended the home visit and asked the MHSU about what had been happening over the past few days. The MHSU was notably thought disordered and was not able to give a full account of what had been happening. He talked about "his idea" which had been stolen. The SpR also asked him why he had removed the back of his TV. He said it was "wrong and needed sorting". He was offered admission but declined this. He was however agreeable to working with CHRT and taking his medication. The SpR spoke with CHRT who agreed to take him on.
08/12/06	When CHRT visited on 8 December the MHSU was not in. The plan was to try and visit again and if he was not in then to take the prescription for his medication to his mother's house.

Date	Contextual Information
11/12/06	SW2 was informed by phone that CHRT had delivered the prescription to the MHSU. He apparently accepted the prescription and told them to "fuck off". CHRT was therefore unable to engage with him in terms of home treatment. As a result further discussions regarding management were held with the SpR. The plan was that if the MHSU had not collected his medication then they would move to a MHA assessment with the MHSU's GP. When they checked with the pharmacy, they found MHSU had not collected his medication so arrangements were made for the MHA assessment on 14 December.
12/12/06	The MHSU's father contacted SW2. The MHSU was apparently "kicking off". He had "squared up to" his father so he had kicked him out. The MHSU then tried to smash up his father's car. The MHSU's father felt his son needed to be in hospital. SW2 advised him that the plan was for a MHA assessment on Thursday 14th. SW2 advised the MHSU's father to call the police in the meantime if there were further problems.
14/12/06	The MHSU was sectioned under S3 of the MHA. Initially he was taken to the psychiatric intensive care ward due to being "unsettled".
11/01/07	The MHSU continued to have thoughts about becoming a millionaire. He did not think he had an illness: "part of recycling", "Happens once a year when the sparrows come out". "Doesn't believe medication helps as society control his thoughts, but not his actions. Wants to get a job".

Date	Contextual Information
25/01/07	The MHSU was discharged from hospital back home. At this time he had been well for two to three weeks and was in remission from his illness. It was thought that cannabis use contributed to relapse. He remained on olanzapine 10mg twice a day. His also remained on enhanced CPA.
31/01/07	CC2 and SW2 visited the MHSU at home. He was noted to be well. He was also noted to be in rent arrears. The records said that "SW2 and myself went through his medication and it appeared from what he had left from discharge he was being compliant. This was objectively reflected in his mental state."
04/02/07	The MHSU was admitted via A&E having had a sudden relapse of his illness. The admission records say that the MHSU reported running up to people in the street the day before admission shouting at them to frighten them. The clinical records also note that A&E advised the inpatient ward that the MHSU was carrying a knife and said he had thoughts to “kill women”. (Note: this was never substantiated).
05/02/07	It is noted during the ward round that the MHSU reported stabbing someone's tyres as he thought “someone was shagging his wife”. He admitted carrying a knife in his flat in case the door was broken down. He could then stab someone in the stomach and “be real”.

Date	Contextual Information
08/02/07	SW2 visited the MHSU at home as he was on home leave. He noted that MHSU appeared settled and well. He did not return to the ward on this day as was expected but the following day when he was discharged. The overriding opinion was that this admission was precipitated by cannabis use. His recovery was remarkably quick which was not the pattern for this MHSU if he had been medication non-compliant for any length of time. The speed of his relapse also was suggestive of the use of cannabis.
12/02/07	The MHSU was discussed at the SWC CMHT team meeting.
15/02/07	CC2 and SW2 visited the MHSU at home. He was noted to appear well and compliant with his medication. The MHSU said he was not smoking cannabis since his discharge from hospital. It was recorded that he had food in his flat and that he said he was eating and sleeping well. SW2 and CC2 recorded that the MHSU was at the best they had seen him. The next visit was planned for three weeks' time.
08/03/07	The home visit took place as planned but the MHSU was not in. All his windows were boarded up. SW2 made contact with his mother who advised that she had seen the MHSU on 4 March (Sunday) and that he had lost his keys so had broken into his flat. Initially he tried a crowbar but this did not work so he smashed the windows. His mother advised SW2 that her son did not appear to be addressing his hygiene. SW2/CC2 contacted the MHSU's wife, CHRT, and the Local Housing Authority (LHA) officer. The LHA officer advised that the MHSU was putting his tenancy at risk.

