External Investigation into the Case of AL

Incident date: 21st June 2008

Investigator: Pat Shirley - Associate Caring Solutions (UK) Ltd

Investigation report date: March 2011

Contents

Executive Summary

1. Incident description and consequences

AL is a male who, at the time of the fatal assault upon his mother JL was 45 years old and lived with her.

On June 21st 2008 AL killed his mother on the way home from a meal to celebrate his birthday, hitting her over the head with a blunt instrument and then strangling her. Evidence from the pathologist raises a question about the sequence of events as pathology findings would suggest that he strangled JL before hitting her over the head. On June 22nd he entered a Police station and reported that he had killed his mother. He was arrested and sectioned under the Mental Health Act by a Psychiatrist from Avon and Wiltshire Partnership Trust.

He is currently subject to a section 37/41 treatment order and is to be held in a Medium Secure Hospital until he is deemed to be no longer a risk to himself or others.

2. Background and Context

NHS Dorset covers the same geographical area as Dorset County Council, which comprises six District/Borough Councils. Hence the boundaries of NHS Dorset run from Lyme Regis in the West to Christchurch in the East, Portland in the South to Gillingham in the North.

Community based services are directly commissioned by the Trust and are managed by their provider arm – Dorset Community Health service (DCHS). These services include Mental health services for patients in the North and South West geographical areas only.

Note: NHS Dorset commissions Mental Health Services from Dorset Healthcare University NHS Foundation Trust for the patients in the South and East locality.

AL's clinical care was being managed by services within the North Dorset Locality and during his time as a patient he had been cared for by both inpatient and community mental health services.

3. Terms of Reference

The key questions the external investigator developed from the terms of reference are:

1. Was the assessment, treatment and care for AL appropriate
2. Was the internal investigation timely and did the methodology identify all the lessons to be learned
3. Were all key issues and lessons to be learned identified
4. What progress has been made on the action plan
5. What processes are in place to embed the learning
6. Are recommendations appropriate and comprehensive and flow from the lessons learned
7. Risk assessment and policies – what was in place then and now.

8. Was the communication between agencies, services, friends and family effective, this to include the sharing of appropriate risk information

9. Was key information recorded then – how is it recorded now

10. Does the organisation have effective communication and case management systems in place.

11. Were family and friends engaged appropriately during the internal investigation.

Key questions developed from the [1]Capsticks Homicide assessment are:

1. Is it the case that following discharge on 2.07.07 there were no indicators of risk leading up to the homicide.

2. Was the information disclosed by the neighbour in the few days prior to the homicide communicated to the community services and what was done with it.

4. Level of Investigation

The investigation is a level 3 Independent Investigation

5. Findings

1. The assessment, care and treatment was appropriate, however there were missed opportunities to monitor AL more closely. .

2. The internal investigation was as timely as it was able to be given that the process had to be halted due to the legal process. The methodology followed the recommended NPSA process and was both thorough and robust. The only exception being the GP who was not interviewed, although information from his clinical notes was reviewed.

3. Key issues were identified within the internal investigation and lessons learned have clearly transferred to the action plan, with the exception of (1) safeguarding (2) Mental Health Act 1983 (amended 2007) knowledge, application and practice (3) the involvement of the GP and Police and (4) strengthening overall clinical leadership and team management.

4. All actions and recommendations have been progressed and using the [2]NHSLA framework comply with either level 1 or level 2 with clear plans in place to progress the actions further.

5. Dorset Community Health Service (DCHS) provided a forum for learning from the event which covered the findings within the internal report. On-going learning is steered through the network system. This system is worthy of note as it provides both an excellent communication route as well as effective monitoring of training and development.

[1] Capsticks Solicitors carried out the initial analysis of the Dorset Community Health Trust's Internal report. From this they raised two points to be investigated in more detail as part of the external review.

[2] The National Health Service Litigation Authority has developed a risk assessment framework underpinned by a range of NHSLA standards and assessments. Most Healthcare organisations are regularly assessed against these risk management standards. Section 9.4 details their application to the internal report action plan.

6. The internal investigation recommendations are appropriate; however need developing further in relation to leadership, safeguarding, Mental Health Act application, and stakeholder involvement.

7. Risk assessment and policies are clear and underpin activity relating to risk management. Three areas to address are: The Risk Strategy; medical staff risk training; review of assessment form criteria.

8. Communication across agencies was not effective and within the internal and external report there are examples of this. DCHS, the Police, GP and Wiltshire County Council all held risk information about AL and JL and opportunities to share information were missed.

9. Key information was not recorded, however this practice is now monitored and audited. There are incompatible electronic systems across agencies which will create barriers to sharing relevant and timely information and will slow down response times. Compatibility between systems is planned to be reviewed, as yet this has not commenced.

10. The organisation has developed excellent caseload and communications systems which are monitored and audited. This process has now been rolled out across the Adult Mental Health Services. This will need further auditing to ensure it is embedded in practice.

11. There is no evidence that the family was considered during the course of the investigation. There is no explanation in the Internal report to mitigate this omission.

12. Whilst it could not have been predicted that AL would kill his mother there was a missed opportunity to identify that AL was becoming acutely unwell and therefore carry out a fuller assessment on his compliance with medication and his risk behaviour.

13. There is no evidence that the Community Resource Worker (CRW) or the Community Services were in receipt of any concerns expressed about AL just prior to the incident.

6. Contributory/Associated Factors

The findings of the external investigation has determined several contributory factors:

1. Patient: AL had a severe and enduring mental illness. A significant factor to this was his paranoia towards his neighbours and others whom he thought were monitoring him. Within this he exhibited risk behaviours which were unpredictable and impulsive.

2. Carer: JL as the main carer was not involved in the care of AL or in the decisions about his care. This was a missed opportunity to engage with JL and ensure she could communicate any concerns she might have about AL.

3. There was no carer assessment for JL, had there been there would possibly have been an opportunity to discuss her anxiety about AL. JL was also discharged from the Wiltshire County Council(WCC) safeguarding team very early given AL would be discharged home.

4. Assessment Processes: The Trust Protocols and Policies in relation to CPA and Risk Assessments were not followed. This led to poor and uninformed decisions about AL's community follow up which did not match his clinical needs.

5. The decision to revoke AL's Section 2 was made after only 4 days. This did not allow enough time to fully assess AL's mental state, the subsequent potential impact of JL, and ensure a focus on his mental state as part of his care programme within the community.

6. Communication: There was poor communication with the Police, WCC, GP, neighbour and JL. All of whom held relevant information about AL in relation to his risk behaviour and the impact on JL. The CRW was not aware that AL's medication had been reduced. There was poor communication between WCC and the Mental Health Services.

7. Resources: The decision not to replace the CPN was a missed opportunity to closely monitor AL.

8. Leadership: The overall clinical and team leadership within both the community team and the Inpatient setting is not demonstrated as robust and effective. There is no evidence that documentation, risk management and clinical interventions were monitored and where appropriate challenged within a supervision or caseload management framework. The decision to revoke AL's section was not challenged. The North Dorset mental health team did not focus on those patients with a severe and enduring mental illness. This would have impacted on the decision to replace the CPN.

7. Root Causes/Causal factors

1. The findings from the external investigation has not determined fundamental contributory or causal factor. JL was vulnerable and had previously been at risk as a result of AL's impulsive risk behaviour. However, there is no evidence to suggest that he planned to Kill her. His risk behaviour was unpredictable and impulsive, given this, it would not have been possible to predict that he would kill his mother.

8. Lessons Learned

1. The internal report covered many lessons learned. The findings were developed into recommendations which have been followed up as part of an internal Trust action plan.

2. The external Investigation concurs with these and the internal action plan developed from the findings. However, the external investigation adds areas for consideration in relation to Leadership; Safeguarding; Mental health Act application and practice; Caseload management and supervision; Cross boundary Relationships; Medical staff; Information systems; and Trust arrangements post April 2011.

9. Recommendations

1. Leadership: The Trust action plan should include a specific action on the strengthening of overall clinical leadership and team management to ensure this remains effective and strong.

2. Safeguarding: The Trust action plan should include a specific action on safeguarding in relation to a review of assessment documentation, staff knowledge and training, and communication with others, both internal to the Trust and externally to other agencies.

3. Mental Health Act Management: The Trust action plan should include a specific action on Mental Health Act (2007) management. This to ensure staff knowledge, practice and application is clinically appropriate.

4. Caseload management and supervision: The organisation will need to ensure that further auditing is carried out on caseload management and supervision to ensure it is embedded in practice.

5. Involvement of Others: The Trust action plan should include specific actions on raising the awareness of mental health with other agencies such as the GP and the Police and also ensuring all involved in a patient's care contribute to a patient's plan of care.

6. Internal Reviews: The Trust should ensure that any further internal review must take account of all those involved in the patient's care. Whilst this may be difficult because of legal proceedings it should not become a barrier to enabling learning.

