An Independent Investigation into the care and treatment of a Service User

11 January 2013

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1.0 EXECUTIVE SUMMARY

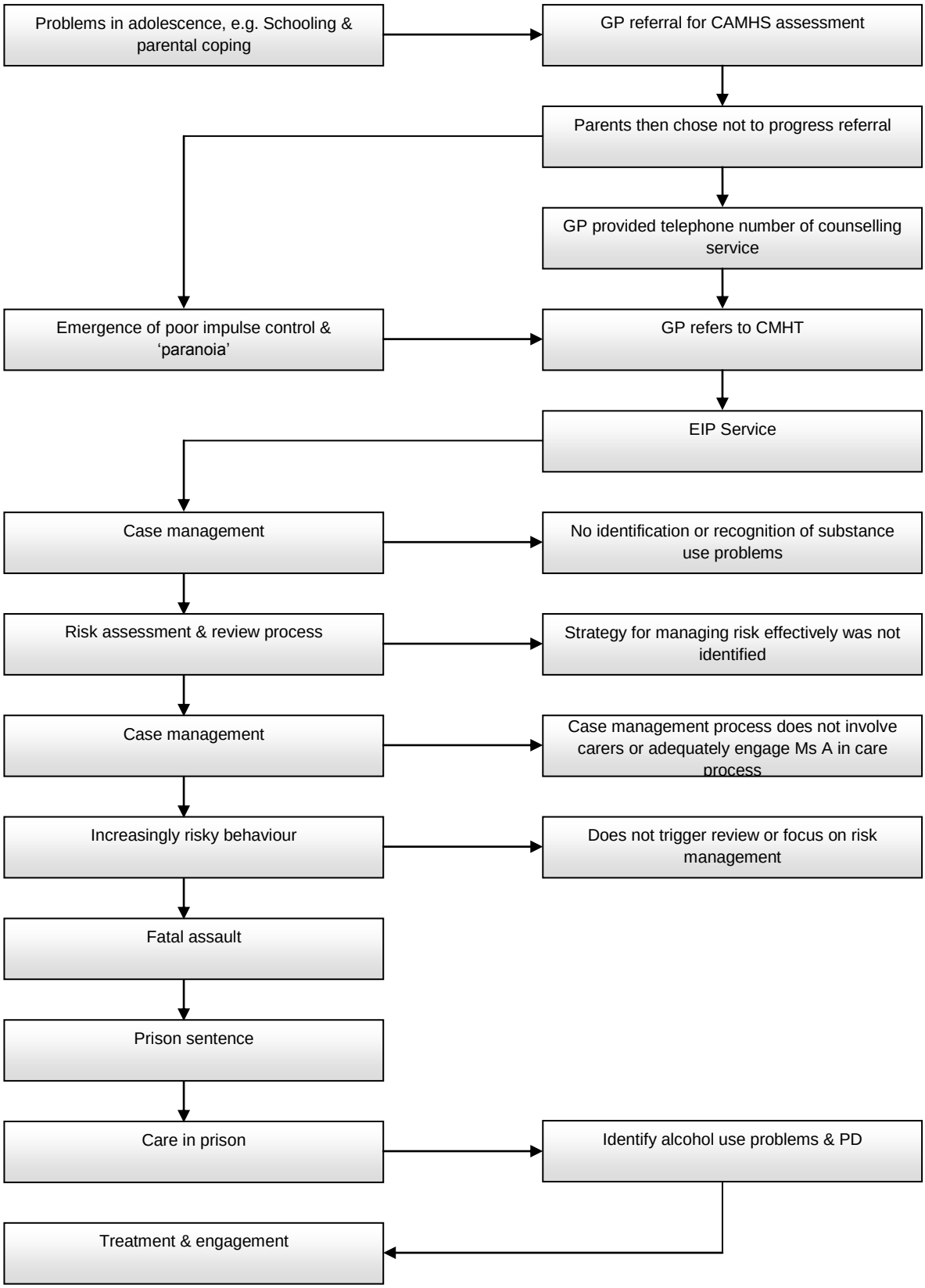
1.1 Ms A was a complex individual with a troubled history when she presented to Cheshunt CMHT in October 2007, from where she was referred to the newly re-established EIP Service in Hertfordshire ('the EIP Service'). Ms A's care from secondary services was largely delivered by the EIP Service. The EIP Service is a service which strives to provide best practice in relation to the treatment of emerging psychosis.