Date	Contextual Information
12/03/07	Concerns about the MHSU were highlighted at the CMHT meeting. The plan was to attempt to visit him again. "Discussed on at risk register".
12/03/07	CC2 and SW2 attempted a home visit but again the MHSU did not appear to be in. On this occasion it was not possible to leave a message for him as the communal front door to the flats was locked. SW2's record notes that they would try later in the week and that it would "probably be better to try first thing as the MHSU is more likely to be in".
15/03/07	The MHSU's mother contacted SW2. She advised that her son visited her on 10 March (Friday) telling her that he had smashed the windows of his flat. He told her that he did this "because the voices told him to do this". He came back on 11 March and was distant and twitching, talking incoherently, and mentioned something about killing himself. He was very unsettled and when asked why he couldn't settle he said that "he had been walking around the fields". He left and then came back on the Tuesday asking for money. Again he was agitated and mumbling to himself. The MHSU's mother also gave SW2 her son's new contact numbers. SW2's record notes the MHSU's mother reporting he was unkempt and smelly and said "no thanks" when a wash was suggested.
15/03/07	SW2 attempted to contact the MHSU via both his new numbers. There was no answer. CHRT was contacted so that the MHSU could be placed on Red Alert with assessment for admission if necessary. The inpatient ward was also contacted. The plan was for a further home visit on 16 March.

Date	Contextual Information
16/03/07	SW2 and CC2 made successful face to face contact with the MHSU at home. He was noted to be presenting with "some odd content in conversation". He was also noted to be pleasant in his manner. There were a number of social issues that needed to be addressed. SW2 was to support the MHSU with these. The MHSU took medication in the presence of CC2 and SW2. Medication was also taken to his mother's so he had a supply there as well as at home. SW2's record notes that "he did not seem perturbed by our presence". SW2 liaised with CHRT. They agreed to raising MHSU to amber alert and that they would call in on Saturday.
17/03/07	CHRT tried to make contact with the MHSU but was not successful.
19/03/07	CC2 and SW2 visited the MHSU at home. The records say that he appeared to be mentally well. CC2 and SW2 asked the MHSU why he did not answer the phone when CHRT rang. He had no explanation. He took medication in front of CC2 and SW2. It was also noted that the MHSU was to appear in court re rent arrears on 22 March (Thursday). Support was offered for this which he accepted.
22/03/07	SW2 attended Court with the MHSU.
27/03/07	Home visit - successful contact. The MHSU was noted to be mentally well. CC2 and SW2 discussed the windows to the flat with him which he said he would "sort out". No other problems noted or reported.

Date	Contextual Information
11/04/07	Home visit attempted by SW2 - unsuccessful.
16/04/07	SWC CMHT meeting. Feedback about the MHSU was given including his non-presence for his appointment at home. The plan was to seek an update from the MHSU's mother. This call was made. The MHSU's mother advised that she had seen her son a couple of days ago. He seemed well saying a few odd things but most of the time he was "lucid". She confirmed that she had given him medication. She advised that her son has been spending a lot of time with his son and his wife.
26/04/07	Home visit by SW2 - successful contact. The records note that the MHSU seemed well. He had his court appearance that week regarding his rent arrears. The MHSU confirmed that he was taking his medication - mostly at his mother's and at his wife's.
30/04/07	The MHSU was discussed at the SWC CMHT meeting. No problems were noted. It was reported that he was taking medication when prompted to do so.
02/05/07	Home visit by SW2 and CC2 - successful contact. The MHSU was noted to be well and claiming compliance with medication. SW2 had done a letter for him regarding court and also housing. SW2 noted that the MHSU looked "slightly grubby" but that the flat was clean and tidy.

Date	Contextual Information
14/05/07	Home visit by SW2 and CC2 - successful contact. The MHSU was thought to be well. The records say that he spoke about returning to work although he couldn't find employment. He was thinking of becoming self employed but needed tools to do this and couldn't afford them. SW2 said that he would look into the availability of a grant for him.
25/05/07	Home visit by SW2 - successful contact. The MHSU was again noted to be "quite well". He did however describe an odd phenomenon where he felt as though he was "sinking when crossing the road". SW2 asked the MHSU to take his medication while he (SW2) was there which he did. The charitable trust that SW2 was hopeful would provide a grant for the MHSU was discussed and the MHSU advised that it was not a viable option for him as he would need a guarantor. Other options were therefore suggested.
30/05/07	CPA review.