7. Cross boundary Relationships: (a) The Trust Risk Strategy must be reviewed to take account of all organisations it links with. (b) The current mental health safeguarding network criteria should be revised to include links to agencies on the boundaries. (c) The Safeguarding Board Policies should be revisited to ensure they list all organisations they may link with, both within their organisation boundary and across the boundaries.

8. Medical staff: Medical staff should receive formal risk training so that a consistent approach to risk management is applied across the mental health services.

9. Information systems: Progress should be made to ensure that the different systems are as compatible as possible, or where this is not feasible design manual systems to overcome this.

10. Organisational changes post April 2011: Assurance must be provided by the Trust that post the new organisational arrangements the action plan will continued to be monitored and progressed.

MAIN REPORT

1. Incident description and consequences

1. AL is a male who at the time of the fatal assault upon his elderly mother was aged 45. They resided together.

2. On June 21st 2008 he killed his mother on the way home from a meal to celebrate his birthday, hitting her over the head with a blunt instrument and then strangling her. Evidence from the pathologist raises a question about the sequence of events as pathology findings would suggest that he strangled JL before hitting her over the head. This is not confirmed by AL.

3. Following the fatal assault on his mother AL tried to kill himself by taking an overdose and jumping into a river. Having failed in this attempt he handed himself in to the police shortly after.

4. On June 22nd he entered a Police station and reported that he had killed his mother. He was arrested and sectioned under the Mental Health Act by a Psychiatrist from Avon and Wiltshire Partnership Trust.

5. He is currently subject to a section 37/41 treatment order and is to be held in a Medium Secure Hospital until he is deemed to be no longer a risk to himself or others.

2. Pre-investigation risk assessment

A risk rating was carried out at the commencement of the external review process. This was rated at 15 as the likelihood of the incident occurring and the potential severity were high. A post investigation risk assessment will be completed following the external investigation process. This will take into account the clinical and risk behaviour of AL during his time with the mental health services; the incident; the Trust's response to the incident; AL's current potential clinical and risk behaviour.

3. Background and Context

1. NHS Dorset covers the same geographical area as Dorset County Council, which comprises six District/Borough Councils.

    1. Weymouth and Portland Borough Council
    2. West Dorset District Council
    3. North Dorset District Council
    4. Christchurch Borough Council
    5. East Dorset District Council
    6. Purbeck District Council

2. Hence the boundaries of NHS Dorset run from Lyme Regis in the West to Christchurch in the East, Portland in the South to Gillingham in the North. It includes the urban conurbation of Weymouth and Portland, the seaside towns of Swanage and Lyme Regis, the market towns of Bridport, Blandford, Dorchester, Sherborne, Shaftsbury, Wimborne, and Wareham and large areas of rural countryside with many scattered villages.
3. Community based services are directly commissioned by the Trust and are managed by the provider arm – Dorset Community Health Service (DCHS). Their service portfolio includes:

- Community services, operating out of GP practices, health centres and eleven community hospitals providing over 300 beds across Dorset
- Older peoples' mental health
- Community Adult Mental Health Services including Acute Care
- Drug and Alcohol Services
- Offender healthcare services for the Dorset Prison Partnership
- Support services including Estates, IT, Finance and HR

Note: Services in South and East Dorset are provided by Dorset Healthcare University Foundation Trust (DHUFT).

4. The integrated mental health services managed directly as part of DCHS cover a population size of 240,000. Within their portfolio they provide a range of Mental health Services across a wide age spectrum. Within Older Persons services these are in-patient and community and day services. Within Adult Services there are adult acute in-patient units, community 'Access and Wellbeing Teams, Recovery Teams and Home Treatment Team. For younger people ages 14 – 35, there are Early Intervention in Psychosis Teams for individuals experiencing their first episode of psychosis.

5. Within all the services there are a range of professionals, these include; medical and nursing staff; social workers; occupational therapists, and psychologists.

6. At the time of the Homicide there were three locality structures (i) Weymouth and Portland, (ii) Dorchester and Bridport, (iii) North Dorset. Each was managed by a Locality Manager who reported to the Director for Mental Health Services within DCHS.

7. In February 2011 the services were realigned into two Localities (i) Weymouth and Portland (ii) Central and North Dorset. These are managed by 2 Integrated Service Managers who report to the General Manager for Adult Mental Health Recovery Services, who in turn reports to the Director for Operational Services.

Note: From July 2011 Dorset Community Health Services was acquired by DHUFT.

AL's clinical care was being managed by services within the North Dorset Locality and during his time as a patient he had been cared for by both inpatient and community mental health services.

4. Terms of Reference

The terms of reference for the external investigation set out the following:

4.1 Purpose

A comprehensive report which contains the lessons learnt and recommendations based on the evidence arising from the investigation.

4.2 Objectives

- To evaluate the mental health care and treatment of the individual including risk assessment and risk management.

- To identify key issues, lessons learnt, recommendations and actions by all directly involved health services.

- Assess progress made on the delivery of action plans following internal investigation.

- Identify lessons and recommendations that have wider implications so that they are disseminated to other agencies and services

4.3 Key Questions

The key questions the external investigator developed from the terms of reference are:

1. Was the assessment, treatment and care for AL appropriate

2 Was the internal investigation timely and did the methodology identify all the lessons to be learned

3 Were all key issues and lessons to be learned identified

4. What progress has been made on the action plan

5. What processes are in place to embed the learning

6. Are recommendations appropriate and comprehensive and do they flow from the lessons learned

7. Risk assessment and policies – what was in place then, and what is in place now.

8. Was the communication between agencies, services, friends and family effective; did this include the sharing of appropriate risk information

9. Was key information recorded then – how is it recorded now

10. Does the organisation have effective communication and case management systems in place

11. Were family and friends engaged appropriately during the course of the internal investigation.

Key questions developed from the Capsticks Homicide assessment are:

a. Is it the case that following discharge on 2.07.07 there were no indicators of risk leading up to the homicide.

b. Was the information disclosed by the neighbour in the few days prior to the homicide communicated to the community services and what was done with it.

4.4 Key Deliverables

The external Investigation will deliver:

1. A full Report

2. An Executive Summary

3. A presentation to SHA South West Board

4. An up to date position on the Internal Investigation Action Plan

4.5 Scope

The investigation will commence in November 2010 and be completed by April 2011

4.6 Investigation type and process

This is a single incident external investigation which required one investigator with peer review to oversee the process. The process employed was:

- Review of documentation – strategies, policies & procedures, clinical notes, Wiltshire County Council practitioner notes, information from other agencies, training records, court statements

- Interviews with staff, family member (cousin), General Practitioner (GP), AL

- Email contact with Police, Wiltshire County Council

- The extensive tabular timeline in the internal report was used as a reference, confirm and challenge point

- A 24 page evidence trail was compiled from documentation, interviews, case notes, statements

- A summary of all documentation used was complied and will form part of the full report

4.7 Communication:

- The report will be presented to the Strategic Health Authority Board for consideration and subsequent publication.

4.8 Investigating Commissioner:

- The Investigation has been commissioned by the South West Strategic Health Authority in accordance with Department of Health Guidelines

4.9 Investigator:

- The Investigator is a RGN, RMN, DMS with significant knowledge of mental health services and systems, having recently retired as an Executive Director of Nursing and Governance, a post which she held for 6 years.

- Prior to that she has worked as a senior clinician and manager in both inpatient and community mental health settings. The Investigator has also taken part in several investigations, both as an individual investigator and as a panel member.

- Peer review was provided by Dr Colin Dale, Chief Executive of Caring Solutions (UK) ltd. Dr. Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health.

- Dr. Dale has successfully worked on a large number of projects and investigations in recent years. He is currently the Vice Chairman of a NHS mental health foundation trust , a member of the Mental Health Review Tribunal and a Senior Research Fellow at the University of Central Lancashire.

5. Level of Investigation

- The investigation is a level 3 Independent Investigation

6. Involvement and Support of Patient & Relatives

1. As part of the Investigation AL was interviewed to give him an opportunity to discuss his recollection of the event and to ascertain his view of his clinical care from both the GP and DCHS. Full support was given to AL during this process by his Consultant Psychiatrist and the clinical team which now manage his care.

2. Discussion also took place with AL's next of Kin. Whilst the next of kin, who did not live locally, was not able to give an opinion on AL's clinical care because she was not informed by either AL or JL of its seriousness, she was able to express how she found his living conditions to be and offer an opinion on what would have been observed by a professional had they visited the home.

3. A person not able to be interviewed as not contactable was a neighbour of AL and JL. This person was particularly supportive to JL and AL over a number of years and intervened positively as AL became more unwell. It has however, been possible to get the neighbour's perspective from their statement given to the police after the homicide.

7. Involvement and support provided to staff Involved

1. At the time of the incident several debriefing sessions were carried out with staff involved in AL's care and treatment. Once the internal investigation was concluded a learning event took place for all staff involved. This was externally facilitated and gave an opportunity for staff to discuss the findings and recommendations from the investigation.

