NHS
East Midlands

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

Undertaken by Verita

Ref 9090

January 2010

VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of AJ, BL and CL

A report for
NHS East Midlands

December 2009

Authors:
Alan Watson
Dr Sally Adams
Dr Simon Wood

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

Verita
53 Frith Street
London W1D 4SN

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website www.verita.net

Content

Reference

This report refers to all individuals named in the report anonymously. AJ is referred to as "she" because that is the wish of her parents, but in some direct quotes from people or documents AJ is referred to as "he" which was her wish at the time. AJ's parents are generally referred to as Mr and Mrs J.

Abbreviations/glossary

A&E	accident & emergency department
AMHS	adult mental health services
B&B	bed & breakfast
CAMHS	child & adolescent mental health services
CAT	community alcohol team
CBT	cognitive behavioural therapy
CPA	care programme approach
CPN	community psychiatric nurse
CMHT	community mental health team
CRT	crisis resolution team
DBT	dialectic behavioural therapy
DLA	disability living allowance
DNA	did not attend
DH	Department of Health
DSH	deliberate self-harm
EDT	social services' emergency duty team
GP	general practitioner
ICU	intensive care unit
LAMP	Leicester action for mental health project
LRI	Leicester royal infirmary
L1	constant observations
L2	intermittent observations
L3	general observations
MARACIS	trust clinical information system
MDT	multi-disciplinary team
MHA	Mental Health Act 1983
MHRT	mental health review tribunal
NPSA	national patient safety agency
O/P	outpatients' clinic
OT	occupational therapist
PALS	patient advice and liaison service
PCT	primary care trust
PICU	psychiatric intensive care unit
RCA	root cause analysis

RMO	responsible medical officer
SAE	serious adverse event
section 2	a 28-day assessment order of the Mental Health Act 1983
section 3	a six-month treatment order of the Mental Health Act 1983
section 5[2]	a 72-hour doctors' holding power (Mental Health Act 1983)
section 5[4]	a six-hour nurses' holding power (Mental Health Act 1983)
section 135	the power to enter premises and take a person to a place of safety (Mental Health Act 1983)
section 136	police power to remove a person to a place of safety (Mental Health Act 1983)
SHA	strategic health authority
SHO	senior house officer
SpR	specialist registrar
T&R	treatment and recovery
TRAIL	a trust adult mental health clinical governance circular, which advertises good practice and shares lessons learnt from complaint and SAE investigations.

Medications will be referred to as they were in the source documents we consulted. This means that sometimes the trade name, and sometimes the generic name, will be mentioned.

1. Introduction

1.1 This independent investigation into the care and treatment of AJ, BL and CL was commissioned by NHS East Midlands. It follows the Department of Health (DH) guidance circular HSG (94)27, *the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005. The terms of reference for the investigation are set out in full in section two of this report.

1.2 At 12.27am on 4 January 2006 a fire at a council property in a small town in west Leicestershire was reported to the fire and rescue services. They attended the scene and extinguished the fire. They discovered the body of a woman who was later identified as AJ. A post mortem examination found that she had extensive head injuries. Her death became subject to a murder inquiry.

1.3 On 5 January 2006, BL, who was 37 and CL, who was 13, were arrested and charged with murder. Both were convicted of murder at Leicester Crown Court on 19 October 2006. BL admitted the charge at Leicester Crown Court and was given the mandatory life sentence on 30 November 2006. The judge set the minimum period after which he would be considered for parole at 12-and-a-half years. CL denied the charge. He was ordered to be detained at Her Majesty's pleasure with a minimum of 12 years before parole would be considered.

1.4 The Crown Prosecution Service lodged an appeal for BL and CL to receive longer sentences. The Court of Appeal decided that BL's sentence should be extended to a minimum of 15 years before parole could be considered.

1.5 AJ, BL and CL were all known to the Leicestershire Partnership Trust (LPT). AJ had been a patient of the trust since 1988. She had a long and complicated history of contact with the trust which is summarised in the main part of this report. She had been treated as an inpatient during 2005, but at the time of the incident was living alone in her council flat. After the incident the trust completed an investigation whose terms of reference were agreed by the trust board and NHS East Midlands. This followed the guidance to health and social services authorities from the Department of Health to hold an internal investigation to establish a clear chronology of events leading up to the incident, to determine the underlying causes and to establish whether action was needed in relation to

trust policies, procedures, environment or staff. The internal investigation was reported to the private part of the trust board in November 2006.

1.6 BL and CL were also known to the trust. BL had several short periods of inpatient treatment and at the time of the incident was receiving outpatient care. The Leicestershire Partnership Trust and Hinckley and Bosworth Primary Care Trust (PCT) commissioned a panel to review the circumstances of BL and CL's care. (CL had been assessed by the trust child and adolescent mental health service (CAMHS) in September 2005). The review panel submitted its report to NHS East Midlands in November 2006.

1.7 Our investigation began in December 2007 and we were allowed access to the case notes of the three people involved in February 2008. The terms of reference for the investigation were agreed with NHS East Midlands and the family of AJ. We have had the full cooperation of the trust in completing the investigation, both in relation to access to documents and staff, several of whom were interviewed as witnesses. We have also had the full cooperation of other agencies involved in the care and treatment of AJ, BL and CL. These include the GP services provided by the primary care trust, Leicestershire county council, Leicestershire Constabulary, the youth offending service, the local housing department and the education services. Part of our terms of reference, set out in section two of this report, was to comment on the joint work between the various public agencies involved with AJ, BL and CL.

1.8 We are particularly grateful to AJ's parents for their contribution to the investigation. They agreed to be interviewed and gave us background information at a time of great personal loss. We would like to thank them for helping us to understand the events that led up to the tragic death of their daughter.

Background to the incident

1.9 AJ was 38 at the time of the incident. She was born and brought up in a village in Leicestershire and lived with her parents, brothers and sisters. She went to school locally and was described as a tomboy who liked sports. She was an intelligent and articulate student and after leaving school attended a local college and completed a typing course. She found work locally in an office and was living with her parents until she moved to her own flat in the same village, close to her parents.

1.10 AJ began to have mental health problems when she was about 21 and was referred to the local mental health services suffering from depression. She saw a psychiatrist and complained of low mood, suicidal thoughts and worries about her sexuality and gender. She had two outpatient appointments and then wrote to the doctor to cancel further appointments. She was referred to mental health services again in 1996 and became an inpatient with psychotic symptoms. She remained an inpatient for about one month. After this her contact with mental health services became more frequent and she had many inpatient admissions, some of which were compulsory admissions under the Mental Health Act 1983.

1.11 We describe the history of AJ's contact with services in some detail in this report. In summary, she had a complex relationship with the mental health services. Her diagnosis was difficult to determine. She had problems with low mood and depression. She had worries about her sexuality and that she was gay. She also abused alcohol over a number of years. At times she seemed to experience psychotic thought disorder and would complain about hearing voices. The complexity of her problems brought her into contact with several parts of the trust's mental health services. Apart from being treated as an inpatient on many occasions, she was also referred to the trust psychology services, the alcohol services, and to the personality disorder service. In the course of her contact with services she had assessments and there were various plans to support her in the community, some of which were more successful than others. AJ's parents remained concerned about her during these years and were often involved in discussions with professional staff about the best way to help her.

1.12 There were periods when AJ received support from the trust that she found helpful, and times when she was at odds with the professionals. There were incidents of self-harm including one when she jumped from an upstairs window at her accommodation and was seriously injured, later developing a life-threatening infection in hospital.

1.13 In the last year of her life, AJ moved from homeless persons' accommodation to a council flat in a town in west Leicestershire. She was having contact with members of the care team from the trust and had been assessed by the psychology services for admission to a therapeutic community. The team found AJ difficult to work with and there were problems agreeing and sticking to a care plan. She decided that she did not want to take up the offer of help from the psychology service. She had a short inpatient admission in June 2005, her last period in hospital.

1.14 In the second half of 2005 AJ had a new consultant psychiatrist at the trust. He thought she was suffering from a personality disorder and should be encouraged to take more responsibility for her contact with services. AJ started to reduce her contact with services at this time, saying that she did not want to see mental health professionals. She was drinking and getting into trouble with the police for a number of offences including criminal damage and threats to kill, after incidents in the neighbourhood. Her self-care and conditions in her flat were neglected and she resisted attempts from family and care workers to help improve the situation. AJ's parents were concerned about her and complained to the trust that she was not receiving adequate care. They thought she should have been admitted to hospital.

1.15 As a result of pressure from the family, a consultant psychiatrist, her GP, and an approved social worker carried out an assessment on 19 December 2005 at AJ's flat. The outcome was that the team did not feel that she should be admitted to hospital under the Mental Health Act and that she was not mentally ill. AJ's parents told us that they felt strongly that this was a mistake by the team and that if she had been admitted to hospital she would have avoided the attack on 4 January 2006 which led to her death. We examine this decision by the care team in some detail in the main part of this report.

1.16 At this time BL lived in the flat below AJ. At the time of the incident he was 37 and had been living at the flat since being re-housed from homeless families' accommodation. BL had been separated from his wife RL for several years. BL and RL had two children, and there was also an older step-child. The family were known to the social services department of Leicestershire county council although the local authority had never considered that there were grounds for a statutory intervention under the Children Act.

1.17 BL had lived in the Leicester area for some years. He had worked as a labourer and in driving jobs, but had not worked regularly through the 1990s. He had a history of contact with mental health services since 1994 when he was treated as an inpatient after suicidal thoughts brought on by the failure of a business that year. He had four periods of treatment, the last in December 2004. Following discharge he was followed up through outpatient appointments during 2005. He was a frequent visitor to his GP and often complained of feeling anxious, low mood and tension. He was also in trouble with the police after an armed robbery at a local shop and an assault on the shopkeeper in 2005. He attended some psychiatric outpatient appointments during 2005. The trust crisis

resolution team saw BL because the GP was concerned about his mental state and they assessed him and offered advice on his future treatment. He was drinking too much and taking anti-depressant medication.

1.18 During some of his contacts with services BL complained about the behaviour of AJ, his neighbour, who he said was making his life a misery by being noisy and sometimes banging on the windows of his flat. There was an incident in December 2005 when water from her flat came through the ceiling of his flat. He reported this to the police.

1.19 BL often went to his GP surgery for help, complaining of anxiety, panic attacks, feeling paranoid about going out and being tense. The GPs prescribed medication for these symptoms. BL took it together with cider. BL had been referred to the community alcohol service but refused their help after one visit. He also failed to attend what turned out to be his last outpatient appointment with the trust psychiatrist on 30 November 2005.

1.20 BL's son, CL, usually lived with his mother. He was 13 at the time of the incident. His school were worried about his behaviour and in 2005 had referred him to the CAMHS, who saw him once. The youth offending service was supervising CL in the latter part of 2005 and he was attending their programmes as required and making some progress in educational achievement.

1.21 On 3 January 2006 BL had been to see a GP who had prescribed anti-depressant medication. Later that day he rang the police to complain about AJ who he alleged had damaged a car belonging to his friend. The police also received an abusive call from AJ. They received four emergency calls in the early evening. We discuss these more fully in the main part of this report. The fire and rescue service was called early on 4 January 2006 to respond to a fire in AJ's flat. They discovered her body. She had extensive head injuries. At the trial of BL and CL for her murder, there was evidence that she had been attacked with socks filled with stones, an axe and other metal instruments and also stabbed. The perpetrators had then set fire to the flat.

Action after the critical incident

1.22 The killing of AJ prompted a number of actions by public services. The trust convened two internal investigation panels as required by the DH guidance to examine all aspects of the care and treatment of AJ, BL and CL. The panels were made up of trust employees and external members. The panels interviewed a number of witnesses. They reported to the trust board in November 2006. Representatives of the trust met the family of AJ to discuss the findings.

1.23 Some of the other agencies involved with the victim and perpetrators reviewed their own involvement including social services, the youth offending services, and the police. We have had access to those reviews and the background documentation on which they were based. Hinckley and Bosworth PCT did not have a review of the involvement of the GPs in the care and treatment of BL and AJ, but GPs participated in our review and attended as witnesses.

1.24 NHS East Midlands commissioned Verita to complete an independent investigation into the care and treatment of AJ, BL and CL. Details of team members are outlined in appendix A. The terms of reference for the investigation appear in section two of this report.

Reading this report

1.25 One of the aims of our investigation is to identify service improvements by reviewing the case histories and making recommendations. This is to help the trust and partner agencies to improve services, to implement change and reduce the likelihood of a similar recurrence. Part of the task is to present an accurate account of the contact with services for AJ, BL and CL. This has inevitably led to a detailed report because the history of service contact, particularly for AJ, was complex. In this report we have endeavoured to disclose only relevant information. We have tried to be proportionate in our approach, for example we have only interviewed key witnesses rather than everybody who has been involved in the care and treatment of AJ, BL and CL. We hope we have provided a balanced and evidence-based report incorporating all the evidence we have reviewed.

1.26 We give separate accounts for each individual of their contact with services and also try to identify common themes for the trust, for example in how care planning is organised.

Abbreviations and references

1.27 When we first delivered this report to the SHA we referred to people by name, apart from CL's mother and sisters as well as BL's partner. We decided to draft the report with witness's names. However the SHA were given legal advice that the report needed to be anonymised so that the human rights of the individuals involved could not be breached and therefore concluded that the public interest would be served if the report was published in an anonymised form. At their request we therefore anonymised the report.

1.28 The complexity of the subject matter obliges us to refer throughout the report to the many health and social care professionals. Where necessary we identity the person's relationship with one of the subjects of the investigation or the job title of the professional at the point of their introduction to the text. A list of those we interviewed as part of the investigation appears at appendix B.

1.29 At the time of the homicide Hinckley and Bosworth PCT were responsible for primary care services and commissioning of local secondary mental health services. These responsibilities are now held by Leicestershire County and Rutland PCT to whom relevant recommendations are addressed. At the time of the incident Hinckley and Bosworth PCT were responsible for the provision of primary care services. However in October 2006 the PCTs in England and Wales were reconfigured and NHS Leicestershire County and Rutland (NHS LCR) replaced the former Charnwood and North West Leicestershire, Hinckley and Bosworth, Melton, Rutland and Harborough and South Leicestershire PCTs. NHS LCR's role is to work with other partners to improve public health, ensure high quality, effective health services are available. It does this through providing primary care services itself, contracting with independent contractors such as GPs, and buying specialist healthcare services such as acute hospital and mental health services. Where the report refers to 'the PCT' it is referring to what was Hinckley and Bosworth. Where the report refers to NHS Leicestershire County and Rutland it is assuming the trust will oversee any recommendations made referring to primary care services and ensure all service providers in Leicestershire address the short falls identified in the report.

2. Terms of reference

The terms of reference for this investigation, agreed by NHS East Midlands were:

To undertake a systematic review of the care and treatment provided to AJ by Leicestershire Partnership NHS Trust and the care and treatment of BL and CL also by Leicestershire Partnership NHS Trust to identify whether there was any aspect of their care and management that could have altered or prevented the events of 4 January 2006 which resulted in the homicide of AJ by BL and CL. 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 AJ and BL.
    - To identify whether the risk assessments of AJ and BL 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.
    - To identify whether the clinical assessment of CL following his referral to CAMHS was adequate and followed by appropriate action.
    - To examine whether the trust fulfilled its safeguarding responsibilities including whether protection of vulnerable adult's policy was relevant to AJ and child protection policy to CL and if so, whether they were adhered to.
    - To examine the adequacy of collaboration and effectiveness of communication within the trust between and within directorates and service teams involved in the care and treatment of AJ, BL and CL.

- To examine the adequacy of collaboration and effectiveness of communication with other agencies who may have been involved in the care and treatment of AJ, BL, CL including; primary care, housing, social services, probation services, police, youth offending team and school nursing.

- To examine the adequacy of collaboration and effectiveness of communication between the trust and AJ's family including:

  - Reviewing the adequacy of the trust's response to the complaints made by AJ's family about her care and treatment prior to her death.

  - The involvement of carers and the voluntary sector in care planning and risk assessment.

- To establish whether the recommendations identified in the trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the trust in response to these recommendations.

- To identify any learning from this investigation through applying root cause analysis (RCA) tools and techniques as applicable.

- To report the findings of this investigation to NHS East Midlands.

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 Leicestershire Partnership Trust.

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

Publication

The outcome of the review will be made public. NHS East Midlands 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 six months following consent being obtained from all parties.

The review team will submit monthly progress reports to the commissioners and Mr and Mrs J's advocate.

3. Executive summary

3.1 At 12.27am on 4 January 2006 a fire at a council property in a small town in west Leicestershire was reported to the fire and rescue services. They attended and put out the fire. They discovered the body of a woman who was later identified as AJ. She was found at post-mortem examination to have suffered extensive head injuries and her death became subject to a murder inquiry. On 5 January 2006 BL, who was 37 and CL, who was 13, were arrested and both were charged with murder. Both were convicted of murder at Leicester Crown Court on 19 October 2006. They were sentenced on 30 November 2006 at Leicester Crown Court by the trial judge, His Honour Judge Pert QC. BL, who had pleaded guilty, was sentenced to a mandatory term of life imprisonment. The judge set the minimum period after which he would be considered for parole at 12-and-a-half years. In relation to CL, who had pleaded not guilty, the sentence was that he should be detained at Her Majesty's pleasure, with a minimum period of 12 years before parole would be considered.

3.2 NHS East Midlands commissioned this independent investigation in October 2007. The terms of reference for our investigation are stated in section two of this report. After the incident the Leicestershire Partnership Trust (LPT) completed two internal reviews. One reviewed the care and treatment given to AJ, and the other considered the care and treatment of BL and CL. The review panels reported their findings to the trust board in November 2006. Their reports included a number of recommendations and we have reviewed progress on the implementation of them in this investigation.

3.3 AJ, BL and CL were all known to the trust. AJ had an extensive and complicated history of treatment from 1988 to 2005. She had contact with a wide range of trust services and had many inpatient episodes, some of them under the provisions of the Mental Health Act (MHA). She had been treated with a range of psychiatric interventions, with varying degrees of success. During 2005 she was under the care of trust services, mainly as an outpatient, but there were also brief periods of inpatient care. She had been living in homeless person's accommodation since her last hospital discharge and in March 2005 she was rehoused to a flat in a small town in Leicestershire.

3.4 During 2005 AJ gradually withdrew from contact with mental health services and the team working with her had difficulty maintaining contact with her. She had no social contacts during this period and spent a lot of time alone. She also drank alcohol to excess

and this brought her into conflict with the police and she was charged with offences committed in the neighbourhood in 2005. There was a change in her care team in May 2005 and the new team decided on a different approach that gave her more responsibility for making and maintaining contact with services.

3.5 AJ's parents were committed to supporting her and had been involved in meetings with the care team for some years. They recognised that their daughter had long-standing mental health problems and were anxious to support her as much as possible. Sometimes she rejected their help and was hostile to them, but they remained supportive. They had meetings with the care team in 2005 because they were concerned with the deterioration in their daughter's mental health and the poor living conditions in her flat. They disagreed with the view of the care team that AJ should take more responsibility for her own care and thought that she should have been detained in hospital under the Mental Health Act for assessment. They made a formal complaint to the trust about the care their daughter was receiving in 2005.

3.6 We have completed a comprehensive review of the care and treatment offered to AJ, including a detailed chronology of events in 2005. We found that the trust had offered a good level of service to AJ despite the difficulties of diagnosis and the complexity of presentation of her mental health problems. However, we found that the change of approach from the care team in 2005 was not managed well. The structure for the delivery of care was set down in the care programme approach (CPA). We found that there was a failure to follow trust policy and guidance during 2005. This resulted in a reduction in contact with AJ and failure to monitor her mental health regularly. This was accentuated by AJ's own reluctance to engage with services.

3.7 In December 2005 there was a meeting of the care team involved with AJ to which her parents were invited. The outcome of the meeting was that a mental health assessment was carried out on 19 December 2005 at AJ's flat. The team assessing AJ thought that she was not mentally ill and saw no grounds to admit her to hospital under the Mental Health Act. AJ's parents disagreed with this assessment and thought that their daughter should have been in hospital. They thought that the poor state of AJ's flat was evidence that she was unwell and needed hospital treatment. A few days later, early in January 2006, AJ was the victim of a fatal attack by BL and CL.

3.8 We have completed a detailed assessment of the care offered to AJ and reviewed documentary evidence as well as interviewing most professional staff involved in her care. Our findings are set out in section five of this report.

3.9 BL had also been known to the trust for some years and had had four periods of inpatient care, the last in December 2004. He was treated for anxiety and depression, and had also abused alcohol and prescribed medication. During 2005 he was treated as an outpatient and also had frequent contact with GP services. He had been found guilty of violent offences and had a history of family breakdown. He had two children. He also had an older step-daughter. At the time of the offence he had been separated from his wife for three years.

3.10 BL and his family were well known to social services in Leicestershire and we reviewed the history of contact with the services. The children were never subject to statutory intervention by the department and both BL and his wife were able to take responsibility for them.

3.11 During the second part of 2005, the trust saw BL as an outpatient. He did not always keep his appointments and when he did he complained about feeling tense and angry. Sometimes he felt paranoid. He also made frequent GP visits. He was prescribed medication to help with his feelings of anxiety and depression but it was also noted that he was drinking excessively. He complained to the doctors about his upstairs neighbour, AJ, who he said was noisy and sometimes abusive. He called the police about her because water from her flat leaked into his property on 1 January 2006. He visited the GP on 3 January 2006 and received a prescription for medication. Later that day, after telephoning the police to complain about AJ's behaviour, and with his son CL, he attacked AJ. BL and CL later set fire to AJ's flat.

3.12 We reviewed the care and treatment offered to BL and found that the trust allocated him the standard level of the CPA. In fact, he met the criteria for the enhanced level which would have ensured a more active approach to monitoring his mental health. The practice of following him up through outpatient appointments was flawed because he did not always comply. The crisis resolution team from the trust saw him once in response to a GP request. Their intervention was thorough, but was not followed up actively. BL was himself asking for more contact from mental health services and we found that he

would have been more responsive to help offered through, for example, the community mental health team and a named worker.

3.13 We found that the GPs who treated BL did not always have access to specialist advice about his management in the community. He saw a number of doctors who prescribed medication and noted that he was drinking excessively. In turn, the psychiatrist from the trust who BL saw as an outpatient was not aware of the medication prescribed by the GP practice. The intervention by the crisis resolution team was a missed opportunity to engage more actively with BL. We make recommendations about the links between primary and secondary health services designed to improve the continuity of care.

3.14 BL's son, CL, was 13 at the time of the incident. He had lived for periods with both his parents after their separation in 2002. He was known to the mental health trust because he had been referred to the child and adolescent mental health service (CAMHS) in 2005.

3.15 The CAMHS saw CL in September 2005 and made an assessment of his needs. The CAMHS took no further action after the assessment because by this time CL was being supervised by the youth offending service. We found that the assessment by the CAMHS took insufficient account of the social care aspects of CL's family life and did not take account of information known by his school and social services. The results of the assessment were not shared with the youth offending service even though they were identified as the lead agency in his supervision.

3.16 We found that the links between services involved with the L family were not always effective in relation to sharing information and taking action. We have had full cooperation from a number of agencies involved with the L family. We have reviewed the involvement of each of these agencies and looked at documentary evidence supplied by them. We also interviewed staff who worked with the family or who had managerial oversight of the work. We have produced a detailed chronology for the year 2005 showing the contacts that AJ, BL and CL had with services.