Date	Contextual Information
31/05/07	The MHSU attended for OPA follow up with his CP. He remained on olanzapine 20mg. His consultant counselled him about cannabis-related harm. Enhanced CPA continued. It was noted that the MHSU was living apart from his wife and child but saw them regularly. It was also noted that the MHSU appeared to be symptom free and as "about as well as he gets in the clinic setting".
04/06/07	Home visit attempted by SW2 - unsuccessful contact. Consequently SW2 telephoned the MHSU's mother for information. She reported that she had seen him the previous week and had no concerns. She thought he was at his wife's. She agreed to contact SW2 if she has any concerns.
11/06/07	The MHSU was discussed at the CMHT meeting. The plan agreed was for CC2 and SW2 to try and make contact with the MHSU that week.
13/06/07	The MHSU's mother contacted SW2. She reported that her son was well at present. However he was staying with his wife who was not well. The MHSU's mother was concerned and asked for the telephone number for her son's wife's team. This was provided to her. SW2 asked her to let him know what transpired.

Date	Contextual Information
14/06/07	Acute psychiatric inpatient services contacted CC2 to advise that the MHSU's wife had been admitted to hospital. The plan was for the MHSU to take care of his son with the help of his parents.
19/06/07	SW2 made telephone contact with the MHSU's mother. She advised that her son was well, and doing well with looking after his son. She was asked to contact SW2 if she has any concerns.
25/06/07	The MHSU's CMHT was contacted by the ward caring for his wife. It is reported that the MHSU had been to see his wife with their son. The visit was noted not to have gone well and the MHSU left the clinical area abandoning his son on the ward. The MHSU's mother was contacted to come and collect the child. On receiving this report SW2 tried to contact the MHSU by phone.
26/06/07	Home visit by SW2 - unsuccessful contact. Neither had the MHSU's mother seen or heard from her son.
28/06/07	Home visit by SW2 - unsuccessful contact. Consequently a follow up call was made to the MHSU's mother. She again had not heard from him. She was concerned about her son and also her grandchild.

Date	Contextual Information
29/06/07	The MHSU's mother contacted SW2. She told him that she had reported her son missing but the police had found him "safe and well". SW2 stated that he would visit her son that same day.
29/06/07	CC2 completed a full risk assessment for the MHSU. It Included a risk profile, including court attendances, and convictions for ABH, drink driving, ram raiding and driving whilst disqualified.

Date	Contextual Information	
29/06/07 continued	The Indicators of relapse were recorded as: ▪ non compliance ▪ bizarre thought and speech content ▪ weight loss ▪ disturbed sleep pattern ▪ getting into fights ▪ misuse of cannabis ▪ paranoid beliefs about wife ▪ auditory and visual hallucinations ▪ disengagement from family. Reducing risk activities were recorded as: ▪ compliance with meds ▪ engagement with care team ▪ increased support from care team ▪ monitoring and support from family ▪ reduced social isolation ▪ encourage self care.	Crisis and contingency plan was recorded as: ▪ Discuss and coordinate as much information from various sources as possible to inform decision making process ▪ Liaise with family and support networks especially MHSU's mother ▪ Bring to attention of RMO known concerns requiring action ▪ Urgent CPA and urgent OPA or home visit ▪ Child protection ongoing assessment - place MHSU on at-risk register. Contingency plan is recorded as: ▪ refer inpatient admission ▪ consider MHA.

Date	Contextual Information
02/07/07	The MHSU was discussed at the CMHT meeting and remained on the "at risk register". SW2 also made a home visit where he met with the MHSU who advised him that his wife had "pissed him off" and his son was "doing his head in" (hence dumping him on his wife's ward). He had not been to his mother's because he believes his brother would "beat him up" and his mother would "do his head in". The MHSU had picked up his supply of medication - however, SW2 did not think he had been taking it as there were too many tablets remaining.
06/07/07	Home visit by SW2 - successful contact. It was noted that the MHSU had been to see his wife. He appeared well. However he had still not had contact with his mother. The MHSU did not want to discuss anything about the incident. SW2 and the MHSU agreed a visit for the following week.
09/07/07	The MHSU was discussed at the CMHT meeting. No problems were noted. SW2 and CC2 were to visit that coming week.
11/07/07	Home visit by SW2 and CC2. It was an unsuccessful contact. The MHSU did not appear to be in. No note was left due to access challenges.
16/07/07	The MHSU was discussed again at the CMHT meeting. There were no immediate concerns about him.
20/07/07	There was a family meeting which the MHSU was to attend but did not. SW2 and CC2 were in attendance.
23/07/07	The MHSU was discussed again at the CMHT meeting. There were no immediate concerns about him.