2. All staff involved in the external investigation had an opportunity to get informal support either from their manager or peer group.

8. Information and Evidence gathered

1. Appendix 1 sets out the list of documents used to gather evidence for the external investigation. Other information was gathered by the following:

   Face to face interviews

   - AL
   - AL & JL's General Practitioner
   - DCHS staff x 8
   - NHS Dorset Non Executive Director
   - AL's Current Consultant Psychiatrist

- AL's Previous Consultant Psychiatrist – post incident[3]

Telephone Contact/interviews

- Wiltshire County Council
- AL's Next of Kin

Email/letter

- Dorset constabulary
- Wiltshire County Council

9. Findings

This section has been considered within the framework of the key questions developed from the Terms of reference as follows:

9.1 Was the assessment, treatment and care for AL appropriate

1. On the 11/6/07 AL was first assessed by DCHS Mental Health Services at Salisbury hospital following an overdose of paracetamol with vodka. He had spent the last 2 nights sleeping in his car with JL. Evidence from the assessment clearly indicates a level of paranoia. The assessment is summarised as "A 43 year old man with increasing paranoid ideas in context of normal mood. Took spontaneous overdose and no further intent to self harm". On the same day an urgent referral was made by the assessor to the CMHT.

2. The police, who had been involved when AL had taken the overdose, referred JL to the Police Vulnerable Adults department, the reason for the referral was psychological abuse of JL (being made to sleep in the car for two nights and then AL taking an overdose in front of her). A Vulnerable Adult assessment was carried out by case workers from Wiltshire County Council and the Vulnerable Adult Unit from Salisbury Police. Records following referral indicate that it was thought to need an emergency strategy meeting (ESM). As measures were put in place to support AL it was thought that this would reduce the risk to JL and the case was closed.

3. On the 12/6/07 AL was reviewed by a Consultant Psychiatrist and a Community Psychiatric Nurse (CPN) from DCHS. It was considered that AL had developed a mild psychosis, he was persuaded to take medication – Risperidone which is an antipsychotic medication and prescribed to treat both acute and chronic psychosis. AL agreed to be followed up by local Community Mental Health Team (CMHT). The internal report does not indicate at this point what consideration has been given to the safety of his mother.

4. On the 13/6/07 a neighbour contacted JL who said that AL had gone left home and had not returned. He told JL that he wasn't coming back and that he was going to the railway line. The neighbour contacted the Police and the Mental Health Services who contacted the Police Vulnerable Adults Department to report their concerns regarding JL.

[3] AL's Consultant Psychiatrist at the time of the incident, was not interviewed as part of the external review. The Psychiatrist had contributed significantly to the internal report, therefore little could be gained by a further interview.

5. On the 14/06/07, in the early afternoon, AL rang his mum. He was clearly paranoid about people out to get him. He was persuaded to return home and then detained by the Police under a section 136 and taken to an In-patent unit. He was considered to be at risk to himself and others and detained under section 2 of the Mental Health Act (1983).

6. The Emergency Duty assessment carried out when he was detained under the Mental Health Act notes that AL had gone off in his car and left a note stating that he was being hounded to death and that he and his mother would meet horrible deaths. The assessment also describes that his mother had become ill five years previously and that AL had not worked since. However his mother was noted to be independent. Found at the house were 2 carriers bags which contained an air gun, a length of plastic clothes line, writing pads and envelopes, a bottle of vodka, a large number of paracetamol tablets and a letter saying that AL and JL would meet an awful death. The police were called back that night and took away the pistol, note and length of cord. The suicide note was faxed to the In-patient Unit and the Police requested that they be informed should a decision be made to release AL given the need to review JL's security and overall risk.

7. On the 14/6/07 JL was visited at home by case workers from Wiltshire County Council and the Vulnerable Adult Unit from Salisbury Police. JL confirmed that she did not feel at risk from AL although she found the time in the car difficult because she did not have her medication with her. Following the visit it was agreed that an Emergency Strategy meeting (ESM) should be conducted and that this should involve the Mental Health Team. It was agreed to arrange this for the following week as AL had been detained under the Mental Health Act and was expected to be an in-patient for at least 3 weeks.

8. On the 15/06/07 a Consultant Psychiatrist held a Case Conference at the In-Patient Unit. In this AL's paranoia, his thoughts about his harm to himself and his mother and the suicide note was discussed. He thought he was being monitored by CCTV and passing drivers were looking for him and checking his number plate. It was noted that he had not taken the Risperidone originally prescribed for him on the 13/06/07.

9. On the 18/6/07 AL's section 2 was revoked and he became an informal patient. AL expressed to the Consultant that he was "feeling down and tired from the pressure of not being able to find a job". The nursing entry records AL as being "relaxed and sociable". AL was sectioned in total for 4 days. As an informal patient he could have left the in-patient unit at any time. It is questionable that a full assessment could have been carried out on AL in relation to both his on-going mental health and his risk behaviour towards his mother. This potentially put his mother at significant risk. It is not documented that his mother's risk was considered when his section was revoked. This was a missed opportunity to carry out on-going assessments of AL, to ensure the continued safety of his mother JL, to potentially keep the focus on his on-going mental health monitoring as part of his care programme.

10. On the 20/06/07 the case worker from Wiltshire Country Council (WCC) contacted the in-patient unit to get an update on AL's progress and to ensure that both Wiltshire and the CMHT who would be following him up would be involved in the discharging process. They were informed that AL was going home on home leave that day. The case worker expressed concerns at this decision and requested to speak to the 2 Psychiatrists, who were both on leave. The case worker then contacted the CMHT who would follow AL up post discharge. A CPN contacted another Consultant Psychiatrist who intervened and AL's leave was delayed although he was by that time no longer on a section and could have left the unit at any time.

11. On the 22/06/07 an ESM took place on the In-Patient Unit. This was attended by the Vulnerable Adult case workers from WCC, Salisbury police VA Unit and a staff member attending from the In-Patient Unit. The outcome of this is documented in JL's record, held by WCC. The concerns surrounding the potential risks to JL if AL was discharged back to the family home were expressed by the case workers. The case workers also spoke with AL who it is noted appeared lucid and was quite distraught that he could have caused his mother harm.

12. Following the ESM both case workers felt that there was no further role for them. This is due to the fact that AL was under Dorset care and would, if needed be followed up by Dorset County Council.

13. On the 25/6/11 AL was accompanied home with an Occupational Therapist. The visit went well although mild paranoia about people on the estate was observed and noted.

14. On the 26/6/07 AL's mild paranoid ideas were noted during a review by a Consultant Psychiatrist. However AL was granted leave for a long weekend. No link appears to have been made about the paranoia which originally brought him into hospital under section and the subsequent risk behaviour towards his elderly mother. Whilst his vague paranoia was noted during a review by the Consultant Psychiatrist it was still considered that he was well enough to go home for the weekend. JL's safety was not considered.

15. On the 30/6/07 and prior to discharge a [4]Care Programme Approach (CPA) assessment was carried out by a CPN from the Community Mental Health Team (CMHT) who would be following AL up in the Community. AL was placed on an Enhanced CPA,

People on enhanced CPA are likely to have some of the following characteristics:

- they have multiple care needs, including housing, employment etc, requiring inter –agency co-ordination;
- they are only willing to co-operate with one professional or agency but they have multiple
- care needs;
- they may be in contact with a number of agencies (including the Criminal Justice System);
- they are likely to require more frequent and intensive interventions, perhaps with medication management;
- they are more likely to have mental health problems co-existing with other problems such as substance misuse;
- they are more likely to be at risk of harming themselves or others;
- they are more likely to disengage with services.

16. At the CPA it was agreed that the CPN plus an experienced community resource worker, employed by Dorset County Council (DCC) but deployed to work within the integrated mental health services, would be involved in his follow up care. The CPA assessment did not highlight his risk behaviour to JL, should he become unwell. The focus of the CPA was to get AL involved in activities in the community to reduce his social isolation.

[4] DoH Guidance; Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach 1999

17. One month after AL's discharge the CPN left the team and was not replaced. The Consultant Psychiatrist became AL's Care Coordinator with the main worker remaining the DCC community resource team worker (CRTW). AL, at his interview for this investigation said, "A CPN visited and said I was getting better and then he left. He probably should have been replaced".

18. At interview for the external investigation one interviewee described this as "A stand out feature of this incident was the way the "carer disappeared from the picture". We failed to protect her because we couldn't/didn't even see her."

19. During July it is documented that the CRTW tried to contact AL via the telephone without success. An appointment to see AL was finally made on the 30/7/07. Her focus continued to be on his social inclusion.