3.17 We reviewed the response of the trust and partner agencies to the death of AJ. The trust organised two internal investigations. We have reviewed the progress made by the trust in implementing the recommendations. We found that progress on some of the recommendations was difficult to follow and that the timescales for implementation of

actions had been exceeded. There is a need for the trust to adopt a more systematic approach to implementation of actions on recommendations and to regular review of progress.

3.18 We would like to thank AJ's parents for their help in completing the investigation. They gave evidence as witnesses at a time of great personal loss.

Recommendations

We have produced 18 recommendations. Each recommendation is followed by a letter, where A relates to a response needed by the trust within three months of publication; B relates to a response needed by the trust within six months and C relates to a response needed by the trust within 9-12 months.

Operation of the CPA policy

R1 The trust should ensure that care coordinators under the CPA follow policy and guidance in relation to frequency of contact with service users (A). The trust should monitor compliance with CPA requirements (C).

R2 The trust should ensure that managers who allocate roles under the CPA are aware of risks to staff and ensure that appropriate allocation takes place where gender is an issue (A).

R3 The trust should ensure that care coordination through the outpatient system is sufficiently rigorous and that service-users who do not attend are followed up appropriately (the DNA policy) (A).

R4 The trust should ensure that decisions from multidisciplinary meetings are accurately recorded and appropriate follow up action taken (A).

Links between primary and secondary care

R5 The trust and NHS Leicestershire County and Rutland PCT should devise a system for the reliable and timely exchange of information about prescribing for people with mental health problems known to both primary and secondary care services (B).

R6 NHS Leicestershire County and Rutland PCT should review the support available to GPs who act as the main contact for people with mental health problems (B).

R7 The trust should review how the crisis resolution team links with other trust services to ensure that their interventions are followed through (B).

R8 The trust should ensure that all clinicians are fully aware of the DNA policy, implement it appropriately and notify other stakeholders of DNA issues (A).

R9 The trust considers how best to deal with patients who disengage from services and who might be a risk to themselves and others who may not be detained under the Mental Health Act (B).

The CAMHS

R10 The trust should ensure that the CAMHS takes full account of the social care aspects of family functioning in their assessments (A).

R11 The trust should ensure that the CAMHS communicates the results of assessment with all agencies and partners who have an interest in the case (A).

R12 The trust should ensure that the CAMHS gathers comprehensive information about service-users and families from partner organisations as part of their assessment process (B).

The trust response to complaints and investigations

R13 The trust should review the operation of the complaints system and systems supporting the investigation of incidents to ensure that service-users and carers receive

timely information on their complaints and are fully included in discussions about their care (A).

R14 The trust should develop a risk register which integrates the outstanding risks and recommendations identified from historical serious untoward incident investigations with other risk data (B).

R15 The trust should identify a senior member of staff to manage the risk register process to ensure that actions on risks and recommendations are completed within agreed timescales and resources (A).

R16 The trust board should receive a six-monthly report on the progress of recommendations after serious untoward incidents (B).

R17 The trust should specify the time, manpower and financial resources required to complete an action associated with a recommendation (B).

R18 The trust should develop a system to prioritise recommendations and actions, based on those with the greatest impact on improving care for patients and reducing similar incidents in the future (A).

4. Details of the investigation

Approach to the review

4.1 The guidance for internal investigations by mental health trusts was issued by the Department of Health in HSG (94)27. The guidance requires them to conduct formal internal reviews of critical incidents. In the case of homicides and other exceptional events the SHA is required to commission an independent investigation into the circumstances of the incident. In June 2005 the guidance was amended and required trusts to conduct an investigation into the circumstances surrounding any critical incident and to use a structured investigation process such as root cause analysis (RCA).

4.2 The review was undertaken in private. It comprised a large but proportionate number of formal interviews and an examination of available and relevant documentation, see appendix C for list of documents we reviewed.

4.3 We jointly conducted interviews with every individual identified as relevant and who had agreed to participate. This included the staff from Leicestershire Partnership Trust, GP surgery 2, Leicestershire social services department, Hinckley and Bosworth borough council's housing department, Leicestershire police and youth offending service. We also interviewed the perpetrators BL and CL as well as the victim's (AJ) parents, Mr and Mrs J. We undertook 45 interviews. A list of people who attended for interview can be found in appendix B.

4.4 We offered interviewees the opportunity to comment on the factual accuracy of interview transcripts or to add to them and to comment where appropriate on relevant extracts of this report while it was in draft.

4.5 AJ's current responsible medical officer was invited to speak with the panel but declined. This should be borne in mind when reading this report.

4.6 CL's mother also decided not to meet with the panel.

4.7 We make findings, comments and recommendations based on interviews with those referenced in appendix B and the information available (appendix C).

Structure of this report

4.8 Section 5 provides a brief biography of AJ followed by a chronological summary of the factual background and context to her care and includes our general comments and conclusions about the care and treatment AJ received.

4.9 Section 6 provides a brief biography of BL followed by a chronological summary of the factual background and context of his care. It also includes our general comments and conclusions about the care and treatment BL received.

4.10 Section 7 provides a brief biography of CL followed by a chronological summary of the factual background and context of his care together with our general comments and conclusions regarding the care and treatment CL received.

4.11 Section 8 provides an overview of Leicestershire county council social services department's involvement with the L family. This section concludes with our general comments and conclusions regarding social services involvement with the L family.

4.12 Section 9 provides an overview of the role of the police service in relation to AJ, BL and CL. This section concludes with our general comments and conclusions about the police role.

4.13 Section 10 provides an overview of the housing department's involvement with AJ and BL. This section concludes with our general comments and conclusions about the housing department's role.

4.14 Section 11 provides an analysis of the trust internal reports written before BL's and CL's conviction in November 2006. We also review the progress the trust has made with the implementation of recommendations from these two internal reports.

5. The care and treatment of AJ

5.1 AJ was born in Leicester in 1967. She lived in a village outside Leicester during her childhood and adolescence. She had an uneventful school life and left at the age of 16 with no formal qualifications. After school she was employed on a youth training scheme undertaking clerical work. She worked until the age of 21 when she had her first contact with mental health services and reported feeling stressed and anxious at this time. She continued to be in close contact with her parents, and after leaving home, lived in her own flat near to their home.

History of AJ's contact with mental health services

5.2 AJ had a long and complex history of contact with mental health services from June 1988 onwards. We summarise her contact from 1988 to the end of 2005. Our terms of reference required us not to repeat the work of the internal investigation.

Summary of contact with mental health services from 1988 to the end of 2005

5.3 In June 1988 AJ was first referred to specialist psychiatric services by her general practitioner, GP1. AJ was low in mood and expressing suicidal thoughts connected with her sexuality and gender. AJ had two outpatient appointments before she wrote to her psychiatrist, consultant psychiatrist 1, to cancel further appointments.

5.4 In May 1996 AJ began to experience psychotic symptoms and was admitted to adult mental health unit [AMH] ward A. She stayed for a month and was referred to social services for a social care assessment and to the local day unit. AJ declined the social care assessment and was unable to attend the day unit because of work commitments.

5.5 In August 1998 AJ was re-referred to mental health services and, in November 1998, consultant psychiatrist 2 saw her in his outpatients' clinic. At this time, consultant psychiatrist 2 felt that AJ's presentation was indicative of *"an anxiety/phobic state superimposed on paranoid schizophrenia"*. AJ was offered follow-up outpatient appointments and was again referred to the day unit.

5.6 Between August 1998 and September 1999 AJ developed a dependency on alcohol and her mental state fluctuated between low mood and anxiety with suicidal thoughts and stability, increased motivation and optimism about her future. She was referred to an anxiety management group and to the CMHT for a community psychiatric nurse (CPN) assessment.

5.7 In September 1999 AJ was assessed by and accepted for CPN input. She met the criteria for enhanced CPA. CPN1 was allocated to work with her and for the next four years maintained a positive working relationship that AJ valued. The relationship was particularly helpful to AJ when she was not an inpatient.

5.8 Between September 1999 and August 2000 AJ was admitted to AMH unit ward B on six occasions, usually for no longer than a month and sometimes for less than a week. On one occasion AJ was admitted for alcohol detoxification, although generally her admissions followed overdoses of prescribed medication. The service for people who self-harm assessed AJ at Leicester royal infirmary (LRI) once, but generally she refused to go to the LRI and would be admitted directly to AMH unit ward B. Overall, AJ's prevailing symptoms were anxiety and low mood, a preoccupation with acne scarring low self-esteem and alcohol misuse. AJ expressed transient psychotic symptoms and her pattern of self-harm increased in frequency and intensity. In particular, AJ experienced impulsive thoughts of jumping out of the window of her flat and made superficial cuts to her face, in order to remove spots and acne scars. AJ's attendance at outpatient appointments was erratic and she did not take her prescribed medication consistently.

5.9 Between August 2000 and November 2001, AJ started cognitive behavioural therapy and was maintained in the community. AJ initially found the cognitive behavioural therapy helpful, but in May 2001 she began to express feelings of dissatisfaction with the treatment and, in June 2001, cognitive behavioural therapy was discontinued. AJ took two overdoses of prescribed medication and was assessed by the deliberate self-harm service at LRI on two occasions. Increasingly, AJ began to misuse her prescribed diazepam because she felt she needed it to help her have the confidence to leave the building and, in July 2001, she stopped taking her regular antipsychotic medication. AJ later experienced transient psychotic symptoms and, in November 2001, she was identified for fast-track admission, which meant that she could self-refer to AMH unit ward B.

5.10 Leicestershire county council completed a carer's assessment of AJ's parents on 31 August 2001. The assessment gave a full account of the impact of AJ's mental health problems on the family at that time and concluded with a plan of action that included putting Mr and Mrs J in touch with carers' groups in the area.

5.11 Between November 2001 and March 2003 AJ was admitted to AMH unit ward B nine times, usually drunk and often after self-referral via the fast-track procedure. AJ occasionally experienced transient psychotic symptoms and took several overdoses of prescribed medication. Misuse of prescribed medication was once again identified and measures to minimise this were put in place. AJ also increasingly presented as hostile and verbally abusive towards ward staff.

5.12 In June 2002, AJ was detained on a section 5[2] of the MHA (a doctors' 72-hour holding power) pending a full assessment, which was then followed by section 3 (a six-month treatment order) because of her risk of absconding and risks to herself and to others. AJ was then transferred to the trust's psychiatric intensive care unit, from which she was referred to treatment and recovery services (T&R). AJ was not accepted by the service because consultant psychiatrist 3, the assessing psychiatrist, felt she showed little evidence of a chronic psychotic disorder and believed that the personality disorder service would better meet her needs. In July 2002, AJ was discharged from the section 3 after a mental health review tribunal (MHRT) decided her problems were to do with being lonely, alcohol misuse and her having negative feelings and thoughts about her skin.

5.13 In August 2002 AJ was referred to the personality disorder service. She failed to attend follow-up assessment appointments after her first assessment and eventually decided that this was not the best placement for her at that time.

5.14 In September 2002 AJ jumped out of the window of her flat while she was on leave from AMH unit ward B. She was admitted to LRI with a fractured spine and put in an immobilising body. She later became seriously ill with other complications and spent time on a ventilator in LRI intensive care unit. She was treated on various wards at the LRI for just over a month before being transferred back to AMH unit ward B. AJ consistently maintained that her intention had not been to kill herself and that she regretted her actions.

5.15 In January 2003 AJ asked to be transferred to T&R services and, in February 2003, she was re-referred to the service by consultant psychiatrist 4. She was assessed by consultant psychiatrist 3 from the T&R service but it did not accept her at this time. In June 2003, consultant psychiatrist 3 wrote to AJ explaining that that she (consultant psychiatrist 3) would need to liaise with the team before making a decision but that T&R services would certainly reconsider her referral.

5.16 In May 2003 AJ was admitted to AMH unit ward B where she was treated until December 2003. AJ self-referred and was drunk. Again, her prevailing problems were considered to be alcohol misuse, anxiety, low mood, a preoccupation with her skin, low self-esteem and transient psychotic symptoms. During her admission, AJ absconded from the ward repeatedly, drank excessive amounts of alcohol and presented in a hostile way towards health care professionals.

5.17 In June 2003 AJ made threats to kill CPN1 and she cut her name into her forearm. AJ twice left AMH unit ward B and went to look for CPN1 at the CMHT base. On one occasion she was persuaded to take a taxi back to the ward and on the other the police brought her back.

5.18 In July 2003 CPN1 was withdrawn from AJ's care and AJ was detained on a section 3 of the MHA. After further threatening telephone calls to CPN1 and several episodes of absconding from the ward, AJ was transferred to the psychiatric intensive care unit for four days. Consultant psychiatrist 4 re-referred AJ to the personality disorder service and asked for a risk assessment of her by forensic services. On 22 September 2003 she was seen by a consultant clinical psychologist with the forensic mental health service. The assessment concluded that while there were some factors that indicated a risk of violence, the actual risk of serious physical violence was not substantial and that there was more risk of further episodes of self-harm.

5.19 In September 2003 AJ complained about the withdrawal of CPN1 from her care. She was not happy with the trust's response to this complaint and asked for an independent tribunal about it. The complaint was sent to the independent chair of the tribunal who decided that no hearing was needed. Also at this time, AJ asked that her consultant be changed and, in October 2003, RMO1, a responsible medical officer, took over.

5.20 Adult mental health services and T&R services liaised regularly about AJ's case between June and December 2003. In November 2003, AMH unit ward B was informed that AJ could have the next available bed at the T&R unit 1 inpatient ward - providing she was allocated a social worker from the CMHT because the care management team in T&R did not have capacity to take on her case. A referral was made and community care worker 1 with CMHT was initially allocated to work with AJ, but in April 2004 her case was transferred to social worker 1, who was from the same team. He remained involved with AJ until her death in January 2006.

5.21 In December 2003 AJ's care was transferred to the T&R unit 1, where she was treated until November 2004. Consultant psychiatrist 3 took over the role of RMO (responsible medical officer). AJ's problems were attributed to low self-esteem, negative concerns about her skin, gender dysphoria, alcohol misuse and borderline personality disorder. Her mental state fluctuated considerably during her admission to T&R unit 1 and seemed to be related to her alcohol intake and to her thoughts about changing gender. Some of the more disturbed consequences of AJ's mental state included:

- transient psychotic symptoms
- an incident in which she set fire to herself
- a belief she would die before she was 40 because of her decision to change her gender
- several incidents of verbal and physical aggression
- a conviction that her sexual feelings towards a nurse at the T&R unit 1 were reciprocated.

5.22 She was twice detained on a section 5[2] MHA, but did this not progress to a longer period of compulsory detention on either occasion.

5.23 Throughout AJ's inpatient stay at the T&R unit 1 the multi-disciplinary team (MDT) considered several care options for her. In January 2004 the personality disorder service assessed her but felt that exploratory psychotherapy would produce further distress. AJ was referred for dialectic behavioural therapy (DBT) but her levels of distress led to this assessment being postponed. In February 2004 AJ began cognitive behaviour therapy. These sessions ran only until March 2004 when the cognitive behavioural therapy therapist left the service. The MDT continued to believe that a psychotherapeutic approach was the most appropriate intervention for AJ and consultant psychiatrist 3 approached the lead

consultant in the personality disorder service for advice on managing AJ's disturbed behaviour and guidance on preparing her for psychotherapy in the future.

5.24 In June 2004 AJ was referred to psychology services for an assessment of her appropriateness for cognitive behavioural therapy and, at her request, work on anger and aggression. After an initial assessment in September 2004, the psychology department decided they needed more time to make a decision about AJ's suitability for the services. After this extended assessment period, consultant psychiatrist 5 and consultant psychiatrist 6 from psychology services concluded in January 2005 that AJ's uncontrolled behaviour was a wish for containment and that expecting her to be responsible for herself might increase the risks to herself and to others. Psychology services advised that a more secure and containing environment was required in order for AJ to undertake psychotherapeutic work. However, they were prepared to offer her brief psychological input if necessary. AJ was re-referred to the personality disorder service in January 2005 for inpatient psychotherapy.

5.25 Occupational therapy staff at the T&R unit 1 tried throughout AJ's inpatient stay to provide a structure to her day and offered her anxiety management. The MDT tried to secure AJ's engagement in a disciplined and manageable drinking plan, but AJ found it difficult to adhere to it and reacted angrily when staff tried to implement it. Consultant psychiatrist 3 approached the trust's dual diagnosis nurse consultant for advice on how to manage AJ's alcohol misuse, her associated disturbed presentation, and how to help AJ reflect on the negative impact of her alcohol misuse on herself and those around her. The notes do not document any specific advice.

5.26 In October 2004 AJ decided to seek gender reassignment surgery and began to research the topic. This coincided with an improvement in her psychiatric condition. Consultant psychiatrist 3 cooperated with AJ over her decision, referring her to the trust's lead consultant on gender dysphoria, consultant psychiatrist 7. However, she was not accepted into the trust's gender identity clinic because her case was too complex for the service and the lead consultant did not immediately support AJ's desire to start hormone therapy because of her age and because she smoked.

5.27 As part of her pursuit of gender change, AJ requested that she be referred to as male in all case records and correspondence, and that all historical records be changed. Advice from trust and social services solicitors stated that the Gender Recognition Act was

not yet in force and suggested that she be referred to as male from now on, but that previous records should not be changed. AJ changed her name by deed poll in October 2004.

5.28 Improvements in AJ's condition when she began to research gender dysphoria were transitory and her admission to the T&R unit 1 ended in an incident of violence that required police intervention. AJ was then transferred to the challenging and behavioural unit (CB unit).

5.29 From November 2004 until December 2004 AJ was an inpatient at the CB unit. She arrived drunk and refused to stay on the unit informally. She was detained on a section 5[2] MHA and was placed in seclusion in the interests of the safety of others. AJ reported auditory hallucinations but her presentation was felt to be indicative of borderline personality disorder and gender dysphoria rather than schizophrenia.

5.30 In November 2004 AJ visited a private consultant in London, consultant psychiatrist 8, about her gender dysphoria. Consultant psychiatrist 8 agreed to hormone treatment with a plan for AJ to have a mastectomy after six months and a hysterectomy and oophorectomy (removal of uterus and ovaries) one to two years later. AJ obtained a statutory declaration of her intention to change gender. The medical management of this treatment became a shared responsibility between consultant psychiatrist 8 and AJ's GP, GP2, with whom she was registered as a temporary patient at GP surgery 1. Consultant psychiatrist 8 wrote to consultant psychiatrist 3 with the details of his assessment and treatment plan. AJ began to have regular hormone injections as part of consultant psychiatrist 8's treatment.

5.31 As part of the care plan for AJ's return to the community, social worker 1 completed housing applications to the local council and informed them that AJ needed ground-floor accommodation because she had jumped out of a window earlier. AJ was keen to be discharged and on 7 December 2004 was found temporary accommodation at a local hotel providing bed and breakfast accommodation in Leicester. She responded well to the discharge and functioned well in the accommodation found for her, despite the accommodation being above ground level.

5.32 In December 2004 AJ made a formal complaint about the attitudes of professionals at the CB unit to her gender dysphoria. AJ was dissatisfied with the trust's response and

sought the help of the patient advice and liaison service (PALS). In February 2005 AJ told the trust's complaints manager that she had received an explanation of events during her admission to the CB unit and no longer wished to pursue the following elements of the complaint:

- a perceived delay in her referral to a gender specialist
- her seclusion on the ward
- the loss of the original statutory declaration notice
- the sensitivity of doctors and nurses about gender dysphoria
- her wish for her clinical records to reflect her new gender.

5.33 After AJ received the trust's response to this complaint there was no further communication between AJ and the complaints manager. AJ declined the offer of a residential placement with the personality disorder service because she feared that professionals within the service would have a negative attitude towards her gender dysphoria.

5.34 After discharge from the CB unit, AJ was followed up by consultant psychiatrist 3, CPN2 and social worker 1. CPN2 and social worker 1 made two joint visits to AJ in the weeks after her discharge but after a CPA review on 31 January 2005 they began to visit her separately on alternate weeks. At this CPA review it was agreed that AJ should have out-of-hours contact with the city-based crisis resolution team if necessary and was to refer herself to drug and alcohol services.

5.35 In February 2005 AJ went to the T&R unit 1 and said she was going to kill herself. The police were called and they used their powers under the MHA to remove her to a place of safety (section 136). A MHA assessment was carried out and AJ was not considered to be detainable.

5.36 The crisis resolution team assessed AJ in March 2005 when she said *"God moves me around"* and that she believed that she was going to die. The crisis resolution team felt that this episode was a consequence of her impending move to permanent accommodation (a first-floor flat) and that her regular care team would be better placed to address these issues. The crisis resolution team informed AJ of their telephone support procedure which AJ agreed to use. AJ moved to permanent accommodation in early March 2005.

5.37 In April 2005 AJ wrote to CPN2 saying she no longer wanted contact with him because of his attitude towards her gender dysphoria. Her relationship with social worker 1 deteriorated because he referred to her as *"she"* in a set of CPA review minutes. In the weeks that followed, AJ expressed a wish to cease all contact with mental health services because of the mention in her risk assessment of risk to others and because she did not feel she had a mental health problem.

5.38 In May 2005 due to structural changes to the T&R services, consultant psychiatrist 9 replaced consultant psychiatrist 3 and CPN3 replaced CPN2. CPN3 took over the role of CPA care coordinator during an emergency CPA meeting to review the roles of members of the MDT. The CPA meeting on 10 May 2005 was attended by both consultant psychiatrist 3 and consultant psychiatrist 9. A decision was taken to downgrade AJ to the standard level of CPA.

Comment

The decision to re-grade AJ to the standard level of CPA was surprising because the same meeting noted that AJ was a person with a complex history and current presentation. She was also subject to section 117 MHA at this time which was another indicator of complexity and placed a statutory obligation on health and social care services to provide after care.

5.39 On 6 June 2005 AJ's mother contacted the GP with concerns that AJ had been hearing voices. A Mental Health Act assessment was carried out. AJ was reluctant to allow the assessment team into her flat, but agreed to the assessment in the presence of her mother. AJ was detained under section 2 MHA (a 28-day assessment order) and was admitted to AMH unit ward C early on 7 June 2005. She became aggressive after admission and was restrained and put into seclusion. She was transferred to T&R unit 2 inpatient ward on 10 June 2005. She at first displayed violent and disturbed behaviour but there was no evidence of schizophrenia. The section 2 order was lifted within a few days and her medication was rationalised. Upon discharge on 16 June 2005 AJ was not on any prescribed medication.

5.40 After discharge from T&R unit 2 AJ remained in the community. She failed to attend outpatient appointments or to respond to letters and telephone calls from consultant psychiatrist 9. Social worker 1 carried out two welfare checks with police,

where it was noted that her living environment was disordered, but that her mental state was not a cause for concern.

5.41 Throughout the summer of 2005 AJ's parents repeatedly expressed their dissatisfaction with her mental health care. They perceived her level of support to be inadequate and her diagnosis to be incorrect. They wrote several letters to the trust's senior management team and phoned the professionals involved in AJ's care many times. They believed AJ was psychotic and more unwell than she had ever been.

5.42 In a later part of this section we analyse in some detail the contacts between AJ, her family and the mental health services from 2005 until her death.

5.43 On 6 September 2005 a Mental Health Act assessment of AJ was carried out but the assessment team did not think she was suffering from any serious symptoms of mental illness. A CPA review was held after this assessment and AJ was re-graded to enhanced CPA.