Date	Contextual Information
25/07/07	Home visit by CC2 and SW2 - successful contact. The records say: "MHSU appearing mentally well and informing us that he is compliant with medication". It was also recorded that he said he forgot about the family meeting. SW2 noted that he spoke with one of the child support team. The plan was for SW2 and this professional to do a joint home visit to meet with the MHSU so that the child support professional could go through the behaviour contract with him regarding contact with his wife and son.
01/08/07	Home visit by SW2 - successful contact. SW2 advised the MHSU of the planned visit with the professional from child support and why. The MHSU was noted to appear mentally well and was mainly "lounging around the house", seeing his son and wife but not together.
08/08/07	Home visit by SW – unsuccessful contact. The MHSU did not answer the door. The windows were ajar which gave the impression that the MHSU might be in. The child support worker gave the behaviour contract to SW2 so that he could get the MHSU to sign it. SW2 made a telephone call to the MHSU's mother. She advised that she had seen the MHSU over the weekend. He was OK. He did not however mention that he had a home visit or why. His mother is noted to have thought that her son may be being "avoidant". She agreed to ask her son to contact SW2 when she next had contact with him.
13/08/07	The MHSU was discussed at the weekly CMHT meeting. The plan was for CC2 and SW2 to visit on 15 August. The focus of their visit was the behavioural contract.

Date	Contextual Information
15/08/07	The home visit took place as planned. The MHSU was not in. A look through the window revealed that the "flat had been trashed and sofa appeared to have been slashed with a knife and there also appeared to be pieces of wood on the floor". It was noted that: “The MHSU’s neighbour from the above flat came to the window and advised that the previous night he had been making a lot of noise. He also informed us that around 4.30am he had been on the phone shouting at somebody for a couple of hours.” The plan was to contact the MHSU’s mother and his wife’s ward where his wife was an inpatient. On contacting the MHSU’s mother, she advised that she found him to be "in and out", However she also thought that he was in control of himself as he settled down when she challenged him. Assertive outreach was also "informed of situation".
15/08/07	It is very clear from the SW2 record that CC2 and SW2 were concerned about the MHSU’s mental state. His wife’s ward was contacted and a telephone call was made to the MHSU’s mother. She agreed to keep SW2 informed of any contact and SW2 agreed to contact AOT and keep her informed.
16/08/07	SW2 made another call to the MHSU’s mother. She advised that she had spoken with her son on 15 August. He was at his wife’s flat. She spoke mainly with his wife who stated that the MHSU was fine. However his mother said she could hear him ranting in the background. He was reported as saying: "My knee's busted and my head's messed up but otherwise I'm OK". SW2 said to the MHSU’s mother that he would contact AOT today to highlight concerns, and advised her to encourage his wife to get the MHSU to contact SW2, and to take his medication.

Date	Contextual Information
16/08/07	SW2 informed AOT of the current concerns re the MHSU and his wife. The main concern was the child's welfare. AOT did not think that the MHSU's wife would jeopardise boundaries regarding her son. The plan was to encourage the MHSU to take his medication, and to utilise his support network. The plan was also to monitor the situation for any further deterioration in the MHSU.
17/08/07	SW2 and CC2 were advised that the MHSU had been arrested.

APPENDIX 2: QUESTIONS ASKED BY THE FAMILY OF MISS K AND THE FAMILY OF THE MHSU

When the family of Miss K met with the SHA on 31 January 2009 they had a number of areas that they wanted to ensure were addressed during the investigation process. All bar two were accommodated within the terms of reference that had been agreed for the investigation. The two areas not initially accommodated were:

- information relating to the MHSU's arrest/criminal history; and
- the appropriateness of the MHSU's housing arrangements.

For ease of reference these issues are detailed here, in addition to their inclusion in the main body of the report.

