NHS
East Midlands

An Independent Investigation into the Care and Treatment of AB a person using the services of Nottinghamshire Healthcare NHS Trust

Undertaken by Verita

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VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of AB

A report for
NHS East Midlands

June 2010

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1. Introduction

1.1 On 25 September 2006 AB stabbed and killed his daughter's partner, FD, outside AB's home in Clifton, Nottingham.

1.2 At Nottingham Crown Court AB was found guilty of murder and sentenced to 13 years imprisonment.

1.3 For ten years leading up to the homicide AB was known to Nottinghamshire Healthcare NHS Trust. His care was primarily delivered on an outpatient basis although he did have a number of brief admissions to hospital.

1.4 Following the incident the trust commissioned an internal investigation. It was conducted by a general manager of adult mental health services at the trust; a consultant psychiatrist of adult mental health in the city and south sector at the trust and the social care lead at Nottingham City local authority social care department.

1.5 The terms of reference for the internal investigation were dated October 2006, although the investigation report was undated. The trust produced an action plan to monitor and support the implementation of the internal investigation recommendations.

1.6 This independent investigation was commissioned by NHS East Midlands with the full cooperation of Nottinghamshire Healthcare NHS Trust (the trust). The investigation was commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005.

1.7 The independent report quotes from contemporaneous documents and from the evidence of witnesses we interviewed. In order to assist the reader, we sometimes replace abbreviations which appear in the documentation with the full text, and we sometimes correct spelling or grammatical mistakes to help make the meaning clear. Where the existence of such mistakes is relevant to the issues discussed, the passages quoted appear precisely as in the evidence.

1.8 Nottinghamshire Healthcare NHS Trust is one of the largest providers of mental health and learning disability services in the country. It serves the population of Nottinghamshire which is around 776,500**.**

1.9 The trust provides services in community teams, acute inpatient wards, medium secure services (Arnold Lodge in Leicester and Wathwood Hospital near Rotherham) and high secure services at Rampton Hospital near Retford.

2. Terms of reference

Commissioner

2.1 This independent investigation was commissioned by NHS East Midlands with the full cooperation of Nottinghamshire Healthcare NHS Trust (the trust). The investigation was commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005.

Terms of reference

2.2 The aim of the investigation was to undertake a systematic review of the care and treatment provided to AB by Nottinghamshire Healthcare NHS Trust and to identify whether there was any aspect of his care and management that could have altered or prevented the events of 25 September 2006. The full terms of reference are contained in appendix A.

2.3 The investigation team reviewed the quality of the health and social care provided by the trust and assessed whether this adhered to trust policy and procedure. The team paid particular attention to the following:

- Whether the care programme approach (CPA) had been followed by the trust with respect to AB.
- Whether the risk assessments of AB were timely, appropriate and followed by appropriate action.
- The adequacy of AB's care plans.
- The delivery, monitoring and review of AB's care including standards of documentation.
- The Mental Health Act assessment process.
- The appropriateness of continued prescribing of anti-psychotic medication.

- The appropriateness and implementation of a shared care protocol between mental health and primary care services.

- Whether the recommendations identified in the trust's internal investigation reports were appropriate and to what extent these recommendations were incorporated into action plans that were implemented.

2.4 The review team has sought to identify learning from this investigation through applying root cause analysis (RCA) tools and techniques as applicable.

2.5 The investigation team has completed its investigation within six months of all documents being received from the trust.

3. Approach and structure

Approach to the review

3.1 The investigation team comprised of:

- Chris Brougham, senior investigator, Verita
- David Knight, investigation manager, Verita
- Tim Amor, consultant psychiatrist and professional adviser.

3.2 We met with AB and his ex-wife who he had identified as his next of kin. We also met with AB's daughter (FD's partner) and FD's mother. This helped us to gain a thorough understanding of the incident from the perspective of those directly affected.

3.3 We interviewed staff from Nottinghamshire Healthcare NHS Trust who provided care and treatment for AB as well as staff who told us about the internal investigation report and the progress made since the report was completed. We were not able to meet with either consultant psychiatrist 1, who the trust told us has passed away, or consultant psychiatrist 2, who has left the country. Both of these doctors treated AB but with respect to their involvement in this case we have had to rely upon the documentary evidence.

3.4 The investigation team followed established good practice in the conduct of interviews. All interviewees were given the opportunity of being accompanied at their interview. They were provided with the opportunity to comment both on the factual accuracy of their interview transcripts, and where appropriate, on relevant extracts of this report while it was in draft form.

3.5 We have provided a list of those interviewed in appendix B.

3.6 We examined documentary evidence including policies and procedures from the trust, AB's clinical records and the internal investigation report.

3.7 A list of documents reviewed is included at appendix C.

3.8 We have analysed the evidence received and made findings and recommendations to the best of our knowledge and belief based on our interviews and the information available to us.

3.9 A list of abbreviations used in this report is provided at appendix D.

4. Executive summary and recommendations

Executive summary

4.1 On 25 September 2006 AB stabbed and killed his daughter's partner, FD, outside AB's home in Clifton, Nottingham. He was later found guilty of murder and sentenced to 13 years imprisonment.

4.2 For ten years leading up to the homicide AB was intermittently a patient of Nottinghamshire Healthcare NHS Trust. His care was primarily delivered on an outpatient basis. He also had a number of brief admissions to hospital.

The internal investigation

4.3 Following the incident the trust commissioned an internal investigation. Its terms of reference are dated October 2006, although the investigation report is undated. The internal investigation report was sent to NHS East Midlands in May 2008.

4.4 The internal investigation team was of appropriate seniority and experience but the leader of the internal investigation team was the manager responsible for the clinical area in which AB's care was provided. This raised questions about the independence and objectivity of the internal investigation. However we found no evidence that objectivity had been compromised. The internal investigation report does not include any evidence that either AB's or FD's family were consulted or engaged.

4.5 The trust produced an action plan to drive and monitor the implementation of the recommendations arising from the internal investigation. This action plan has subsequently been updated.

AB's care and treatment

4.6 During AB's engagement with secondary mental health services from December 1996 to the homicide in September 2006 he was seen by nine psychiatrists including four consultant psychiatrists, one locum consultant psychiatrist, one associate specialist from the Nottinghamshire forensic

service, a specialist registrar, a staff grade psychiatrist and an independent psychiatrist who assessed AB to produce a court report.

4.7 Diagnoses recorded in AB's clinical notes included paranoid personality disorder, explosive personality disorder, mixed personality disorder with paranoid and antisocial traits, paranoid personality disorder and impulsive disorder, delusional disorder characterised by paranoid personality delusions and depressive symptoms and paranoid personality state.

4.8 After the homicide a consultant forensic psychiatrist concluded in a report for Nottingham Crown Court that AB:

> "…*suffers from personality disorders that conform to the Mental Health Act category of psychopathic disorder; however these are not amenable to medical treatment and it is not appropriate to make a recommendation for disposal under the Mental Health Act at this time."*

4.9 AB's clinical presentation included symptoms - such as hearing voices - which might have been expected in a person suffering from psychosis. This served to make his diagnosis more complex. Each doctor with whom he had contact concluded that his primary problems were based in his personality rather than psychosis. It is evident that it was extremely difficult to come to any firm conclusion about AB's diagnosis even though he had been known to psychiatric services for many years.

4.10 AB's failure to attend some outpatient appointments was followed up and new appointments were offered in accordance with trust policy. AB's late and unannounced arrivals were dealt with flexibly. We found evidence of good practice in the trust in this respect.

4.11 On a number of occasions AB was offered referrals to specialist and therapeutic services such as anger management, cognitive behavioural therapy (CBT) and alcohol services but AB did not take up these offers. AB may have benefitted from services suggested by clinicians. He missed an opportunity to understand and manage his anger problems.

Care programme approach (CPA)

4.12 Between 1997 and 2006, overall the trust carried out the care programme approach (CPA) for AB in line with the national guidance and local policy. In one instance there was no documented evidence of CPA in the discharge summary following AB's discharge from hospital, but follow up arrangements were made for him and a copy of the discharge summary was sent to AB's GP.

Risk assessment

4.13 The risk AB posed to others was clearly documented. Formal risk assessments were not completed during his many attendances at outpatients, but this was in line with trust policy at the time. Discussions with AB in outpatients were recorded making clear his responsibility for his actions and their consequences. Formal risk assessments were undertaken during his admissions to hospital.

Medication

4.14 During the period of his engagement with secondary mental health services AB was prescribed a range of anti-psychotic and anti-depressant medication. He was also treated with benzodiazepines, hypnotic medication and mood stabilisers.

4.15 It was reasonable for the doctors treating AB to negotiate the use of various anti-psychotics with him over the years. His treatment with antidepressants was appropriate given his recorded symptoms. It was also reasonable to assess the efficacy of carbamazepine, a mood stabilising medication, over a period of several months.

Shared care protocol

4.16 The trust's shared care protocol (between consultant psychiatrist and GP) for atypical antipsychotic drugs was used because AB was prescribed olanzapine. This protocol needs to be reviewed to clarify whether patients who do not have diagnoses of schizophrenia and related disorders or bipolar disorder but who receive such medication need to be subject to it.

Use of the Mental Health Act 1983

4.17 AB was admitted to Queen's medical centre twice under sections of the Mental Health Act 1983. The use of the Act was appropriate as was the discontinuation of the relevant sections of the act on his discharge from hospital.