5.44 On 14 November 2005 social worker 1 wrote in AJ's social work notes that consultant psychiatrist 9 had told him he had been advised by consultant psychiatrist 10 to seek senior management support to close AJ's case. He also noted that consultant psychiatrist 9 recommended he seek similar support on this issue. However, consultant psychiatrist 9 did not record the conversation in AJ's medical notes and disputes that the conversation took place.

5.45 On 24 November 2005 Mr J telephoned the senior nurse at the Leicester Partnership Trust because he was concerned about AJ's mental state and the disrepair of her flat. He was particularly concerned that AJ was not allowing her family entry to the flat and he requested an immediate multi-agency meeting. On 2 December 2005, social worker 1 told Mr and Mrs J that a meeting had been arranged for 15 December 2005. They felt that the meeting should be sooner so, before and as well as the meeting of 15 December 2005, social worker 1 and his team manager, team manager 1, met them on 9 December 2005.

5.46 A conference meeting was held on 15 December 2005. At this meeting Mr J and the family's advocate restated their concerns. There is some dispute about the conduct of this meeting and we examined in detail later.

5.47 On 19 December 2005 social worker 1 gained a warrant under section 135 MHA (the power to enter premises and take a person to a place of safety) to enter AJ's flat accompanied by the police to conduct a MHA assessment. Consultant psychiatrist 9, social worker 1 and GP3 did this assessment. AJ was not considered mentally ill. Her flat was untidy and, as well as the broken windows noted during the MHA assessment in September 2005, the glass in her front door was broken. With AJ's agreement, social worker 1 telephoned the district council and spoke to the housing officer about repairs.

5.48 On 28 December 2005 Mrs J telephoned the local district council about the state of AJ's flat and was told by the housing department that they had not received any contact from social worker 1 over this issue. However, the social work notes record that liaison had taken place, as noted above.

5.49 On 31 December 2005, Mrs J wrote a second letter of complaint to the trust, expressing her discontent over the outcome of the Mental Health Act assessment on 19 December 2005 and the fact that it had been carried out by consultant psychiatrist 9, not an independent doctor as the family thought had been agreed at the meeting on 19 December. Mrs J also pointed out that AJ's flat lacked security and weatherproofing. The trust received this letter on 4 January 2006.

5.50 On 4 January 2006 the news of AJ's death was relayed to the care team.

Comment on history of contact with the trust

From 1988 to 2005 AJ had a complicated history of contact with trust services and this complexity meant that she had contact with a wide range of specialist services at different times.

These episodes were characterised by:

- ***Transient psychotic experiences***
- ***Abuse of alcohol***
- ***Self-harm***

- *Threats to harm herself and sometimes other people which were sometimes carried out*

- *Difficulties in relationships with family members and with professionals working with her*

- *Periods of inpatient treatment either as a detained patient under the MHA or as a voluntary patient. There were some examples of difficult behaviour requiring restraint and use of seclusion, some involving police.*

- *Some periods of relative stability, for example the period from September 1999 to July 2003 when AJ had CPN1 as her care coordinator and consultant psychiatrist 4 as her RMO.*

- *Little evidence from the case notes of sustained periods of improvement*

- *Difficulties in reaching a definitive diagnosis*

- *Issues about gender including active measures on the part of AJ to achieve gender re-assignment.*

- *Continued involvement of AJ's parents in efforts to achieve a stable lifestyle*

- *Complaints by AJ and her parents to the trust and Mental Health Act Commission about her treatment*

- *A pattern of crisis intervention and management followed by care plans that were not always achieved. There were consistent difficulties in engaging AJ with agreed care plans.*

- *AJ's parents remained engaged but shared the frustrations of the care teams in achieving any lasting improvement to AJ's mental health and social functioning.*

- *In the last year a progressive detachment by AJ from services and a lack of engagement with any social network. She showed increasing isolation and anti-social behaviour in the context of alcohol abuse.*

- *No positive working relationships with members of the care team in the last months of involvement*

- *AJ's diagnosis and treatment were complex and difficult throughout her contact with mental health services. They became the focus of disagreement between the parents and the responsible medical officer.*

- *A deteriorating relationship between AJ's parents and the care team as they pursued a complaint about her care in 2005.*

The trust tried many times in the period under review to provide appropriate care and treatment to AJ. This included referral to specialist services for example the alcohol treatment services, personality disorder services, psychology services, treatment and recovery services, the deliberate self-harm services, cognitive behavioural therapy and help with gender re-assignment. Some of these interventions were successful in the short term, but none produced a satisfactory longer-term and stable solution for AJ or her family.

Professionals working with AJ tried hard to engage her and in some cases had to endure threats to their own safety as a consequence. On the whole, communication by the trust with AJ and her parents was good and there were examples in the case notes of good practice. In particular the involvement of CPN1 for about four years in a therapeutic relationship with AJ was positive.

Diagnosis remained a difficult and complex area for mental health professionals because at times AJ presented with psychotic symptoms but these tended to be transient and the conditions for a firm diagnosis of a psychotic illness for example schizophrenia, were not always satisfied. More often a diagnosis of personality disorder was preferred. Alcohol use and abuse was also a constant in AJ's presentations of illness. The difficulty of diagnosis was reflected in the many assessments by different parts of the trust mental health service recorded on file. At times AJ required detention in hospital under the provisions of the Mental Health Act.

We consider that there was a growing sense in the trust in 2005 that it had tried all the approaches it had to offer and this led to an attempt to disengage and give AJ more responsibility for contact and her treatment programme. This was reflected in the view of consultant psychiatrist 9 when he took over AJ's care. The decision to re-grade AJ to the standard level of CPA in May 2005 was unjustified in view of the complex history and range of unresolved problems. The allocation of a female care coordinator at the same meeting took no account of evidence that AJ became too attached to female workers and had threatened to kill CPN1.

January to May 2005

5.51 In this section we look more closely at the detail of the care and treatment during the last year of AJ's life. This was a period when AJ's parents were dissatisfied with the change of approach taken by the clinical team and had complained to the trust about AJ's care. We have therefore set out in greater detail the history of contact during this period.

5.52 In January 2005 consultant psychiatrist 3 was AJ's consultant. AJ had been assessed by the trust psychology services but was not accepted for treatment by the personality disorder services. The outcome of psychology assessment was that risk-management strategies must involve working with AJ to understand the causes of her rage, anger and pain and what practical measures needed to be taken to maintain the safety of AJ and others. This included helping AJ develop different ways of managing her emotional experiences over time. Consultant psychiatrist 5 and consultant psychiatrist 6 (clinical psychology) suggested that AJ required a consistent environment with clear boundaries which could offer emotional containment. They felt that AJ's inner world was disturbed and that staff might find themselves taking sides, either wanting to rescue or punish her. Therefore they recommended that staff involved with AJ should meet regularly to consider these issues in order to plan appropriate responses and offer some containment of her behaviour.

5.53 AJ was to be offered an assessment at the end of January 2005 by the personality disorder services. The plan was that if found to be suitable, and AJ agreed to work with the service, then AJ would be an inpatient during the week but would live elsewhere at weekends. AJ was concerned about how entering into the residential programme would affect social security benefits and hence finances to pursue private gender reassignment.

At this time gender reassignment was an important issue for AJ. She was pursuing it through private consultations and she was having fortnightly hormone injections.

5.54 A CPA review took place on 31 January. It noted that AJ had attended personality disorder unit (PD unit) 1 for assessment since the last review. AJ had controlled her drinking in the two weeks before the meeting, had not harmed herself and had not engaged in deliberate self-harm. AJ had not approached the drug and alcohol service. AJ was also keen that she should be referred to as *"he"* and that all her case notes should be changed to reflect this decision. It was agreed that AJ's gender could not be changed on her notes but the team was aware that the Gender Recognition Act might have affected this. The team was to refer to AJ as a male. Consultant psychiatrist 3 was to contact PD unit 1 about their future input and advice. Social worker 1 and CPN2 were to visit AJ fortnightly, on alternate weeks. This pattern was not always followed. The care coordinator at this point was social worker 1 and he was to pursue housing issues. CPN2 agreed to contact the crisis resolution team about out-of-hours contact. AJ was to refer herself to the drug and alcohol service.

5.55 On 7 February 2005 police detained AJ under section 136 MHA. She had developed a fixation with a female worker at T&R unit 1. She had gone to T&R unit 1 drunk and threatened to kill herself. She remained in police custody overnight. AJ became increasingly more settled as her time in custody progressed. She complained of hearing voices but otherwise she was rational and not apparently over agitated or troubled. AJ could not recall having intended to kill herself and did not express any suicidal intent. She was concerned that she might be admitted to hospital. AJ was felt to be socially isolated but not detainable. A mental health assessment was completed on 8 February and decided that AJ should return to the homeless person's accommodation. AJ was allocated a council flat later that month and moved on 28 February 2005 to a small town in west Leicestershire.

5.56 On 15 March 2005 a CPA review meeting was held. AJ said she liked her flat. She complained of being in constant physical pain but said she did not believe she needed constant support from mental health services. She was on the waiting list for a mastectomy and had been diagnosed with cervical spondylosis and sciatica. The note of the discussion shows AJ had been recommended for a residential programme at Francis Dixon lodge which would include dialectical behavioural therapy (DBT). However, AJ felt that inpatient admission would be a repeat of past experiences and that importantly for

her, her gender change would not be recognised. AJ had had a private consultation with a consultant psychiatrist in London in November 2004 about gender reassignment and had been prescribed hormone therapy which was being administered by the GP.

5.57 AJ and social worker 1 had submitted applications for a community care grant and housing and council tax benefit. AJ had received the trust's response on gender re-assignment and was seeing PALS in relation to this matter. The crisis resolution team had been contacted since the last review and were aware of the out-of-hours plan for AJ's care. The agreed plan was for consultant psychiatrist 3 to contact PD therapists about DBT and the treatment and recovery psychology service. CPN2 and social worker 1 were to visit AJ fortnightly, on alternate weeks. CPN2 was to contact the crisis resolution team to clarify out-of-hours contact.

5.58 On 4 April 2005 there was a meeting between social worker 1, consultant psychiatrist 3, AJ and Mr and Mrs J. AJ had expressed concern about the mention of harm to others in her risk assessment and consultant psychiatrist 3 informed AJ that there was a risk to others when she was drunk. AJ stated she did not want contact with the services because she was concerned about her benefits. There was discussion at the meeting about gender reassignment, which was a central issue for AJ at this time. AJ planned to pay privately for the gender reassignment surgery. AJ was informed that the lead consultant on gender dysphoria would see her only in conjunction with a psychiatrist. Mrs J was critical of administration of hormones by consultant psychiatrist 1 and GP2.

5.59 AJ declined a placement within personality disorder services.

5.60 Mr and Mrs J were concerned that AJ had been accommodated in a first-floor flat, because she had a history of jumping from buildings. They also believed that AJ was *"wallowing in self-pity"*, cutting herself and that there was a perceived lack of support from the crisis resolution team. Mrs J said that AJ threatened her on the previous Friday and was unhappy with arrangements with the crisis resolution team. Consultant psychiatrist 3 explained the recommendation from the assessment by the psychologists at the PD unit which was for day care from Monday to Friday with the offer of an inpatient stay at weekends if necessary. AJ agreed to consider the PD unit.

5.61 On 20 April 2005 AJ telephoned social worker 1 to say that she did not want to see him anymore because he had referred to her as *"she"* in the notes of the meeting. On the

same day AJ was visited at home by CPN2 who discussed accommodation, benefits, going to college, finding a job, applying for a loan for private gender reassignment and social worker 1's role in helping her to apply for benefits. AJ was informed that she would have a new CPN from May.

5.62 On 26 April AJ wrote to CPN2 stating that she did not want contact with him because she didn't like his attitude. AJ felt he was smirking at her medical condition. AJ enclosed a copy of a letter she had written to the press complaints commission and felt he might disclose information to a non-authorised person. AJ was unhappy that information had been sent to her old GP without her consent and threatened to take CPN2 to court if he *"harmed her again"*. AJ refused input from the services because of the ignorance of the staff. CPN2 passed the letter on to his team manager.

Comment on care and treatment January to May 2005

The main themes in the relationship between AJ and the mental health services at this period were:

- ***Her change in accommodation status from bed and breakfast accommodation to her own flat. Despite the fact that she had injured herself seriously by jumping from an upstairs window, she was allocated a first-floor flat. The view was that her strong desire to leave temporary accommodation outweighed the risk of not being accommodated on the ground floor.***

- ***Plans for a greater input from the clinical psychology services did not take place. The view was that psychology-based approaches to treatment might be helpful but there were also doubts about the ability of AJ to tolerate the treatment programme and the degree of stress she might experience. The programme would have required her sustained cooperation and it seems that this was not given.***

- ***There were continuing difficulties over maintaining a planned approach to her care. There were regular CPA meetings but plans were not always achieved. There were crises between meetings and it was difficult for all parties to follow a care plan.***

- ***There were some examples of self-injurious or threatening behaviour from AJ. AJ said she did not want anything to do with mental health services yet she maintained a demand for services and at times was challenging of them.***

- ***Gender re-assignment was a continuing and important theme for AJ during this period and she was actively pursuing both medication and surgery. She was prepared to seek help privately, though the financial cost worried her. She was having regular hormone injections from her GP as prescribed by a private consultant as part of a gender re-assignment programme. AJ was sensitive about gender status and took offence when people referred to her as a woman. She wanted to be referred to as a man and wanted all her clinical notes changed to reflect that preference.***

- ***AJ was on the enhanced level of CPA and there were regular reviews in which AJ's parents participated. The approach from mental health services was broadly consistent with the CPA policy and several members of the clinical team to review tried to implement care plans. AJ's parents were not wholly satisfied with the approach but were engaged with the team.***

- ***The issue of diagnosis remained problematic but was not central to the approach adopted by the clinical team at this point. The main aim was to provide a supportive framework of contacts, and to include AJ's parents in planning.***

The level of care the trust provided was appropriate and mostly satisfied the requirements of the CPA, although the regularity of visits to AJ was not always maintained as set out in the care plan. AJ did not have a close working relationship with any member of the team, but efforts were made to sustain a care plan. It was difficult to maintain a treatment plan because AJ's compliance varied and her own wishes were not always clear.

Change of consultant in May 2005

5.63 On 10 May 2005 consultant psychiatrist 9, a locum consultant, took over responsibility for AJ. On the 11 May 2005 there was an emergency CPA review to discuss future input from the multi-disciplinary team. AJ was regraded to the standard level of

the CPA. AJ was to be seen by CPN3 and consultant psychiatrist 9 in outpatient's clinic. The care coordinator role passed to CPN3.

5.64 This marked a change in emphasis in clinical approach. Consultant psychiatrist 9 and the multi-disciplinary team reviewed AJ's care and decided that the approach should be based on:

- seeing AJ as an outpatient only
- giving AJ more responsibility for her own recovery
- not seeing AJ at home because she posed a threat to female workers
- recognising that earlier attempts at management had not been successful.

5.65 It was decided that CPN3 should be the care coordinator. Social worker 1 was no longer the care coordinator but he continued to be involved in some aspects of the care planning, particularly in relation to housing issues, and as an approved social worker in subsequent assessments under the Mental Health Act.

Comment

The allocation of a female care coordinator was surprising given that AJ had previously made threats to female workers allocated to her. The trust CPA policy implied that the care coordinator would have frequent contact with a service user.

5.66 On 6 June 2005 a mental health assessment was carried out after a referral to the GP by AJ's mother. AJ was detained under section 2 MHA and remained on AMH unit ward C for four days before being transferred to T&R unit 2. AJ was violent and disturbed at first but the assessment was that there was no evidence of schizophrenia so the section 2 order was lifted after a few days. AJ was not on any medication when discharged from the ward.

5.67 AJ remained in the community but did not respond to calls from the clinical team and did not attend outpatient appointments. AJ's parents were unhappy with the approach of the clinical team and made a formal complaint to the trust on 5 July 2005. They thought her diagnosis was incorrect and the level of support she was offered inadequate. They were concerned about the state of her flat and thought that she should have been offered supported accommodation after discharge from hospital.

The trust response to the complaint from AJ's parents

5.68 Mrs J wrote a letter of complaint on 5 July 2005. The trust responded on 2 September 2005 acknowledging the family's concerns but explaining that they were not able to disclose any clinical information because AJ had not given her consent. In their internal response to the complaint which was not shared with the family, the consultant and the CPN care coordinator reiterated the view that AJ was not suffering from a psychotic illness, that personality disorder was a more appropriate diagnosis and that gender dysphoria and alcohol misuse were significant factors. Consultant psychiatrist 9 wrote:

> *"[AJ's] diagnosis has been personality disorder most likely borderline type with gender dysphoria. By nature of the personality disorder that she suffers from it is not unlikely to have brief psychotic experiences. I however, do not believe that [AJ] has a more enduring mental illness such as paranoid schizophrenia. It is also apparent to me that most of the difficulties that arise within her care are in the social context and appear to be accentuated when she is under the influence of alcohol…*
>
> *It is my opinion [AJ] is capable of taking a degree of responsibility but this does not seem to be the case at the moment, rather what I see is that all responsibility for her behaviour and functionality has been shifted to professionals…"*

5.69 CPN3 wrote:

> *"In relation to their view that [AJ] has a psychotic illness, this view is not shared by the team. We feel that there is little evidence to support this and it is more likely that [AJ] presents with characteristics associated with Personality Disorder…. It is felt that [AJ] needs to work in partnership with the services, in the past it is felt that the situation has escalated when responsibility is taken away from her…[AJ] is well aware of how to request help should it be required. In my opinion [AJ] should be encouraged to seek help in a responsible manner rather than seek out her parents to do this on his behalf…"*

Comment

The trust response to the complaint was not timely and contained little information that would have been helpful to the parents. The response from the trust was also limited and did not acknowledge that the parents had been engaged in care plans and meeting staff with care responsibility for some years. The decision by the care team to shift responsibility for contact to AJ was not fully explained to the parents. Whilst we accept that AJ had not given her consent for personal information to be shared with her family, we believe that the trust could have provided some useful information to her family.

Mental health assessment on 6 September 2005

5.70 After a conversation between Mrs J and consultant psychiatrist 9 the mental health team carried out an assessment under the MHA. AJ's father entered her flat with a key. AJ was angry about the team's presence and said that she did not want contact with mental health services and was not going to pursue gender re-assignment because it was *"too much hassle"*. The team did not consider that admission under the MHA was justified. After the assessment a CPA review was held and changed AJ's status under the CPA to enhanced due to the complexities of her care. CPN3 remained the care coordinator.

CPA meeting on 20 September 2005

5.71 The CPA review was called as a result of MHA assessment on 6 September and the focus was how to improve engagement with AJ. The agreed plan was that AJ would remain on enhanced CPA because of the complexities of her needs. The team agreed to continue to offer AJ support by visiting or seeing her in outpatients' clinic in pairs. AJ had refused the PD unit's input but this was still to be considered as an option. The care coordinator at this point was CPN3. The CPA review noted that the diagnosis was of personality disorder with depressed mood and pseudo-psychosis. Consultant psychiatrist 9 explained to Mrs J in the meeting the importance of staff seeing AJ in pairs. Consultant psychiatrist 9 asked Mrs J for her advice in relation to her complaint about how he should work with AJ. She explained that AJ had threatened to kill her brother. AJ's threats to kill CPN1 (a former CPN care coordinator) were also raised. Consultant psychiatrist 9 explained that the MHA assessment on 6 September 2005 indicated that AJ was not detainable under the Mental Health Act.

5.72 Consultant psychiatrist 9 explained that AJ's diagnosis was borderline personality disorder with transient psychosis, for which the treatment was medication, psychotherapy and social support, all of which AJ had refused. Consultant psychiatrist 9 said that he was willing to visit AJ and prescribe medication. AJ declined a carer's assessment. Consultant psychiatrist 9 advised the family to contact the police if AJ made any further threats to kill them. Consultant psychiatrist 9 suggested that AJ's accommodation be reassessed in order to assure AJ's mother that her needs were being met. AJ did not attend this meeting.

5.73 The CPA review included a check list of identified risk areas. The record shows that risks were identified for misuse of alcohol, compliance with medication, harm to others and access and potential risks in relation to self-neglect, self-harm, fire risk or damage to property and vulnerability or exploitation. The next review was planned for 24 January 2006 and AJ remained on the enhanced level of CPA.

Family concerns and response to the trust complaints investigation

5.74 AJ's family remained concerned about her mental state and her living conditions. Mrs J wrote to the trust on 11 October 2005 and commented on the fact that AJ had isolated herself. She was not responding to telephone calls and was not dealing with letters and bills. Mrs J was concerned about the poor condition of the flat and again showed disagreement with the team's diagnosis offered, the lack of medication and effective monitoring. Mrs J reported that AJ believed she was in contact with Princess Diana and expressed the view that AJ had been *"abandoned"* by the care team.

5.75 The senior nurse said in her reply to Mrs J on behalf of the trust that consultant psychiatrist 9 had been asked to arrange a meeting with AJ's parents so that a care plan could be discussed and agreed. Mr J telephoned the senior nurse on 24 November to press for a meeting because of AJ's mental state and the condition of the flat. A meeting of the team with AJ's parents was arranged for 15 December. Mr and Mrs J felt it should have been arranged sooner so social worker 1 and his team manager met them on 9 December. At this meeting AJ's parents asked for an independent psychiatric assessment of their daughter.

Meeting with the multi-disciplinary team on 15 December

5.76 Mr J attended part of this meeting, supported by an advocate from Leicester action for mental health project (LAMP). CPN3 took minutes. The trust internal investigation reviewed the content of the meeting and concluded there had been discussion of the family wish for an independent assessment and that when Mr J had left the meeting most staff there thought a decision had been made to follow this course. However, consultant psychiatrist 10's recollection was that although the family view was aired, no decision had been made. He thought their view was one of the points to take into consideration by consultant psychiatrist 9 and consultant psychiatrist 10, who made the decision that consultant psychiatrist 9 should complete the assessment himself.

Assessment of AJ on 19 December 2005

5.77 On 19 December social worker 1 obtained a warrant under section 135 MHA to enter AJ's flat. The assessment was completed by social worker 1, GP3 and consultant psychiatrist 9. The police attended. The assessment team did not think that AJ met the criteria for compulsory admission under MHA. The action agreed was that social worker 1 would contact the housing department about repairing the front door glass and the broken window. We asked the team members who completed that assessment whether the decision not to admit AJ was difficult or marginal. They were all clear that admission was not appropriate and that AJ was spontaneous and rational in her replies to questions. They noted that the flat was untidy. Later that day, social worker 1 telephoned the district council housing department to discuss repairs to the flat.

Events after 19 December assessment

5.78 After the assessment Mrs J wrote again to the trust on 31 December to complain about its outcome and the fact that it had not been done by an independent doctor. She had telephoned the district council on 28 December about the state of the flat. The police visited AJ's flat on 1 January 2006 after a complaint from BL that water was leaking into his flat from the one above. The police were concerned about the state of the flat and made a referral to the social services emergency duty team.

Care and treatment from May 2005 to January 2006

Use of the CPA

5.79 At the date of the incident, the trust CPA policy (2003) was the key practice guidance in operation. The trust reviewed the CPA policy in 2006 and introduced a new policy from January 2007.

5.80 The CPA policy (2003) stated that the care coordinator should:

- coordinate the care package
- keep in contact with the service user and advise the other members of the care team of changes in circumstances which might require review of the care plan; this included service-users in placement with other service providers.
- Ensure that planned services were provided (and continued to meet assessed needs) and to call reviews where circumstances indicated it was necessary.
- Arrange reviews.