The MHSU's previous arrest/criminal history

Leicestershire police researched the MHSU's "bad character evidence" as part of its investigation into the circumstances of Miss K's death. It reported that there are crime reports in relation to the MHSU and stated that: "*Although there is some similar fact, very vague, as previous tends to be ex-partner, not strangers and no suggestion of weapons used*."
The IIT has interpreted this to mean that there is evidence of the MHSU behaving badly towards his wife, and that there was some degree of domestic violence (verbal and physical). However there is no evidence that weapons were used. Furthermore there is no evidence that the IIT is aware of on police files that the MHSU assaulted anyone other than his wife in the 11 years preceding the incident.

The specific references noted as part of the investigation into Miss K's death were:

- SW/03671/00-0 - Assault on previous partner. (Punches to face)
- SW/03805/00-8 - Assault on previous partner. (No physical assault, harassment).
- SW/02538/01-3 - Damage to local pub. (Complaint withdrawn - no weapon used).
- Intel. report - MHSU had tried to take *his* child from school.

Police National Computer print-out shows:

- Convictions: 24
- Offences: 64
- Reprimand/warning/caution(s): 2 offences.

Summary of convictions
Date first convicted: 02/08/90
Date last convicted: 04/03/08.

Convictions comprised of:

- 3 offences against the person (1990—2008)
- 4 offences against property (1995—2001)
- 31 theft and kindred offences (1990—1996)
- 3 offences relating to police/courts/prisons (1995—2001)
- 1 firearms/shotguns/offensive weapons (1996)
- 22 miscellaneous offences (1990—2001).

Summary of reprimands/warnings/cautions
Date first reprimanded/warned/cautioned: 11/12/06
Date last reprimanded/warned/cautioned: 27/06/07

- 1 offence against the person (2006)
- 1 offence against property (2007)

There is nothing in the MHSU's conviction history after 1996 that suggests that he posed any prevailing or residual risk of serious harm, or threat of harm, to the general public.

The appropriateness of the MHSU's housing
This issue is dealt with in full in section 4.4 page 72 of this report. In brief, the tenancy of the MHSU was entirely appropriate. He moved in with his wife and was residing with her for a period of six months, without incident, before his tenancy was formalised. This is the standard applied to all individuals moving in with someone who has an existing tenancy. The fact that the MHSU had a mental illness was not a consideration in relation to his tenancy. He did not require supported housing so there was no reason to treat him any differently than any other prospective tenant.

The family of the MHSU also had a range of questions. These were:

- The lack of information provided to them about the crisis and contingency plan for their son.
- The inability of the mental health professionals to gain forcible access to their son's flat when he was at home but wasn't letting them in. This concern is focused on the times where the MHSU's parents considered their son to be unwell.
- The MHSU's parents also found it frustrating that when their son was unwell he could be rude – e.g. told CHRT to "fuck off". They felt that the CHRT didn't persist. In their experience their son when unwell behaved like this. Their son, when well, did not.
- Why their son was not prescribed depot injections instead of oral medication.

- The MHSU's parents did not always feel that their concerns were listened to by the mental health professionals, this was particularly in December 2006 when on 12 December they believed their son to require hospital admission.
- The MHSU's parents do not recall ever being offered a Carer's Assessment.
- Following the incident the MHSU's parents felt that they did not receive any support from the Trust and on the Monday after the incident when the MHSU's mother contacted their son's CMHT no-one returned her call.
- The MHSU often had money problems and was in rent arrears which did threaten his tenancy. Was appointeeship considered at any time?
- On more than one occasion the MHSU's family took him to the inpatient ward that knew him to try and get him admitted. They were told to take him to A&E. The family do not understand this, when the ward staff knew him and A&E would not be able to help.

All of the above questions have been addressed within the main body of the investigation report.

APPENDIX 3: INVESTIGATION METHODOLOGY

The investigation methodology was structured and embraced the key phases detailed in the National Patient Safety Agency's e-learning toolkit. Key activities were:

- Critical appraisal of the MHSU's clinical records and the identification of areas that the IIT needed to understand better.
- Document analysis.
- Face-to-face and telephone interviews and discussions with staff working in LPT and the local housing association.
- Obtaining written information relating to the provision of information to carers.
- Liaison with Leicestershire Constabulary.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

The primary sources of information used to underpin the findings of this investigation were:

- Leicestershire Constabulary's records.
- The MHSU's mental health records.
- The trust's own internal investigation report.
- Interviews with the MHSU's consultant psychiatrist between 2002 and 2007.
- Interviews with two additional medical staff who had contact with the MHSU between 2002 and 2007.
- The MHSU's care coordinator and social worker between 2004 and 2007.
- A selection of staff working in assertive outreach who knew the MHSU's wife.
- A meeting with the housing officer at the local housing association.
- A review of witness statements collected at the time of the incident.
- A meeting with the parents of the MHSU.
- A review of key policies and procedures.