Services for people with personality disorders

4.18 Specialist services for people with personality disorders were developed in Nottinghamshire and many other parts of the country in the mid 2000s. We agree with the conclusions of the trust's internal investigation that had AB been receiving care and treatment now it is likely he would have been referred to such services. However, AB told us that he would not have accepted referral to specialist services for people with a personality disorder.

4.19 We understand the difficulty the trust had in implementing the internal investigation recommendation to review all patients with a diagnosis of personality disorder. We commend the trust's focus on developing care pathways and channels of communication between community mental health teams (CMHTs) and the Nottinghamshire personality disorder and development network (NPDDN). It appears however that this work has been slow to gain impetus. It is important that the training and secondment initiatives identified in the trust's action plan are encouraged and continue.

Conclusion

4.20 AB's care was primarily delivered on an outpatient basis, although he had a number of brief admissions to hospital.

4.21 In relation to diagnosis, the majority view throughout his contact with services was that he suffered from a personality disorder.

4.22 AB was offered referrals to specialist and therapeutic services but he did not take up these offers.

4.23 AB was not referred to the trust's personality disorder services. However he told us that he would not have accepted a referral to specialist services for people with a personality disorder.

4.24 AB had a number of convictions for burglary, assault and driving offences. His history of convictions was known by the trust and AB was told by psychiatrists that he would be held responsible for his behaviour.

4.25 We have made recommendations concerning CPA, safeguarding children, personality disorder services and the management of serious untoward incidents. We have found no evidence though to suggest that this incident was predictable or preventable.

Recommendations

R1 The trust should ensure that CPA reviews are now undertaken and recorded before patients are discharged from inpatient services.

R2 The trust should review the shared care protocol for atypical antipsychotic drugs to clarify whether patients other than those with diagnoses of schizophrenia and related disorders and bipolar disorder who receive such medication should be subject to the protocol. The review should also consider whether doctors other than the patient's consultant psychiatrist may sign the document.

R3 The trust should reassure itself that the implementation of its current policy and procedures for safeguarding children are robust, particularly in relation to cases where risk requires clinical staff to consult the trust's lead person on safeguarding children or in cases where referral to the local safeguarding (child protection) team is indicated.

R4 When the trust's serious untoward incident policy is next reviewed, the trust should take the opportunity to include reference to the need for members of internal investigation teams to be independent of the service and/or geographical area within which the incident occurred.

R5 The trust should ensure that victims and their families are involved and supported in accordance with the SUI policy.

R6 The trust should ensure that information on care pathways for people with a diagnosis of personality disorder is published and disseminated as soon as possible.

R7 The trust should monitor and evaluate the accessibility and effectiveness of consultative advice provided by NPDDN to CMHTs on the management of patients with a diagnosis of personality disorder. This could involve either an extension of the current study of referrers' views of NPDDN or a clinical audit of a sample of cases from CMHTs and NPDDN.

5. Chronology of AB's care and treatment

Family life

5.1 AB was born in Nottingham in 1957. He described his childhood as unhappy and from the age of 11 he was raised in children's homes. When frustrated he described dealing with his emotions through damaging property. For example, he broke windows and while at school he hit a teacher with a chair. He left school with no qualifications and after leaving school had a number of jobs but has been unemployed since 1979.

5.2 AB married in 1976 but later divorced in 1988. He and his ex-wife lived together intermittently after 1988 and were living together at the time of the homicide. They have four children one of whom died in early childhood.

Forensic history

5.3 Before AB killed FD he had a number of convictions for burglary, assault and driving offences. They are summarised below:

Conviction date	Offence	Sentence
January 1974	Assault occasioning actual bodily harm	Care order
January 1974	Breach of conditional discharge*	Fine
May 1975	Taking conveyance without authority	Fine – license endorsed
May 1975	Aiding and abetting/no insurance	Fine – license endorsed
May 1975	Driving whilst disqualified by reason of age	Fine – license endorsed
July 1975	Burglary and theft – dwelling. Convicted on three counts – further 19 offences taken into consideration	Borstal
March 1981	Burglary and theft – non dwelling	Community service order 180 hours
March 1981	Obtaining property by deception	Conditional discharge 18 mths
March 1982	Breach of community service order	Three months imprisonment
September 1995	Common assault	Conditional discharge 1 year
September 2002	Assaulting a police officer	Four month curfew with electronic tagging

Chronology of contact with mental health services

5.4 AB was known to mental health services from 1974 when he was aged 17 and took an overdose of aspirin. In 1980 he took an overdose of paracetamol.

5.5 In December 1996, following an overdose of ibuprofen, AB was assessed by a psychiatric social worker with the deliberate self-harm team at the Queen's medical centre (QMC). He did not attend the follow-up appointment offered but subsequently contacted the psychiatric social worker again and was seen on 23 April 1997. He told her that prior to his overdose he had been to the funeral of his grandchild, that he had experienced problems managing his anger in the past and that on one occasion he feared he could have killed his wife with a baseball bat had someone not been present. He was also worried that he could have killed his 18-year-old son.

5.6 On 24 April 1997, the psychiatric social worker referred AB to the south and west community mental health team (CMHT) because "*although AB's anger has been around at one level for a long time, he now feels he is at risk of harming others and is very keen to receive help".*

5.7 In May 1997 AB was assessed by a specialist registrar to consultant psychiatrist 1 and CPN1, a community psychiatric nurse, from the South and West CMHT. AB described a lifelong pattern of having a very short temper and "…*that at times he will fly into a violent rage"* with his family and had thoughts of killing them. He said that he had almost committed serious violence on family members on several occasions but had been stopped by others. He also told them that:

> *"…he often thinks people are staring at him, and will tackle strangers in the street, accusing them of staring at him."*

5.8 The specialist registrar noted that AB had an explosive temper and probably had a paranoid personality structure. He prescribed carbamazepine (a mood stabilising drug), arranged an outpatient follow up appointment and CPN1 agreed to examine the possibility of anger management training. We were unable to find evidence that this referral was completed.

5.9 AB attended a number of outpatient appointments with the specialist registrar during May and July 1997. He told the specialist registrar that his wife had left him following an outburst from AB. The specialist registrar increased AB's dose of carbamazepine as the lower dose did not seem to be beneficial. This was to be reviewed in August 1997. AB was thinking about whether he should accept

a referral to cognitive behaviour therapy. In August 1997 he remained reluctant to take up the offer of cognitive behaviour therapy, primarily as this would mean having to meet new people which AB found difficult. The specialist registrar was leaving his post and as AB was not willing to see his successor, the specialist registrar discharged him. He wrote to AB to inform him of his discharge and also advised him that should he decide to see the specialist registrar's successor then he should ask his GP to re-refer him to the mental health service.

Comment

Given that AB declined to see another psychiatrist, discharging him from the service was a reasonable course of action.

5.10 Five months later in February 1998 AB's GP, GP1, re-referred him to the community mental health team. AB was assessed by consultant psychiatrist 1 whose three main concerns are summarised below:

- Phobic anxiety – *"these paranoid feelings are not delusional and he acknowledges that his response is irrational".*
- Concerns about his temper. Consultant psychiatrist 1 noted that AB had become *"almost dangerously violent to his family…he says he receives no warning or has no intention of becoming aggressive but…flies into a violent rage".*
- That *"his way of managing situations he disliked with temper (smashing windows/getting into fights etc) was a lifelong habit".*

5.11 Consultant psychiatrist 1 was concerned that AB's phobic anxiety and fear about losing control was leading him to become housebound. He concluded that AB had:

> *"…no enduring symptoms of depression and has had no features of psychosis or any signs or symptoms of organic changes".*

5.12 He suggested cognitive behaviour therapy (CBT) and AB agreed with this course of action. Consultant psychiatrist 1 also changed AB's medication from dothiepin to paroxetine (both antidepressants) and added a prescription for thioridizine (an antipsychotic drug.) He arranged an electroencephalograph (EEG) and a computerised tomography (CT) scan for AB to rule out the

possibility of an organic reason for his problems with his temper.

5.13 On 13 May 1998 AB was reviewed by consultant psychiatrist 1 in the outpatient department. Consultant psychiatrist 1 recorded that AB:

> *"…still has very strong views about morality and standards of behaviour and believes those who abuse drugs or behave unlawfully should be eradicated. His daughter is living with a young man who abuses illicit drugs.* [AB] *is very angry about it. This causes arguments/friction with* [his] *daughter and his ex-wife."*

5.14 The notes indicate that AB was still waiting to go to court on charges of carrying an offensive weapon. AB had been arrested by the police as he was threatening to beat a man with a baseball bat after the man had threatened AB's son. AB also told consultant psychiatrist 1 that he was experiencing difficulties with his neighbours. He complained that his neighbour's children were making too much noise and he could not concentrate to work at the computer or to read. He told consultant psychiatrist 1 that he had tried to speak to his neighbour and had approached the housing department with no success. He said that if the situation was not resolved then he *"might take aggressive action like burning the house down".* Consultant psychiatrist 1 tried to telephone the housing office but with no success and subsequently wrote to the housing office manager advising that the situation needed resolving and that AB had threatened to take matters into his own hands. Consultant psychiatrist 1 noted:

> "*…due to his unusual personality and his past history of violence, potentially there is a high risk of him carrying out these threats."*

5.15 Consultant psychiatrist 1 concluded that AB had no signs of mental illness, other than fluctuating phobic anxiety leading to an avoidance of crowds, but had a serious personality disorder with rigid views and an explosive temper. He recorded that any violence would not be as a "*consequence of mental illness*" and that he discussed this at length with AB.