20. On the 3/8/07 and the 14/9/07 AL was seen as an outpatient by his Consultant Psychiatrist. His medication regime was to continue. He continued to be supported in the Community by the CRTW. On the 16/11/07 he was again reviewed by the Consultant Psychiatrist as an outpatient; AL's Risperidone was reduced. He saw the Consultant Psychiatrist again on the 18/1/08 and his Risperidone was reduced further. During this time he also had support from his GP and saw him on the 13/8/07, 29/1/08, and 11/2/08.

21. AL continued to progress well with on-going monitoring from the GP, and the CRTW. On the 18/4/08 he attended a further Out Patient Appointments (OPA) with the Consultant Psychiatrist where he again presented as well, no paranoid symptoms evident. His medication regime was continued.

22. On the 11/6/08 he had agreed with the CRTW to meet the staff of [5]'Stepping Stones' for further rehabilitation and on the 13/6/08 he had an OPA with the Consultant Psychiatrist. AL presented as well, no evidence of paranoia, to the extent that his Risperidone was again reduced and a plan was made to reduced his Citalopram over the next few weeks.

23. Despite how he presented to the CRTW and at his OPA it was clear from the statement given to the Police by the neighbour that JL was very concerned about his moods. A family member at interview for the external investigation reports finding pots of AL's medication and repeat prescriptions which had not been processed. AL at his interview stated that he felt he didn't need it and didn't like taking medication. Whilst there is excellent involvement of the CRW the documented focus was on reducing social isolation and not one of monitoring mood and subsequent risk.

24. On June 21/6/08 AL killed his mother on the way home from a meal to celebrate his birthday, hitting her over the head with a blunt instrument and then strangling her. Evidence from the pathologist raises a question about the sequence of events as pathology findings would suggest that he strangled JL before hitting her over the head.

25. During the external investigation it came to light via the next of kin that AL and JL were living in "squalor". A family member described it as "unbelievable, it was like going back 40 years. The general cleaning was done as best as it could have been but there was loads and loads of rubbish. The curtains were moth eaten. In AL's bedroom – he locked himself away – there was uneaten food on the floor, a single bed with no bedding".

[5] Stepping Stones supports individuals with mental or physical disabilities who wish to become volunteers.

Conclusion to section 9.1

1. In summary to this section, the assessment, care and treatment was appropriate, however there were missed opportunities to monitor AL more closely and ensure the safety of JL both when AL was an in-patient and when he was discharged home to the community. These are described in more detail as Care Delivery Problems (CDP) in table 1.

Table 1 Section 9.1 – Care Delivery Problems

Care delivery Problem
Safeguarding risks to mother not followed through by the Mental health Services There is evidence that his mother was at risk as a result of his paranoid behaviour, however this risk is lost sight of during his in-patient stay and subsequent community follow up.

Care delivery problem
AL's section 2 was revoked 4 days after its application. This allowed little time to carry out an on-going assessment of AL, in terms of both his on-going mental health monitoring and the subsequent risk potential behaviour to his mother.

Care delivery problem
Risk information not considered during his admission and on discharge. The CPA documentation does not describe the risks to the mother, should AL become unwell again, and his community care was therefore focussed on reducing his social isolation and not his potential risk behaviour.

Care delivery problem
Safeguarding information not found in Health Records. The ESM carried out on the 22/6/07 is not set out in AL's health records, although a record of this is in the WCC case notes.

Care Delivery problem
No follow up for JL following the ESM. Case workers from WCC should have followed up with a telephone call to JL once AL was discharged.

Care Delivery problem

The CPN was not replaced when the allocated one left

There was a missed opportunity for the CPN to build a relationship with AL & JL, assess AL's level of compliance with his medication, and assess his living conditions.

9.2 Was the internal investigation timely and did the methodology identify all the lessons to be learned?

1. The internal Investigation commenced in July 2008 but was suspended between August 2008 and April 2009 at the request of the Police to ensure that its process did not prejudice the prosecution. The investigation recommenced in April 2009, once sentence had been passed on AL and concluded at the end of May 2009.

2. Two internal investigators were identified, the Medical Director and the Head of Professional Practice and Quality improvement, both skilled at working at a strategic, operational and clinical level. Access to an external expert was arranged by NHS South West to support the internal processes.

3. The investigation process was overseen by an Internal Investigation Oversight Group. This was chaired by the Mental Health & Offender Health Services Director. There were clear terms of reference for the investigation.

4. The investigation process followed the guidance set out by the NPSA Root Cause Analysis Investigation.

5. Liaison and communication was a key focus, both internally with relevant staff members, the Trust Board and with external Agencies such as the Police in Wiltshire and Dorset, and local authorities' in Wiltshire and Dorset & NHS South West. A communication plan was established to ensure clear two-way communication with all stakeholders.

6. The investigation was thorough in terms of approach, paperwork review and interviews with those who had been involved in the care and treatment of AL. One omission was the GP, as he was not interviewed although the GP clinical notes of both JL and AL were reviewed as part of the investigation process.

Conclusion to section 9.2

1. The internal investigation was as timely as it was able to be given that the process had to be halted. The methodology followed the recommended NPSA process and was both thorough and robust. Section 9.3 addresses the lessons learnt.

Two points to note are:

- The Trust expressed their frustration at not being able to progress with the investigation. This created anxiety for the staff and the organisation who were committed to exploring how this event happened so that any lessons could be learnt. The Trust felt this was a significant issue and requested that it be raised as part of the external investigation. The external investigator supports this view.

- The GP was not involved in the internal investigation process, although his clinical notes were reviewed. When interviewed by the external investigator the GP reflected that he had regular training on safeguarding Children but not Safeguarding Adults. He found this a useful reflection and has now rectified this. Whilst JL did not present as a Vulnerable Adult to the GP review processes should be an opportunity for reflection and learning for all involved.

9.3 Were all key issues and lessons to be learned identified

1. The internal report covered the key issues and set them within the framework of Care and Service Delivery Problems. The specific areas the report covers is as follows:

2. Assessment of Risk –lack of involvement and recognition of JL as vulnerable also no review of early warning signs and a trigger to raise concern

3. Communication – no involvement of GP in AL's care planning; no comprehensive CPA meeting which would have enhanced communication; The CRTW was not aware of the reduction in AL's medication; AL was transferred from one ward to another during his in-patient episode but his risk was not reassessed; no broader assessment of the carers needs.

4. Records – quality of staff entries generally poor; the completion of assessments generally poor;

5. Staffing levels - in one in-patient unit regarded as low which may have contributed to poor documentation and poor assessment

6. Policies – key Policies such as the CPA process and pathway, and Mental Health Act requirements were not followed; carers assessment not carried out.

7. CPN allocation – CPN allocated as care coordinator to AL when he was discharged but had very little contact with him as he left his post. In his interview for the internal investigation he states that he advised the team Leader of the CMHT that AL would need a further Care Coordinator as he had recently been in hospital, taken an overdose, had a history of psychosis and was in early stages of recovery.

8. Allocation of another Care Coordinator – Consultant Psychiatrist allocated however did not set up CPA meeting or copy CRTW into his outpatient letters to the GP.

9. GP – in 2003 JL consulted the GP who had both AL and JL as patients. JL spoke of her concerns about AL re his mental state and that he was threatening to burn the house down. The GP notes do not indicate whether he considered a referral to the psychiatric services at the time.

10. Police – a few days before AL's admission the Police received calls from AL showing him to be clearly anxious and concerned about people in the house. The Police took no action and did not alert the Mental Health Services.

11. Two key clinical issues not identified were (1) the on-going safeguarding of JL and (2) the revoking of AL's section 2 after 4 days. Both were missed opportunities to consider and monitor AL's on-going mental illness and the subsequent the potential risks relating to JL.

12. One key service delivery issue not identified was the need to strengthen overall clinical leadership and team management to ensure both clinical and resource decisions are effective and robust

13. The Care Delivery Problems relating to the GP and the Police are considered by the internal report to be outside the scope of the investigation.

Conclusion to section 9.3

Key issues were identified within the internal investigation and lessons learnt have clearly transferred to the action plan. The external report will cover as recommendations within section 14 the following:

1. Two areas not sufficiently identified as Care Delivery Problems were Safeguarding and Mental Health Act application and management in relation to the revoking of AL's section after such a short period of time.

2. One key Service Delivery issue not identified was the need to strengthen overall clinical leadership and team management to ensure both clinical and resource decisions are effective and robust

3. Two areas identified but not taken forward to the action plan are the involvement of the GP and Police.

9.4 What progress has been made on the action plan

1. Several key leads were identified to focus on specific areas within the action plan. All were interviewed as part of the External investigation. Evidence against each recommendation and action was supplied by the key leads.

2. There is evidence that the action plan has been monitored via the governance structures within the Trust. One concern expressed by a Trust member is that post the new organisational arrangements for the Trust in April 2011 the process currently used for monitoring the action plan may be lost.

3. The measurement framework applied to the action plan is those applied by the National Health Litigation Authority (NHSLA) which uses a set of risk management standards within Healthcare Organisations. These are set at 3 levels and the principle applied to each level can be applied to the action plan progress.