APPENDIX 4 SOURCES OF INFORMATION USED TO INFORM THE ITT'S FINDINGS

The sources of information used to inform the investigations findings were:

- The MHSU's mental health records.
- The original investigation report commissioned by LMHTT completed in 2006.
- A meeting with the 'author' of the LPT's internal investigation report
- A meeting with the Service Manager for adult services in Leicester City
- A meeting with the MHSU's mother and father
- A meeting with the family of Miss K
- Email and written correspondence from Leicestershire Constabulary
- Email correspondence with the Service Development Officer (MH) in Strategic Commissioning & Service Development at Leicestershire County Council.

One-to-one interviews with:

- The MHSU's consultant psychiatrist (Cons P 1)
- The specialist registrar to Cons P 1
- The consultant psychiatrist who covered Cons P 1's annual leave (Cons P 2)
- The MHSU's community psychiatric nurse from 2004
- The MHSU's social worker from 2005
- The team manager for the South West city Community Mental Health Team (SWCMHT)
- The deputy manager for the in-patient unit
- One of the named nurses for the MHSU on the adult inpatient ward
- The MHSU's current consultant psychiatrist
- A housing officer at Leicester Housing Association
- Members of the city assertive outreach team who cared for the MHSU's wife

A group meeting with a selection of staff on the in-patient ward who had experience of caring for the MHSU

Telephone communication with:

- The senior nurse for SWCMHT
- A Carer's Assessor for LPT

LMHTT policy documents relating to:

- the Care Programme Approach
- incident investigation
- 'being open'
- CMHT operational policy

APPENDIX 5 GLOSSARY

THE CARE PROGRAMME APPROACH (CPA)[23]

CPA is the framework for good practice in the delivery of mental health services. In early 2008 the 'Refocusing the Care Programme Approach Policy and Positive Practice' document was published[24]. This made changes to the existing Care Programme Approach.

One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, the principles and values do. CPA still aims to ensure that services will work closely together to meet your identified needs and support you in your recovery. If you have a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When you're needs have been identified and agreed a plan for how to meet them will be drawn up and a care coordinator will be appointed. You and your views will be central throughout the care and recovery process.

There are four elements to the Care Programme Approach:

- Assessment – this is how your health and social care needs are identified.
- Care Co-ordinator – someone is appointed to oversee the production and delivery of your care plan, keep in contact with you, and ensure good communication between all those involved in your care.
- Care Plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of your care and support.
- Evaluation and Review – your care plan will be regularly reviewed with you to ensure that the intended outcomes are being achieved and if not that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as "enhanced CPA".

MOTIVATIONAL INTERVIEWING

The concept of motivational interviewing evolved from experience in the treatment of problem drinkers, and was first described by Miller (1983) in an article published in Behavioural Psychotherapy. These fundamental concepts and approaches were later elaborated by Miller and Rollnick (1991) in a more detailed description of clinical procedures. However a clear definition of motivational interviewing was not stated at this time.

---

[23] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php

[24] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

In 1995 Rollnick and Miller provided the following definition[25]:
"*Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence*."

Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal.

The spirit of motivational interviewing
Rollnick and Miller (1995) said that they
" believe it is vital to distinguish between the spirit of motivational interviewing and *techniques* that *we* have recommended to manifest that spirit. Clinicians and trainers who become too focused on matters of technique can lose sight of the spirit and style that are central to the approach. There are as many variations in technique there are clinical encounters.

The spirit of the method, however, is move enduring and can be characterized in a few key points.