5.16 By AB's next appointment with consultant psychiatrist 1 in June 1998 his housing situation appeared to have improved. AB was in dispute with his ex-wife about the custody of their 15-year-old son. He appeared emotional and tearful but not depressed. Consultant psychiatrist 1 completed a form to assist with AB's claim for disability living allowance on which he noted AB's explosive temper

and violence, paranoid feelings that people are looking at him and his fear of losing control of his anger.

5.17 Consultant psychiatrist 1 reviewed AB again in August 1998. AB had been assaulted by a man who had broken his jaw. As a result he felt more unsafe than before and was staying with his daughter while he was waiting to be re-housed. His EEG results were reported as being normal but his broken jaw meant that he had not been able to attend his CT scan. Consultant psychiatrist 1 arranged to see him again in two months.

5.18 Consultant psychiatrist 1 saw AB again in October 1998. He recorded that AB was still touchy and sensitive with an explosive temper but that there were no paranoid delusional beliefs or other psychotic experiences. AB was frustrated about the time it was taking to re-house him but he was not making any threats to resolve this with hostility or violence.

5.19 AB was advised to gradually increase his social outlets, undertake cognitive behaviour therapy methods of controlling his temper and to continue with his existing medication. AB did not take up the offer of cognitive behaviour therapy.

5.20 When AB was seen again by consultant psychiatrist 1 in December 1998 the council had offered him three housing options none of which were acceptable to him and he had returned to his original address. Consultant psychiatrist 1 referred to AB's mood as "*euthymic*" (normal) with no morbid thoughts or psychosis.

5.21 AB did not keep his appointment in February 1999 but attended in March 1999 when he told consultant psychiatrist 1 that he was still experiencing problems with his housing. Consultant psychiatrist 1 noted that he was not psychotic or depressed. In May 1999 he had been given a flat in Clifton (on the outskirts of Nottingham) and was pleased. Consultant psychiatrist 1 recorded that he appeared settled and was coping. His care programme approach (CPA) level was recorded as level one. This means that the service user has standard needs and has contact with only one professional. AB did not attend his appointment in August 1999.

5.22 In October 1999 AB told consultant psychiatrist 1 he thought he was being followed by a police officer and that others had told him that the police officer had been asking about his possible involvement in a case of manslaughter. Consultant psychiatrist 1 noted that AB was not sleeping and

was experiencing an increase in his anxiety. Otherwise AB appeared settled but consultant psychiatrist 1 recorded *"need to see if not developing paranoid psychosis"*. He increased AB's prescription for thioridizine (an anti-psychotic medication).

5.23 In December 1999 AB again told consultant psychiatrist 1 that he was being followed by a "*bloke*" who he thought might be a police officer and who was mischievously responsible for arranging for curries and pizzas to be delivered to AB's house. His car had also been stolen. When we met with AB as part of this investigation he told us that he was still unsure if these experiences were real or not. Consultant psychiatrist 1 recorded that there was a significant increase in paranoid perceptions and *"? paranoid psychosis"*. He increased his dose of thioridizine but with a view to changing his medication to trifluoperazine (a different anti-psychotic medication) if AB showed no improvement.

5.24 When consultant psychiatrist 1 reviewed AB in February 2000, AB complained of hearing voices in his head, he was experiencing panic attacks and was afraid to go out. He reported neither suicidal thoughts nor any thoughts of harming others. In keeping with his plan from the previous appointment consultant psychiatrist 1 changed AB's medication from thioridizine to trifluoperazine. When he was seen in April 2000 AB appeared more settled and the voices were less prominent since he had been taking trifluoperazine. He was still experiencing anxiety but was able to go out with family and friends.

5.25 When AB attended his appointment with consultant psychiatrist 1 in August 2000 he had recently been *"attacked by a stranger"* and had a broken jaw. This was the second time in two years that AB has sustained a broken jaw as a result of an assault. He complained that he was hearing foreign voices in his head and could hear noises outside his flat. He had not been taking trifluoperazine but had continued taking thioridizine. Consultant psychiatrist 1 saw him again in September 2000 when he appeared more settled although still complaining that he was hearing voices and was being followed. His CPA level was recorded as level one.

5.26 AB did not keep his appointment in December 2000 but attended in February 2001 when he was again having difficulties with his neighbours. A security camera he had installed had been smashed and he was bothered about curries and pizzas which he had not ordered being delivered to his home. He told consultant psychiatrist 1 that he had become housebound as his anxieties had increased considerably. Consultant psychiatrist 1 noted that AB had no delusions or hallucinations

but was suffering from a paranoid personality disorder with fluctuating depression, anxiety and agoraphobia. He noted that AB was shopping in the very early hours of the morning to avoid contact with other people. Later that month consultant psychiatrist 1 contacted the housing department to see if he could assist in getting AB another property.

5.27 AB saw consultant psychiatrist 1 on 15 May 2001 in the outpatient department. AB complained that he was still being harassed and that eggs and tomatoes had been thrown at his house. He also said that he was hearing voices – which were like whispers, or foreign voices, and which he heard mostly at night. He was still avoiding contact with other people and felt that people stared at him, he was fearful that he would lose control. He complained that he was drowsy during the day and that his family had to check on him during the day and night. The benefits agency had recently declined his application for disability living allowance and he was contesting their adjudication. AB had already employed a solicitor to assist with the claim and consultant psychiatrist 1 agreed to provide a medical report. As AB told him that he was drowsy consultant psychiatrist 1 reduced his dose of trifluoperazine and suggested that AB should take chlorpromazine only if he was unable to sleep but should continue to take his antidepressant. He also considered referring AB for another EEG (electroencephalograph) although tests taken earlier in AB's care had all shown no abnormalities. He noted that AB remained on CPA level one.

5.28 On 24 May 2001 AB was admitted to ward A42, a mental health ward at the Queen's medical centre, via the accident and emergency department. He had been found in a ditch in Kegworth after being missing from home for two days. While on the ward he became agitated and distressed at being restricted to the ward and threatened to break a member of staff's neck.

5.29 AB's ex-wife contacted ward staff to tell them that he may have taken an overdose (clinical notes indicate that he had taken an overdose of procyclidine, a medication taken to prevent side effects from anti-psychotic drugs such as thioridizine or chlorpromazine) and he was transferred to a general medical ward. He became angry and threatening and threw a chair causing it to break. He was restrained by staff.

5.30 In the general medical ward AB was seen by the psychiatric senior house officer (SHO) as he had said that he wanted to be discharged from hospital. AB told the SHO that he had intended to kill himself, had no reason for living and would attempt to kill himself again. The situation was discussed with senior medical staff and given the concerns that AB was at risk of harming himself if he left

hospital he was placed on section 5.2 of the Mental Health Act 1983[1] on 25 May 2001. Later that evening once his physical condition had stabilised he was transferred to another mental health ward.

5.31 On 26 May 2001 while being informed of his rights under section 5.2 of the Mental Health Act 1983, AB told staff that he would leave hospital and would use violence to do so if that was necessary. He removed a drawer from the hospital wardrobe and threw it against the bedroom door; he then removed a second drawer using it to smash the bedroom window before trying to leave via the window. He was restrained by nursing staff. Following this incident he was transferred back to A42 and nursed on high level observations. Later that day he appeared more settled and received some visitors.

5.32 On 27 May 2001 he was reviewed by a SHO, at the request of nursing staff. AB appeared settled and indicated that he was willing to stay in hospital on an informal basis. His observation levels were reduced to medium, at intervals of ten minutes with the proviso that nursing staff would increase his observations if necessary. Staff discussed the possibility of discharging AB from section 5.2 of the Mental Health Act 1983. At 11.40am the SHO completed an 'audit of outcome of detention under section 5(2) of the mental health act' form in which she recorded – "*this gentleman has improved and he is willing to stay informally. Discussed with SpR* [specialist registrar] *on call, who suggested that section 5(2), be rescinded".* AB also told the doctor that he wanted to change his consultant and was advised to request this in writing.

5.33 At 11.30pm AB could not be found on the ward. Ward staff spoke with AB's ex-wife who said that he had intended to return home and she was happy with his returning. He was placed on leave.

5.34 AB voluntarily returned to the ward the following day. He did not appear to be agitated and was willing to stay to be reviewed the next day. On 29 May 2001 he was reviewed again. There was no evidence of psychotic symptoms or depression or confusion. AB told staff that he had heard voices on the day before his admission and that he had overdosed to try to stop the voices. He also said that he thought the voices were part of a conspiracy against him. Later that day AB was shouting about the state of the dormitory floor. The situation was defused by staff.

[1] Section 5.2 applies in the case of a patient who is an inpatient and is detained in the hospital for a period of 72 hours.

5.35 AB remained on the ward during 30 May 2001 but on 31 May 2001 he told the staff nurse that he wanted to discharge himself. His behaviour had been noted to be appropriate with no signs of psychosis or depression. He was unwilling to stay for either the ward round or to be seen by the duty doctor and at 11.30am he discharged himself against medical advice. A discharge form was completed which indicated that AB was at level one CPA.

5.36 When we met with AB he told us that he got on well with consultant psychiatrist 1, however AB wrote to consultant psychiatrist 1 on 31 May 2001 requesting transfer to another consultant. In his letter AB stated that he believed that consultant psychiatrist 1 was part of a conspiracy against him.