These are:

Level 1 – Policy: evidence has been described and documented

Level 2 – Practice: evidence has been described and documented and is in use

Level 3: Performance: evidence has been described, documented and is working across the whole organisation

Appendix 2 sets out the findings of the action plan developed within the internal review

Conclusion to Section 9.4

1. All actions and recommendations have been progressed and using the NHSLA framework comply with either level 1 or level 2 with clear plans in place to progress the actions further. Assurance must be provided by the Trust that post the new organisational arrangements the Action Plan will continue to be monitored and progressed.

9.5 What processes are in place to embed the learning

1. Once the action plan was agreed a workshop was held for staff. This was externally facilitated and feedback shows that it was well received. There were approximately 30 staff at the event. Wider staff groups were provided with briefings and communication.

2. Ongoing learning is developed through a series of Network forums and underpinned by a Mental Health Work Programme. Each network has a focus such as:

    - Safeguarding Adults
    - Carers
    - Risk Management & Suicide Prevention

3. Each clinical area has a staff lead in a specific Network area and attends the relevant network on behalf of the team. Networks have on-going action plans which cover local/national issues and information; training and development; and where applicable links to other agencies. One area to note is that the Network relating to Safeguarding Adults only identifies links to DCC and not WCC or other boundary areas. One other benefit for a network is that any issue can quickly be disseminated to the clinical areas via the network leads.

Conclusion to section 9.5

1. DHCS provided a forum for learning from the event which covered the findings within the internal report. On-going learning is steered through the network system. This system is worthy of note as it provides both an excellent communication route as well as effective monitoring of training and development.

Notable practice

Learning is developed through a series of Network forums represented by staff leads from each clinical area. Each network has a specific focus. This provided an excellent forum for developing learning and sharing local and national issues/findings

9.6 Are recommendations appropriate and comprehensive and do they flow from the lessons learned. A summary of the identified recommendations from the internal review are:

1. Care Coordinator arrangements must be sufficiently focussed on service users with serious mental health problems

2. All staff have up to date knowledge and skills in assessing and managing risk

3. A Risk management lead to be in place for all areas to ensure robust risk management processes and training and updates in risk management

4. Individuals who move through the mental health system have clear care pathways in place

5. Ensure sufficient attention is paid to assessment, care planning and support to carers

6. Hold discussions with WCC regarding the process of follow up of Adult Protection assessment and cross boundary working.

7. Staff caseloads should be reviewed regularly

8. Multi-disciplinary and professional supervision needs to be in place

9. Medical workforce capacity needs to be reviewed in the locality

10. The staffing establishment needs to be improved for one of the in-patient units.

Conclusion to section 9.6

1. Recommendations are clear and explicit and flow from the Care and Service Delivery problems identified within the report with the exception of Leadership, Safeguarding, Mental Health Act management, and communication with GP and Police.

2. In relation to Leadership, the action plan should include a recommendation to strengthen overall clinical leadership and team management. In both the community team and the Inpatient setting this was not demonstrated as robust and effective. Whilst there is good evidence that that this has been reviewed, the organisation will need to ensure that both clinical leadership and team management remains effective and strong.

2. In relation to safeguarding, whilst there is a clear recommendation to review adult protection and cross boundary working this should be expanded to take account of safeguarding assessment and practice for all staff, this in relation to the Care Delivery Problem set out in section 9.1 of the external Investigation report.

3. With regard to Mental Health Act application knowledge and practice, the action plan should include a recommendation to ensure staff knowledge and safe practice in relation to the Mental Health Act 2007 (amended from the 1983 Act)

4. In relation to communication with the GP and Police the internal report states that this was outside the remit of the investigation. The external Investigation does not support this view and the terms of reference for the internal investigation does not preclude this. Given that both the GP and the Police held information about AL's mental state it is vital as part of learning that links are made with both to ensure that mental health awareness is highlighted.

All other care delivery problems set out in section 9.1 are addressed within the current action plan.

9.7 Risk assessment and policies – what was in place then and now.

1. There is a Risk Management Strategy which was first presented to the Trust Board in August 09. It is unclear what was in place before this time. The Strategy clearly identifies the structure to identify and address key risk issues across the DCHS. The strategy has been communicated internally to staff and externally to other agencies. An exception to this communication is WCC.

2. Risk management is a standing agenda item within the governance structure for the Trust and within the mental health services via their Quality and Practice meetings. Risk is reported to the Trust Board via the Governance minutes and the Trust Risk Register.

3. With the Mental Health services risk management is embedded via a network forum (described in section 9.5). This sets out actions relating to the key issues such as risk management and CPA.

4. All staff identified attend Risk & Safety training with the exception of medical staff who receive updates on risk via their attendance at Conferences and other fora.

5. Within the Mental Health Work Programme 2010-2011 Safeguarding Training and Risk and Safety Training is classified as mandatory. There is clear evidence to demonstrate attendance at both with the exception of medical staff who do not attend risk management training.

6. Risk assessment documentation is in place now and was in place in 2008 but not complied with as already identified. One point of note is that on the Criteria/Risk of Client for CPA or Standard Care form CR1 (04/10) MH there is a section on Safeguarding children/adult protection concerns. The questions which underpin this section however only focus on children.

7. Audit on risk assessment practice has been carried out and this is on-going with more audits planned.

8. A caseload Profiling Audit Tool is used to review caseloads and team workloads. This has an extensive section on risk factors.

Conclusion to section 9.7

1. Risk assessment and policies are clear and underpin activity relating to risk management.

2. The risk strategy should include WCC and other boundary organisations as part of its communication.

3. Medical staff should receive formal risk training so that a consistent approach to risk management is applied across the mental health services.

4. The assessment form - Criteria/Risk of Client for CPA or Standard Care form CR1 (04/10) MH should include questions relating specifically to Safeguarding Adults.

9.8 Was the communication between agencies, services, friends and family effective, this to include the sharing of appropriate risk information

1. This case involved several agencies throughout AL's lead up to and involvement in the Mental Health services. These include the Police, neighbours, JL, GP, DCHS, WCC. All held information about AL's mental health and risk behaviour.

2. Opportunities as far back as 2003 were missed to share and discuss AL and to listen fully to JL. The neighbour clearly witnessed AL's behaviour and shared her concerns with both the Police and DHCS.

3. The Police and WCC did share risk information with DHCS mental health services but this was not fully communicated between staff.

4. Inclusion of the GP at AL's CPA could have highlighted the length of time he had actually been unwell and given an insight to the level of his paranoia and subsequent risk behaviour which had been developing since 2003. This may have also triggered the need to discuss AL with JL as she had been highlighting concerns to the GP.

5. One key area is that County Councils work to geographical boundaries and Health work to GP boundaries. AL and JL lived in Wiltshire and therefore came under WCC. However their GP Practice was in Dorset. This meant that mental health staff had to liaise with WCC and normally liaised with DCC.

6. The current Dorset Safeguarding Board terms of reference has a heading - Links with other bodies. This does not include Swindon or Wiltshire Safeguarding Vulnerable Adults Alliance.

Conclusion to section 9.8

1. Communication across agencies was not effective and within the internal and external report there are examples of this. DCHS, the Police, GP and WCC all held risk information about AL and JL and opportunities were missed to share this information in a coordinated manner. Shared information was fully communicated between the mental health staff.

2. The Mental Health Services now have a strategy in place to highlight the needs of carers. Also audits on Risk assessment processes now take place. Communication between agencies is not a feature of the action plan as highlighted in section 9.6 and will be addressed within the report recommendations.

The current action plan addresses the Service delivery Problem relating to cross boundary. A review of appropriate specified links to other agencies will be recommended in section 14.

Table 2 – Service Delivery Problems in Section 9.8

Service Delivery Problem
County Councils work to geographical boundaries and Health work to GP boundaries. AL's GP was in Dorset, thus he was treated by Dorset Mental health Services. JL, who did not personally need the services of Mental Health was assessed and support by WCC. This meant that there had to be crossed boundary working. It is evident that the communication across the boundary was not effective.

Service Delivery Problem

Dorset Safeguarding Board terms of reference does not specify links to all other relevant Safeguarding Boards.

9.9 Was key information recorded then – how is it recorded now

1. The DCHS mental health service assessment framework demonstrates that there is a process for establishing key information.

2. Since 1991 there has been various Department of Health (DoH) Guidance relating to the Care Programme Approach. Each Trust is required to embed this within Mental Health Services, which is to include risk assessment and carer needs. In 2008 the Guidance was enhance to refocus CPA and to combine both the CPA and case management processes. Each Trust was required to comply with this.

3. In 2002 the DoH also launched the mental health implementation Policy Guide on Acute Adult Inpatient Care Provision which Trusts were required to comply with. Within the guidance it states:

    - Effective service user centred assessment of needs and risks must be carried out using established procedures and assessment tools for measuring symptoms, risk and social functioning. It is important that these procedures are relevant, standardised and streamlined to minimise unnecessary paperwork and protect time available for direct patient contact.