5.81 For patients reluctant to engage with services the policy stated that:

> *"If, after all attempts to persuade them to accept, the service user still wholly rejects the plan, the team should offer, where appropriate, to keep in contact on a regular basis in consultation with the service users GP and support network. If this offer of contact is declined, then the team may, after appropriate assessment of risk, discharge the service user from the care programme approach process. However, if it is decided that discharge is not safe, alternative interventions must be considered on the basis of a thorough mental health assessment."*

5.82 AJ was subject to the enhanced level of CPA at the time of her death. The designated care coordinator was CPN3. She had only one face-to-face meeting with AJ in the period from May 2005 to January 2006. In interview CPN3 said:

> *"I only actually saw AJ once, and AJ had been admitted to the AMH unit and then transferred to the rehabilitation unit at T&R unit 2, and I took the opportunity then to go over and see AJ, really because the previous attempt of seeing AJ in a neutral*

venue had been unsuccessful, so I saw AJ in a bid to try and establish some contact and rapport, and that, unfortunately, was the only time I saw AJ."

5.83 In relation to the low frequency of contact, we asked whether this was partly for resource reasons. CPN3 said:

"From my view when I started that obviously it was wholly inadequate to have one CPN…"

5.84 She added that at the time she was the only CPN on the care management team so there were no male CPNs available on the team who could have taken on the care coordinator role.

Comment

As well as the issue of frequency of contact, we question the decision to allocate a female care coordinator when previous experience suggested that AJ had been over-attached to female workers. She made threats to kill a female CPN who had worked with her for some time and had threatened other female staff on the ward to whom she became attached.

The trust's practice in relation to the gender of care workers was inconsistent with several examples of allocation of a female worker after her threat to kill CPN1. For example community care worker 1 was allocated after discharge in 2004 until social worker 1 took over the role.

CPN3 was the designated care coordinator but social worker 1 continued to be involved in AJ's care and in liaison with her parents. Social worker 1 offered a thread of continuity in AJ's care and continued to try to carry out elements of the care plan. However, his relationship with AJ deteriorated and he did not have the confidence of AJ's parents.

There was a contradiction between the practice adopted by the clinical team under consultant psychiatrist 9's leadership and the requirements of the trust CPA policy. Consultant psychiatrist 9 took the view that AJ should be encouraged to take responsibility for contact with the mental health team, whereas the expectation of the enhanced level of CPA is that there should be regular contact and active review

of the patient's mental state. The designated care coordinator did not fulfill the requirements of the role.

After the last discharge from hospital in June 2005 the plan to follow AJ up regularly was not carried out and contacts were largely prompted by the family or by AJ's failure to attend outpatient appointments. Consultant psychiatrist 9 wrote to AJ and tried to phone her but did not succeed in maintaining contact. The shift of emphasis in the care plan when consultant psychiatrist 9 took over as RMO was significant. It gave greater responsibility to AJ to maintain contact and accept responsibility for her actions. It was contrary to the parents' view and wishes about care. It relied on the active participation of AJ which was never achieved.

Since the incident the trust has completed a review of the CPA guidance and introduced a new policy in January 2007. There is an action plan for the implementation of the new policy and we have received a recent update on progress. The new policy is more concise and brings greater clarity to the processes underlying the CPA but relies on the compliance of managers and front-line staff. Some parts of the implementation have not yet been achieved.

An audit of CPA practice in the trust shows that compliance with its requirements is variable.[1] The audit of 500 service users, carried out between September and October 2007, showed that in four key performance measures the trust showed worse performance than the national average, as measured in the national patient survey 2007. The proportion of trust service users with no named care coordinator was 44 per cent (England average 29 per cent), the proportion with no care plan was 51 per cent (England average 45 per cent), the number who had not had a review in the last year was 65 per cent (England average 47 per cent) and the number of people without access to an out of hours contact number was 66 per cent (England average 66 per cent).

The meeting between the family and the care team on 15 December 2005

5.85 We met several professionals who attended this meeting and spoke to Mr J and the family advocate. We also read the minutes of the meeting and comments in the case notes

[1] Leicestershire Partnership Trust care programme approach case-note audit autumn 2007

about the meeting. The discussion centered on concern for AJ's mental state and the plan for the next steps. Mr J, supported by his advocate, clearly asked for an independent psychiatric assessment. Most of those at the meeting felt that this had been agreed. However, consultant psychiatrist 9 and consultant psychiatrist 10 decided that consultant psychiatrist 9 would complete the assessment. They did not feel that a collective decision had been reached to arrange an independent assessment and thought it would be expedient for consultant psychiatrist 9 to make the assessment. As consultant psychiatrist 10 said in interview:

> *"It seemed to me that the quickest way of doing something about this would be for (consultant psychiatrist 9) and (social worker 1) to contact the GP and go and see her straight away".*

5.86 Other views of the meeting were that the arrangement of an independent assessment was central to the family's wishes. As service manager 1 (service manager with LPT) said to us:

> *"In the pre-meeting I actually asked the views of the other professionals in the meeting and gave my own view around whether it was worth actually, rather than complicate matters, whether we could also address that fact by carrying out a Mental Health Act assessment, offering them a Mental Health Act assessment, but offering that that was done by another medic.*
>
> *The reason that I felt that that would be beneficial was it would in effect give them the second opinion that I think they would have wanted in a very straightforward way, but it would also address the needs of the Mental Health Act assessment."*

5.87 Mr J clearly thought that there had been an agreement for an independent psychiatric assessment. In interview he said:

> *"…The main thing is this independent psychiatrist thing. It wasn't something that I asked for or AJ suggested. We thought it was a good idea when it came up, and they all agreed and that was that.*
> *Q. So your understanding when you left the meeting was that an independent psychiatrist –*
> *Mr J: Not understanding, they had agreed it between themselves."*

Comment

Decision-making in the meeting was flawed. It was clearly important to the family that an independent assessment was arranged but the doctors at the meeting reached their own conclusion, which was to use the usual procedures and for consultant psychiatrist 9 to complete the assessment. This may have been expedient, and consultant psychiatrist 9 was competent to carry out the work, but it went against the family's wishes and the expectations of other professionals in the team. When taking into account the context of the meeting, including the presence of a family member who had made a complaint to the trust, the failure to agree to an independent assessment was misguided and in particular failed to give due weight to the family's concerns. Most people attending the meeting thought it showed a lack of respect for the family's views and a breach of the agreed outcome of the discussion at the meeting.

The Mental Health Act assessment on 19 December 2005

5.88 This formed the crux of the disagreement between the family of AJ and the multi-disciplinary team. AJ's parents believed she was clearly mentally ill as evidenced by her behaviour and the state of her flat, and that she needed to be detained in hospital. They believed that if she had been detained, she would not have been the victim of the attack by BL and CL on 3 January 2006. The parents had pressed the trust to make an assessment and admit AJ and this had been the focus of the meeting Mr J attended on 15 December.

5.89 The trust had followed agreed procedures for arranging mental health assessments. Social worker 1 had obtained a warrant under section 135 of the Mental Health Act to enter the premises. He had arranged for the police to give support role if enforced entry was necessary. GP3 had been asked to attend the flat at 2.00pm and had done so.

5.90 Consultant psychiatrist 9 was delayed and did not arrive at the flat until about 3.00pm by which time the GP had returned to his surgery to await a call to return to the flat when consultant psychiatrist 9 arrived. Entry to the flat was easy because the front door glass was broken and it was possible to step through the broken door. The accounts of the professionals involved of the interview with AJ are consistent. She was initially angry that the assessment was being carried out but became calmer. Consultant

psychiatrist 9 found no psychotic phenomena and thought that hospital admission was not appropriate.

5.91 We asked whether this decision was difficult to reach or whether those present were unanimous.

5.92 GP3 had difficulty recalling the assessment:

> *"Q. We are going to ask you about this interview on the 19th. Were you all present together – you, consultant psychiatrist 9 and social worker 1? Were you all there with AJ?*
> *A. I am assuming we all were – with consultant psychiatrist 9, social worker 1.*
>
> *Q. And the decision from that assessment was that it was not appropriate to admit AJ under the Mental Health Act?*
> *A. I have it written here that he was declining help offered from the social services re repairs to the house, and help for himself, and he no longer wished to pursue gender reassignation.*
>
> *Q. Was that a straightforward decision not to admit AJ at the time? Or was it marginal in your mind? Give us the flavour of it.*
> *The chair of the local medical committee (who accompanied GP3 to the interview): You probably cannot remember.*
> *A. I actually cannot quite remember. I can still remember being perhaps angry. In actual fact, he was logically arguing why he did not need the services any longer."*

5.93 Social worker 1 said there was no disagreement about the outcome of the assessment. In interview he recalled:

> *"Q. Was this one a close call, do you think, about whether it was appropriate to use the powers of the Mental Health Act to detain AJ for assessment, or was it fairly clear-cut that it was not appropriate?*
> *A. I think it was fairly clear-cut. Clearly there were concerns about AJ's living situation, her life and risks, and I felt at the time were unquantifiable risks that might have emerged from that, and in terms of risks, if AJ had presented with*

mental illness, because of the risks I would have argued very strongly for her detention. But I have worked with a lot of people with presenting psychosis before and since, and in my current job I see a wide range of people, but I did not think that AJ – and I could accept that AJ had experienced transient experiences of psychosis. I think I had experienced when she was in temporary accommodation she did speak about the voice of God. It did not seem to fit a mainstream mental illness. It was something to do with anxiety, to do with anxiety-related experience. AJ was not having any of those experiences at the time either. So from my review it was quite clear-cut."

5.94 Similarly, consultant psychiatrist 9 told the trust internal investigation that AJ had been angry and difficult to engage in the initial phase of the assessment and was particularly angry that the police were present. Later she was calmer and he could see no evidence of psychotic thought disorder. He thought the most accurate diagnosis was of borderline personality disorder. The agreed outcome from the assessment was that social worker 1 would contact the housing department about repairing the broken windows.

Comment

In relation to the assessment we found that:

- ***it was carried out by relevant professional workers experienced in diagnosis of mental illness***

- ***the issue of risk to AJ did not arise in any of the contemporaneous accounts of the interview. There was no discussion at the time of a threat to AJ from BL, and her vulnerability was not seen as a reason for admission to hospital* "in the interests of her own health or safety".**

- ***the practical outcome was that social worker 1 took action to contact the housing department***

- ***there was a lack of timely communication with AJ's parents about the outcome of the assessment given that they had recently met with the clinical team and complained about the trust's handling of AJ's care.***

- ***the outcome of the assessment was unsatisfactory to AJ's parents***
- ***consultant psychiatrist 9's contemporaneous recording of the outcome of the assessment was inadequate.***

Discussion of diagnostic issues

5.95 The difficulty of diagnosis was a consistent theme throughout AJ's care and an area of dispute between the parents and the responsible medical officer in the second part of 2005. Here we explore these issues in greater detail.

5.96 Consultant psychiatrist 9 set out his views about the care and treatment of AJ in a letter to the senior nurse dated 18 August 2005. He said that he had taken over responsibility for AJ in May 2005 from consultant psychiatrist 3. Consultant psychiatrist 9 had made several appointments for AJ which she had not kept. Consultant psychiatrist 9 had met AJ after her admission to AMH unit ward C in June 2005. He did meet her on 15 June at T&R unit 2 and there was an agreement to meet after discharge but AJ did not keep this appointment. Consultant psychiatrist 9 wrote to AJ to ask her advice about how best to engage with the care team. Consultant psychiatrist 9 believed that AJ was largely suffering from a personality disorder. He wrote:

> *"I have also had two physical contacts with AJ during one of the such contacts we had a very long interview with AJ. It seems rather obvious to me that a large part of AJ's difficulties arise as a result of the nature of AJ's personality in the context of misuse of alcohol. AJ's diagnosis has been a personality disorder most likely borderline type with gender dysphoria. By nature of the personality disorder that AJ suffers from it is not unlikely to have brief psychotic experiences. I, however, do not believe that AJ has a more enduring severe mental illness such as paranoid schizophrenia."*

5.97 Consultant psychiatrist 9's view, which he maintained in his interview with the trust internal investigation, was that AJ should be encouraged to take more responsibility for her care:

> *"It is my opinion that AJ is capable of taking a degree of responsibility for his own life as he has shown in other aspects of his life…I believe that AJ is able to attend reviews in the clinics … agreed with AJ beforehand."*

5.98 Consultant psychiatrist 9's view brought him into sharp disagreement with AJ's parents who maintained consistently that she was mentally ill and should have been treated in hospital. AJ's own view recorded in meetings and conversations in the second half of 2005 was that she was not mentally ill and did not wish to have contact with the mental health services. She had moved from a position of intense engagement with services in earlier years (as in the example of attachment to CPN1) to one where she felt the mental health services had little to offer. Her view was antagonistic to further contact as evidenced by her letters to the trust in 2005. In April 2005, for example, she wrote to her CPN, CPN2, to say that *"I've decided not to have a CPN now or ever…"*

5.99 Assessments arranged in response to family pressure confirmed consultant psychiatrist 9's view that AJ was not suffering from a mental illness and that she was firmly rejecting further contact with services.

5.100 Consultant psychiatrist 9's approach marked a substantially different view from the one the clinical psychologists suggested in early 2005. In a letter to consultant psychiatrist 9 dated 27 June 2005, consultant psychiatrist 6 summarised the contact with AJ after her referral to the psychology services when she was an inpatient at T&R unit 1 in 2004. Consultant psychiatrist 6 said that there had been an offer of treatment at the therapeutic community but AJ had decided not to take this up. The offer remained open if she changed her mind. Consultant psychiatrist 6 also noted that she had discussed the value of individual psychotherapy for AJ with consultant psychiatrist 3 but that AJ remained against *"any form of psychological intervention at this time"*. AJ was focused on the idea of gender reassignment. In the letter, consultant psychiatrist 6 offered to facilitate a continuing professional forum for members of the MDT involved in AJ's care as an alternative contribution from the clinical psychology services:

> *"It seemed important for the MDT to meet regularly to offer an opportunity to discuss, share and think through a range of issues related to working with AJ. This would facilitate continued development of the MDT's psychological understanding of AJ's ongoing difficulties in order to be able to plan appropriate responses and offer some level of containment."*

5.101 This left it open for further contact from the psychology services and team discussion of the best approach to AJ's care.

5.102 We invited consultant psychiatrist 9 to meet the investigation team to discuss his involvement in the AJ case. Consultant psychiatrist 9 was interviewed as part of the trust internal investigation and we have had access to the transcript of that interview. Consultant psychiatrist 9 was invited to meet our investigation team but he declined on the grounds that he had no further information to add to what he had already stated to the internal inquiry. We think it would have been helpful to our investigation to meet consultant psychiatrist 9. His decisions were critical to the approach taken by the trust after he became the RMO and his participation in meetings of the multi-disciplinary team and with AJ and her parents were central to the quality of care offered.

Comment on the issues of diagnosis

The issue of diagnosis became a battleground and focus of debate between the family and the clinical team, particularly consultant psychiatrist 9, in 2005. This obscured the possibilities of alternative approaches based on social care models. The change in approach was agreed at a CPA meeting but AJ did not support it. The new approach was based on AJ taking more responsibility for her own management. There was no evidence that AJ was capable of fulfilling her component of the care plan i.e. sticking to a plan consistently and self-monitoring. Similarly, the plan was not agreed with AJ's parents who were known to be involved. They never agreed with the approach and saw it as a "hands off" attitude from the trust.

Monitoring the impact of hormone therapy

5.103 AJ started hormone injections after consulting consultant psychiatrist 8 in November 2004. These were administered by GP2, at GP surgery 1 where AJ was registered as a temporary patient. Consultant psychiatrist 8 had written to consultant psychiatrist 3 who was the RMO at the time and consultant psychiatrist 3 had written to GP2. She had also written to consultant psychiatrist 7, programme director of the Leicester gender identity clinic. When AJ was rehoused to a flat in Leicestershire in March 2005 she registered with a local GP at GP surgery 2. She was seen mainly by GP3 who was involved in several mental health assessments during 2005 and in the last one on 19 December 2005.

5.104 From the GP records, the hormone injections seem to have stopped in May 2005, the last recorded administration of Sustanon being on 25 May 2005. The GP records show

that AJ was not a regular visitor to the surgery and that her pursuit of gender reassignment waned during the second half of 2005. GP3 or partners were involved in mental health assessments but had difficulty getting access to the flat and on occasions were told by AJ that she did not want any contact with them. The last contact with AJ was the assessment visit on 19 December when GP3 recorded that *"AJ calm, no depressive/thought disorder elicited, declining help offered from social services re repairs to house , no longer wishes to pursue gender reassignment."*

5.105 Sustanon is the trade name of testosterone. The guidance for the use of this drug indicates that blood and liver function of a person receiving it should be monitored. It is also recognised that it can result in a number of side effects; of particular relevance to AJ would be, we consider, the known effects of depression, anxiety, irritability, nervousness and acne. The guidelines say treatment should be given under expert supervision.

Comment

We conclude that the arrangements for treatment and monitoring were unsatisfactory and the supervision weak. We are not satisfied that an arrangement between a private consultant 100 miles away, and a GP, apparently without any meaningful involvement of local mental health services, was adequate.

Findings in relation to the care and treatment of AJ

5.106 AJ had a long and well documented history of contact with the trust and its predecessor organisations. Her mental health history was complex. Assessment and treatment of her mental health needs involved many professionals and brought her into contact with specialist services in the trust.

5.107 The trust made sustained efforts over a long period to provide appropriate care and treatment for AJ. This involved many individual practitioners and parts of the services. Success was variable with some examples of good practice and relative stability. AJ was difficult to work with and the best efforts of the professionals involved in her care were frustrated by her refusal or inability to comply with treatment plans.

5.108 AJ's parents were engaged with her mental health care over the years and did all they could to help her. They were in regular contact with the professionals working with her and were a key part of treatment plans and the monitoring of her mental state.

5.109 Multi-disciplinary input to AJ's care was good. She had access to psychiatrists, CPNs, psychologists, social workers and nursing staff who coordinated care plans. AJ formed close relationships with some staff and was at times threatening to them. She sometimes needed to be detained under the Mental Health Act and intensive nursing techniques to ensure her health and safety.

5.110 The CPA was used as a framework for care planning and review. There were problems with delivery of the CPA in the last six months of 2005. The care coordinator did not have regular contact with AJ and for a period she was assigned to the standard level of CPA despite the complexity of her mental health needs. AJ was not sufficiently engaged with the care plan. There were disagreements with her family over the approach in the care plan and misunderstandings in the care team about the agreed approach.

5.111 Consultant psychiatrist 9 took a new approach to the care and treatment of AJ. However, it relied on the cooperation of AJ and her active engagement. She was unable or unwilling to be a partner to the plan. It centered on her active participation at a time when she had decided not to have contact with the mental health services and it failed. Other approaches based on social care might have had more success.

5.112 In 2005 we feel there was a growing sense that the trust had done all it could and this led to an attempt to give AJ more responsibility for contact and her treatment programme. This was reflected in the view of consultant psychiatrist 9 when he took over AJ's care. The decision to re-grade AJ to the standard level of CPA in May 2005 was unjustified in view of the complex history and range of unresolved problems. The allocation of a female care coordinator at the same meeting took no account of the threat AJ posed to female workers.

5.113 Risk assessment was completed as part of the care plan but this was not followed through into a more active approach to monitoring AJ's mental health. AJ's parents and the care team viewed differently her disengagement from mental health services in the last six months of 2005. The family saw it as a sign of AJ's ill health while the care team thought it was her choice and saw no grounds to intervene under the Mental Health Act.

5.114 Consultant psychiatrist 9 and consultant psychiatrist 10 failed to take sufficient account of the family wishes for an independent assessment after the meeting on 15 December 2005. An independent assessment would have been appropriate and was the

preferred outcome for the family, their advocate and all other professionals at the meeting. The doctors took insufficient account of the parents' views and did not give adequate weight to the multidisciplinary meeting where the decisions should have been taken. We recognise that medical staff may take the view that they have ultimate responsibility and therefore should make the ultimate decisions. This should not preclude the involvement and consideration of the views of other members of the team, nor should it excuse the changing of decisions without adequate communication and explanation.

5.115 An appropriately qualified and experienced team carried out the assessment on 19 December 2005. AJ's parents did not accept the outcome and maintained that hospital admission was necessary.

5.116 The attack on AJ was made more likely by her proximity to BL and by her behaviour, which at times was anti-social and had brought her into contact with the police.

6. The care and treatment of BL

6.1 BL was born in a town in Buckinghamshire in 1968. He was the youngest of three siblings with two older sisters with whom he no longer has contact. His parents divorced when he was young and he was brought up by his mother and step-father. They also separated when BL was an adult. He maintained some contact with his step-father but this was a source of conflict with his mother. Social history material we reviewed describes BL as having an unsettled childhood, with the family moving several times because of his step-father's job, requiring him to change schools. He described himself as a latch-key kid who tended to fend for himself. He said he had difficulties at school and was a bit of a loner who was picked on. He was often in fights at school and was eventually expelled. His formal education ended at age 15.

6.2 He had a number of jobs including working as a forklift truck driver, working in a timber yard and a large number of agency jobs. During the period under review he was unemployed. BL had a police record and in 1989 was found guilty of wounding (cutting of a man's throat with a knife) for which he was sentenced to 18 months in a young offender's institution. Other offences concerned mostly petty theft and motoring.

6.3 BL was married once and also had a *"common law"* marriage. He had two daughters from the first marriage but lost contact with them after about five years when he and his wife separated. His second marriage produced two children. His second wife also had a child, from a previous relationship. BL and RL separated in 2002 and BL cared for the children on his own for a period. The history of family life at this time is recorded in more detail in the section of this report dealing with social services involvement.

Details of contact with trust services taking a summary approach up to 2005

Inpatient treatment episodes

6.4 BL was first admitted to psychiatric services on 17 July 1994 under the care of consultant psychiatrist 11. This followed a referral from his GP. He had suicidal thoughts precipitated by the loss of his business earlier that year. He was discharged on 25 July 1994.

6.5 On 8 August 1994 he was admitted to the psychiatric unit via the accident and emergency department (A&E) at Leicester royal infirmary after an overdose of 35 paracetamol tablets and two-and-a-half bottles of whisky. He remained in hospital until 31 August 1994 when he was discharged.

6.6 BL was then offered outpatient appointments but the failed to attend and he was discharged from hospital care in December 1994.

6.7 On 17 March 2003 BL was admitted to AMH unit ward B under the care of consultant psychiatrist 12. He was referred by his GP with symptoms of depression and suicidal thoughts after his recent divorce. The contemporary record says there was no evidence of thought disorder and although he was having suicidal thoughts he was considered a low risk of acting on them. He was discharged on 25 March and did not attend his follow-up appointment in May 2003. He was discharged from outpatient care by letter to his GP on 18 September 2003.

6.8 BL was next admitted to AMH unit ward B on 10 December 2004 after a referral to consultant psychiatrist 4 from GP4, his GP who had been treating him for anxiety and depression. BL was feeling anxious and paranoid and thought that people were out to get him. He carried martial arts weapons to protect himself. He had moved to a small town in Leicestershire after 18 months in homeless accommodation in Hinckley. On admission it was noted that he had been experiencing anxiety and depression for some months, had been taking prescribed medication and had concerns that someone was out to get him. He said that his head was full of violent thoughts and that and that he had thoughts of shooting himself or doing something bad to get back in prison.