5.37 Consultant psychiatrist 1 responded to AB's request on 11 June 2001. He agreed to arrange for another consultant to take over AB's care but indicated that this might take *"a few weeks".*

5.38 On 15 June 2001 a discharge summary completed by consultant psychiatrist 1 indicated that AB was on level one CPA and that follow up care would be provided by a new consultant.

5.39 AB was next seen on 17 July 2001 by consultant psychiatrist 3, a locum consultant psychiatrist. AB told consultant psychiatrist 3 that he was hearing voices, that his medication was not helping with his aggression and that he did not feel able to leave the house as he felt people were looking at him.

5.40 Consultant psychiatrist 3 recorded that the *"patient's diagnosis has been undecided in the past, a previous diagnosis of paranoid personality disorder being made. A paranoid schizophrenia or schizo-affective disorder also needs to be considered as a diagnosis".* She increased AB's dose of risperidone (an atypical antipsychotic medication), prescribed zopiclone to assist with his sleeping and arranged to see him again the following month.

5.41 AB saw consultant psychiatrist 3 again on 21 August 2001. Consultant psychiatrist 3 noted that risperidone did not appear to be helping AB and changed his medication to quetiapine. Consultant psychiatrist 3 suggested that if quetiapine did not prove to be helpful then olanzapine be considered and she noted this for the new consultant who would be taking over AB's care in October 2001. AB's home had been burgled earlier that month and this combined with his increased irritability, forgetfulness and sleeplessness had lead to his ex-wife moving back in with him.

5.42 On 27 September 2001 AB's solicitors requested access to AB's clinical records in order for an independent psychiatrist to complete a report with respect to AB's benefits agency disability living allowance appeal. The independent psychiatrist assessed AB on 5 October 2001 and completed his report on 3 December 2001. The independent psychiatrist recorded that AB was not psychotic or depressed at the time of his assessment. He concluded:

> *"In summary then, the psychiatric diagnosis is that of an explosive personality disorder since childhood with increasing emerging paranoid aspects of his personality, at times slipping into psychotic experience of paranoid schizophrenia."*

5.43 AB did not attend an appointment arranged with consultant psychiatrist 2 in November 2001. Consultant psychiatrist 2 wrote to AB's GP advising that a new appointment would be made. There is no record of the new appointment being organised.

5.44 On 6 January 2002 AB was arrested for assaulting his ex-wife, his son and a police officer who attended the incident. Records indicate that AB physically attacked his youngest son and his ex-wife following a heated argument. AB was highly abusive to the police officers when they arrived at the incident. He threatened to kill one officer and the officer's family. He also spat a mixture of blood and saliva in the officer's face.

5.45 On 7 January 2002 AB was bailed to attend Nottingham Magistrates Court at 2pm on 11 January 2002. He was charged with assault on his ex-wife and youngest son contrary to section 39 of the Criminal Justice Act 1998 and an assault on the police officer occasioning actual bodily harm contrary to the offences against the Person Act 1861.

5.46 On 8 January 2002 AB made an unscheduled visit to the outpatient department and requested to see his consultant. Because AB had missed his November appointment he had not yet met his new consultant, consultant psychiatrist 2. He told staff that he did not feel able to return home as his ex-wife and son were still there. He appeared close to tears. The entry in the notes concerning this visit is unsigned.

5.47 On 9 January 2002, in response to AB's visit, consultant psychiatrist 2 wrote a letter to the housing department in support of AB regaining access to his council house.

5.48 On 13 January 2002 AB took an overdose of zopiclone, diazepam, quetiapine and co-dydramol (a pain killer) and one and a half bottles of vodka. He was admitted to D55 ward at the Queen's medical centre via accident and emergency. The medical notes indicate that AB's daughter had called an ambulance and the police had a 'suicide' note. He was given a saline infusion and his heart was monitored. On 14 January 2002 he was detained under section 5.2 of the Mental Health Act 1983. There is a record in the clinical notes that states:

> *"The patient is unwilling to stay in hospital and is expressing suicidal ideas and strong intent. He is at high risk of suicide due to his apparent depressed state, lack of social support and recent relationship loss. He requires further assessment of his mental state and need for psychiatric* [presumably review] *prior to discharge".*

5.49 AB's transfer/discharge summary from D55 indicates that he was "*aggressive on the unit"* and "*in agreement with section".*

5.50 On 14 January 2002 AB was admitted on section 2 of the Mental Health Act 1983 to Thurland ward, a low secure forensic ward, as he had threatened to 'trash' A42 (the ward where he had been admitted in 2001). He told a staff nurse that he had been experiencing problems with his anger prior to the assault on his ex-wife and son and that his overdose was not an attempt to kill himself more to try to control and *"rid his anger".* He appeared to settle quickly and following a review by consultant psychiatrist 4, AB was transferred to A42 on 17 January 2002.

5.51 AB was unhappy at being transferred to A42 as he was no longer in a single room but in a shared bay. He refused to sleep in the shared bay and spent the night sitting/sleeping in the communal area of the ward. He refused that evening's medication. The following morning he sat outside the nursing office. He refused his morning medication and the clinical notes stated he would not take it until he had been seen by *"the fucking quack".* He was described as '*hostile*' to nursing staff.

5.52 Consultant psychiatrist 2 attended the ward and told AB that he would be seeing him at length later that afternoon. AB later approached staff and asked to see consultant psychiatrist 2. He was advised that consultant psychiatrist 2 had informed him that he would see him later that day. He then left the ward and was "*aggressive in manner"* and although nursing staff shouted after him he had already left. The missing person's procedure was initiated.

5.53 The ward received a telephone call from consultant psychiatrist 2's secretary who:

> "*informed us that AB had just telephoned her stating that he was not happy to return to the ward unless he was given a side room and an English speaking doctor. Stated that if this did not happen and that he was brought back to the ward he would leave again and it would take 10 of us to stop him*."

5.54 Consultant psychiatrist 2 reviewed AB's care in his absence. Based upon his brief meeting with AB that afternoon, information from A42 nursing staff and discussion with the medical staff who had cared for AB on Thurland ward he concluded that AB had no mental illness but was suffering from personality problems with paranoid and antisocial traits and had declined all offers of treatment. He discontinued AB's section and noted that any future admissions should be on the basis of previously agreed treatment goals. He also noted that AB had told staff that he had been involved in a disagreement with his son and ex-wife.

5.55 On 30 January 2002 AB was reviewed by consultant psychiatrist 2 in the outpatient department. He recorded:

> *"As he was fairly calm we had the opportunity to discuss his problem at a bit more length. There was no major mental illness at this time and I sought confirmation of the diagnosis – paranoid personality disorder and impulsive disorder. He showed some insight into his personality and anger management problems and we agreed on the following approach: we will try to relieve his anxiety and paranoia by trying him on antipsychotic medication."*

5.56 Consultant psychiatrist 2 also agreed to look into temporary input from a community psychiatric nurse to support AB in his efforts to obtain work and to develop an emergency plan to enable AB to cope better with his anger.

5.57 Consultant psychiatrist 2 completed AB's discharge summary on 4 February 2002. He concluded that AB had "*no mental illness, but adjustment problems with depression and behavioural problems…with problematic anger management and paranoid personality traits".* His treatment plan was to continue to see AB as an outpatient but:

"I am not optimistic about the possibilities as there seems to be no major mental illness and AB should be held responsible for his behaviour".

5.58 On 5 February 2002 consultant psychiatrist 2 wrote to a community psychiatric nurse (CPN) coordinator at the south and west CMHT, to request that a CPN be identified to carry out some short term work with AB. Consultant psychiatrist 2 enclosed the discharge summary he had completed the previous day and a copy of his letter to AB's GP following his last outpatient appointment.

5.59 Consultant psychiatrist 2 reviewed AB again on 28 February 2002. AB appeared more settled on risperidone. He was living alone as his ex-wife had left the flat after the earlier assault. Consultant psychiatrist 2 noted that AB was not *"motivated to start work*" but was willing to consider drawing up an emergency action plan to manage his anger. There is however no evidence that this was followed up.

5.60 A community psychiatric nurse, CPN2, met with AB on 7 March 2002 following consultant psychiatrist 2's referral for assistance with anger management and finding work. Consultant psychiatrist 2 recorded that he had discussed the referral with AB at his outpatient appointment on 30 January 2002. CPN2 recorded that AB told him that he did not know why he had been asked to attend as he did not feel that the service had anything to offer him.

5.61 When we met with AB as part of the independent investigation he told us that he had never received any anger management training, however he also told us *"one of the male doctors may have done* [referred him for anger management] *but at the time I was paranoid and I don't think I would have taken it up anyway"*. He said that after his discharge from hospital he felt *"dumped in the public domain".*

5.62 AB did not attend his outpatient appointment on 26 March 2002. Consultant psychiatrist 2 wrote to him asking whether this had anything to do with his meeting with CPN2 in March. Consultant psychiatrist 2 asked AB to attend for another appointment when they could "*clarify possibilities and role*[s]".

5.63 Consultant psychiatrist 2 followed up the failed outpatient appointment in line with the trust's 'Did not attend (DNA) policy' by offering AB another appointment.