    - Risk assessment should focus not only on the inpatient care phase but should look at community living and include risks to the service user, e.g. loss of income, housing, stigma. A joint assessment between community and inpatient teams improves accuracy and comprehensiveness.

4. Whilst CPA and risk management processes were available they were not followed. This would be the vehicle for recording key information. Practice is now audited, and this will be on-going as set out in the internal investigation action plan. In the case of AL key information included his relationship and risk behaviour to JL, his uncertainty about taking medication, and his living conditions were not recorded.

5. One concern expressed by staff during the external investigation is the inability to access other Agency information systems, even when the Trust moves to the RIO system. Whilst work is being done to look at compatibility of systems this is not yet complete.

In summary to section 9.9

1. Whilst national guidance and local policies are in place key information was not recorded. However, this practice is now monitored and audited. Incompatible electronic systems will create barriers to sharing relevant and timely information and will slow down response times. Compatibility between systems is planned to be reviewed but as yet this has not commenced. A request to commence this will be recommended in section 14.

Table 3 – Service Delivery Problem – section 9.9

Service Delivery Problem
Different electronic systems across organisations – no two organisations share the same systems. Wiltshire CC, Dorset CC, AWP, Dorset PCT all have different systems so it makes accessing intra organisation information very difficult.

9.10 Does the organisation have effective communication and case management systems in place?

1. One of the recommendations' from the Trust internal report was 'All staff should have their caseloads reviewed regularly'. Appendix 2 - action plan - sets out the evidence to show current compliance with this recommendation. Via the current caseload monitoring system, caseloads are monitored and measured in terms of complexity and risk at both team and individual practitioner level. This allows team resources to be deployed more effectively, and also improves significantly the monitoring of individual caseloads.

Conclusion to section 9.10

1. The organisation has developed excellent caseload, supervision and communications systems which are monitored and audited. This process has now been rolled out across the Adult Mental Health Services. This will need further auditing to ensure it is embedded in practice. This will be included as a recommendation in section 14

9.11 Were family and friends engaged appropriately during the course of the internal investigation?

1. The terms of reference for the internal report do make reference to AL, JL and a cousin who lives elsewhere, and also about wanting to interview a known service user. It is not clear in the terms of reference the status of this statement, or the intention with regard to appropriate engagement with the cousin.

2. The Trust have stated that they contacted the family on two occasions and the Next of Kin declined contact. Friends of AL, who were at the time themselves accessing mental health services were given support. Contact with family and friends however was not noted within the minutes of the internal investigation Oversight Group or the Communication Plan.

3. The Initial Service Management Review asks the date of first contact with the victim's family if applicable. This has been completed as N/A no other family identified, where as AL does have a cousin who, whilst not local to the area, was in contact with them both.

4. There is also a neighbour who is referenced in the case notes of WCC. The neighbour was an active support to both AL and JL. There was no engagement with the neighbour during the internal investigation as the neighbour had moved away from the area. The neighbour was a police witness; therefore legal proceedings prevented an earlier interview.

Conclusion to section 9.11

1. The documented evidence does not clearly indicate that the family were considered during the course of the investigation.

9.12 Is it the case that following discharge on 2.07.07 there were no indicators of risk leading up to the homicide.

1. The focus of AL's recovery was based on reducing his social isolation and eventually getting him back to paid employment. He presented as engaged with this approach. He also presented as stable up to and including the outpatient appointment held on the 13/6/07.

2. During the week of the 13/6/08 AL confided to the CRW that he was concerned the neighbours thought he was lazy for not working. This was not communicated to the Consultant Psychiatrist. The CRTW worker was not aware that AL's medication had been reduced. This was a missed opportunity to review how AL presents when he is becoming more acutely unwell.

3. During his previous admission it was recognised by WCC that JL was at risk when AL was acutely unwell. This should have been noted as a possible risk trigger factor as part of his care programme.

Conclusion to section 9.12

1. Whilst it could not have been predicted that AL would kill his mother there was a missed opportunity to identify that AL was becoming acutely unwell and therefore carry out a fuller assessment on his compliance with medication and his behaviour at home.

9.13 Was the information disclosed by the neighbour in the few days prior to the homicide communicated to the community services and what was done with it?

1. On the 14th June JL expressed to the neighbour that she was concerned for AL. This is noted in the neighbour's statement to the police. It is stated that this concern was raised to the neighbour on the 14th June and the next time the neighbour saw them was on the day of the incident. This cannot be confirmed as part of this investigation with the neighbour as they are not contactable.

Conclusion to section 9.13

1. There is no evidence that the CRTW or the Community Services were in receipt of any concerns expressed about AL just prior to the incident.

10. Contributory/Associated Factors

1. The National Patient Safety Agency(NPSA) determines "contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care Delivery or Service Delivery problems occurring". Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence".

2. The findings of the external investigation does determine that there are several contributory factors which effected the delivery of safe and effective care to AL and JL.
   These factors are:

Patient:

1. AL had a severe and enduring mental illness. A significant factor to this was his paranoia towards his neighbours and others whom he thought were monitoring him. Within this he exhibited risk behaviours which were unpredictable and impulsive

Carer:

1. JL as the main carer was not involved in the care of AL or in the decisions about his care. This was a missed opportunity to engage with JL and ensure she could communicate any concerns she might have about AL.

Assessment Processes:

1. The decision to revoke AL's Section 2 was made after only 4 days. This did not allow enough time to fully assess AL's mental state and the subsequent potential impact of JL. It also potentially reduced the focus on monitoring AL's mental health as part of his care.

2. The Trust Protocols and Policies in relation to CPA and Risk Assessments were not followed. This led to poor and uninformed decisions about AL's community follow up which did not match his clinical needs.

3. There was no carer assessment for JL even though she fitted the criteria for one. Had she been supported there would have been an opportunity to express her anxiety about AL which could have led to a review of AL's care.

4. The safeguarding assessment was followed up WCC but JL was discharged from this very early in the process. Given that AL would be discharged back to the family home WCC should have remained involved.

Communication:

1. There was poor communication with the Police, WCC, GP, neighbour and JL. All of whom held relevant information about AL in relation to his risk behaviour and the impact on JL.

2. None of the above had been invited to care planning meetings. This was a missed opportunity to share this relevant information.

3. There was little communication between the Consultant Psychiatrist and the CRTW. The CRTW was not aware that AL's medication had been reduced so was not alert to the possibility of AL becoming acutely ill.

4. There was poor communication between WCC and the Mental Health Services. Cross boundary does present a challenge to clinicians and practitioners but this cannot become a barrier to effective communication.

Resources:

1. The decision not to replace the CPN was a missed opportunity to closely monitor AL in terms of his medication compliance, the clinical impact of reduction to his medication, his relationship and behaviour to JL, his living conditions and finally to hear of any concerns expressed by JL.

2. The decision for the Consultant Psychiatrist to be the care coordinator for AL was not appropriate given the level of monitoring AL required within his community setting.

Leadership:

1. The overall clinical and team leadership within both the community team and the Inpatient setting is not demonstrated as robust and effective. There is no evidence that documentation, risk management and clinical interventions were monitored and where appropriate challenged within a supervision or caseload management framework.

2. The North Dorset mental health team did not focus on those patients with a severe and enduring mental illness. This would have impacted on the decision to replace the CPN when the previous one left.

3. There does not appear to have been a clinical challenge to the decision to revoke AL's section 2 after only 4 days. Had his section remained in place there would have been more of an opportunity for on-going monitoring which could have led to a care programme which clearly identified AL's need for on-going clinical mental health monitoring.

11. Root Causes/Causal factors

1. The NPSA determines a root cause as "a fundamental contributory factor which if removed would either prevent or reduce the chances of a similar type of incident happening in the future". Whilst there are several contributory or associated factors, which have been identified in section 10, the findings from the external investigation has determined that there is no one fundamental contributory or causal factor. Whilst JL was vulnerable and had previously been at risk as a result of AL's impulsive risk behaviour; there is no evidence to suggest that he planned to harm her. His risk behaviour was unpredictable and impulsive, therefore it could not have been predicted that he would have killed his mother.

12. Lessons Learned

1. The internal report covered many lessons learned in relation to:

    - Clinical care and risk management and coordination
    - Communication internally and across organisations
    - Compliance with policies;
    - Records keeping
    - Staffing levels
    - CPN allocation

- Carer needs and involvement
- GP decision making process with regard to referrals to mental health services.
- Police involvement
- Team focus in relation to mental health complexity and severity

2. The findings were developed into recommendations which have been followed up as part of an action plan (see section 9.4**)**

3. The external Investigation concurs with these and the internal action plan developed from the findings, however adds:

Leadership:

1. The overall clinical and team leadership within both the community team and the Inpatient setting was not demonstrated as robust and effective. There is no evidence that documentation, risk management and clinical interventions were monitored and where appropriate challenged within a supervision or caseload management framework.