1. **Motivation to change is elicited from the client, and not imposed from without.** Other motivational approaches have emphasized coercion, persuasion, constructive confrontation, and the use of external contingencies (e.g., the threatened loss of job or family). Such strategies may have their place in evoking change, but they are quite different in spirit from motivational interviewing which relies upon identifying and mobilizing the client's intrinsic values and goals to stimulate behaviour change.
2. **It is the client's task, not the counsellor's, to articulate and resolve his or her ambivalence***.* Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. Many clients have never had the opportunity of expressing the often confusing, contradictory and uniquely personal elements of this conflict, for example, "If I stop smoking I will feel better about myself, but I may also put on weight, which will make me feel unhappy and unattractive." The counsellor's task is to facilitate expression of both sides of the ambivalence impasse, and guide the client toward an acceptable resolution that triggers change.
3. **Direct persuasion is not an effective method for resolving ambivalence***.* It is tempting to try to be "helpful" by persuading the

[25] http://www.motivationalinterview.org/clinical/whatismi.html

client of the urgency of the problem about the benefits of change. It is fairly clear, however, that these tactics generally increase client resistance and diminish the probability of change (Miller, Benefield and Tonigan, 1993, Miller and Rollnick, 1991).

4. **The counselling style is generally a quiet and eliciting one***.* Direct persuasion, aggressive confrontation, and argumentation are the conceptual opposite of motivational interviewing and are explicitly proscribed in this approach. To a counsellor accustomed to confronting and giving advice, motivational interviewing can appear to be a hopelessly slow and passive process. The proof is in the outcome. More aggressive strategies, sometimes guided by a desire to "confront client denial," easily slip into pushing clients to make changes for which they are not ready.
5. **The counsellor is directive in helping the client to examine and resolve ambivalence***.* Motivational interviewing involves no training of clients in behavioural coping skills, although the two approaches not incompatible. The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a need for further intervention such as skill training. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a client-centred and respectful counselling atmosphere.
6. **Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction***.* The therapist is therefore highly attentive and responsive to the client's motivational signs. Resistance and "denial" are seen not as client traits, but as feedback regarding therapist behaviour. Client resistance is often a signal that the counsellor is assuming greater readiness to change than is the case, and it is a cue that the therapist needs to modify motivational strategies.
7. **The therapeutic relationship is more like a partnership or companionship than expert/recipient roles***.* The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behaviour.

Viewed in this way, it is inappropriate to think of motivational interviewing as a technique or set of techniques that are applied to or (worse) "used on" people. Rather, it is an interpersonal style, not at all restricted to formal counselling settings. It is a subtle balance of directive and client-centred components. shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost (Miller, 1994).

RISK ASSESSMENT

Risk assessment and risk management should be part of the routine care provided to a mental health service user. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However the general principles of risk assessment and risk management relies on undertaking an assessment and identifying aspects of an individual's behaviour and lifestyle that might pose a risk to self, or to others, and to the qualification of that risk where possible. Once risks are identified it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

SUPERVISED COMMUNITY TREATMENT ORDERS

Supervised Community Treatment Orders (CTOs) were implemented in England and Wales as part of the Mental Health Act 2007, on 3rd November 2008.

The CTO is, alongside the changes in professional roles, the most significant change to the Mental Health Act 1983 brought about by the Mental Health Act 2007. Both the value and ethics of CTOs were debated widely during the Act's passage through Parliament. Many patients' groups expressed grave reservations about their use, stating that if a person was ill and presenting sufficient risk as to require compulsion, this should be in hospital with the full range of necessary support. Some professionals view CTOs as a less restrictive alternative for a group of patients who require compulsion, usually through lack of insight into their illness, but don't require detention in hospital. The Government stated that CTOs were to help tackle so-called 'revolving door' patients, those who improve in hospital, are discharged, stop their medication and relapse, requiring readmission.

What a CTO achieves

The law as passed, permits a patient to be placed on a CTO after one brief period of detention on a 'treatment' order in hospital. Many professionals have expressed concerns as to how CTOs will operate, particularly in relation to having separate teams for in and out-patients, the role of crisis resolution teams and the lack of acute beds. Further issues are the complexity of Parts 4 and 4A Mental Health Act (consent to treatment) in relation to CTOs, the role of conditions placed on patients, their medical treatment and recall and the practical aspects of treatment (including the role of the police).

NHS East Midlands
Octavia House
Interchange Business Park
Bostock's Lane
Sandiacre
Nottingham
NG10 5QG

www. eastmidlands.nhs.uk

Consequence UK Ltd
Lydes House
392 Pickersleigh Road
Malvern
Worcester
WR14 2QH

www.consequence.org.uk