1.2 Ms A was an individual who, whilst displaying possible symptoms of psychosis in the early stages of her contact with the EIP Service, was also displaying characteristics which were suggestive that her diagnosis might in fact be more complex and involve other issues.

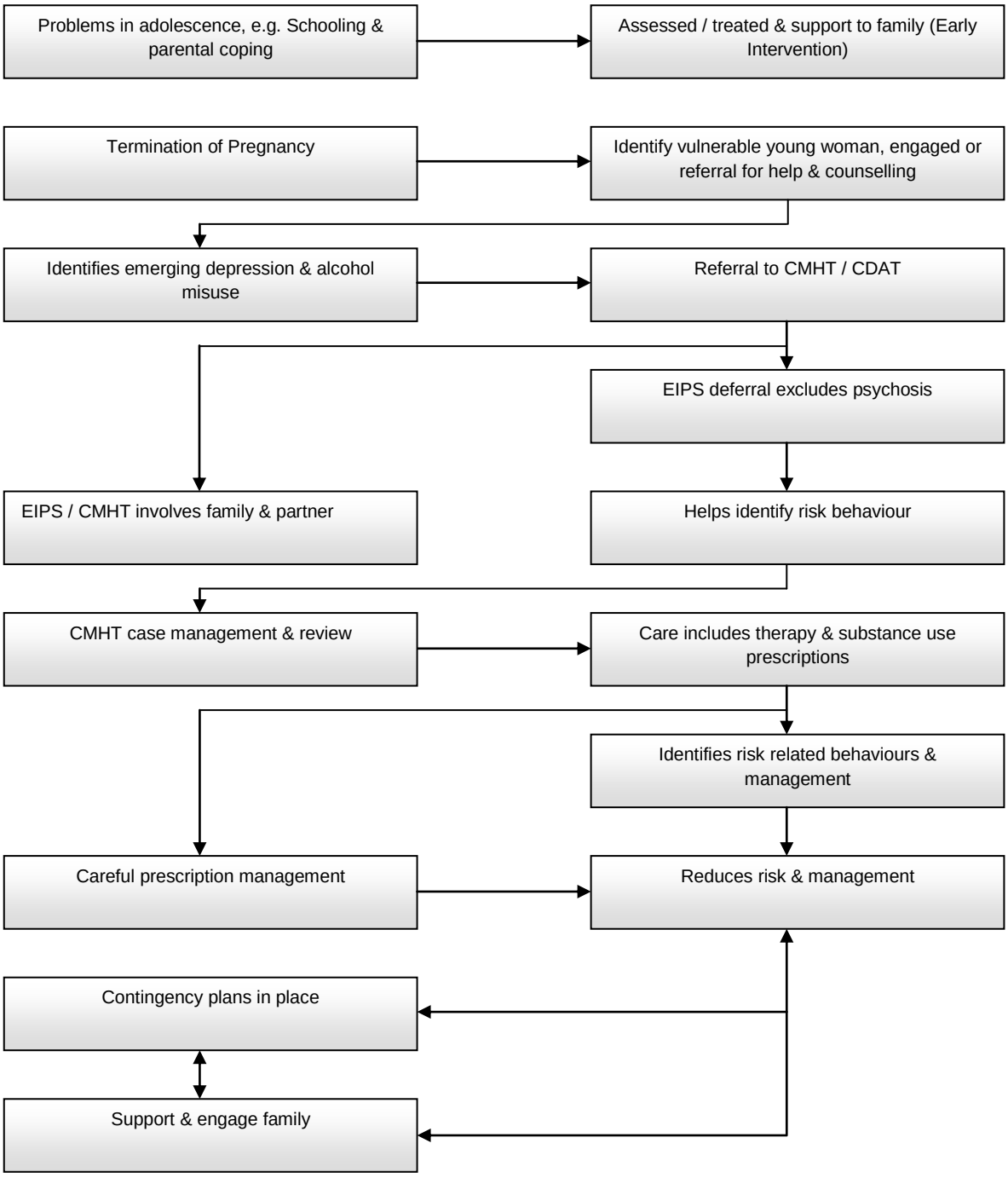
1.3 The Independent Investigation Team has concluded that Ms A's professional carers struggled to comprehensively formulate the nature of Ms A's mental health problems and prioritise the impact of substance abuse upon her various symptoms as the service was primarily orientated to the treatment of psychosis. As a service user, Ms A was visible to those providing her care. However, her treatment was not managed in terms of her posing a risk.