5.64 On 20 June 2002 the outpatient clinical coordinator received a letter from AB requesting a change of consultant. AB wrote that he was "*not satisfied with the doctor I have so I would be grateful if you could look into this matter".*

5.65 Consultant psychiatrist 2 responded to AB's request for another consultant on 27 June 2002. He advised AB that he regretted that AB had chosen not to take up his offer of further outpatient appointments and that he was not in a position to arrange for AB to see another psychiatrist. He advised AB that he was discharging him to the care of his GP. Consultant psychiatrist 2 also wrote to GP2, AB's GP, to advise him that AB had "*disengaged*" from the service and was being discharged back to the GP's care. He wrote:

> *"AB is suffering from a mixed personality disorder with paranoid and antisocial traits. There is no mental illness in the precise sense of the word.*"

5.66 On 17 July 2002 the clinic coordinator received an undated letter from AB. AB had received consultant psychiatrist 2's letter (presumably the letter dated 27 June 2002) and had written in response. AB stated that consultant psychiatrist 2 was "*an incompetent foreign TWAT*" and that foreigners should be treated like vermin and be killed, that the country needed a Hitler and 'Molosovich [sic]' who would ensure that all foreigners coming into the country were gassed. He concludes:

> *"KILL ALL FOREIGNERS AND ANY ONE WHO HELPS THEM THAT'S WHAT I BELEAVE [sic]."*

5.67 On 22 July 2002 the clerk to the justices from Nottingham Magistrates Court wrote to the trust requesting that a psychiatric report be prepared in relation to the court hearing involving AB following the assault on a police officer in January 2002. On 6 August 2002 an associate specialist from the Nottingham forensic service contacted AB to arrange an appointment to see him.

5.68 The associate specialist saw AB on 12 August 2002 and completed his report on 19 August 2002. He noted that there were significant discrepancies between AB's account of the offence and the witness statements provided by his ex-wife, son and police officers. He described AB's mood as "*rather angry and suspicious*". AB told the associate specialist about his paranoid thoughts and concerns that people were against him, his fear of crowds and that he heard whispers and voices. The associate specialist concluded that AB was fit to plead and noted:

"…in my view, [AB] is suffering from a delusional disorder, characterised by paranoid personality delusions and depressive symptoms. AB also presented with anti-social personality traits with impulsive behaviour, very low tolerance to frustration and a low threshold for discharge of aggression".

5.69 He also assessed AB's risk as a:

- risk to himself – linked to psychosocial stressors such as family problems and bereavement. The associate specialist considered this risk to be low.
- risk to others – linked to paranoid beliefs, impulsivity and lack of control. The associate specialist considered this risk to be medium to high.

5.70 The associate specialist concluded that AB did not require compulsory hospital admission and, as such, detention under the Mental Health Act was not appropriate, but that his risk of reoffending could be reduced through support, monitoring and offence focused work such as a community rehabilitation[2] order with psychiatric treatment.

5.71 The associate specialist recorded that AB told him that he was seeing a psychiatrist at Queen's medical centre *"who monitors his medication and mental state although recently his General Practitioner is involved"*.

5.72 After August 2002 and the associate specialist's court assessment AB did not have any contact with specialist mental health services until November 2003 when GP3 at his GP practice re-referred him back to the service.

5.73 On 12 September 2002, at Nottingham magistrate's court, AB was convicted of assaulting a police constable in relation to the incident that took place on 6 January 2002. He did not receive a community rehabilitation order but was sentenced to a four month curfew order with electronic tagging. He was also ordered to pay compensation and costs.

5.74 On 9 December 2003 the south and west CMHT contacted AB offering him an appointment with

[2] A community rehabilitation order is a sentence that is ordered by a court and served in the community under the supervision of the probation service. The offender must cooperate fully with the supervising officer.

consultant psychiatrist 5 on 5 February 2004. AB was offered an appointment with consultant psychiatrist 5 because consultant psychiatrist 2 had moved post. On 2 February 2004 south and west CMHT sent another letter offering an appointment on 11 March 2004. It is not clear from the records whether the original appointment intended for 5 February was sent in error or whether it was rearranged for 11 March 2004.

5.75 The staff grade psychiatrist to consultant psychiatrist 5 reviewed AB on 11 March 2004. A friend accompanied AB to the appointment. AB complained to the staff grade psychiatrist that he slept badly, heard voices talking gibberish like a foreign language and that he felt that people were talking about him. He also described episodes of wandering. He was finding that the paroxetine he was now taking did not seem to be working and the staff grade psychiatrist suggested that if the dose was to be reduced it should be done over a number of months.

5.76 The staff grade psychiatrist was employed in the staff grade post in January 2004 having previously worked as a child psychiatry consultant. The staff grade psychiatrist was identified as AB's CPA care coordinator and remained as the care coordinator until the time of the homicide.

5.77 AB had another appointment on 14 May 2004. He arrived late for the appointment. The staff grade psychiatrist recorded that "*after he caught sight of an electrical button with 'that' he left".* She wrote to GP2, AB's GP, that she could not see much benefit in bringing him to the clinic again.

5.78 However, the staff grade psychiatrist saw AB again on 25 June 2004. He complained that he was feeling paranoid and this was preventing him sleeping and that quetiapine made him feel unsteady and therefore he did not take it when he needed to leave the house. The staff grade psychiatrist changed his antipsychotic medication to olanzapine. She gave him a handwritten note to give to his GP clarifying this change.

5.79 On 30 June 2004 GP4, another GP within the practice that AB attended, faxed the outpatient department for clarification of AB's medication and was advised to stop his quetiapine and continue with olanzapine.

5.80 AB did not attend his next appointment on 6 August 2004. The staff grade psychiatrist wrote to him on 11 August 2004 and suggested that he contact her if he wanted to make a further appointment. AB wrote back to request an appointment but then failed to keep it on 1 October. The

staff grade psychiatrist wrote to GP2 on 7 October to tell him that she was, therefore, discharging AB from the clinic.

5.81 AB called the outpatients department and explained that he had mixed up the dates for his appointment in October 2004. The clinic coordinator liaised with the staff grade psychiatrist who agreed to make another appointment.

5.82 On 5 November 2004 a letter was sent to AB on behalf of consultant psychiatrist 6, the consultant psychiatrist who was now in charge of AB's care. The letter explained that '*due to unforeseen circumstance'* AB's appointment had been changed from 10 December to 6 December. When the staff grade psychiatrist saw AB on this revised date she recorded that the change of medication to olanzapine appeared to have been beneficial although AB still had complaints about paranoid feelings and auditory hallucinations. The staff grade psychiatrist suggested increasing his dose of olanzapine and reviewing his paroxetine as it was questionable whether this was of any value. She agreed to see AB again in two months' time.

5.83 On 7 January 2005 the patient record services at the trust received a request from the Department for Work and Pensions for a factual report on AB for disability living allowance. On 25 January 2005 the staff grade psychiatrist completed the forms supplied. She recorded AB's diagnosis as paranoid personality state ICD10 (international classification of disorder), F60 (specific personality disorders) and F60.3 (emotionally unstable personality disorder) and concluded that "*DLA support will be beneficial*".

5.84 On 14 February 2005 the staff grade psychiatrist saw AB again. He told her that he felt best when he was taking thioridizine and that he was still feeling paranoid. AB's dose of olanzapine was increased and it was noted that no abnormalities had been detected on his EEG.

5.85 AB's application for disability living allowance was not successful. On 6 April 2005 French & Company, AB's solicitors wrote to the staff grade psychiatrist requesting a psychiatric report supporting his appeal against the decision. AB provided a form giving authority for disclosure of his records.

5.86 AB's next outpatient appointment with the staff grade psychiatrist was on 11 April 2005. He was accompanied by his elder son. AB told the staff grade psychiatrist about his paranoid feelings

about other people and his thoughts about his younger son who he said "*should be six foot under".*

5.87 On 3 May 2005 French & Company, AB's solicitors, wrote a second letter to the staff grade psychiatrist concerning AB's disability living allowance appeal. They requested a further psychiatric report and had a number of queries in addition to those indicated in their letter dated 6 April 2005. The letter asks that the report cover that AB *"can recall temptations and thoughts about violent attacks with weapons on close family members".*

5.88 On 23 May 2005 AB was found collapsed in a bedroom by a neighbour. There was evidence that AB had vomited white tablets. He was admitted to a general ward at the Queen's medical centre via accident and emergency. Evidence of at least five different types of tablets was found in a sample of vomit collected by the ambulance service.

5.89 While on the general ward AB was assessed by a mental health liaison nurse from the department of psychological medicine at the Queen's medical centre. AB told the mental health liaison nurse that he was stressed out by his son's behaviour and was drinking a bottle of vodka a day to deal with his anxiety. He was not able to give a reason for his overdose. He appeared settled with no thoughts of suicide. The mental health liaison nurse concluded that the overdose appeared to be impulsive and that AB was likely to have been found as his son and ex-wife both visited regularly and he had not tried to conceal himself. The mental health liaison nurse developed a treatment plan that was summarised as follows:

- Outpatient appointment with the staff grade psychiatrist– due 13 June 2005
- Alcohol clinic appointment at the Queen's medical centre due 31 May 2005
- Focus line number given[3]
- AB requested increased frequency of outpatient appointments and was to discuss this at his next outpatient appointment with the staff grade psychiatrist.

5.90 On 9 June 2005 the mental health liaison nurse wrote to GP4 at AB's GP practice. He outlined AB's action plan. The mental health liaison nurse recorded that AB had ongoing problems with

[3] The Churchill House project includes a telephone helpline service known as Focusline, which offers confidential support, information and emotional support to people in Nottingham. This service is available to any adult who has a mental health problem, carers and professional agencies. Source: Rethink website.

paranoia and that AB had told him about hypnogogic and hypnopompic[4] hallucinations and that he was hearing foreign voices.