6.9 By 21 December 2004 BL had improved and was seen in the ward round. He was discharged with a care plan that involved medication and a referral for cognitive behavioral therapy and anxiety management. In fact BL was followed up through outpatient appointments and the plan for cognitive behavioral therapy was not taken up.

Contact with mental health and primary care services in 2005

6.10 During 2005, BL had a number of contacts with the trust through outpatient appointments and through the crisis resolution team. He also saw GPs from the local group

practice. The details of contacts during this period appear in the chronology section of this report and in a separate appendix giving a summary of specific contacts with the trust.

6.11 After discharge from the mental health unit in December 2004 BL failed to keep his first outpatient appointment on 20 January 2005. Trust grade doctor 1 then saw him on 23 February 2005 and reported that he was taking medication but suffering mood swings, was violent and angry and felt like hitting people. Trust grade doctor 1 saw BL again on 2 March 2005 and noted that he still felt angry and had been involved in a fight.

6.12 On 30 April 2005 George Elliot Hospital, Nuneaton A&E referred BL to the crisis resolution team after an overdose. A member of the crisis resolution team spoke to BL by telephone and assessed that the overdose had been the result of heavy drinking and that there was no longer a risk of self-harm. The case was closed to the crisis resolution team.

6.13 On 1 June 2005 trust grade doctor 1 saw BL as an outpatient. He said he had taken the overdose in April when drunk because his wife had spoken about plans to take the children to the USA. Trust grade doctor 1 said in a letter to the GP on 15 June 2005 that BL's mood was fine, that there were no signs of psychosis and that his partner (WP) was supportive.

6.14 On 1 September 2005 GP5 wrote to consultant psychiatrist 4 to say that BL had not found junior medical staff helpful and requested that consultant psychiatrist 4 see BL personally.

6.15 On 7 September 2005 trust grade doctor 2 saw BL and noted that "*he had thoughts of killing his neighbour*". There was no evidence of a psychiatric condition but *"a lot of anger"* and the doctor linked this to BL's abuse of drugs and alcohol. BL had requested that a CPN be appointed to allow him someone to talk to. Trust grade doctor 2 discussed this request with consultant psychiatrist 4 on 9 September 2005 and they agreed to:

- review BL's medication
- request that BL's GP provide *"practice therapist"* input
- give BL information about anger management
- ensure that BL's next appointment was with consultant psychiatrist 4 rather than trust grade doctor 2.

Comment

The response to the content of the interview between BL and trust grade doctor 2 was a missed opportunity to engage BL more actively in treatment. The care plan recorded in the case notes was flawed in that it relied on the presence of a practice therapist (a service that was not available at his local surgery) and upon BL being willing to read and act on a leaflet on anger management. BL did not in fact attend an appointment with consultant psychiatrist 4. BL was willing at this time to see a professional from the community mental health team.

6.16 On 26 September 2005 there was a note on file that there was a telephone contact to say that BL was taking Temazepam but that the medication prescribed on 9 September was making him *"nasty and aggressive"*. On 27 September 2005 trust grade doctor 2 wrote to GP6 to say that an adjustment had been made to BL's medication-Venlafaxine had been reduced to 25mg daily and Chlorpromazine stopped because BL said that this made him more aggressive. BL reported that he was troubled by a woman who lived in the flat above him who was noisy and often laughed at him.

6.17 On 29 September 2005 GP6 saw BL at his surgery. BL was agitated and expressing suicidal ideas. He wanted to be admitted to hospital *"for his own protection"* (GP6's note). GP6 contacted the crisis resolution team and they offered an assessment at the surgery next day.

6.18 On 30 September 2005 a crisis resolution team nurse, saw BL at the surgery. The crisis resolution team assessment was that:

- BL was a 36-year-old man experiencing low mood, anxiety and suicidal ideation but with no plans to act on his ideas. He was due to appear in court to answer charges of armed robbery and was also awaiting trial for common assault.

- He thought he needed help to deal with the triggers for his violent behaviour-childhood sexual abuse, a chaotic childhood, not having enough access to his children and increased dependency on alcohol and Temazepam.

- He had a long history of alcohol abuse and had recently become dependent on Temazepam.

6.19 The crisis resolution team plan was to:

- refer BL to community drugs services for alcohol counseling
- send him information on anger management
- ask the GP whether he could arrange anger management for him
- ask that his next outpatient appointment be brought forward
- close the case to the crisis resolution team.

6.20 There was a discussion between the crisis resolution team nurse and consultant psychiatrist 4 which confirmed the details of the assessment. Consultant psychiatrist 4 advised the crisis resolution team to refer BL to the community alcohol team and arranged for his next outpatient appointment to be brought forward to 30 November 2005. The crisis resolution team nurse completed a risk assessment form. The risk summary was that BL was at risk of suicide, deliberate self-harm and aggression or violence to others. The assessment concluded by saying that BL was motivated to accept help and needed referral to the drug and alcohol services. The crisis resolution team nurse referred BL to the community alcohol team (CAT).

6.21 On 4 October 2005 BL saw GP3 and complained about anxiety. GP3 recorded that BL was still getting *"panic attacks"* which he (BL) described as getting frustrated and lashing out at people. He was drinking a litre of strong cider a day and taking Temazepam and Flupentixol. GP3 recorded that BL's impulsive thoughts about slashing wrists had gone since chatting to the crisis team and that an appointment had been made at the CAT. There were no self-harm thoughts or depressive interpretation.

6.22 The crisis resolution team nurse wrote to BL on 7 October 2005 to say that a referral had been made to the CAT. It enclosed a leaflet on anger-management and BL was advised to contact his GP if he experienced further difficulties and required re-referral to the crisis resolution team.

6.23 BL made further visits to the GP surgery in October 2005 before his appointment to see the CAT on 8 November 2005. On 7 October he saw GP7 and complained of knee pain for which he was prescribed Ibuprofen 400mg and given a tubular bandage. On 10 October he saw GP9 and complained about anxiety attacks. He told GP9 that he was waiting for sessions for temper and alcohol problems. He was prescribed Temazepam 10mg-7 tablets.

On 14 October he saw GP8 and complained of anxiety for which he was prescribed Temazepam 10mg-7 tablets and Flupentixol 500 Micrograms-4 tablets.

6.24 On 11 October 2005 the surgery noted receipt of a letter confirming the crisis resolution team assessment and noting that BL had been referred to the community alcohol service. The file note says *"he appeared motivated to accept these changes as he understands his aggression is increasing and finding it difficult to control"*. The surgery also received a copy of the referral to the CAT on 14 October 2005. GP8 saw BL again at the surgery on 14 October 2005 and prescribed Temazepam and Flupentixol. GP6 saw BL at the surgery on 20 October 2005 and noted that the previous day BL had gone to A&E with a panic attack. He was prescribed Flupentixol and Zopiclone tablets. On 25 October 2005 GP9 saw BL and noted from his conversation that BL was *"due to go to prison in December"*. He was drinking more than 1.5 litres of cider a day and suffered a depressed mood. The doctor noted that BL complained of delayed onset of sleep because a neighbour disturbed him in the early hours. He was prescribed diazepam. On 31 October 2005 BL failed to attend an appointment with GP6. He did not give a reason.

6.25 BL attended his appointment with the CAT on 8 November 2005 accompanied by his partner (WP) and saw the community alcohol practitioner. The community alcohol practitioner told the us:

> *"BL was referred for assessment by the county crisis team and I saw him just for one assessment appointment. He was not very pleased at having been referred to us, and he was quite angry, and only came to the assessment to see who was calling him an alcoholic. So I spent some time calming him down and saying, "Nobody's calling you an alcoholic. Let's look at your drinking and see why somebody might have thought it was a good idea to refer you". So he did a diary sheet of his drinking for the previous week and he told me that he drank one litre of white cider every day for that week. Then he sorted of turned and seemed to realise he was being drawn in to something he did not want, and then he just got up and left."*

6.26 The community alcohol practitioner wrote to the crisis resolution team to tell them the outcome of the meeting and advised that they should re-refer BL if he changed his mind about wanting help from the CAT. On 30 November 2005 BL did not attend his outpatient appointment with consultant psychiatrist 4. This appointment had been changed from a previously arranged one.

Comment

The intervention by the crisis resolution team was timely and demonstrated a correct use of the referral pathways from primary to secondary care. The assessment was well documented and gave a good analysis of the problems BL experienced at the time. The crisis resolution team worker did everything she said she would. The weakest part of the care plan was that it relied on BL's compliance with a referral to the alcohol team and his motivation to accept their advice.

6.27 During November 2005 BL visited the GP surgery seven times. These contacts are summarised as follows:

- on 1 November he saw GP8 complaining of anxiety (prescribed Diazepam 2 mg-7 tablets)

- on 2 November he saw GP6 (prescribed Zopiclone tablets 7.5 mg)

- on 8 November he saw GP9 and complained of a panic attack, that he was drinking a lot, feeling anxious and that the alcohol team had *"signed him off today"*. GP9 noted that BL was scared of his somatic symptoms and carried a brown paper bag to help deal with his panic attacks (prescribed Paroxetine Hydrochloride tablets 30 mg, 7 tablets).

- On 15 November GP9 saw him and recorded that BL was due to appear at a crown court on 23 December, was waiting for a forensic psychiatric assessment appointment from forensic psychology services and that BL denied any alcohol problems. GP9 noted that BL smelt of alcohol but appeared less anxious (prescribed Zopiclone tablets 7.5mg nocte for insomnia, 7 tablets).

- On 16 November he saw GP9 and complained of weight loss and diarrhoea and was prescribed Omeprazole capsules 20 mg

- On 22 November he saw GP10 who noted that BL suffered from generalised anxiety disorder, that Seroxat was helping him with his anxiety and that he still has some "*ocd symptoms*".

- On 28 November he saw GP6 and complained that neighbour problems were breaking his sleep and was prescribed Diazepam tablets (2mg, 7 tablets) Paroxetine Hydrochloride tablets 30mg, 7 tablets and Zopiclone tablets 7.5 mg, 7 tablets, for insomnia.

6.28 In December 2005, consultant psychiatrist 4 wrote to BL advising him that because he had not attended his outpatient appointment on 30 November, another had been made for him for 22 February 2006. Consultant psychiatrist 4 had also sent a fax to forensic psychiatrist 1 on 29 November 2005 in response to forensic psychiatrist 1's request for BL's last discharge summary and clinic letter.

6.29 BL continued to make regular visits to the GP surgery during December 2005. These contacts are summarised as follows:

- On 2 December he saw GP3 and was prescribed Zopiclone tablets, 7.5 mg

- On 5 December he saw GP10 who noted that BL had had cider and Zopiclone together one night recently and had fallen on the floor and hurt his ribs. He was "*smelling of booze*".

- On 13 December he saw GP9 who noted that BL had an appointment with forensic services that day and prescribed Paroxetine tablets 30mg, 7 tablets, Diazepam 2mg, 7 tablets and Zopiclone tablets 7.5mg 7 tablets.

- On 19 December he saw GP6 who noted that BL had apparently been assaulted a few days ago. He prescribed Paroxetine tablets 30mg, 10 tablets, Diazepam 2 mg, 10 tablets and Zopiclone 7.5 10 tablets and noted that BL was *"seeing forensic psychology*".

- On 28 December BL saw GP3 and complained of piles and was prescribed hydrocortisone and lidoncaine ointment.

6.30 BL's last visit to the GP practice was on 3 January 2006 when he saw GP9. GP9 noted that BL had a crown court appearance in two days' time, that the neighbour upstairs was behaving erratically and had smashed his friend's car up, that she woke him up at night and that he had been abusing Diazepam to calm himself. He was still thinking

about abuse in his youth and the memory of a girl dying in his arms after a road traffic accident. GP9 noted that BL smelled of alcohol.

Comment

BL had frequent contact with the local surgery and we document those consultations in some detail for the three months leading up to the incident in January 2006. He was willing to seek help from GPs. His concerns are well documented and centre on his experiences of anxiety, feelings of being unable to cope and thoughts of self-harm or aggressive feelings towards others. The GPs also received reports from the mental health services at the trust, the crisis resolution team they called in and the community alcohol team. The GP surgery also supplied notes to the forensic service in relation to BL's assessment before a court appearance. BL saw several partners at the surgery. The system in use for case recording gave all doctors access to previous notes through the electronic patient record.

We question the wisdom of prescribing further supplies of hypnotic and/or benzodiazepine medication to a patient known to be drinking heavily to the point of injury. The combination with alcohol is known to be problematic. We also consider that there should have been a higher index of suspicion that BL was abusing his medication – examination of the dates and numbers of tablets suggests that their use may have been more frequent than that intended by the prescriber.

6.31 BL had ready access to GPs at the surgery but no GP was the 'case holder' and in the system in use could not have been in this role. As GP9 pointed out:

> *"…it does seem that BL saw quite a few doctors in 2005/6 and that perhaps wouldn't have happened under the old "own list" system, and probably the fragmentation of care has been exacerbated by the imposition on general practice that we have to see the patients on the day…that has fragmented continuity of care to the detriment, I feel, of care to patients".*

6.32 None of the GPs interviewed saw themselves as having a 'case responsibility' for BL. They responded to individual presentations at the surgery and there was no review or 'taking stock' activity in their case record. For example, the fact that BL was suffering from anxiety, drinking alcohol and taking psychotropic medication is recorded in several entries, but the pattern of prescription remained similar.

6.33 BL's compliance with outpatient appointments at the trust was variable but he frequently visited the local surgery. We explored the issue of whether mental health advice and support could have been delivered more successfully to him in that setting:

"Mr Watson: What mental health services were available through, at practice level, if you like, through primary care?
GP6: In what way?

Q. Did you have access to counsellors? CBT therapists? Primary care mental health workers? Social workers? Psychology?
A. No. I mean, I can't remember when practice counsellors came in. They may have started then. But they would have said of somebody like this, 'But he's being seen by secondary care, so he's not suitable for us'. I can't remember, whether we had practice counsellors in place - nothing else attached to the practice. There were mental health nursing staff, but they are secondary care attached, not attached to us.

Q. Right. So if you had patients who were reluctant to engage with secondary mental health services, was it possible to arrange for them to be seen at the practice?
A. By a consultant? I don't know. You can always ask for a home visit. But I don't think I have ever asked anybody to be seen in the surgery rather than in hospital Outpatients - no experience.

Q. Did the development of the crisis resolution team mark a big improvement for you?
A. Not as far as I was concerned, no.
Q. Because?
A. Because it prevented me talking directly to another doctor, about the issues. It is fine in that you pass it to someone else and they decide what to do with it, but it added an extra layer of assessment - which I guess, they would say was fine."

6.34 GPs interviewed relied on the secondary care services provided by the trust for psychiatric expertise. The first port of call was the crisis resolution team which replaced

an earlier system that relied on a 'doctor to doctor' referral route. No accessible mental health services were based in the primary care service that BL could have used. GP6 said of the crisis resolution team service:

> *"It did not seem to offer an answer to his problems. It recorded all his problems, but I don't think anyone quite knew what to do to help him. They had suggested anger management but we no longer had access to anger management through the local mental health nurses. In previous years, they had run anger management courses, but they had given him some leaflets about other people who could do it and I wrote a letter to the psychiatrist asking if he could help, but I don't think he had access to it either."*

6.35 In view of this, the issue of liaison between the services was critical. On the one occasion a GP referred to the crisis resolution team the response was timely and the advice helpful. However, BL chose not to follow through the advice to work with the community alcohol team and did not go back to the service after the first visit.

6.36 BL was seeing doctors from the trust as an outpatient and at the same time seeing GPs fairly often. The system for notifying GPs of the outcome of outpatient consultations was the doctor's letter. It appears from the trust case file that these were not always sent or there was a delay in sending them after a consultation. There was no system at the time for notifying GPs when a patient did not attend (DNA). There was no system for notifying the hospital-based doctor of medication prescribed by the GPs. Therefore, it was possible for parallel systems of prescription and medication to exist. The psychiatrists seeing BL as an outpatient knew nothing about what GPs were prescribing. During the latter part of 2005 BL was prescribed psychotropic medication without reference to the mental health team. We asked GP6 about this:

> *"Dr Wood: …It looks as though the practice was prescribing medication of one sort and another and the secondary services and consultant psychiatrist 4 were prescribing one thing and another and it often appeared, to me at least, to be happening in parallel. You would both be prescribing either the same stuff or related stuff. I could not quite get who had prescribed what and how it was decided as to who would prescribe what.*
> *GP6: I don't know I can answer that because I don't know – you would have to see what his letters to us said. Often, they will initiate something and expect us to*

carry on. I don't know. We would obviously not intend to duplicate prescriptions but I don't know the answer to that. It may be that he had initiated them and we were carrying on, or the patient had not picked up the prescription at the hospital. That often happened."

Comment

BL had frequent contact with GPs from the local surgery and was willing to seek their help. The system of consultation in place acted against the successful management of his mental health problems because:

- ***no single GP was the case-holder so no one could build up a picture of his needs***

- ***GPs could not be CPA coordinators under the terms of the CPA policy at the time***

- ***GPs did not consider themselves skilled in relation to risk assessment***

- ***the surgery had no ready access to psychological therapies appropriate to BL's needs***

- ***GPs did not have access to anger-management intervention which had previously been available through the orchard resource centre***

- ***The coordination of the GP's prescribing of psychoactive medication and monitoring of its effects and the specialist input from the trust remained at a routine level. The intensity of monitoring from the trust remained low key at a time when BL's difficulties were escalating. This was despite the intervention of the crisis resolution team which had demonstrated heightening concern about risk.***

Forensic psychiatry assessment

6.37 BL was seen on 13 December 2005 by forensic psychiatrist 1 at the East Midlands centre for forensic mental health. Forensic psychiatrist 1 was asked by the court to

prepare a report for BL's court appearance on 5 January 2006. Her report is dated 29 December 2005. In preparing her report forensic psychiatrist 1 had access to BL's GP notes, extracts from mental health notes from AMH unit 1, copies of prosecution witness statements and evidence, and copies of the indictment against BL.

6.38 The focus of the assessment was BL's mental state at the time of the alleged offences on 23 April 2005. The offences were attempted robbery and having an offensive weapon. Forensic psychiatrist 1 was also asked to consider whether BL *"would have been able to form mens rea at the time of the alleged offence"* and to consider the effects of chlorpromazine at a normal dose and in overdose upon BL. (*Mens rea* is a legal concept which is concerned with the person's mental state at the time of an alleged offence).

6.39 Forensic psychiatrist 1's report contains detailed information about BL's family, personal history, education, employment, relationships and previous medical history. She also reviewed his psychiatric history and drug and alcohol use. The offence concerned was an attack on a shopkeeper with a martial arts weapon in the course of an attempted robbery. Witnesses said that BL entered the shop swinging a *"rice flail"* hitting the shopkeeper and trying to hit him several more times. BL allegedly shouted to the shopkeeper to *"open the till"* but left the shop and drove away without taking any money. Witness statements from other people in the shop at the time confirmed that account. Members of BL's family conformed that he had left home that day with weapons described as *"nan-chucks"* concealed in the back pocket of his trousers and said that he was *"going to rob a shop"*. A nan-chuck is a Japanese rice flail type of weapon.

6.40 BL's account to the forensic psychiatrist of his recent contact with medical and psychiatric services was broadly consistent with the information in records. It included his referral to the crisis resolution team, GP visits, and referral for alcohol abuse counselling. Forensic psychiatrist 1 notes in her assessment correspondence from the crisis resolution team dated 6 October 2005 recording their recent assessment. It notes his abuse of Temazepam, his mood fluctuation and his statement that *"I get violent and kick off when I am up"*. He said the slightest thing could set him off. He reported that he had a violent reputation in the area and did not have any real friends. He was taking Temazepam and drinking a litre of cider at night. It was noted that he had recently threatened a neighbour with an axe as he felt this person was 'winding him up' and laughing at him, but he had managed to stop himself from assaulting the neighbour.

6.41 After thoroughly reviewing the information provided from a number of sources, forensic psychiatrist 1 conducted a mental state examination. She found that BL presented as extremely anxious at the start of the interview, but that this improved over time. There was no evidence of paranoid ideation or other psychotic symptoms. BL reported anxiety and sometimes being too anxious to leave his flat. In terms of insight, BL felt that he had had mental health difficulties for at least six years and probably longer. He expressed mixed feelings regarding his contact with mental health services often asking for help but generally feeling dissatisfied with the help offered citing examples such as counselling that had not been helpful or medication that had *"made him go mad"* rather than helping. BL said that he was willing to continue with psychiatric treatment and follow up and said that the recent prescription of Seroxat had been helpful. This report was not made available to the trust.

6.42 Forensic psychiatrist 1's opinion and recommendations were:

- BL had a long history of generalised anxiety disorder, panic disorder and recurrent episodes of depressive illness. He also showed a number of problematic personality traits, particularly of an emotionally unstable type. For example *"unstable mood, relationship instability, deliberate self-harm and other impulsive behaviours, as well as difficulties managing his temper resulting in a long history of aggressive behaviour"*. She noted that he had difficulty maintaining therapeutic relationships and erratic compliance with treatments.

- BL continued to suffer with anxiety, panic attacks some depressive symptoms and forensic psychiatrist 1 offered the view that *"in the light of his psychiatric history and associated risks, BL should be encouraged to maintain and build upon his engagement with the mental health services if he is to achieve any long-term stability in his mental state and behaviour"*.

- BL believed that his over use of prescribed medication was a contributing factor in his offending and that on the day of the offence his use of the drug chlorpromazine *"overwhelmed him"*.

- Forensic psychiatrist 1 considered that although use and abuse of drugs had an effect on his behaviour, his long history of aggressive behaviour pre-dated the use

of medication and anger management difficulties continued after the discontinuation of chlorpromazine.

- The link between chlorpromazine and increased aggression was not established and in fact *"in therapeutic doses (as taken by BL) chlorpromazine causes varying degrees of sedation, drowsiness and apathy"* (forensic psychiatrist 1's report).

- It was unlikely that BL's use of medication accounted for his behaviour: *"…the effects of medication tend to have a gradual rather than abrupt onset and as the evidence suggests BL was unimpaired immediately prior to the incident, used rice flails with a degree of dexterity during the incident and drove a car immediately after, it is unlikely that his mental state was impaired to such an extent as to render him incapable of forming the necessary intent".*

Comment on forensic services

The issue of whether to refer BL to forensic psychiatry services did not figure greatly in the discussions about his care and treatment. When the crisis resolution team assessed him there was some discussion between the crisis resolution team nurse and consultant psychiatrist 4 about such a referral. Consultant psychiatrist 4 decided to bring forward the next outpatient review. BL was seen by the forensic psychiatry service for a different reason - as part of the assessment for his crown court appearance in January 2006. The assessing psychiatrist had access to his notes at the partnership trust and to the GP notes. The focus of the assessment was whether BL had the ability to form intent at the time of the offence in 2005. The assessment was detailed and thorough. It contained a reference to BL's thoughts about harming a neighbour, but did not identify BL as a dangerous threat in the community. Our view is that in late 2005 he would not have met the criteria for intervention by the forensic services and we agree with the finding of the internal investigation "…* **we do not believe…that a forensic assessment would have led to the forensic service taking over the responsibility for his care and treatment" (pg 89).***

The threshold for referral to forensic services varies between services around the country. We conclude that BL's activities did not mark him out as an obvious candidate for referral to such services for specific intervention. For many such services it would be expected that a non-detained patient in the community would

and could be managed by general psychiatry colleagues. The LPT is not different in this regard and we conclude that there was no failing in not referring him in the latter three months of 2005 or at any time before. As well as their role in managing individuals directly, the forensic services also have a role in advising those working within criminal justice agencies in relation to mental health matters. It was this role which prompted the involvement of forensic services.