1.4 The Independent Investigation Team has set out below in diagrammatic format an outline of what happened in the delivery of Ms A's care. The Independent Investigation Team has also produced a diagram indicating what could have happened in the delivery of care by way of illustration.

What happened in the delivery of Ms A's Care



What could have happened in the delivery of Ms A's Care



1.5 It is the view of the Independent Investigation Team that there were a number of missed opportunities in the care and management of Ms A. Whilst these opportunities would not necessarily have made the Deceased's death predictable or indeed preventable, they do provide an important vehicle for learning in order for the NHS in Hertfordshire to improve and enhance the care which it provides to service users such as Ms A.

1.6 The root causes and major contributory factors to the missed opportunities occurring in the delivery of Ms A's care are more fully set out in the key points sections of this report. The missed opportunities arose due to a number of inter-related factors. Neither the actions of any individual nor the failure of a specific control mechanism could be said to be the sole root cause of problems in the provision of care to Ms A, but these missed opportunities raise concerns about overall quality of care. However, the cumulative effect was that despite the majority of pieces of the complex jigsaw which made up Ms A's difficulties being present at an early stage of her involvement with the EIP Service, they were simply not pieced together.

1.7 It is not the function of an Independent Investigation to place blame on any individual, but is instead to look at what has happened in order to understand what has gone wrong and how the risk of this happening in the future can be minimised.

1.8 Hindsight bias in an investigation of this nature is a constant concern for the Independent Investigation Team. It is clear that the psychiatrists involved in Ms A's criminal proceedings believed that she suffers from a personality disorder. Staff Grade 1, a psychiatrist, recognised the possibility that Ms A might have been suffering from a personality disorder. The Independent Investigation Team takes the view that there is strong evidence to suggest that Ms A had a personality disorder, given the information which she provided to Social Worker 1 and the progression of her symptoms during the course of her care by EIP Service.

1.9 However, Ms A never received any treatment for this disorder and instead was diagnosed as suffering from depression. The treatment provided was sub-optimal and not fully in accordance with NICE Guidelines or BNF recommendations in relation to depression. This has had a very significant impact upon risk assessment and reduction through appropriate psychological therapy and case management.

1.10 What is clear is that clinicians adopted an often inconsistent approach to Ms A's diagnosis. At no stage has Ms A's symptomatology been drawn together in order to understand her presentation and the significance of each of her symptoms.

1.11 Established clinical guidelines for a number of conditions were not followed. There was an over-emphasis upon providing Ms A with medication in response to her problems, as opposed to psychologically informed care and treatment. This may unwittingly have deprived Ms A of an opportunity to develop internal resources to enable her to learn how to control her anger and regulate her mood.

1.12 Ms A's presentation was complex, not least because of the disparity between what she reported to the EIP Service and their observations of her. At a number of points in her care, Ms A's case would have benefited from discussion at a multi-disciplinary review meeting or indeed as part of the Care Programme Approach ('CPA') process. This would have provided an opportunity for other members of the EIP Service to question the diagnostic formulation or otherwise review the care which Ms A was given. The Independent Investigation Team believes that such discussion would have added quality to the diagnostic process. Multi-Disciplinary Team ('MDT') meetings, if appropriately utilised, would have provided coordinating mechanisms in the diagnostic and management processes surrounding Ms A's care.

1.13 Equally, the Independent Investigation Team has concerns about whether supervision was effective in this case (see Paragraph 19.1 onwards). Hertfordshire Partnership Foundation Trust ('HPFT') has not been able to provide any supervision records relating to Staff Grade 2. She was a highly qualified clinician and was on the Specialist Register, although employed in a staff grade position at the time she was treating Ms A. However, she had not previously worked in an EIP Service and had worked in the United Kingdom for a period of less than two years. Consequently, supervision was still appropriate.

1.14 Further, a number of individuals involved in Ms A's care were at an early stage in their professional careers, or had recently joined the EIP Service for the first time. The Independent Investigation Team believes that in these circumstances a robust supervision structure was necessary to support these individuals in delivering quality care to service users. The Independent Investigation Team could not find any evidence of such a robust structure being in place at the time of Ms A's care.

1.15 In reaching its conclusions, the Independent Investigation Team noted that there were some examples of good practice present in Ms A's care.

1.16 HPFT operates an integrated electronic management system which meant that the majority of contacts with Ms A were recorded and were accessible to the MDT which delivered her care.

1.17 HPFT established a multi-disciplinary service which actively sought to recruit service users and made strenuous efforts to change the referral culture in relation to the target group of EIP Service users. Once established, the Service maintained a stable team with many members of staff responsible for Ms A's care having remained within the Service since the time of her care.