Safeguarding:

1. One key issue not identified was the on-going safeguarding of JL. This is set out as care delivery problem in section 9.1. The internal report does identify safeguarding in relation to cross boundary working; however, it is clear from the external investigation that safeguarding was not considered by the mental health staff at any point.

2. The assessment form - Criteria/Risk of Client for CPA or Standard Care form CR1 (04/10) MH should include questions relating specifically to Safeguarding Adults and not just children.

Mental Health Act Management:

1. One key issue not identified is the revoking of AL's section 2 after 4 days, which also does not appear to have been clinically challenged. Therefore the action plan should be amended to include a section on Mental Health Act management, its application, decision making and practice.

Caseload management and supervision:

1. Caseload, supervision and communications systems were not effective and did not allow for regular monitoring and review of individual cases. Whilst excellent systems are now in place across the Adult Mental Health Services, the organisation will need to ensure that further auditing is carried out to ensure they remain embedded in practice.

Involvement of Others:

1. The GP had known both AL and JL. His input to the Care Programme Approach would have been invaluable, as clearly concerns were being expressed by JL as far back as 2003. The Care Programme Approach should ensure that opportunity to input to the process is given to GPs and all other workers involved in a patients care.

2. The GP was also not interviewed as part of the internal investigation. During his interview for the external investigation he was able to reflect on GP training needs in relation to Safeguarding Adults. This was an opportunity that could have been missed had he not been interviewed.

3. The Police held information about AL which could have raised further questions about his impulsivity in relation to risk behaviour.

Cross boundary Relationships:

1. The Trust Risk Strategy does not include WCC and other boundary organisations within its section on communication. Strategy documents are significant drivers of organisational practice and as such should ensure they are both internally and externally focussed.

2. The Dorset Safeguarding Board Terms of reference has a heading - 'Links with other bodies'. This does not include either Swindon or Wiltshire Safeguarding Vulnerable Adults Alliance. A review of appropriate specified links to other agencies is required.

3. The mental health safeguarding network does not include links to WCC, only Dorset. The safeguarding network is a significant driver for raising awareness and as such must look at links to all cross boundary organisations.

Medical staff:

1. Whilst the action plan (recommendation 3) states that all staff must receive training and updates in risk, medical staff do not have formal training.

2. Medical staff should receive formal risk training so that a consistent approach to risk management is applied across the mental health services.

Information sharing:

1. Concern was expressed about the different electronic systems and the potential barrier this created in obtaining current and timely clinical information and may continue to create in the future.

Organisational Changes post April 2011

1. The monitoring of the Trust internal action plan in relation to lessons learned from this incident is carried out via the current governance system. In April 2011, when the Trust moves into a host arrangement with Dorset Healthcare University NHS Foundation Trust, the governance system may change. It would be important to seek assurance that any new governance system takes account of any current outstanding action plan with regard to ongoing monitoring and compliance.

13. Post investigation Risk assessment

1. In light of the findings from the external investigation, the post investigation risk assessment remains at 15. Whilst it is recognised that there are many lessons to be learnt from this incident, due to the unpredictability of AL's risk behaviour, AL's masking of his symptoms and the day to day behaviour towards his mother JL, the incident in all probability could not have been predicted.

14. Recommendations

Leadership:

1. The Trust action plan should include a specific action on the strengthening of overall clinical leadership and team management to ensure this remains effective and strong.

Safeguarding:

1. The Trust action plan should include a specific action on safeguarding in relation to a review of assessment documentation, staff knowledge and training, and communication with others, both internal to the Trust and externally to other agencies.

Mental Health Act Management:

1. The Trust action plan should include a specific action on Mental Health Act (2007) management. This to ensure staff knowledge, practice and application is clinically appropriate.

Caseload management and supervision:

1. The organisation will need to ensure that further auditing is carried out on caseload management and supervision to ensure it is embedded in practice.

Involvement of Others:

1. The Trust action plan should include a specific action on raising the awareness of mental health and accessibility to mental health services with other agencies such as the GP and the Police.

2. The Trust action plan should include a specific action on ensuring all involved in a patient's care are invited and given the opportunity to input to a patient's plan of care.

3. The Trust should ensure that any further internal review must take account of all those involved in the patient's care. Whilst this may be difficult because of legal proceedings it should not become a barrier to enabling learning.

Cross boundary Relationships:

1. The Trust Risk Strategy to be reviewed to take account of all organisations both within Dorset and at the boundaries.

2. The current mental health safeguarding network criteria to be revised to include links to agencies on the boundaries.

3. The Safeguarding Board Policies should be revisited to ensure they list all organisations they may link with, both within their organisation boundary and across the boundaries.

Medical staff:

1. Medical staff should receive formal risk training so that a consistent approach to risk management is applied across the mental health services.

Information systems:

1. Progress should be made on making electronic systems as compatible as possible or where this is not feasible design manual systems to overcome this.

Organisational changes post April 2011

1. Assurance must be provided by the Trust that post the new organisational arrangements the Action Plan will continue to be monitored and progressed via its governance arrangements.

15. Acknowledgements :

The investigator would like to express her thanks to;

1. The staff at Dorset Community Health Services for their responsiveness and openness to this external investigation process
2. The General Practitioner
3. The Police
4. Wiltshire County Council
5. AL for his willingness to meet with the Investigator, for his openness and candidness.
6. The Consultant Psychiatrists currently involved with AL
7. AL's cousin
8. Dorset County Council
9. AL's solicitor

NHS South West

South West Strategic Health Authority

Type C – a single investigator (with peer reviewer)

Terms of Reference for an Independent Investigation of the case of AL

1. Overall aims and Objectives of an Independent Investigation of the case of AL

- to evaluate the mental health care and treatment of the individual including risk assessment and risk management;
- to identify key issues, lessons learnt, recommendations and actions by all directly involved health services;
- assess progress made on delivery of action plans following internal investigation;
- identify lessons and recommendations that have wider implications so that they are disseminated to other agencies and services.

2. Terms of Reference

1. Review the assessment, treatment and care that AL received from Dorset Primary Care Trust.
2. Review the care planning and risk assessment policy and procedures.
3. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
4. Review the policies and procedures for individuals who have family relationships with staff members.
5. Review documentation and recording of key information.
6. Review communication, case management and care delivery.
7. Review Trust Internal investigation of the incident to include timeliness and methodology to identify:
   - whether all key issues and lessons learnt have been identified;
   - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
   - review progress made against any action plan;
   - review processes in place to embed any lessons learnt.
8. Review any communication and work with families of victim and perpetrator.
9. Establish appropriate contacts and communications with families/carers to ensure their appropriate engagement in the Independent Investigation process.
10. In addition to these general actions specific the points highlighted in the attached Homicide Assessment should be addressed.

3. Outcomes

1. A comprehensive report of this investigation which contains the lessons learnt and recommendations based on the evidence arising from the investigation.

Appendix 2

Documents Reviewed

Dorset NHS Community Health Services

- Internal Investigation (AL)
- Clinical Notes (AL)
- Risk Management Strategy
- Reporting structure for Committees for Governance, Workforce, Finance, Mental Health Act
- Policy & Procedure for Recording, Reporting and Managing Adverse Incidents
- Operational Policy for Psychiatric Liaison service
- Post Incident Learning Event - presentation by Dr Susan Connor
- Mental Assessment Form
- Recovery Plan form plus risk indicators form
- Best Practice Protocol for Carers
- Letter to Wiltshire re Cross Boundary working
- Format of Team Meetings
- Outreach and Recovery Team meeting agenda format
- Clinical team meeting format
- Mandatory Notes on Supervision Proforma
- Supervision and Management & caseload measurement tool – Implementation group TOR
- Presentation on Supervision Launch
- Supervision and Guidance – Policy Launch follow up session
- Practice Governance & Supervision Policy
- Caseload profiling Audit tool
- Caseload weighting score by team
- Caseload weighting score by practitioner
- North Dorset Locality team structure chart – current – reporting process
- North Dorset Locality team structure chart – old
- North Dorset Locality team structure chart – current
- Team Profile
- (AL) Initial management review 72 hours
- Practice and Quality groups – Decisions and Action Notes – June, July 10, Aug 10,

- Sept, Oct, Nov 10,
- Quality and Practice TOR (DEC 09)
- Patient Safety and Risk Management Group minutes – May 10, July 10
- Clinical Governance and Quality Patient Safety Agenda – Oct 10
- Clinical Governance and Quality Patient Safety Group minutes – May 10, July 10, Sept 10,
- Clinical governance Group mins - March 10
- Dr Supervision session process notes, and case presentation
- Email re reviewing medical arrangements
- Caseload profile by catchment area
- Audit of risk assessment and management in North Dorset
- Initial audit of pt journey – with regard to Risk assessment and management from inpatient to North Dorset
- Mental Health Work Programme – 2010-2011
- Press Coverage
- Risk Management Network action plan
- Risk and Safety Foundation in Mental Health training records
- Supervision and Governance Training records
- Safeguard Adult awareness training
- Safeguarding Adults network action plan
- Caring for carers action plan
- Well being and Recovery partnership Annual report