5.91 AB did not attend his appointment with the alcohol clinic on 31 May 2005. A clinical nurse specialist from the Nottingham drug and alcohol team contacted GP4 to advise him that no further appointments would be arranged but that if AB requested help then he could be referred back to the service.

5.92 French & Company, AB's solicitors who were assisting him with his claim for disability living allowance, faxed the staff grade psychiatrist on 2 June 2005 requesting a report at "*your earliest convenience*". On 8 June 2005 the staff grade psychiatrist responded to their request advising that she was not able to provide the report and that they should contact an independent psychiatrist.

5.93 AB did not attend his outpatient appointment with the staff grade psychiatrist on 13 June 2005. A further appointment was arranged and AB attended on 20 June 2005. When discussing the overdose AB told the staff grade psychiatrist that the voices had told him he would feel better if he took the medication. The staff grade psychiatrist recorded:

> "*…it still seems to me unclear whether this man's voices arise out of a psychotic illness or out of a particular personality difficulty*."

5.94 She asked AB to bring his medication with him to the next appointment so they could jointly review what he was taking as he seemed vague about this. They also discussed AB's alcohol intake which had only come to light during his latest admission. AB told her he had cut down his drinking since the overdose and was now only drinking two large vodkas a day. The staff grade psychiatrist thought that AB may have smelt of alcohol but he denied drinking before the appointment.

5.95 AB did not attend his outpatient appointment in August 2005. A further appointment was made.

5.96 AB did not attend his outpatient appointment in January 2006. A further appointment was

[4] Hypnagogic or hypnopompic hallucinations are visual, tactile, auditory, or other sensory events, usually brief but occasionally prolonged, that occur at the transition from wakefulness to sleep (hypnagogic) or from sleep to wakefulness (hypnopompic). Source: Patient UK website.

made.

5.97 AB came to his appointment on 6 February 2006 but was kept waiting for about half an hour. He became involved in an altercation with another patient. The staff grade psychiatrist concluded that nothing was being added to his care by attending outpatient appointments. His attendance was poor and, therefore, she was discharging him back to the care of his GP with the proviso that she would be happy to review him if there were any queries about his medication. This was the last time AB was seen by mental health services prior to the homicide. She wrote to GP2 (AB's GP) on 7 February 2006 confirming the decision to discharge AB.

5.98 GP2 responded to the staff grade psychiatrist's letter on 14 February 2006. He advised that the shared care protocol[5] for olanzapine should be completed and that since AB was not stable his reviews by mental health services should continue *"at least occasionally".*

5.99 The staff grade psychiatrist responded to GP2's letter on 27 February 2006. She provided the completed shared care protocol for olanzapine. We have noted that the protocol requires a signature from a consultant psychiatrist and this was completed by the staff grade psychiatrist rather than consultant psychiatrist 7 who was the consultant who had taken over from consultant psychiatrist 6. When we met with consultant psychiatrist 7 he confirmed that it was usual practice for doctors working within the team to complete shared care protocols.

5.100 The staff grade psychiatrist also responded to GP2's assertion that AB was far from stable. She wrote:

> *"You state in your letter that his condition is far from stable, but my impression is…that there has been little change in the two years that I have seen him. The instability to which you refer is, I think, part and parcel of the personality disorder from which he suffers, and while we have tried with medication to address this, there is not a lot of evidence that the medication makes a significant difference to him."*

5.101 She arranged to see AB again in six months.

[5] A shared care protocol describes how the responsibilities for managing the prescribing of a medicine can be shared between the specialist mental health service and the GP.

5.102 The signed protocol was faxed back to the staff grade psychiatrist by the GP's surgery on 3 March 2006.

5.103 A follow up appointment at the outpatient department was arranged for 5 September 2006. AB did not attend.

5.104 The staff grade psychiatrist told us:

> *"I think I didn't see it as psychiatry's job to police him. Apart from the threats to his son – there was bully's talk, I saw that in the clinic – but that he would murder somebody, there was no indication that that would happen".*

5.105 On 25 September 2006 AB killed FD. FD was his daughter's boyfriend and the father of AB's grandchild.

5.106 In December 2006 a consultant forensic psychiatrist assessed AB in order to prepare a report for Nottingham Crown Court. The consultant forensic psychiatrist concluded that AB:

> "*…suffers from personality disorders that conform to the Mental Health Act category of psychopathic disorder; however these are not amenable to medical treatment and it is not appropriate to make a recommendation for disposal under the Mental Health Act at this time."*

6. Themes from AB's care and treatment

6.1 This section of the report provides a thematic analysis and details the investigators' findings and recommendations. It also presents the main evidence.

Engagement with services

6.2 AB attended many outpatient appointments during the ten years of his engagement with secondary mental health services. There were however numerous occasions when he failed to keep appointments or attended late or arrived without an appointment.

Comment

AB's non-attendances were followed up and new appointments offered in accordance with trust policy. Late and unannounced arrivals were dealt with flexibly. We found evidence of good practice in the trust in this respect.

6.3 The trust made referrals to specialist and therapeutic services such as anger management, cognitive behavioural therapy and alcohol services on a number of occasions but AB did not take up these offers.

Comment

AB may have benefitted from services suggested by clinicians within the trust. He missed opportunities to understand and manage his anger and drinking problems.

Care programme approach (CPA)

6.4 The terms of reference asked us to identify whether the CPA had been followed by the trust. CPA is the process which mental health service providers use to coordinate the care of people who have mental health problems. AB saw consultant psychiatrist 1 in the outpatients' department from 1997 until 2001 when consultant psychiatrist 1 left his post. AB was recorded as being on level one of CPA.

6.5 The policy booklet published by the Department of Health on 25 January 1999 'Effective care

coordination in mental health services' provided NHS organisations with guidance on the changes to CPA. With regard to CPA level 1 it states:

> "*It is important to stress, however, that where the service user has standard needs and has contact with only one professional, that professional will in effect be the person who coordinates their care and any clinical or practice notes will constitute the care plan and record of review. It is not necessary to engage in further bureaucracy for the care of such people. As a minimum, service providers must ensure that central records are maintained on all those in contact with services and that care planning and reviews take place regularly*."

6.6 Consultant psychiatrist 1 was the only professional providing support to AB from 1997 to June 2001. There is written evidence that he was identified as the care coordinator and that regular review meetings and care planning meetings took place. In June 2001 just before consultant psychiatrist 1 left his post, he wrote to AB's GP and advised that an appointment would be made for AB to see his successor and that he would be followed up on the standard level of CPA. From July 2001 to February 2006 AB was seen by a number of psychiatrists at outpatient appointments on the standard level of CPA.

Comment

The trust carried out the CPA for AB in line with the national guidance for CPA for the period between 1997 and 2006.

6.7 In January 2002 AB was admitted to the Queen's medical centre for a period of five days. The patient discharge information form was completed by consultant psychiatrist 2 on 18 January 2002. The discharge form does not give an indication of AB's CPA level. However, it does contain a treatment plan which advised that AB would be followed up in outpatients and referred to a CPN for anger management. The discharge summary also advised that AB did not have a major mental illness and would be held responsible for his behaviour.

Comment

Although there was no documented evidence of CPA in the discharge summary, follow up arrangements were made for AB and a copy of the discharge summary was sent to AB's GP.

The use of formalised CPA on discharge from hospital would have encouraged a more systematic approach to the assessment and management of AB's risk.

Recommendation

R1 The trust should ensure that CPA reviews are undertaken and recorded before patients are discharged from inpatient services.

Risk assessment and risk management

6.8 AB had a well documented history of verbal, written and physical aggression and violence. He had a number of convictions including violent offending. He made threats to harm or kill members of his close family and was arrested for assaulting his ex-wife and adult son. He had a history of self harm by overdoses of prescribed medication. Most of his care was provided by single clinicians on an outpatient basis. Up to March 2004 his care was provided by consultant psychiatrists and thereafter by a staff grade psychiatrist. AB told all of the medical staff he saw that he had violent thoughts towards other people and difficulties in controlling his anger.

Comment

The risk AB posed to others was clearly documented. However, formal risk assessments were not completed during his many attendances at outpatients.

Discussions with AB in outpatients were recorded making clear his responsibility for his actions and their consequences. Formal risk assessments were undertaken during his admissions to hospital.

6.9 The trust's internal investigation team *"considered that appropriate risk assessments had taken place and were documented within the patient notes".* They did not comment on the absence of formal documented risk assessment or on the use of standard risk assessment tools for that purpose. The present trust CPA policy and procedures now require the use of standardised risk assessment tools across the adult mental health directorate.

Diagnosis and clinical management

6.10 All the medical staff who met AB recorded that he was suffering from a paranoid personality disorder. He was also recorded as experiencing anxiety and agoraphobia. He was assessed by a forensic psychiatrist for a court report. The psychiatrist concluded that AB was also suffering from a delusion disorder.

Comment

AB's clinical presentation included symptoms, such as hearing voices, which might have been expected in a person suffering from psychosis. This served to make his diagnosis more complex. Each doctor with whom he had consistent contact over time concluded that his primary problems were based in his personality rather than psychosis. It is evident that it was extremely difficult to come to any firm conclusion about AB's diagnosis even though he had been known to psychiatric services for many years.