1.18 Ms A's referral to the EIP Service was speedy. Once Ms A was referred to the Service, the Independent Investigation Team notes that she was seen promptly and in domiciliary settings throughout her care. The Service adopted an assertive approach in that it sought to maintain

contact with Ms A when she cancelled or rearranged consultations. Equally, the EIP Service utilised different modalities to communicate with Ms A.

1.19 The initial consultation between the service and Ms A involved a nurse consultant and staff grade psychiatrist and thereafter a range of disciplines participated in Ms A's assessment and care. Ms A was also afforded good access to the EIP psychiatrist throughout her care. Ms A was maintained in the EIP Service for a considerable period of time, despite the fact that she did not demonstrate a clear psychosis.

1.20 The Independent Investigation Team is concerned that the supervision structure in operation at the time of Ms A's treatment remains flawed, in that the supervisee and not the supervisor determine consideration of a case. This may allow a case to slip under the radar without detection, as there is no failsafe procedure to ensure that all cases are subject to supervision. Whilst the Independent Investigation Team acknowledges that this is common practice in clinical care within the NHS, it does not provide a secure foundation that ensures all of a supervisee's cases are discussed with supervisors on a regular basis.

1.21 A further concern which the Independent Investigation Team has is the lack of involvement of members of Ms A's family and friends as carers in Ms A's life. The EIP Service had a number of opportunities to meet members of this group. However, it consistently failed to involve them and include their views in Ms A's care.

1.22 The purpose of an Independent Investigation conducted in accordance with HSG (94) 27 is to identify any learning relating to the delivery of care to service users which arises from a homicide involving a mental health service user.

1.23 Following submission of the Independent Investigation Team's report to HPFT, the Trust was able to provide the Independent Investigation Team with an outline of some of the steps which it had taken to improve the quality and safety of the EIP Service since 2008 and in doing so address some of the concerns highlighted by the Independent Investigation Team. The Independent Investigation Team has not reviewed the effectiveness of the actions taken by HPFT.

1.24 The Independent Investigation Team also had an opportunity to work with HPFT and members of the EIP Service to discuss the care of Ms A and gain experience of an individual with a presentation similar to Ms A.

2.0 INTRODUCTION

2.1 Iodem Health Limited was commissioned by the East of England Strategic Health Authority to conduct an Independent Investigation to examine the care and treatment of Ms A.

2.2 On 20th September 2008, Ms A fatally stabbed her boyfriend (the 'Deceased'), at her flat in Cheshunt. At the time of the offence Ms A was 19 and the Deceased was 20 years old. A post-mortem examination revealed that the Deceased died of a single stab wound to the left side of his chest. His injuries were sustained during the course of a violent argument with Ms A. The Deceased had discovered that Ms A had had sexual intercourse with his brother. The relationship between the Deceased and Ms A had been turbulent. Blood specimens showed that both Ms A and the Deceased were over the legal alcohol limit for driving and that the Deceased had taken cocaine in the hours leading up to his death. Ms A had also taken drugs in the period leading up to the Deceased's death.

2.3 Ms A pleaded guilty to the offence of manslaughter due to diminished responsibility. She was sentenced on 18th January 2010 to a total of 7 years and 247 days. Ms A will remain on licence for ten years following her release. Ms A had been receiving care from Hertfordshire Partnership Foundation NHS Trust ('HPFT') at the time of the Deceased's death.

2.4 In accordance with HSG (94) 27 (amended in 2005), under Department of Health guidance, Strategic Health Authorities ('SHAs') are required to undertake an independent investigation:

> *'When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event';* or
>
> *'When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights. Whenever a state agent is or may be responsible for a death, there is an obligation for the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.'*

3.0 INVESTIGATION TEAM

3.1 Iodem Health Limited ('Iodem') undertook the Independent Investigation.

3.2 The Independent Investigation was carried out by the following three individuals who are unconnected with Hertfordshire Partnership NHS Foundation Trust (the 'Trust') and the East of England Strategic Health Authority (the 'SHA'):

- Janet Hawthorne LLB (Hons) - Lead Investigator, Regulatory Lawyer.
- Dr David Ward - Consultant Psychiatrist, Early Intervention in Psychosis and CAMHS Northumberland, Tyne and Wear NHS Foundation Trust.
- Mr Paul Veitch - Nurse Consultant, Stepped Care Services Planned Care Group Northumberland, Tyne and Wear NHS Foundation Trust.