Use of the CPA

6.43 BL, as a patient of the mental health partnership trust, was on the standard level of CPA. The trust policy and practice guidance in use at the time offered the following definition of the standard level of CPA:

> *"The characteristics of people on Standard CPA will include some of the following:*
>
> - *they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;*
> - *they are more able to self-manage their mental health problems;*
> - *they have an active informal network;*
> - *they pose little danger to themselves or others;*
> - *they are more likely to maintain contact with services.*
>
> *Service-users on Standard CPA will require assessment, care planning and review by a named worker from Health or Social Services with input from those disciplines relevant or involved. Service users in this category will have a Care Coordinator, who may be the only member of the team with any input into their care. They will have a care plan that the Care Coordinator will be responsible for implementing and reviewing. It is important that the care plan, reviews and the date of the next review should always be documented. Service users should be given the opportunity to sign the agreed care plan and then receive a copy. Elements of risk and how the care plan manages the identified risk must always be recorded."*

6.44 The application of the policy in relation to BL was low-key and amounted effectively to monitoring through outpatient appointments. BL settled quickly and was compliant when he was an inpatient. He was never detained under the Mental Health Act.

Measured against the criteria for the standard level of CPA, he did not match the characteristics of the approach in that:

- he needed the support or intervention of more than one agency
- he was not able to self-manage his mental health problems
- his support network was limited
- by virtue of his history and current presentation he posed some degree of risk to himself and others
- his contact with services was variable.

Comment

The use of the standard level of CPA in this way was insufficient to coordinate the information and care planning that might have been effective. If BL had been placed on the enhanced level of CPA the degree of monitoring and engagement with him would have increased.

6.45 The underlying purpose of CPA is described in the trust policy of the time as follows:

> *"All mental health service users have a range of needs which no one treatment, service or agency can meet. The principle aim of CPA is getting people to the right place for the right intervention at the right time.*
>
> *There are some people who, as well as their mental health problems, will have learning disabilities or a drug/alcohol problem. In these cases a co-ordinated approach from all the relevant agencies is essential to efficient and effective care delivery."*

6.46 The doctors who saw BL as an outpatient did not complete the trust's CPA documentation. They recorded their findings on the case notes and concluded with a section titled 'care plan'. Typically this noted the medication prescribed and the date of the next planned consultation and amounted to a few lines in content.

6.47 The one occasion when CPA assessment documentation was completed was after the assessment on 30 September 2005 when the crisis resolution team assessed BL. The

crisis resolution team nurse completed the *"Interagency Care Programme Approach assessment and Outline Care Plan"* document on 6 October 2005. She also completed an initial risk screening form (appendix 6, revised 22 October 2004) on 30 September 2005. She completed a seven-page risk assessment tool[2] on 30 September 2005.

Comment

BL had a mental health problem and associated drug and alcohol problems. A coordinated approach was essential for him. In fact, no individual professional brought together all the information known about him. His own inconsistency in seeking help added to the tendency for his care to be disjointed. We agree with the finding of the trust investigation that* "if BL had been placed on enhanced CPA, he might have been more regularly and robustly reviewed". *Therefore we conclude that the CPA was not used consistently to plan and deliver care. We consider more fully later in this report the risk assessment the crisis resolution team completed.

The medication prescribed by the GPs included antidepressants, hypnotics, and benzodiazepine sedatives. Changes were not infrequent. We are not satisfied that there was a robust and rational approach to this prescribing. Multiple preparations were given, each of which may have potentiated the intoxicant and disinhibiting effect of alcohol, and in combination more so. Some of the preparations are addictive and indeed have a street currency. The wisdom of such prescribing without reference to specialist services was questionable, especially given that information exchange was incomplete.

Risk assessment

6.48 The only formal risk assessment on file for BL was the one completed by the crisis resolution team nurse after her assessment at the GP surgery on 30 September 2005. Her initial risk screening assessment included 27 categories of assessment of the risk of self-harm or suicide, harm to others, self-neglect and exploitation/vulnerability. In relation to self-harm, BL was assessed as a positive risk in relation to:

- history of self-harm

[2] Risk assessment tool: adapted by Church (2004) for use in the crisis resolution team using the model and framework by Morgan S, The Sainsbury Centre for Mental Health 2000.

- thoughts or plans which indicated a risk of self-harm or suicide
- mental illness
- current problems with alcohol or substance misuse
- expression of concern (especially from a relative or carer) about the risk of self-harm/suicide

6.49 In relation to harm to others he was rated as positive for:

- a history of harm to others
- current thoughts, plans or symptoms indicating a risk to others
- current behaviour suggesting there is a risk of harm to others
- current problems with alcohol or substance misuse
- expression of concern by others about the risk of harm to others.

6.50 In relation to self-neglect he was rated positively for:

- Non-compliance with medication
- relapse and disengagement risk
- alcohol and substance misuse

6.51 In relation to exploitation/vulnerability BL was rated positively for:

- impulsive behaviour
- anti-social behaviour

6.52 The information on the form noted the need for a fuller risk-assessment and that none of the assessed risks could impact on children or vulnerable adults in the immediate family home, through extended family contact or through informal contact with children/vulnerable adults in the community. It was noted that BL had a conviction for assault.

6.53 The crisis resolution team nurse then completed a fuller risk-assessment using the risk assessment tool. In the section of this assessment on aggression/violence BL scored positively on eight out of 14 factors. Positive scores were recorded for:

- previous incidents of violence

- previous use of weapons
- misuse of drugs/alcohol
- known personal trigger factors
- expressing intent to harm others
- previous dangerous impulsive acts
- signs of anger and frustration
- admissions to secure settings.

6.54 The conclusion of the assessment was:

> *"36 year old unemployed single man experiencing low mood, anxiety and suicidal ideation increased alcohol use and dependence on temazepam which he uses to keep himself calm throughout the day. Believes circumstances exacerbate his poor anger management and he becomes violent. Is motivated to accept appropriate help. Therefore - referral to drug and alcohol services to send him information on anger management and request an earlier review in outpatient department."*

Comment

There was a need for more active case-management based on the needs and risks identified in the assessment. There was enough information for BL to be assigned to the enhanced level of CPA, which would have led to a more active monitoring and supervisory regime. We also note that BL himself was asking for more contact with services, as evidenced by his comment to trust grade doctor 2 on 7 September 2005 during an outpatient review. We conclude that there were missed opportunities to engage BL with community mental health services at this point in his care. His frequent visits to the GP surgery underline his own wish for greater involvement from services to deal with the mental health problems he experienced at this time. There is evidence from the record of BL's contact with social services (given in more detail in a later section) that he was responsive to a consistent relationship with professional workers.

The crisis resolution team assessment gave a detailed and timely account of the risks to self and others BL posed at the end of September 2005. The assessment showed good practice in:

- ***using the CPA assessment tool appropriately***
- ***completing the initial risk screening***
- ***going on to a more detailed risk-assessment***
- ***communicating the outcome to relevant others.***

The limitations of the approach were:

- ***risk to children, extended family members and vulnerable adults in the community was not identified***
- ***the follow-up action depended largely on the cooperation and motivation of BL***
- ***the case was then closed to the crisis resolution team and therefore there was no care coordination beyond the referral to the community alcohol team and routine follow up through outpatient clinic.***

Summary of findings and comments

6.55 BLhad significant contact with mental health services in 2005 and that he also frequently consulted his GP practice.

6.56 The CPA framework was not used effectively in the latter part of 2005. After the assessment by the crisis resolution team, BL should have been placed on the enhanced level CPA and monitored more actively by the mental health services. There was evidence that his level of anxiety and ability to deal with stress were impaired. He asked for greater contact with services but was not allocated to a community mental health team. This was a missed opportunity to engage him in services. There is evidence that he responded positively to intervention from a named professional worker in his record of contact with social services.

6.57 BL was a frequent caller to the GP services. He was prescribed medication for his mental health problems. There was a system failure to share information between the primary care service and the secondary mental health services about his mental state and the treatment being given. BL saw a number of GPs and there was no evidence that they saw a pattern emerging of his increased reliance on alcohol and medication.

6.58 The primary care service followed agreed practice in involving the crisis resolution team when they were concerned about his mental state. The crisis resolution team

assessment was thorough and suggested a treatment plan that BL did not follow. The team did not continue their involvement because it was not their function to do so. There was a need to follow up BL more actively and not rely on his compliance with advice. The trust systems were not sufficiently well coordinated to respond to the needs the crisis resolution team assessment identified.

6.59 BL had a history of violence and threats of violence. He spoke to professionals about thoughts of harming AJ. The level of his violence was not predicted nor could it have been. The police were the most immediate source of prevention but they did not respond to a number of emergency calls on the night of 3 January 2006. The involvement of the police service is reviewed in a later section.

6.60 The forensic psychiatry service saw BL in December 2005 but the purpose of the assessment was to review his mental capacity at the time of an earlier offence. He would not have met the criteria for the service to assume responsibility for his care and treatment at this time.

7. The care and treatment of CL

Details of contact with services

7.1 After the incident in January 2006 Leicestershire Partnership Trust and Hinckley and Bosworth PCT commissioned an internal review into the care and treatment of CL. The trust thought there were important lessons for the service and its partners, even though the involvement of the child and adolescent mental health services (CAMHS) was limited to one assessment interview. Our investigation has broader terms of reference and we have reviewed information and interviewed staff from several agencies involved with CL including the trust CAMHS, education, youth offending services and social services. We have therefore had access to a wider range of information about CL and his family background.

7.2 CL was 13 at the time of the incident. He is the son of BL and RL, who were separated. He has a younger sister, and an older half sister. We describe the family history in more detail in the section of this report dealing with social services involvement. CL was brought up in the Leicester area and attended several primary schools as the family moved addresses. There were difficulties for him at school with reported incidents of bullying. Family life was also turbulent at times.

7.3 CL's school was concerned about aspects of his behaviour, including isolation from other pupils who were said to be afraid of him. His behaviour was also a concern to his mother who told the school he was stubborn and disobeyed her at home. He spent time with older youths in the neighbourhood and stayed out late at night. He had been in trouble with the police.

7.4 CL and his sisters had witnessed family violence for some years and there was a long and well-documented history of domestic violence between BL and RL. At the same time, both parents remained willing to look after the children and despite long periods in homeless families' accommodation, the social care agencies involved thought the parents took adequate care of their children. The parents separated in 2002. Both cared for the children at different times.

Referral to the CAMHS

7.5 CL was referred to the CAMHS team on 30 June 2005 by his school nurse. He was 12 at the time. The referral noted behaviour problems since the age of three, characterised by hyperactivity and more recently poor school attendance. His concentration and behaviour were poor and he often presented as being tired and lethargic in school.

7.6 The nurse wrote that CL had a fixation with fire and had several burn marks on his limbs. He was on police bail for setting fire to a tractor (this was in fact a JCB). She thought that his level of fire-setting was *"moderate to severe"* as described in the ACPC practice guidance. CL said he enjoyed killing things and made spears for that purpose. His behaviour at home was difficult and his mother said he was attention-seeking and always asking her for things. The referral letter was copied to the family GP, the head of year at school, the manager of the child access team at Hinckley social services and the school health team.

7.7 On an accompanying sheet the school nurse noted that CL's parents, BL and RL, had separated three years ago. There was a history of aggression from BL. BL was currently on bail after an attack on RL, who had an alarm the police had given her. BL was prohibited from any contact with the family. CL and his sister had lived with their father for a while after the parental break up. CL's record showed 12 address changes and seven school changes.

Assessment by the CAMHS

7.8 A CAMHS meeting on 4 July 2005 decided after receiving the school nurse's referral to offer a triage assessment. It was arranged for 16 September 2005. CL and his mother were seen by SpR1, specialist registrar (SpR) in child and adolescent psychiatry, and CPN4. A student nurse also attended the meeting. CPN4, although an experienced CPN in adult mental health, had recently joined the CAMHS. SpR1 had not been part of the service at the point of referral but joined between then and when CL was seen.

7.9 The assessment was recorded in the case notes and SpR1 wrote to the GP, and copied to the school nurse. SpR1 reported some of the difficulties experienced by CL and by his mother in dealing with his behaviour. These included the stress caused to the

family by the parents' separation and the fact that CL and his younger sister had lived with their father between the ages of eight and eleven:

> *"He did not like it there as he said his father kicked him and slapped him and was very restrictive but this father did not behave in the same way to his younger sister…his father drinks alcohol and is violent on a number of occasions. Recently dad assaulted mum at home and is now banned from seeing her."*

7.10 SpR1 concluded by saying:

> *"…following the assessment we felt that there were no major emotional issues apparent and there were no underlying psychiatric difficulties. We understand that he is to be seen by the youth offending team for two hours a week from next week and that he is due to move to youth offending school . The assessment ended with the statement "given that the youth offending team would be involved with CL, we will not be seeing him in our service."*

7.11 The CAMHS closed the case and there was no further action after the letters to the school nurse and the GP.

Comment on the CAMHS assessment

The assessment by the CAMHS was consistent with the practice standards of the service at the time. For example, the waiting time from referral by the school nurse to the assessment interview was 11 weeks, two weeks within the national standard for CAMHS. The interview was referred to as a "triage interview". However, we found this to be a misnomer in that triage is a timely activity, taking place promptly to assess the urgency of a case, as in the example of medical triage after an accident. We explored the issue of waiting times with other interviewees and found a number of difficulties for referrers to the CAMHS. These are discussed in a later section.

The CAMHS referral gained great significance in retrospect because of the seriousness of the later homicide by CL. This was not obvious to the participants at the time. Information known to the school was not explored and the social care aspects of the case were not reflected in the assessment. There was no social care input to the CAMHS.

The assessment was limited in scope and in particular did not take account of:

- *The social care aspects of CL's family background. The family was well known to social services and there had been a number of incidents of domestic violence, welfare concerns and custody issues between the parents. The assessment by CAMHS did not explore any of the documentary information available from social services and did not report to them the outcome of the assessment. As a signatory to the ACPC child protection agreement in the county at the time, the CAMHS workers showed no awareness of their role as part of the child protection framework.*

- *There was a failure to communicate the findings of the assessment widely. The letter from SpR1 was sent to the referrer, the school nurse, who had by then retired from the service, and to GP9. We could find no evidence of follow-up from a successor to the school nurse. GP9 did not recall receiving the letter from the CAMHS and when reminded of it told them the letter had not specified any follow-up - it was simply put on file at the surgery. The CAMHS did not copy the letter to the youth offending team, even though they were identified as the lead agency for intervention with CL. They did not refer back to the education service which had prompted the referral because of concerns about CL's behaviour at school, leading to his exclusion. Neither did they communicate with social services, either to check the level of their involvement or to pass on the findings of the assessment interview.*

- *The assessment interview did not explore some of the more disturbing aspects of CL's behaviour known to the education services - for example, their concern about the effects of his visits to stay with his father and the threatening nature of his interaction with fellow students at school.*

Education services

7.12 We interviewed staff from the school who knew CL and were involved in referring him to the CAMHS. CL joined the school in September 2004. The school had little background information about him because he had not previously attended one of the linked feeder schools. As a teacher who knew CL well said:

> *"The disruptive incidents began to happen with CL almost immediately he walked through the door."*

7.13 The education department have collated the school incidents in which CL was involved. Staff at the school became concerned about CL. His attendance was poor at 70 per cent in a school where the average was 95 per cent. He did not come to school prepared for work, was sometimes threatening and aggressive to other children and was subject to a number of fixed term exclusions.

7.14 The school contacted his mother to discuss the problems. At this time CL was hitting other pupils, swearing and refusing to work. CL's mother expressed her concern about his behaviour and said he was not sleeping and was climbing out of the house at night and mixing with older *"unsavoury characters"*. The staff explained to CL's mother that other students were frightened of him because he was so violent and that *"if CL threatened to get you, he would"*.

7.15 Staff at the school were also concerned about the effect on CL of his visits to stay with his father. Their view was that after contact with his father, he returned to school in a more dishevelled state and that his behaviour was worse.

7.16 CL had a number of fixed-term exclusion from school in December 2004, February 2005 and April 2005. On 25 April 2005 the head of year telephoned CAMHS and advice was given to involve the educational psychology service and talk to the school nurse. Staff at the school followed up this advice.

7.17 The school was giving individual input to CL at this time and were also trying to assess his capacity more fully.

7.18 The special educational needs coordinator did a series of tests with him, on a one-to-one basis. They showed not only that CL was not struggling but that he was well above average – even a gifted pupil. The school was clear that no learning difficulties affected his behaviour.

7.19 The school nurse referred CL to CAMHS on 30 June 2005. The school also followed up the suggestion of referral to the educational psychology service on 22 June but there were staff shortages in that service that meant that effectively no service was available. As a member of the teaching staff said:

> *"…we were trying desperately to have CL seen by an educational psychologist. At the time, the school did not have its own educational psychologist. We had obviously made noises at County Hall about that but the EPS service in Leicestershire at the time was very short of practitioners"*

7.20 The school referred CL to the pupil referral unit in July 2005 which effectively marked the end of his attendance at the school. It was at this time that the youth offending service became involved.

Comment

The school staff involved with CL had tried to engage him and his mother in discussion and action about his school difficulties. Staff working with CL were skilled and experienced in working with pupils with a range of social and behavioural problems. Staff who knew CL well were concerned about the degree of disturbance in his behaviour, about the violent imagery he used and about his threatening relationship with other students.

Staff felt that CL was negatively affected by contact with his father, BL, and noted that his demeanour and behaviour were worse after such contact. The school had appropriately experienced staff to assess and suggest strategies for dealing with CL's behaviour but there were difficulties in accessing more specialised behavioural support through the educational psychology service. The referral path to the CAMHS service was cumbersome and the significant delay was accepted as normal for the service. The system required the GP to make the referral and the GP in this case (GP9) saw no reason for doing so. Later the school nurse achieved a referral through her negotiations with the GP.

In the experience of staff at the school, CL was an unusually disturbed pupil of above average intellectual ability.

There was no discussion between the staff at the school who had worked with CL face to face and the CAMHS staff completing the triage assessment. Many of the problems well known to the school were not addressed in the CAMHS assessment.

Education services had no mechanism for reviewing their involvement in the care and treatment of CL after the homicide. There would have been value in including them more actively in a cross-agency review.

Youth offending service

7.21 The Leicestershire youth offending service (YOS) became involved with CL from 2 August 2005 when an eight-month referral order was made for offences of arson (offence on 2 June 2005) and theft from a motor vehicle (offence on 30 March 2005). CL had earlier been found guilty of burglary and had received a reprimand on 9 July 2005. He was found guilty of burglary and theft on 6 September 2005 (offence on 16 August 2005) and received another four-month referral order to run consecutively after the eight-month order.

7.22 The initial referral order panel took place on 24 August 2005 when the contract between CL and the YOS was discussed and agreed. Youth worker 1 was CL's supervisor.

7.23 Work with CL centred on education, but included some work on other issues identified in the referral order contract including reparation work on the effects of starting fires, a referral to the fire unit, victim empathy and offence focussed work. The YOS liaised with his school and the student support services until CL was formally excluded from school and referred to a pupil referral unit (PRU) in September 2005. He started with the PRU on 31 October 2005. Apart from one day's suspension early in November 2005 for poor behaviour and causing damage, he settled down and performed well, receiving support from the YOS basic skills team.

7.24 The YOS also made contact with RL to offer advice on parenting. The YOS did not work with BL because he was not seen as a key part of CL's life at that time and YOS perceived that CL had little contact with his father until November 2005. BL contacted the

YOS on 1 December 2005 to say that he was concerned about CL's weight loss and was taking him to see the doctor. This consultation took place when GP9 saw CL at the local surgery.

7.25 After the incident in January 2006 The YOS completed a management review of their involvement and submitted a local management report to the youth justice board. The youth justice board did not consider there was a need for a further Serious Incident Review under its serious incident procedures. The management review drew attention to the following areas:

- **Case recording**

  The YOS records did not record all the activities completed by the YOS team. The involvement of the CAMHS is recorded on the file but the supervising officer did not record his contact with CAMHS. The YOT officer said he contacted social services several times but the calls were not recorded on file. There was no record of the outcome of the referral order panel review on 7 December 2005.

- **Assessment**

  An ASSET assessment is completed when a young person is first involved with the YOT. Such an assessment was completed in this case and found relevant issues but the management review considered that these could have been linked more closely with offending. The indicators of harm assessment did not recognise fire-setting as a risk of serious harm and so did not trigger a full risk assessment. However, the fire and rescue service were contacted and completed two sessions with CL on the risk of fire-setting. Their view was that they had made little headway with CL, but agreed to do a further fire setting assessment in early January 2006, due in part to CL's lack of engagement with this work. The fire service completed the risk assessment on 21 October 2005. The risk of harm was re-assessed in supervision when other risk factors became known and noted as medium but this was not reflected in a full written assessment.

  The ASSET assessment was not reviewed as required by national standards at the three-month stage.

- **Intervention**

  The management review noted positive elements of intervention, national standards visits were completed, the supervising officer support provided support to RL, the fire and rescue service visited twice, and progress was made on CL's education. However, there was no link between the CAMHS, their assessment and the CPN attached to the YOS. The referral to the social services department on 2 December 2005 was not followed up until after the incident in January 2006.

7.26 The management review made four recommendations:

- to improve the quality of risk assessments and management plans
- to improve the quality of ASSETS (the YOS assessment tool)
- to improve the quality of case records
- to improve referrals to and liaison with specialists and other relevant agencies and recording.

Assessment of CL's mental health needs

7.27 The link between the YOS and other agencies, notably the CAMHS and the education services, did not lead to a full assessment of CL's mental health needs. The CAMHS assessment was not copied to the YOS although the assessors referred to the YOT as the lead agency in CL's care. A link CPN was attached to the YOT on 16 September 2005. Leicestershire Partnership Trust had difficulties recruiting a CAMHS nurse. The head of the youth offending service said:

> *"Originally we had two primary mental health workers; that was the original agreement, and in January 2004 one of them left, and in June 2004, I think it was June-Julyish, the second one left and then we were without someone until September 2005."*

7.28 The head of youth justice and safer communities Leicestershire county council described the availability of mental health expertise on the YOT:

> *"…there had been this referral, CL had been seen by the CAMHS for an assessment, as you probably know. The YOT CPN was going through her induction period, so was*

not fully functioning as CPN in the team. I think in the December, when mother was expressing pretty express difficulties about managing CL's behaviour, one of our basic skills workers did offer the possibility of some contact from a YOT CPN, which was not followed up, partly because some of the problems that had been expressed by mum seemed to be resolved and were not so problematic, so the case manager at the time felt it was not really needed."

Comment

The mental health problems the school saw were not reflected in the YOT's assessments and so remained underestimated or hidden. Linkage between the CAMHS and the worker attached to the YOT team did not help this information exchange.

7.29 The YOT operational team leader said:

Mr Watson "… Would CAMHS not as a matter of routine have communicated to their worker the outcome of the assessment?

A: Not necessarily. What there is, and this is no fault of anybody, I think there is a communication barrier. If we refer, we get a letter because we're the referring agency. If we don't refer, we won't necessarily get a letter or necessarily get the information because in essence we're not the referring agency. Due to confidentiality, is what they would say, that we wouldn't necessarily get that information."