Hampshire Partnership NHS Foundation Trust

Case Summary (AL) complied by Ravenswood Medium Secure Unit – post event

Dorset County Council

Service User referral sheet

Risk Criteria assessment form

Carers Assessment Form

Safeguarding Boards Dorset and Wiltshire

Policy & Procedure for safeguarding Vulnerable Adults in Swindon and Wiltshire

Adult Protection Policy – Bournemouth, Dorset and Poole

Dorset safeguarding Adult Board Terms of Reference

Multi-Agency Safeguarding referral form

Dorset County Council and Dorset NHS Community Health Services

Joint Commissioning Strategy for Carers 2010 – 2013

Wiltshire Constabulary

Domestic Violence Referral Form (AL/JL)

Wiltshire County Council

Notes and letters regarding contact with JL and AL

Notes of meeting with DSCH re AL prior to his discharge – 22/6/07

R G – Solicitor – to AL

Consultant Psychiatrists Reports x 3

Police Statements – staff, Police, neighbours, other witnesses

Pathology report

Solicitor Court summary

NPSA

Good Practice Guidance – February 2008

CAPSTICKS

Homicide Assessment (AL)

DH

Mental health Implementation Guidance – Adult In-Patient Care Provision (2002)

Guidance on the discharge of mentally disordered people and their continuing care in the community (1994)

Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach 1999

Refocusing CPA (2008)

Recommendation	Action	Evidence	NHSLA level of Compliance
The North Dorset Community Mental Health Team need to ensure that there is sufficient focus on service users with serious mental illness and that there are clear co-ordination arrangements in place for service users who have received inpatient care and require home treatment as part of their continuing treatment.	All teams to ensure that everyone in receipt of home treatment or aftercare has a Care Co-ordinator Clinical Leads including Consultant Psychiatrist and Team leaders brief on the action plan Wellness and Recovery partnership strategic direction being implemented 10/11	• Changes to Leadership and realignment of team structures – across services – flow chart presented to show arrangements. Increased leadership via an Integrated Service Manager across all teams who reports to General Manager • Team Profile for Stewart lodge Enhanced Recovery Team • Band 6 Nurse, plus STR worker transferred to Home treatment Service • Engagement event with all relevant staff to present internal report findings – led by external facilitator • Home Treatment pathway agreed • Wellness and Recovery Partnership annual report 09/10	Level 2 - wellbeing & recovery strategy to be fully implemented during 10/11
All Staff to ensure that they have up-to-date skills and knowledge in relation to assessment including risk assessment care planning and all aspects are clearly recorded.	To audit a sample of inpatient and community files to determine standards in these areas. Areas to be audited are Minterne Ward, Stewart Lodge and the community team in North Dorset. Re audit notes by 30 September 2009	• Network Action Plan- Safeguarding Adults • Mental Health Work Programme 2010-2011 Safeguarding Training; Risk & Safety Training; training dates (DCC) • Mental Health Work Programme – medication management 10/11 • Case File/Risk assessment Audits Jan-March 09 & follow up in December 09 Further audits planned Jan-March 11	Level 2 - further audits to be undertaken

Recommendation	Action	Evidence	NHSLA level of Compliance
A risk management lead to be in place for each area to ensure to support the delivery of robust risk management processes, assessment and ensure staff receive training and updates in risk management	To identify risk leads for in patient areas, community services teams Key objectives are agreed for the risk leads Disseminate to teams identified leads and establish communication processes and information on risk to teams	• Risk strategy Policy No 796 • Reporting Structure for Risk to DCHS Board • Network Action Plan – Risk Management and Suicide Prevention - for review Jan 2011 • Criteria/Risk of Client – CPA or Standard care; **Note:** On template there is a section on safeguarding which includes Adult Protection but questions focus on Children • Clinical Risk Indicators – Adult template – **Note**: Under heading aggression there is a statement about abuse to Children/Adults – this should be separate questions • Mental Health Work Programme 2010-2011 Safeguarding Training; Risk & Safety Training; - mandatory • Risk & Safety staff training records Jan 09-March 11 • **Note:** no formal risk training for medical staff – this is carried out by attendance at Conferences etc;	Level 2 – no formal risk training for medical staff

Recommendation	Action	Evidence	NHSLA level of Compliance
Individuals who are moving through the mental health care system, which can include PICU, acute care, home treatment, outreach and recovery, have clear care pathways in place	To audit case files as above and to include whether pathways were followed. A process for monitoring care plans, review to be in place across the pathway of care from in patient-community services To audit case files as above and to include whether pathways were followed.	• Case File/Risk assessment Audits Jan-March 09 & follow up in December 09 Further audits planned Jan-March 11 • Patient tracking via team meetings – formal documented process • Psychiatric Liaison Service operational Policy 796 • Wellbeing and Recovery report 09/10	Level 2 – more audit programmes planned to fully understand effectiveness.
To ensure that sufficient attention is paid to assessment care planning and support of carers. To consider when dedicated links to carers are needed to listen to concerns as well as providing appropriate support.	Existing systems in place. Need to provide a reflective learning opportunity for staff on carers support. Carers to be involved in CPA, relapse signatures Meetings between locality staff and carers lead to be set up	• Section for carers comments in Clinical risk Indicators form • Carer assessment form • Carer Protocol – developed by carers working Group - Jan 2010 • Carers Joint Commissioning strategy – 2010-13 • Mental health Work Programme 10-11 • Caring for Carers Action Plan – Jan 2010 • Carers Network – leads identified for each clinical area **Note – need to audit effectiveness of above**	Level 1– no formal evidence to demonstrate in use and effective
To hold discussions with Wiltshire Social services regarding the process of following up adult protection assessment and cross boundary working	To hold discussions and review the process undertaken by Wiltshire Social services	• Safeguarding network – **note:** does not include links to WCC – only DCC • Letter to Team Manager Wiltshire – dated 5/11/09 addressing joint practice and responsibility	Level 1 – no formal evidence to demonstrate in use and effective

Recommendation	Action	Evidence	NHSLA level of Compliance
All staff should have their caseloads reviewed regularly.	Protocols are required for caseload review Protocol for handover Leave arrangements are reviewed Governance and supervision policy to be implemented A profile of caseloads to be undertaken and discussed and reported to lead director	• Caseload categories established – local Information system SEPIA amended to reflect this • Caseload Profiling audit tool • Caseload weighting data for individual teams and Practitioners	Level 2 – this needs further auditing to ensure it is embedded within practice
Multi-disciplinary and professional supervision needs to be in place. MD supervision should routinely apply to every case being reviewed on a monthly cycle.	To agree a set of standards for multi-disciplinary caseload supervision this will be implemented as part of the supervision policy. To undertake further work to strengthen the medical staffing supervision processes. Process in place so that all staff should have their caseload reviewed regularly.	• Supervision & Management Policy & Caseload Measurement Tool Implementation Group TOR • Practice Governance & Supervision Policy - Policy No 788 – **note** review June 2010 • Supervision Policy Launch event (presentation) • Supervision & Governance follow up event – July 10 • Mandatory Notes – supervision proforma • Clinical team meetings - group supervision proforma • Mental Health Work Programme: 10-11 • Staff training data on supervision Oct 09-Sept10 • Supervision policy & Strategy discussed at Governance Committee Sept 2010 • Supervision Process notes - Medical Staff supervision	Level 2 – in use across the Mental health Services but yet to fully evidence effectiveness

Recommendation	Action	Evidence	NHSLA level of Compliance
Review the medical workforce staffing in the sector to ensure there is sufficient capacity to respond to urgent requests.	Workforce planning for medical workforce to ensure that there is sufficient capacity for service delivery.	• Email dated 13/12/10 suggested review of prescribing role from medical staff to nurse prescriber • 0.5 WTE Speciality Doctor transferred from Central to North Locality – **note:** in place but will move forward in July 10 • Further workforce planning with aim to increase from 1.3 to 2 WTE in North Locality	Level 1 – further workforce planning to be implemented
Improve the staffing establishment for Minterne Ward, this will involve the recommendations of the psychiatric intensive care review for Minterne Ward in terms of staffing requirements.	To reduce the bed numbers from 16 to 12 based in line with national benchmarking. To re-shape leadership arrangements and to adjust the skill mix in line with the National Quality Standards for a Psychiatric Intensive Care Unit	• Bed Numbers reduced from 16 to 12 • PICU action plan • Working on service redesign across Adult Acute care systems • Enhanced care Recovery working group exploring reduction in bed numbers • Home Treatement Locality team in place as an alternative to admission	Level 2 – no evidence of effectiveness