Anti-psychotic medication

6.11 From 1996 onwards AB was treated with antipsychotic medication supplemented by antidepressants. A number of different types of medication were prescribed. Our terms of reference require that we consider the appropriateness of AB's treatment with anti-psychotic medication. In order to ensure a full understanding of the complete picture of his drug treatment we have examined all elements of the psychiatric medication he was prescribed. (See paragraphs 6.12 to 6.18 below.)

6.12 AB received the following anti-psychotic medication over his period of time as an outpatient :

- thioridazine (Melleril)
- trifluoperazine (Stelazine)
- quetiapine
- risperidone
- olanzapine.

6.13 It is widely accepted that anti-psychotics do have a place - and are effective - in reducing some symptoms in patients with personality disorder. They are effective in reducing agitation/irritability and can therefore be useful in reducing the likelihood of aggression or self-harm and may, therefore, improve social functioning.

6.14 In February 2006 AB's GP requested that the shared protocol for treatment with olanzapine should be completed. This had not been initiated by the trust when AB was discharged to the care of his GP on 7 February 2006.

6.15 The shared protocol form was completed by the staff grade psychiatrist on 27 February 2006 and faxed to the GP on 3 March 2006.

Comment

It was reasonable for the doctors treating AB to negotiate the use of various anti-psychotics with him over the years.

*The shared protocol in place in 2006 required a signature from a consultant psychiatrist. It was signed by an associate specialist. We were told that it was normal practice for "***doctors working in the team***" to complete the forms.*

The staff grade psychiatrist's letter to the GP dated 27 February 2006 explained why she had not previously completed the protocol. This was because the protocol **"emphasises particular patients with a diagnosis of either schizophrenia or bipolar disorder, neither of which apply to AB***". The staff grade psychiatrist's rationale was reasonable. Although AB was being treated with an atypical anti- psychotic medication, he did not have a diagnosis of either schizophrenia or a related disorder, nor did he have bipolar disorder. The protocol was titled atypical antipsychotics shared protocol for schizophrenia and related disorders and bipolar disorder.*

Recommendation

R2 The trust should review the shared care protocol for atypical antipsychotics to clarify whether patients other than those with diagnoses of schizophrenia and related disorders and

bipolar disorder who receive such medication need to be subject to the protocol. The review should also consider whether doctors other than the patient's consultant psychiatrist may sign the document.

Treatment with antidepressants

6.16 AB received dothiepin (prothiaden) and paroxetine (seroxat) over the period of time he was seen as an outpatient. He was thought to have been low in mood at times both in his outpatient appointments and when he took overdoses. He had difficulty sleeping and was anxious/irritable in public or in the company of others. This was due to paranoid thoughts.

Comment

It was reasonable for AB to be treated with antidepressants, as all of the symptoms described above could have been helped by antidepressants. Serotonin reuptake inhibitors (such as paroxetine) are also licensed for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder, so could have been helpful in reducing AB's fears in public.

Treatment with benzodiazepines and hypnotic medication

6.17 AB received diazepam (Valium) and zopiclone (Zimovane) during the period he was treated as an outpatient. Although not recommended for long term use, it is not uncommon for these drugs to be used to help patients with sleeping problems and problems controlling their anxiety/irritability during the day. These drugs can cause dependence. Some doctors would argue that using diazepam during the day in someone with an explosive temper might increase the likelihood of aggression (in a similar way to alcohol) but there is no evidence that this was the case for AB.

Treatment with mood stabilisers

6.18 AB was prescribed carbamazepine when he was first seen in 1997. Carbamazepine can be used either as a mood stabiliser or as an anticonvulsant. It has also been used to control explosive temper ('explosive personality disorder' was a category in ICD9, but removed in ICD10).

Comment

It was reasonable to assess the efficacy of carbamazepine over a period of several months.

General comments on AB's medication

Although we have no adverse comments to make about any of the medication AB was prescribed, there seems to have been little consideration given to his compliance with it. AB's actual compliance with any of the medication remains unknown. Information could have been gained from family members attending outpatient appointments or by liaising with the GP to discover whether AB was collecting the scripts from the surgery.

Use of the Mental Health Act 1983

6.19 AB was admitted to hospital twice under sections of the Mental Health Act 1983.

6.20 On 25 May 2001 he was admitted on section 5.2 of the Mental Health Act 1983 having been found in a ditch. Following a brief stay on a mental health ward at the Queen's medical centre he discharged himself against medical advice on 31 May 2001. His behaviour had been noted as appropriate with no signs of psychosis or depression. A discharge form was completed.

6.21 On 14 January 2002 AB was detained under section 5.2 of the Mental Health Act 1983. This followed admission to a mental health ward at the Queen's medical centre the previous day via the accident and emergency department after he had taken an overdose of various medications. Later on 14 January 2002 he was transferred to another mental health ward on section 2 of the act. The section was discontinued following assessment by a consultant psychiatrist on 17 January 2002 and he was discharged from hospital on the same date.

Comment

The uses of the Mental Health Act 1983 to admit AB to hospital and the subsequent discontinuations of the relevant sections of the act were all appropriate.

Safeguarding children

6.22 In April and May 1997 - in separate interviews - AB told a psychiatric social worker and a specialist registrar psychiatrist about problems he had experienced in the past with managing his anger. He described past fears of committing violence on family members and thoughts of killing them.

6.23 AB reported a dispute with his ex-wife about custody of their 15 year old son at an outpatient appointment in June 1998.

Comment

We found no evidence that consideration was given to seeking advice on child protection/safeguarding concerns arising from the fears and thoughts AB reported of his potential for violent behaviour towards his family. No further concerns related to his younger son were found in later clinical notes.

Consideration of matters relating to safeguarding children does not form part of our terms of reference. Because of the time elapsed since the potential concerns in 1997 and 1998 and as the younger son was an adult by 2001 or 2002, we did not pursue these issues further.

6.24 We have been informed that the trusts safeguarding children policy and procedures have all been re-written, and have passed the scrutiny of NHS Litigation Authority level 2 standard as well as audits from the local safeguarding board.

6.25 However to provide reassurance that current policies and procedures are implemented we make the recommendation listed below.

Recommendation

R3 The trust should reassure itself that the implementation of current policy and procedures for safeguarding children are robust, particularly in relation to cases where risk requires clinical staff to consult the trust's lead person on safeguarding children or in cases where referral to the local safeguarding (child protection) team is indicated.

Services for people with personality disorder

6.26 There is no evidence that a referral was made to specialist services for people with personality disorders or that specialist advice on AB's management was sought. Such services were not in place in Nottinghamshire until 2005 when pilot services were established. Work is now underway to establish care pathways between CMHT and specialist services. These include providing advice for CMHTs on management of patients with personality disorders.

Comment

The development of specialist personality disorder services in Nottinghamshire in the mid 2000s reflects the position nationally.

We agree with the conclusions of the internal investigation that had AB been receiving care and treatment now it is likely that he would have been referred to the specialist service.

AB told us that he would not have accepted referral to specialist services for people with a personality disorder.

(Services for people with a personality disorder are considered further in section 8 below).

7. Internal investigation report and recommendations

Review of internal investigation report

7.1 Our terms of reference require us "*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".*

7.2 In order to establish whether the recommendations were appropriate we have undertaken a critical examination of the internal investigation.

Timeliness

7.3 When we met with the author of the internal investigation report, he told us that the investigation faced difficulties in getting an appropriate team in place with the right skills in undertaking investigations using root cause analysis. He described root cause analysis as being new to the trust and adding some stress into the investigation. He also told us that while he was leading the investigation he moved roles and ceased being the general manager for the service. He had anticipated that the investigation would continue but this proved not to be the case and the investigation 'stalled' until he was asked to complete it. The terms of reference are dated October 2006. The final report is undated. NHS East Midlands have informed us that they received the investigation report in May 2008.

7.4 The trust's investigation of serious untoward incidents (SUI) policy in place at the time and dated October 2006 required reports to be completed within 12 weeks of the investigation being concluded. The current policy, dated November 2008 requires reporting within 60 working days of the trust becoming aware of the incident.

Methodology

7.5 Section 2.3 of the report indicates that root cause analysis (RCA) tools have been used to analyse the circumstances in the run up to the homicide. The chronology is extensive and comprehensive. It follows a tabular timeline format in keeping with the application of RCA.

However, we could find no evidence of the use of RCA tools to drill down to fully analyse the issues in greater depth.

7.6 The trust's October 2006 SUI policy did not require the use of RCA in investigations. Reference was however made to training staff in RCA techniques and a RCA analysis tool kit matrix was included as an appendix to the policy document.

Investigation team

7.7 The general manager for the adult mental health service lead the investigation team which included professional medical and social services advice. The internal report indicates that "*members of the investigative team were independent of the clinical service involved in the patients care"*. However the general manager was not independent as he was the manager with responsibility for the clinical area involved in AB's care.

Comment

The internal investigation team was of appropriate seniority and experience. We do not believe that the general manager's objectivity in relation to undertaking the investigation was compromised by his managerial role.

7.8 The trust SUI policy in place at the time did not specify the independence of investigation team members. Subsequent guidance[6] issued by the National Patient Safety Agency (NPSA) in 2008 states that:

> *"…the core investigation team should ideally comprise people of appropriate seniority, objectivity and authority, and be fully trained in the RCA/investigation techniques."*

7.9 The current SUI policy does not explicitly define the level of independence required for investigation team members. It states that:

[6] Independent investigation of serious patient safety incidents in mental health services – good practice guidance; NPSA February 2008

"…the general manager/equivalent will identify the members of the investigation team and the investigation coordinator, ensuring that these staff have sufficient experience and understanding of root cause analysis to conduct the investigation to the required standard."