7.30 The focus of the YOT's intervention was on helping him catch up at school and he was judged to be making good progress. He was largely compliant with the requirements of supervision. His troubled family background was known to the YOT and support was offered to CL's mother. Youth worker 1 said:

"He seemed to be settling down a little bit more and basically buying into the work that we were trying to do with him, and also, once we'd actually started him at the PRU, that seemed to be working fairly well. He'd only been there two or three weeks but he'd had a really good start there."

7.31 There were differing views about the influence of BL on his son. The school thought that CL's behaviour and demeanor deteriorated after weekends with his father. The YOT team, on the other hand viewed the contact in a more positive light. Youth worker 1 said:

> *"He seemed to be having a fairly positive relationship with dad because mum had reported that he'd stopped jumping out of the windows, as he used to do. When he is there he's stopping in and he's sleeping, although he doesn't sleep greatly, but he's actually sleeping. And he is having time over at father's which seems to be what he's asking for, but it seems to be having a positive effect"*

Comment

The work by the YOS with CL was narrowly focused on his attendance for education goals. In the range of offending behaviour presented to the YOS CL was "low tariff" in that his index offences were relatively few and not severe.

The fact that the CAMHS did not share its assessment with YOS limited the potential for exploring CL's mental health needs and the link arrangements were not well established. The presence of a CPN on the YOT did not facilitate a greater awareness and understanding of CL's mental state.

The YOT tried to link with social services but the link was not strong and the agencies operated largely in parallel.

The Leicestershire YOS service completed a management review of their involvement with CL and made recommendations. The YOS continue to be involved with CL after conviction until he reaches the age when the probation service takes over responsibility.

8. Leicestershire county council social services department involvement with the L family

8.1 As well as their involvement with the mental health trust, BL and his son CL, subjects of the trust internal investigations, were known to the social services department (SSD). We interviewed staff from the SSD who were involved in reviewing the SSD involvement with the family after the incident on 4 January 2006. We have also had access to the children's service social care file held by the SSD relating to CL and have spoken to staff who worked directly with the family. We interviewed senior managers in Leicestershire county council children and families service who had been involved in reviewing the SSD involvement with the L family. They saw social services work with the family as supportive, in a welfare role, rather than supervisory and in a child protection role.

8.2 The pattern of contact with social services was to deal with short term problems as they arose. The family was seen as a *"family in need"* and contact was mainly in a supportive role. After contacts in 2004 the file was closed on 4 November 2004.

8.3 In November 2004 BL was allocated a tenancy to a flat in a small town in Leicestershire. He was living there alone.

8.4 The social services file records a number of contacts with BL in April 2005.

8.5 On 25 April 2005 the social services file notes that BL was experiencing considerable mental health problems - anxiety and depression which also resulted in his feeling agitated. Shortly after this contact BL was admitted to George Elliot Hospital after an overdose.

8.6 CL's mother visited the social services office on 5 May 2005. She said she was concerned about BL's mental health, use of alcohol and that he had been stealing from local shops.

8.7 There was also discussion about the school's concern about CL's behaviour and it was noted that RL thought that CL was suffering from attention deficit hyperactivity

disorder (ADHD) and intended to seek help from the GP. It was noted that she was going to see his GP about referring CL to the CAMHS.

8.8 There was further contact in early June 2005 between the school nurse and the SSD about CL's behaviour and the referral to the CAMHS.

8.9 The file records that the school rang on 13 June 2005 to say that the police had been called to RL's house the previous day because BL had threatened RL with a hacksaw. A note from the social services emergency duty team dated 11 June 2005 says that CL was arrested for arson. He admitted having set fire to a JCB causing £80,000 damage.

8.10 On 21 June 2005 the child protection unit contacted social services suggesting that there should be a case conference to examine the risks to children in the family. Team manager 2, team manager of the access team which had many contacts with the L family, said that there were no child protection concerns, that BL had never hit the children and that section 47 procedures would not be justified in a situation where risks to the children from domestic violence were small. The file was closed on 22 June 2005.

8.11 We interviewed team manager 2 and social worker 2. Team manager 2 confirmed that although social services had frequent contact with the family, the focus of involvement was not on statutory intervention to remove children from the situation:

> *Mr Watson: "Could you put this case in some context for us in terms of social services' work at the time? One of the issues is about how active social services were during the length of the case: should you have taken some statutory intervention or not. What kind of case was this in the spectrum of cases you were dealing with?"*
>
> *Team manager 2: "We define them as being children in need, there's no doubt about that. The background was such that there were not a lot of obvious needs, and that is stated quite explicitly in [social worker 2's] assessment. Certainly in the earlier stages when [social worker 2] was involved, or even any time later, it never really hit section 47 levels; we never saw it as a child protection issue."*

8.12 Social worker 2 said BL had been a frequent caller at social services during periods of family difficulty and that he responded to advice and positive reinforcement of his efforts to support the children.

Comment

Social services held the most information about the L family and had a more complete and comprehensive picture of family life than any other agency.

CL's behavioural difficulties were well known. They lasted throughout his school career, from first contact with primary school to his eventual exclusion from secondary school. The social services records include many references to behavioural difficulty in the context of a disturbed family life. We could see no evidence of involvement by educational support services for example, child guidance or educational psychology, before the referral to the CAMHS in 2005. At that point social services were informed about the attempts of the school and the school nurse to engage help from the CAMHS. They also knew that the YOS was involved and so thought they did not need to be.

Social services contact with the family became less during 2005. However they could have done more to bring together information held by several agencies about family members. There were prompts to initiate this greater sharing of information in 2005 from:

- ***the child protection unit (CPU)***
- ***CL's school***
- ***the school nurse and***
- ***the YOS.***

The outcome of the CAMHS assessment was not shared with social services and had not recommended a role for the department.

Our comments on the CAMHS assessment draw attention to the lack of social care content, and the lack of detail about the family history known to social services records. This would have helped to achieve a much rounder assessment of CL's needs

and could have prompted a multi-agency meeting or at least dialogue between agencies with knowledge of the L family.

Summary of findings in relation to the care and treatment of CL

8.13 The trust had minimal contact with CL. He had only one meeting with the CAMHS. However, the role of the service provided a significant opportunity to complete a skilled clinical assessment of his behaviour.

8.14 The assessment by the CAMHS was by relatively new staff, was not sufficiently detailed and was a missed opportunity to review the evidence available from the school and social care agencies.

8.15 The assessment lacked social care input and took no account of safeguarding issues. The information known to social services and the school was not reflected in the assessment.

8.16 The outcome of the assessment was insufficiently shared. It was not shared with the YOS service who were identified as the lead agency in CL's care and supervision.

8.17 Access to skilled specialist advice for the school was slow and cumbersome. Teachers who knew about the day-to-day difficulties that CL presented at school did not have ready access to psychological assessment. The referral path to CAMHS relied on the support of the GP who was not engaged with the family problems and CL's behaviour.

8.18 To the YOS service, CL was a low-tariff offender and their involvement took insufficient account of his behavioural difficulties. They were the lead agency for his supervision. The CAMHS informed them poorly about his behavioural problems. They made some efforts to engage social services in his treatment plan.

8.19 Social services had a great deal of information about the L family. They were less involved at the time of the offence than in earlier years. The problems the family presented did not reach the threshold for statutory intervention. BL in particular was considered to have a positive and caring relationship with his children and was keen to remain their carer.

9. Collaboration and communication of the police service in relation to AJ, BL, CL and other organisations

9.1 The review and good practice section of Leicestershire Constabulary in 2006 undertook a review of police involvement including historical police contact with the victim and perpetrators. The terms of reference were to focus and comment on:

- management of and response to earlier calls from or related to AJ on 3 January 2006
- investigation of the incident before the SIO's (senior investigating officer) involvement
- historical police contact and involvement with the victim BL and CL
- review any naturally occurring issue.

9.2 We have had access to the police review and also interviewed police officers from the good practice section. We reviewed the history of contact of AJ, BL and CL with police services and also the sequence of events on the day of the incident.

9.3 The police review of incidents on 3 January 2006 recorded the following:

- At 5.04pm on 3 January 2006 a 999 call was received from the flat of AJ. From the audio recording, the words *"you bastard"* are heard before the female caller terminates the call. The police review says *"it was not clear from the call itself who the intended recipient of the abuse was, in the absence of any information to support an assumption that it was directed to the call taker, the incident should have been directed to the dispatch desk"*.

- At 5.14pm on 3 January a 999 call was received from the flat of AJ. The BT operator who took the call told the call-taker (the police officer on duty) that there had been no request for help but heard talking in the background. The audio recording contained noises and a scream which led to call-taker to believe an argument was taking place. The call-taker created a grade 1 *"possible domestic"* incident, transferred the call to the dispatch desk and tried to recall the caller but the line was engaged. The log shows that at 5.16pm the dispatch desk operator downgraded the incident to grade 4, linked it to the earlier incident and

inaccurately closed the incident as a duplicate incident. The police review comments that the call-taker graded this incident appropriately but that the subsequent downgrading and closure of the incident by the dispatch desk was not in line with the force policy for investigating incidents of domestic violence.

- At 5.15pm on 3 January a man made a non-emergency call saying that an abusive female had damaged his car. He said that she had gone into a property he could identify – AJ's address, and that she had mental health problems. The call-taker linked this call to earlier 999 calls and transferred it to the dispatch desk. At 5.19pm the dispatch desk tried three times without success to *"secure a resource"* to attend. (The phrase *"secure a resource"* indicates a general call to police officers to attend an incident).

- At 5.35pm the dispatch desk operator called Mr C. The operator clarified that Mr C had actually witnessed the damage to his car and could identify who did it. A visit to Mr C was arranged for the following day (4 January) to discuss his complaint with a police officer.

- The police review found that between the two calls (at 5.15pm and 5.35pm) a 999 call was received from BL. The review says that *"from the commencement of this call, banging could be heard and BL complained about the "psycho woman" living above him*". He said that she was *"totally out of it"* and had tried to smash his windows and get into his door. He was aware that she had damaged a neighbour's car and that she was now back in her flat above him. The call-taker told BL that the police had already received a call about this. BL confirmed that he had not suffered any damage and advised him to get in touch again if there were any more problems.

9.4 The police review commented that four reports occurred within 15 minutes:

"Based upon the premise that it is reasonable to expect that these incidents should be identified as relating to the same person, the fact that a greater emphasis was not placed on ensuring the attendance of a resource, the decisions that were made to close the incidents and the lack of review of those decisions is considered significant".

9.5 The police also reviewed the historical incidents relating to AJ and BL. Between February and December 2005 there were 20 incidents of police contact with AJ. These were responses to incidents when AJ was involved in disturbances in public- for example in July 2005 a local pub landlady phoned because she was concerned that AJ was drunk and trying to stop traffic in the street. Other calls were in relation to action under the Mental Health Act - for example on 6 June 2005 the police responded to a call from social worker 1, an approved social worker who was assessing AJ.

9.6 The police review concluded that the police response to individual incidents was appropriate and that there was some good practice in notifying social services about concerns over living conditions and the submission of intelligence logs. The police review also discussed some detailed issues about how intelligence information was recorded on their systems.

9.7 The police review of their information about BL found that intelligence logs from May 2005 noted his involvement in criminal conduct and profile him as a violent person willing to use a weapon in criminal acts. It noted:

- 23 April 2005 an attempted robbery at a local store where he injured a shop assistant's head using a rice flail.

- On 12 June 2005 he attacked his ex-wife at her home and placed a hacksaw blade against her throat. The review said that *"this was only one of a number of incidents of violence and harassment towards his ex-wife"*.

9.8 The police also reviewed the information held on CL and noted that he was involved in offences of theft from motor vehicles and burglary. In June 2005 he set fire to a tractor and *"whilst in custody for this offence he said he enjoyed setting fires"*.

9.9 The conclusion of the police review of actions on 3 January 2006 was that there were shortcomings in the police response to the calls in the early evening. As the review says:

> *"The reviewing officer acknowledges that attendance by the police as a result of these calls had the potential to diffuse the situation and possibly resolve the problems being encountered by the parties concerned"*.

Comment

The police service completed a thorough review of their involvement with AJ, BL and CL. They found good practice in relation to the history of involvement, for example in responding appropriately to requests for help under the Mental Health Act. However, the police identified that they had not appropriately responded to the emergency calls during the evening of 3 January 2006 when a police presence may have helped reduce any tension between BL and AJ.

10. Housing department collaboration and communication in relation to AJ, BL and other organisations

10.1 Both AJ and BL were known to Hinckley and Bosworth borough council through their contact with the housing department. Both had been accommodated in homeless person's housing before being re-housed in the same locality BL had lived in family accommodation for some time before being re-housed and AJ had been staying in temporary accommodation while waiting for a flat. AJ and BL did not know each other before their allocation of their property which made them neighbours. The housing department were involved with both tenants and we consider that their agency involvement should be included in this investigation to help to complete the picture of circumstances before the incident.

10.2 In December 2004 a representative of the housing department attended a case conference at the hospital. AJ was homeless and the council accepted responsibility for her. We interviewed the community housing manager who recalled:

> *"We then placed her (AJ) in bed and breakfast accommodation because she left hospital, so she was placed in temporary accommodation in Leicester, which is normal practice for us because we haven't got any single person hostel accommodation within the borough. People that are coming in to us that are single and homeless that we've got a duty to provide temporary accommodation for go into bed and breakfast as and where we can find it really. So she was placed in bed and breakfast."*

10.3 AJ was allocated temporary accommodation on 10 December 2004 and was accepted as homeless by the council on 7 February. The council acknowledged their duty to re-house on the basis that AJ had a connection with the area.

10.4 On 10 February 2005 AJ was offered a permanent tenancy and moved in on 28 February. On 15 March a housing officer made an introductory visit.

10.5 The next recorded contact by the housing department was on 4 July when police asked them to board up a broken window in the front door. The housing officer later recorded a meeting with AJ in the street:

"…the housing officer was in the area and saw AJ and went to speak to them about the broken glass in the door and the problems with it and he was asked whether or not the police had sent him because she was being blamed for everything and I think she was quite upset at that point. She said that she broke the glass because she'd lost the key to the property so couldn't get in and out, so was accessing the property through that way. She then started to shout at the housing officer for him to go away, and so he advised her that the lock to the door wouldn't be repaired without an incident number, and left at that point."

10.6 On 19 October 2005 the housing department visited to repair a lock on the back door and noted that the police were present.

10.7 On the 29 December 2005 the community housing manager recalled that:

"…we went out to repair the front door, the boarded-up front door, but the workmen had to leave without completing the job because she became quite aggressive and didn't want the door repairing, and that was again just referred through to the housing officer."

10.8 The housing department had no record of a contact between social worker 1 and the housing officer, which the former recorded as taking place on 20 December. There was no matching record in the housing department's file. We asked about complaints in relation to AJ. The community housing manager said there were no recorded complaints from BL or another tenant in the area.

10.9 BL had a record of contact with housing dating back some years. On 27 October 2002 BL made a housing application for himself and his son, CL, and on 22 February 2003 they moved to a homelessness hostel in Hinckley. The housing department accepted its duty to re-house him on 31 March. BL was offered a property on 24 June but he refused it because he believed the previous tenant had been a drug dealer and thought he might be a target of violence. On 21 March 2004 BL moved to Gainsborough but returned to live in homeless families' accommodation on 19 April 2004. He did not pay rent regularly and a notice to quit was served on him on 30 September 2004. It is clear that BL was both a high priority for re-housing at this time and was receiving support on welfare grounds. As the community housing manager said:

"Then we received a medical form. We have a health visitor for the homeless that visits the hostel and who helps support people. By that time obviously BL had been in the hostel for some considerable time. Sharing facilities, bathroom and kitchen, was starting to take its toll so he applied on medical to try and get some additional priority to move, but we don't process medicals for people in the hostel because they've already got the highest priority that they can have, so it means they wouldn't get any additional priority should we go through that process."

10.10 On 19 November 2004 BL accepted a permanent tenancy.

10.11 There are no records of any complaints about BL or by BL in relation to AJ's behaviour. This was confirmed in our interview with BL:

"Mr Watson: Can I ask you if you ever complained to the Housing department?
BL: No. No, I don't think so.

Q. So you didn't complain to any of the -?
A. No. They wouldn't have done anything anyway. My opinion is they wouldn't have done much anyway, because that little area that I lived in, it was mentally ill people that were living there, or they were alcoholics or drug addicts and they all seemed to be swept into this little corner of the town)."

10.12 We asked if the housing department considered as a matter of policy whether people with a history of mental health problems should be located close to each other. Several interviewees said this area in the town had a reputation as presenting more than the average number of anti-social problems. The community housing manager said:

"…it's not one of the more popular areas in the borough that has to be said. It's got in some respects quite a strong community spirit from people that have lived there a number of years, but there's quite a concentration of council housing which means there's a regular turnover which obviously affects the waiting list. Now, the way that the allocations policy works, people can choose which area they want to be re-housed into, and therefore if people are on our waiting list and they have a quite urgent need to move because they might have a number of problems, such as

homeless cases who have a number of issues that need to be managed and dealt with, we would advise them that the shortest waiting times are in this town ."

10.13 The community housing manager qualified this view with the comment that the high demand for housing meant that people with a history of anti-social behaviour might be located anywhere in the borough:

"… with the housing stock that we've got at the moment and with the demand that we've got, people with issues go in all over the borough because we are looking more and more at people that have a high level of housing need plus other issues."

Comment

The housing department appropriately exercised their duties in relation to AJ and BL. Both were homeless and were offered properties. There is an argument that the properties were not suitable because a ground floor property had been requested for AJ because she had jumped out of a window before. The housing department knew this and the community housing manager acknowledged it but it was mitigated by the fact that AJ was keen to move from the temporary accommodation and had raised no objection to a first-floor tenancy.

10.14 In relation to the close proximity of AJ and BL, the housing department knew that AJ was erratic in behaviour but had received no specific complaints. As the community housing manager said:

"…We've then got a policy about how we deal with neighbour complaints, so it would be a case of having the initial complaints come in, getting a view on those complaints and then going out and visiting the tenant concerned to talk to them about the complaints, put the complaints to them, get basically their side of things and then either if there's nothing to substantiate it, it would be either closed or the case of asking the neighbours to carry on monitoring to let us know if there was an ongoing problem. "

10.15 The housing department were contacted about damage to the property. They made some attempts to make repairs but were put off by AJ's response. They also said that AJ was responsible for damage she had caused.

10.16 We asked if the housing department considered it had a welfare function in relation to tenants with mental health problems:

> *"Q. In relation to the people that we're talking about, AJ, BL, does the housing department have any what you could broadly call a welfare function in relation to those people? You know, people with a known mental health problem.*
> *A. I personally think we do, yes, because we're often the ones that are out there and can pick up on issues as they're arising, hopefully at an early stage. Obviously we do get the contacts from other people as we're out and about in the area, so yes, I think we do have a role, not to deal with them as such and not to resolve those kind of welfare issues necessarily, depending on what they are, but certainly to make sure that those issues are referred on to agencies that could help if it's not within our area of expertise.*
>
> *If it's a welfare issue such as problems with paying the rent due to benefit issues and things then obviously we've got a direct role in that. If it's something that we need assistance from social services with, then I believe we've got that role in referring them on.*
>
> *Q. But in relation to AJ and BL, there wasn't any involvement in that sense.*
> *A. No, no. Obviously, as I've said, with AJ, the housing officer did have some contact there, but with BL, no."*

Comment

The housing department was landlord for both BL and AJ. Several witnesses told us the proximity to each other of people with mental health problems in this area increased the likelihood of friction. Some witnesses said the area was well known as a "dumping ground" for people who were hard to place in accommodation. The housing department resisted this view. Neither BL nor AJ had made formal complaints to them about the behaviour of the other. BL maintained that this would have been pointless because no action would ensue. Links between the housing department and the social care and health agencies working with BL and AJ could have been better. The police, AJ's parents and social services had expressed concern about the state of the property and the housing department response was to repeat that it was the

tenants' responsibility to make repairs. On the other hand, AJ had rejected the department's help when they tried to visit the property to make repairs.

11. Review of the trust investigation reports and progress on recommendations

11.1 The first half of this section provides a review of the trust's internal investigation reports. The second half assesses whether the recommendations in the trust's internal investigation reports were appropriate and asks what progress has been made in implementing them.

11.2 The guidance for internal investigations by mental health trusts was issued by the Department of Health in Health Service Guidance (HSG) (94)27. The guidance requires them to conduct formal internal reviews of critical incidents. In the case of homicides and other exceptional events, the strategic health authority (SHA) is required to commission an independent investigation. In June 2005 the Department of Health issued new guidance on the independent investigations of serious patient safety incidents in mental health settings. The three stages of the independent investigation process are described as:

1. **Initial service management review:** an internal trust review within 72 hours of the incident being known about in order to identify any necessary urgent action.

2. **Internal NHS mental health trust investigation:** using root cause analysis (RCA) or similar process to establish a chronology and identify underlying causes and any further action that needs to be taken. This would usually be completed within 90 days. The standard applied in Leicestershire Partnership Trust is 60 *working* days, which equates roughly to a similar 90 day period.

3. **SHA independent investigation:** commissioned and conducted independently of the providers of care.

11.3 The investigations into the care and treatment of AJ, BL and CL were commissioned as two reports. We review each in turn.

AJ

11.4 A 72-hour initial service management review was not completed for the AJ homicide as specified in HSG (94)27.

11.5 The internal investigation report into the care and treatment of AJ was commissioned by Leicestershire Partnership Trust in January 2006.

11.6 The investigation into the care and treatment of AJ was conducted by five senior members of trust staff.

11.7 The investigation process was guided by terms of reference.

11.8 A systematic incident investigation process was adopted for this significant adverse event. Documents were reviewed and interviews with key witnesses were conducted. The report provides a comprehensive chronology, with a summary in the main body of the report and the detail in an appendix. All persons in the report are anonymised. There is little use of any root cause analysis (RCA) tools.

11.9 Seventeen recommendations were generated for this case.

11.10 Three areas of good practice are identified. For example *"there is good evidence that the care team consistently tried to engage with the personality disorder services and sought advice and direction from them in an attempt to better meet AJ's needs…"*

11.11 The investigation into the care and treatment of AJ took 11 months to complete.

Comment

The panel provided appropriate medical, social, management and nursing expertise to undertake the investigation. However some of the panel members had current or previous managerial responsibility for key professionals in the case and this was a potential conflict of interest.

The terms of reference are comprehensive and were met.

The trust adopted a systematic incident investigation methodology in investigating the care and treatment of AJ. It used appropriate RCA tools for example, tabular chronology. We believe the trust collated and reviewed a large amount of data and interviewed appropriate staff. The trust documentation that we received for this case was extensive, poorly ordered and referenced, and it took us a long time to

acquaint ourselves with it. Staff who attended for interview were positively disposed to the ethos in which the interviews were conducted.

The report provides a comprehensive chronology with a summary in the body of the report and the detail in an appendix. The chronology is largely factually accurate and well referenced. It represents a thorough and time-intensive piece of work. It is however, a complex document to read.

All persons in the report are anonymised, which represented the guidance that the National Patient Safety Agency (NPSA) were outlining in their RCA training at that time. However, anonymising the many people involved in the care and treatment of AJ made the report hard to read.

The report's findings centre on those requiring a response specified in the terms of reference. These are concise and clear, but some analysis of the contributory factors using some RCA tools along with identification of other care and service delivery problems might have been beneficial. It is also helpful to link recommendations to findings.

Seventeen recommendations were generated for this case. Most are targeted, specific and have appropriate timescales. However, a few recommendations focus solely at an individual practitioner level, which we feel limits the greater system learning from these incidents. This also leads to blame of the individuals rather than looking to the failings in the system in which they were working.

We agree that the recommendations produced by the trust for the AJ case are appropriate and comprehensive. These are discussed in more detail in section 11.23.

The trust internal investigation report did not follow HSG (94)27 guidance in that a 72-hour management review was not completed and the internal investigation report was not completed within 60 days. We have since been advised that a 72-hour review is completed as part of the independent investigation process, so that urgent safety changes can be implemented.

BL

11.12 The report into the care and treatment of BL and CL was commissioned by Leicestershire Partnership NHS Trust and Hinckley and Bosworth Primary Care Trust in January 2006.

11.13 The panel for this investigation comprised three external staff, one adviser in RCA, three trust staff and one person employed by Hinckley and Bosworth Primary Care Trust. The panel had expertise in medical, nursing, trust, mental health social work, primary mental health work with child and adolescent mental health, communications and primary care. It was chaired by a mental health nursing expert. Advice on root cause analysis was provided by a patient safety manager from the National Patient Safety Agency. The member of staff from Hinckley and Bosworth Primary Care Trust was not an active participant within the investigation process.

11.14 The investigation process was guided by terms of reference.

11.15 A systematic incident investigation process was adopted for this significant adverse event. Documents were reviewed and interviews with key witnesses were conducted. The report provides a comprehensive chronology, with summary in the body of the report and the detail in an appendix. All persons in the report are anonymised. There is evidence that some root cause analysis tools were used.

11.16 Appropriate local and national documentation was reviewed as part of this investigation. A wide variety of people were interviewed. Several members of staff interviewed commented that the tone of questions was inquisitorial and confrontational.

11.17 Separate chronologies were created for BL and CL.

11.18 The trust's internal investigation report analyses findings under a number of headings and themes.

11.19 The care and service delivery problems (C/SDP) are linked with the recommendations.

11.20 Twenty three recommendations for trust action were produced for BL and CL. Two further recommendations were developed for the primary care trust (PCT) to take forward. We find no evidence that this has been done.

11.21 Good practice was not identified in this investigation.

11.22 The investigation into the care and treatment of BL and CL took 11 months.

Comment

HSG (94)27 states that the second stage of the independent investigation process requires the NHS mental health trust to investigate its own incident internally. Therefore the trust did not need to commission three independent practitioners to conduct the internal investigation.

The terms of reference did not include the education department when reviewing the efficacy of collaboration and communication between agencies. In hindsight this was a limitation of the terms of reference because the school had important information about CL which other agencies did not know.

The process adopted for the investigation appears appropriate and proportionate.

The trust adopted a systematic incident investigation methodology in investigating the care and treatment of BL and CL, using appropriate root cause analysis tools like tabular chronology. Incorporating expert root cause analysis advice enhanced the investigation process and analysis. We believe the trust collated and reviewed a large amount of data and interviewed appropriate staff. The trust documentation we received was extensive, poorly ordered and referenced, so it took us a long time to acquaint ourselves with the data.

The chronologies for BL and CL are presented separately and we consider BL's chronology to be comprehensive, complete and accurate. The chronology presented for CL is limited in length, scope and detail. We feel this limits understanding and linkage with the subsequent analysis.

We reviewed appropriate local and national documentation as part of this investigation and interviewed a wide variety of people. Some people who attended

the trust internal interviews told us some of the trust's interviews were inappropriate in style and tone. We do not know if this was the case, but if so it limits learning from incidents and prevents staff attending these interviews willingly in the future.

The authors of the trust's internal investigation report analyse the findings using a number of headings and themes. It is difficult initially to establish why. Later in the report a number of care and service delivery problems (C/SDP) are identified for BL or CL. These are usefully linked to report findings and recommendations, but we feel that these C/SDP could be more usefully integrated into the body of the report, so that the reader can clearly identify issues and problems as they emerge. Each of the C/SDP has the main contributory factors identified. The C/SDP are linked with the recommendations, which we find helpful.

Twenty five recommendations were produced for BL and CL. National standards such as the clinical negligence scheme for trusts (CNST) are cited to give further evidence for the appropriateness of the recommendation, which represents good practice. Most recommendations are targeted and specific, making implementation easier. Some recommendations are cumbersome, for example;

> **"Ensure that agencies working with adults reflect on what are the triggers for contact with children's services (including CAMHS) and what changes might need to be made to existing policies, procedures and guidelines to prompt adult services staff to contact children's services where appropriate. There is no apparent joint agreement presently and one should be developed. Similarly, consideration should be given to developing a working agreement with other services' agencies on what changes may need to be made to facilitate liaison and communication of risk information across those agencies".**

We suggest that they are broken down in future into their constituent parts, so that it is easier for the trust to develop an action plan and assess subsequent progress.

We agree that the recommendations the trust produced for the BL and CL case are appropriate and comprehensive. They are discussed in more detail in section 11.23.

The trust internal investigation report did not follow HSG (94)27 guidance in that a 72-hour management review was not completed and the internal investigation report was not completed within 60 days. We have since been advised that a 72-hour review is completed to ensure immediate safety changes are implemented.

Progress made by the trust on recommendations and their implementation

11.23 In this section of the report we assess whether the recommendations identified in each of the trust's internal investigation reports were appropriate and ask progress has been made in the implementing them.

AJ

11.24 The following 17 recommendations were identified for action in the AJ internal investigation report:

1. Develop clear standards and guidance for clinicians and managers who are expected to chair complex clinical meetings as part of their role.

2. Develop good practice to ensure that, when decisions made by the MDT are changed by an individual or individuals the reasons for such changes are communicated in full to everyone involved. In instances where the team, or members of it, feel that changes to agreed decisions are inappropriate, it is the responsibility of the chair of the MDT meeting at which the original decision was made to ensure that appropriate action is taken, or that it is reported to the service manager.

3. Appropriately register with consultant 9 the panel's concerns about his working practices and explore an appropriate means for reviewing this.

4. Ensure that issues relating to social worker 3's (social worker 1) practice are raised and addressed with him through the appropriate mechanisms.

5. Ensure that the issues relating to CPN 4's (CPN3) practice are raised and addressed with her through the appropriate mechanisms.

6. Avoid cross-team working where possible. It is recognised that on completion of the mental health improvement partnership (MHIP) the existing community treatment teams and community mental health teams will be integrated, thus reducing the need for cross-team working.

7. Develop mechanisms for ensuring management and supervision arrangements are very clear in cases where care packages span different teams.

8. Continue to put in place robust mechanisms for ensuring the ongoing implementation and monitoring of the CPA process.

9. Ensure that CPA training addresses the role and responsibilities of the care coordinator.

10. Ensure that assessments by specialist services are acted upon and that, if they are not, the rationale for such a decision is clearly documented within the notes.

11. Ensure that the expertise within the personality disorder service is shared across the trust and that specialist guidance, supervision and support is available to all clinicians working in adult mental health services where appropriate.

12. Ensure the implementation of a clear and non-stigmatising approach/strategy for the management of people with personality disorder in adult mental health services. This should be supported by training, adequate time to reflect and access to specialist advice.

13. In partnership with local authorities, develop ways of keeping appropriate staff informed of all options and resources available to meet service users' social care needs.

14. Ensure that there are formal monitoring, supervision and support mechanisms in place for locum consultants throughout their employment with the trust and that there are *"buddying"* arrangements in place with substantive consultant psychiatrists.

15. Make available to all service users and their carers where appropriate written information on diagnoses, treatment options and the alternatives.

16. Ensure that appropriate levels of support and information are available to carers. It is acknowledged that on occasion service users do not want personal and clinical information to be imparted to their carers; however, clinicians should be skilled enough to be supportive and to listen to carers without breaking the service user's confidentiality.

17. Examine mechanisms for interagency communication.

11.25 The following 23 recommendations were identified for action in the BL/CL internal investigation report:

The trust should:

1. Put in place a standard referral procedure to ensure that medical and other staff access and examine records of previous admissions and involvement when assessing patients' needs and risk levels. The trust should monitor this and ensure timely access to all records.

2. Consider producing a standard discharge letter on discharge from the inpatient unit. This should include a diagnosis and treatment plan, including medication and what to do in a crisis. A copy of this should be sent to the patient. We understand that this in progress.

3. Review the purpose and function of junior doctor follow-up clinics in the context of wider community services and the *"New Ways of Working Initiative*".

4. Ensure that medical and other staff are aware of the importance of taking a full alcohol and drug history when assessing patients' needs and risk levels. Joint training and joint arrangements should be commissioned for the management of an individual's alcohol and drug misuse where this is related to the managing of violent behaviour.

5. Work with Leicestershire police to establish a collaborative approach where patients give rise to significant concerns because of reports of repeated violent

behaviour. For such patients a protocol should be developed that will ensure that a full forensic history (including any history of persistent carrying of weapons) can be disclosed to the trust.

6. Consider producing service eligibility criteria to guide medical and other staff as to types and levels of mental health that justify continuing mental health service intervention and levels that do not. Guidance should be issued about the thresholds for referral to the forensic mental health service for assessment. A clear understanding on how to access advice on supervision and management of higher risk individuals should be developed.

7. Develop and issue guidance about thresholds for referral to the forensic mental health service for assessment. A clear understanding on how to access advice and supervision and management of higher risk individuals should be developed.

8. Ensure that the CPA is applied. The processes for auditing the CPA should be reviewed and strengthened to ensure that the policy is implemented across all service settings. Action must be taken where it is apparent that this is not the case. The guidance relating to the application of standard and enhanced levels of CPA should be reviewed, to ensure that clinical understanding of the difference is optimal. Training must be provided regularly to clinical staff (in particular to medical staff) to ensure that there is a full understanding of the policy across all service settings.

9. Review the CPA policy. The current CPA policy is 105 pages long and contains many sub-policies that are not directly related to the application of the CPA. It is not specific enough as to when the CPA should be done and thereafter reviewed. We understand that the current policy is being reviewed and we urge the reviewers to incorporate the recommendations above into the revised guidance.

10. Review the functions of the community services, to ensure that there is a better alignment of consultant psychiatric cover and community teams. Consultant psychiatrists should be aligned with the community mental health

team and should not carry a large caseload of patients on standard CPA, that is, where the consultant is identified as the care coordinator.

11. Ensure that agencies working with adults reflect on what are the triggers for contact with children's services (including CAMHS) and what changes might need to be made to existing policies, procedures and guidelines to prompt adult services staff to contact children's services where appropriate. There is no apparent joint agreement presently and one should be developed. Similarly, consideration should be given to developing a working agreement with other services' agencies on what changes may need to be made to facilitate liaison and communication of risk information across those agencies.

12. Review the risk assessment policy and procedures and ensure that they are more widely known, understood and followed by all staff, in particular by medical staff. Risks to minors and family members should be addressed. Application of the trust's risk policy and procedures should be audited regularly and subsequently monitored in order to gauge the extent of its implementation. If this reveals that corrective action is required, then that must be undertaken.

13. Ensure that all clinical notes are signed in a legible fashion. The trust should monitor and review this regularly.

14. Review its systems for the induction, training, continuing professional development, appraisal, mentoring and personal support of doctors in trust grade posts, to ensure that these doctors' knowledge and skills meet public and professional expectations. An annual appraisal should be mandatory.

15. Ensure that issues relating to consultant 3's (consultant psychiatrist 4) practice are raised and addressed with him through the appropriate mechanisms.

16. Direct the CAMHS management to make necessary arrangements to ensure that the referral management process within the service is effective.

17. Direct the CAMHS management to make the necessary arrangements to ensure that case recording standards are reviewed and improved.

18. Direct the CAMHS management to make the necessary arrangements to ensure that assessment and risk assessment processes are reviewed.

19. Direct the CAMHS management to make the necessary arrangements to ensure that the current triage process is reviewed.

20. Review and develop training for CAMHS clinicians.

21. Develop mechanisms for improving communication between CAMHS and adult services.

22. Direct CAMHS management to review its current management of SAEs.

23. Ensure the effective implementation of the common assessment framework.

The PCT should:

24. Review its guidance and systems to ensure that prescribing in the primary care and secondary care services is based on clear two-way communication and the avoidance of concurrent prescribing and inappropriate prescribing. A protocol for this should be developed in partnership with the trust.

25. Enter into discussions with local GP training providers to develop basic risk of harm assessment training as part of the GP registrars' psychiatric training. Enter into discussions with the trust to provide regular basic risk of harm to others training to the local GP workforce.

11.26 The trust has a clear action plan template which provides information on the following:

- recommendation
- action agreed (against the recommendation)
- level of action to be taken forward (corporate, directorate, departmental and individual)
- action by (lead person)
- expected timescales

- resource requirement
- expected evidence of completion
- progress to date

11.27 We found that 49 recommendations were focused on corporate action, 16 on directorate action, three were for departmental action and three were for individuals.

11.28 The trust has appointed appropriately senior members of staff to take responsibility for leading the action.

11.29 Many of the expected timescales for actions being completed have been exceeded. In some cases the trust has given itself a short time to implement an action, yet in others it has given itself much longer – in one case six years.

11.30 The trust internal investigation report for BL/CL says the strategic health authority and NHS East Midlands were to review progress six months after it was submitted.

11.31 The trust does not describe the actual resources required to complete an action in terms of finance, time or manpower.

11.32 Progress on implementing recommendations is partially complete.

Comment

The AJ investigation report produced 17 recommendations and the BL/CL investigation report produced 23 recommendations. Both reports divided recommendations for action. We agree that most recommendations link effectively to the investigation and analysis. The trust has a clear action plan template, which facilitates a consistent approach across the trust.

We found that 49 recommendations were focused on corporate action, 16 for directorate action, three were for departmental action and three for individuals action. We were therefore pleased to see that most actions focused on corporate change rather than on individuals. This suggests that the investigation has focused on improving systems and processes. Change at this level is likely to lead to improved sustainability and spread of improvements across the whole organisation

rather than create pockets of good practice. We agree that some recommendations from these investigations should focus on individual practitioner improvements but it is not possible to check the progress of two members of staff who left the trust after this incident.

The trust appointed senior members of staff to take responsibility for leading the action, but when we requested an update on progress on each recommendation the senior nurse has had to contact each action lead and co-ordinate a response. We feel that it is only thanks to her efforts that this information has been filtered to them. This would suggest there is no centralised system in the trust for coordinating, managing and tracking risks and actions.

Some recommendations have been effectively implemented. For example, recommendation 9 in the BL/CL investigation concerns the length and unwieldiness of the CPA policy. We have found the CPA policy to have been shortened and re-structured to make it easier to read. Appendices for supporting information and links with national guidance have been improved. The trust have continued their work in this area and we have reviewed a further amended and improved CPA policy for implementation in October 2008.

Many of the expected timescales for action have been exceeded. The senior nurse at Leicestershire Partnership Trust (LPT) agreed that this was the case and the trust is reviewing these. Our analysis of progress on recommendations finds that of 66 actions eight are incomplete, 16 are partially complete or require on-going action, and three actions require evidence.

The section in the action plan that relates to "resources required" *often states* "none" *but we found that some of the recommendations (for example, training) would cost more money. The trust acknowledges that all actions demand time and manpower but they state* "none" *if the action can be completed within existing resources.*

We were concerned that 40 recommendations had arisen from these two investigation reports, resulting in 66 actions. This is a significant number for the trust to manage and implement. A system of prioritisation might be a useful way of identifying the order for completing recommendations.

Most recommendations have been implemented fully.

Appendix A

Independent investigation team

Alan Watson - lead investigator

As an inspector for the Social Services Inspectorate, Alan led national inspections on mentally disordered offenders and compulsory mental health admissions. In 2005 he was seconded to work with the Healthcare Commission on the development of mental health improvement reviews, a new approach to evaluating mental health services, for which he helped to develop the assessment framework and test the methodology in pilot sites throughout the country. Alan also has extensive experience of strategic planning and service development across all social services functions, including joint planning with health authorities and the voluntary sector. Since 2006 he has worked as an independent health and social care consultant specializing in mental health

Dr Sally Adams – senior investigator

Sally is an experienced human factors practitioner who began her career in high reliability organisations, including nuclear power and process control, before joining the NHS over 10 years ago. Sally's main area of expertise is incident investigation using root-cause analysis methodology for all types of healthcare investigations. Sally has left Verita since the majority of work on this investigation was completed.

Dr Simon Wood – expert clinical adviser

Simon is a consultant forensic psychiatrist.

Appendix B

List of individuals mentioned in report

(X indicates that a person was interviewed by the panel)

Name	Position	Interviewed	Service user
(name deleted)	acting senior education officer	X	CL
(name deleted)	mental health nursing expert		
(name deleted)	national patient safety agency manager		
(name deleted)	YOT operational team leader		
(name deleted)	chair of local medical committee		
(name deleted)	head of youth justice and safer communities Leicestershire county council	X	CL
(name deleted)	community housing manager	X	AJ BL
(name deleted)	clinical director of CAMHS	X	CL
(name deleted)	community alcohol practitioner	X	-
(name deleted)	community care worker with CMHT		
(name deleted)	consultant clinical psychologist		
(name deleted)	consultant in social care	X	AJ
(name deleted)	deputy head teacher	X	CL
(name deleted)	detective inspector	X	-
(name deleted)	medical director	X	AJ BL CL
(name deleted)	civilian investigator	X	-
(name deleted)	senior educational needs coordinator	X	CL
(name deleted)	staff nurse on Acton ward at Bradgate	X	BL
(name deleted)	student nurse		
(name deleted)	support worker for crisis resolution and home treatment team	X	-
(name deleted)	AJ's family advocate (LAMP)	X	AJ
(name deleted)	head of youth offending service	X	CL
(name deleted)	housing officer		
AJ	victim		
BL	perpetrator	X	-
community care worker 1	community care worker with CMHT	X	AJ
consultant psychiatrist 1	consultant psychiatrist		
consultant psychiatrist 2	consultant psychiatrist		
consultant psychiatrist 3	consultant psychiatrist	X	
consultant psychiatrist 4	consultant psychiatrist	X	BL CL
consultant psychiatrist 5	consultant psychiatrist		
consultant psychiatrist 6	consultant psychiatrist		
consultant psychiatrist 7	consultant psychiatrist		

consultant psychiatrist 8	consultant psychiatrist		
consultant psychiatrist 9	consultant psychiatrist		
consultant psychiatrist 10	consultant psychiatrist	X	AJ
consultant psychiatrist 11	consultant psychiatrist	X	AJ
consultant psychiatrist 12	consultant psychiatrist		
consultant psychiatrist 13	consultant psychiatrist		
consultant psychiatrist 14	consultant psychiatrist	X	AJ
consultant psychiatrist 15	consultant psychiatrist	X	-
CPN1	community psychiatric nurse	X	AJ
CPN2	community psychiatric nurse		
CPN3	community psychiatric nurse	X	AJ
CPN4	community psychiatric nurse	X	-
CRT nurse	crisis resolution team nurse	X	-
CL	perpetrator	X	-
forensic psychiatrist 1	forensic psychiatrist		
GP1	general practitioner		
GP2	general practitioner		
GP3	general practitioner	X	AJ
GP4	general practitioner		
GP5	general practitioner		
GP6	general practitioner	X	BL
GP7	general practitioner		
GP8	general practitioner		
GP9	general practitioner	X	BL CL
GP10	general practitioner		
GP11	general practitioner	X	BL CL
Mr J	AJ's father	X	AJ
Mrs J	AJ's mother	X	AJ
RL	CL's mother		
RMO1	responsible medical officer		
senior nurse	Leicester Partnership Trust senior nurse	X	AJ BL CL
service manager 1	service manager	X	AJ
service manager 2	service manager, family support, early years and disabled children	X	BL CL
service manager 3	service manager for the children's access service	X	BL CL
social worker 1	social worker, crisis resolution team	X	AJ
social worker 2	social worker, children's access	X	BL CL
SpR1	specialist registrar in child and adolescent psychiatry	X	
team manager 1	team manager, south CMHT	X	AJ
team manager 2	team manager, children's access	X	BL CL
team manager 3	team manager, crisis resolution team	X	AJ BL

trust grade doctor 1	trust grade doctor		
trust grade doctor 2	trust grade doctor		
WP	BL's partner		
Youth worker 1	youth offending service	X	CL

Appendix C

Documents reviewed

Policies and procedures

Action plan updates

AMH service counties

Art psychotherapy (12 July 2006)

Care programme approach policy and practice (August 2003)

CLAP newsletter

Clinical psychology service (January 2007)

Clinical supervision policy

CPA policy and practice (January 2007)

CPA policy and procedure questionnaires (November 2001)

Crisis resolution team/service information

CRT operation policy (September 2007)

Group analytic psychotherapy

Guidelines for managing patients with personality disorders (17 October 2006)

Guidelines for the use of initial risk screening tool (November 2001)

Guidelines on DNAs/cancellations/failed home visits (November 2001; 22 November 2005)

Operational policy for forensic services and adult mental health

Organisational chart

Parenting skills group

Personality disorder service information

Psychology services information

Policy for the admission of children and adolescents to an adult ward (August 2008)

Risk management strategy and policy (January 2004)

Stop and think group work programme

Supervision policy (January 2006)

The understanding yourself group (September 2007)

Therapy through activity programme (TTA) (June 2007)

Trust board and directors

Trust DNA policy

AJ records

Aston ward care plan

Complaints file

Family's chronology and psychiatric report provided by AJ's family advocate

AJ internal investigation file, including interview notes

Medication records

Notes from Heath Lane surgery

Primary care records

Psychiatric report by AJ's family advocate

Consultant psychiatrist 14's report on medical management of AJ

BL records

Primary care records

Psychiatric report by forensic psychiatrist 1 dated 29/12/05

Social service records

CL records

Primary care records

Social service records

Summary of CL incidents completed by CL's school

Patient records

Other documentation

2012 service model inpatient workstream (28 May 2008)

2012 Vision – management structure (20 June 2008)

A short update to what's on offer for service users with personality disorders and those trying to support them (July 2006; August 2006)

Adult mental health services – Trail issue (Issue 10)

Agreed care plan form

Care programme approach (CPA) case-note audit (Autumn 2007)

CLAP newsletter (1st Edition)

Clinical audit proposal form

Clinical forum for personality disorder flyer

Clinical networks workstream final report (May 2008)

County crisis resolution and home treatment team

CPA refocus task and finish group meeting (21 August 2008)

Criteria/risk of client for CPA or standard care form

Developing, reviewing and monitoring information given to service users (May 2006)

Executive summary

Exemptions for care coordinator role (September

Exemptions to CPA process

Functions and responsibilities of the CPA care coordinator

Guidelines for managing patients with personality disorder (12 December 2006)

Incidents and complaints as 'improvement opportunities' interim recommendations (version 7)

Integrated locality workstream report (May 2008)

Judge's sentencing remarks on BL and CL

Lead consultants/clinicians meeting (27 March 2007)

Leicestershire and Rutland personality disorder strategy (Paper F)

LPT care programme approach policy document for implementation (October 2008; Version 3)

Paper for senior clinical group meeting (12 December 2007)

Parenting skills group

Record of CPA review (August 2008)

Refocusing on the care programme approach (CPA) task and finish group (September 2008)

Review of serious untoward incident reporting processes and learning lessons (12 June 2008)

Section 117- recommendations for future monitoring/recording (August 2008)

Section 117: local guidance (June 2008)

Section 117: minutes of meeting held (7 August 2008)

Stop and think poster

Trust board meeting (June 2008)

Trust wide CPA action plan

YOS management review

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

www. eastmidlands.nhs.uk

Verita
53 Frith St
London
W1D 4SN

www.verita.net