Recommendation

R4 When the trust's serious untoward incident policy is next reviewed, the opportunity should be taken to include reference to the need for members of internal investigation teams to be independent of the service and/or geographical area within which the incident occurred.

7.10 A list of witnesses is not provided.

7.11 The care delivered is not clearly benchmarked in the report against either national or local policies. Although the investigation found that "*all care and interventions with AB were appropriate within Trust policies procedures and operational protocols".* The report does not list the policy documentation reviewed.

Supporting and involving victims and their families

7.12 The report does not include any evidence that either AB's or FD's family were consulted as part of the internal investigation.

7.13 The 2008 NPSA guidance provides information on how trusts should involve families of victims or perpetrators in an internal investigation. The trust SUI policy in October 2006 did not provide guidance on engagement with families. However, the current SUI policy includes a section on *"Support - Victims, perpetrators, families and carers"* in accordance with NPSA guidance.

Recommendation

R5 The trust should ensure that victims and their families are involved in internal investigations and supported in accordance with the SUI policy.

Content of the report

7.14 The report includes sections on:

- personal history
- forensic history
- psychiatric history
- findings and recommendations
- final conclusions.

It covers:

- engagement with services
- diagnosis
- risk assessment
- services for people with personality disorders.

7.15 A comprehensive chronology from 1997 and the full terms of reference are provided as appendices to the report.

Internal investigation recommendations

7.16 The internal investigation report made two recommendations:

- "*Now that specialist PD [personality disorder] services are available and established within the Trust a review of all patients registered to generic mental health caseloads should take place to identify the numbers of patients with PD and no formal mental health diagnosis and consideration be given to referral to PD services."*

- *"Consideration should be given to what effective liaison and support systems can be put in place to support generic services in dealing with PD presentation clients and what care pathways can be developed to be inclusive of those presenting with significant personality disorder."*

7.17 Services for people with personality disorders and issues concerning the implementation of the recommendations of the internal investigation are discussed further in section 8 below.

8. Learning the lessons

Action plan

8.1 The trust produced an action plan to monitor and support the implementation of the internal investigation recommendations.

8.2 The latest version of the action plan appears to be fairly recent but is undated. Against the two recommendations a number of actions are identified. For each action a lead manager is named and timescales for completion are set. The planned start dates for actions range from 2007 to August 2009. A section is provided for comments on progress, resources and evidence and a colour code is used to show current status for each action.

8.3 Problems are noted with the implementation of the first recommendation – for review of all patients with a personality disorder registered to generic caseloads. In the progress column the latest action plan states:

> *"Diagnosis of Pd has historically been poorly diagnosed and therefore these figures would provide limited accuracy and therefore questionable value."*

And

> *"This recommendation has proven to be extremely difficult to gather the required information. The only info…is able to extract from our IT systems is for discharged inpatients or at change of consultant."*

8.4 It is clear from the action plan, however, that work is continuing on identifying and developing care pathways between adult mental health services and the Nottinghamshire personality disorder and development network (NPDDN). Staff from NPDDN attend adult mental health single point of access (SPA) meetings regularly across the trust apart from the county south area. The processes in that area of the trust are being reviewed to ensure consistency. Two staff secondments have recently been made from CMHTs into NPDDN. The intention is for the seconded to take back the knowledge and skills that they have acquired and to develop positive working relationships between the CMHTs and NPDDN. Senior managers and modern matrons are continuing to progress work on care pathways and communication.

8.5 The trust has commissioned a study of referrers' views of NPDDN. An interim report of the study has been produced. A final report is due following completion of the study in December 2009.

8.6 The implementation of the second recommendation about identifying the support systems available to generic services from personality disorder services has been progressed. A review of personality disorder training and supervision in CMHTs has been completed. Training has been developed locally and delivered by members of NPDDN. Basic awareness of personality disorder and "stop and think" training is now well established across the trust. A process is in place for individuals and teams to identify training or consultation needs. These may be met through discussion with NPDDN. A new course 'working with borderline personality disorder' began in September 2009.

8.7 The latest version of the action plan notes:

> *"…it is important to state that the NPDDN is an opt in, group only, non forensic service. It is therefore not appropriate for all patients with a diagnosis of PD to be referred to the service. However (adult mental health) staff are encouraged to engage with NPDDN staff for consultation and supervision to support and develop them in dealing with complex cases".*

Comment

We understand the difficulty the trust has had in implementing the internal investigation recommendation to review all patients with a diagnosis of personality disorder. We commend the focus on developing care pathways and channels of communication between CMHTs and the NPDDN. It appears however that this work has been slow to gain impetus. It is important that the training and secondment initiatives are encouraged and continue.

Recommendations

R6 The trust should ensure that information on care pathways for people with a diagnosis of personality disorder is published and disseminated as soon as possible.

R7 The trust should monitor and evaluate the accessibility and effectiveness of consultative advice provided by NPDDN to CMHTs on the management of patients with a diagnosis of

personality disorder. This could involve either an extension of the current study of referrers' views of NPDDN or a clinical audit of a sample of cases from CMHTs and NPDDN.

Conclusion

8.8 AB's care was primarily delivered on an outpatient basis, although he had a number of brief admissions to hospital.

8.9 In relation to diagnosis, there are several mentions of possible psychotic symptoms in AB's clinical notes, although the majority view throughout his contact with services was that he suffered from a paranoid (or other) personality disorder.

8.10 AB was offered referrals to specialist and therapeutic services such as anger management, CBT and alcohol services but he did not take up these offers.

8.11 AB was not referred to the trust's personality disorder services. However he told us that he would not have accepted a referral to specialist services for people with a personality disorder.

8.12 AB had a number of convictions for burglary, assault and driving offences. His history of convictions was known by the trust and AB was told by psychiatrists that he would be held responsible for his behaviour.

8.13 We have made recommendations concerning CPA, safeguarding children, personality disorder services and the management of SUIs. We have found no evidence though to suggest that this incident was predictable or preventable.

Appendix A

Terms of reference

The full terms of reference for this independent review were as follows:

Undertake a systematic review of the care and treatment provided to AB by Nottinghamshire Healthcare NHS Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of 25 September 2006.

The investigation team is asked to pay particular attention to the following:

- To review the quality of the health and social care provided by the Trust and 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 AB;

- To identify whether the risk assessments of AB were timely, appropriate and followed by appropriate action;

- 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);

- Examine the appropriateness of continued prescribing of anti-psychotic medication;

- Examine the appropriateness and implementation of a shared care protocol between mental health and primary care services.

- 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 these recommendations.

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

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

Approach

The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations.

Should the reviewers identify a serious cause for concern, this should be notified to the SHA and the trust immediately.

The investigation will be undertaken in two phases.

Phase one

This will be an information and fact-finding phase incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

Phase two

This will include interviews with key staff and managers – either individually or in groups. Fieldwork will be carried out at a neutral venue within a reasonable distance from Nottinghamshire Healthcare NHS Trust.

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

Publication

The outcome of the review will be made public. East Midlands Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the investigation panel, relatives and other interested parties.

Review team

The review team will comprise of appropriately skilled members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work promptly and effectively, with the full process completed within 6 months following consent being obtained from all parties.

The review team will submit monthly progress reports to the commissioners and victims/ perpetrators families as agreed.

Professor Dame Catherine Elcoat
Director of Nursing and Patient Care
East Midlands Strategic Health Authority

Appendix B

List of interviewees

- consultant psychiatrist 7
- service manager, personality disorder service
- staff grade psychiatrist
- GP3
- general manager of adult mental health services at the trust/author of the internal investigation report
- AB

We also met with, but did not interview:

- AB's daughter/FD's partner
- FD's mother
- AB's ex-wife

Appendix C

List of documents reviewed

National documents:

- Personality disorder: No longer a diagnosis of exclusion - National Institute for Mental Health in England January 2003
- Effective care coordination in mental health services – a policy booklet, Department of Health on 25 January 1999

Trust documents:

- AB's clinical records
- Procedure for do not attends (DNA's)/cancellations - Nottinghamshire Healthcare NHS Trust
- Nottinghamshire adult mental health services care programme approach procedures – Nottinghamshire Healthcare NHS Trust
- Investigation of serious untoward incident – Nottinghamshire Healthcare NHS Trust
- Reporting, management and investigation of serious untoward incidents (clinical and non clinical) – November 2008
- Atypical Antipsychotics Shared Protocol for Schizophrenia and Related Disorders, and Bipolar Disorder - 2004

Appendix D

List of abbreviations used

A&E	Accident and emergency department
AWOL	Absent without official leave
CMHT	Community mental health team
CPA	Care programme approach
CPN	Community psychiatric nurse
CT	Computerised tomography
DLA	Disability living allowance
EEG	Electroencephalograph
GP	General practitioner
MHA	Mental Health Act
NIMHE	National Institute of Mental Health in England
NPDDN	Nottinghamshire personality disorder and development network
PCT	Primary care trust
QMC	Queen's medical centre
RCA	Root cause analysis
RMN	Registered mental nurse
SHA	Strategic health authority
SHO	Senior house officer
SpR	Specialist registrar

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