3.3 Biographies of the members of the Independent Investigation Team are attached at Appendix **A**.

4.0 PURPOSE OF INVESTIGATION

4.1 Independent Investigations conducted in accordance with HSG (94) 27 are entirely separate from the legal processes that take place following a homicide. The aim of these investigations is not to investigate the circumstances of the offence, but to enable the providers of care to learn lessons and make improvements for the benefit of future service users, their carers and the public. Very few service users receiving NHS treatment for mental health problems are a danger to other people, and the fact that a service user commits a criminal offence does not necessarily mean that their mental health led or contributed to them committing it.

4.2 Consequently, the principal purpose of the Independent Investigation into the care of Ms A was to provide NHS East of England with clear recommendations about what action it needs to take to maximise any learning from this case, and ensure that it is used to improve mental health services across Hertfordshire.

5.0 TERMS OF REFERENCE

5.1 The following Terms of Reference were agreed with the SHA for the Independent Investigation. It was envisaged that the Independent Investigation was to be carried out in two stages and conducted in accordance with the National Patient Safety Agency Good Practice Guidance for Independent Investigations. The full Terms of Reference of the Independent Investigation are set out at Appendix **B**.

Stage 1

Following the review of clinical notes and other documentary evidence:

- Review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and Action Plan.
- Review the progress that the Trust has made in implementing the Action Plan.
- Agree with the SHA any areas (beyond those listed below) that require further consideration.

Stage 2

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of her offence.
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Review the whole patient pathway with particular attention to the transfer of care points.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Consider any other matters arising during the course of the investigation, which are relevant to the occurrence of the incident or might prevent a recurrence.
- Provide a written report to the SHA that includes measurable and sustainable recommendations, ensuring the recommendations are relevant to the present day and take account of any changes made by the Trust following their own internal investigation.

6.0 METHODOLOGY

6.1 During the initial stages of the Investigation, the Independent Investigation Team gathered a significant amount of documentary evidence relating to Ms A. The following documentary information and records concerning Ms A's care were obtained:

- General Practitioner records;
- Clinical records maintained by HPFT;
- HPFT Policies and Procedures relevant to Ms A's care;
- Marie Stopes International records;
- Cheshunt School summary records;
- Psychiatric reports and witness statements compiled during the course of criminal proceedings involving Ms A.

6.2 These documents were used to form the basis of the Independent Investigation and plan subsequent interviews with key participants in Ms A's care.

6.3 The Independent Investigation Team was able to interview the main participants in Ms A's care. A total of 15 witnesses were interviewed by the Independent Investigation Team. A list of interviewees is attached at Appendix **C**.

6.4 Interviews were held between 13 June 2011 and 4 November 2011. Prior to the interview, each witness received a letter from the Investigation Team Leader explaining how the interviews were to be conducted. Each interviewee was provided with a copy of the Independent Investigation's Terms of Reference and a bundle of relevant documentation prior to the interview. Interviewees were afforded an opportunity to be accompanied by a colleague or friend for support.

6.5 Each witness interview was attended by the Investigation Team Leader together with one other member of the Independent Investigation Team. To ensure the interviews were targeted, credible and sensitive, the expertise of the Investigation Team member was linked to the area of work and expertise of the interviewee. For example, a Consultant Psychiatrist attended all medical interviews.

6.6 The interviews were transcribed from NEAL recording equipment. Following their interview each interviewee was given a copy of the transcript of their interview and was asked to correct any errors of transcription or to add anything they felt had been omitted. The transcripts were then sent to all Independent Investigation Team members to review.

6.7 Following the interviews, the Independent Investigation Team met to discuss and review the information gathered, identify and analyse the issues and prepare its report.

6.8 The Independent Investigation Team then undertook steps to ensure the factual accuracy of the report involving HPFT and individuals who provided care to Ms A.

6.9 In addition, HPFT was able to provide the Independent Investigation Team with an outline of some of the steps which it had undertaken to improve the quality and safety of the EIP Service since 2008. The Independent Investigation Team has not reviewed the effectiveness of these actions.

6.10 The benefit of hindsight can introduce unfairness into any investigation. Hindsight bias occurs when people who know the answer overestimate its predictability or obviousness, compared to the estimates of those who must guess the outcome without advance knowledge. The Independent Investigation Team has remained acutely aware of the danger of hindsight bias throughout the investigation and has tried to recognise its impact and correct it when possible.

6.11 In carrying out this investigation, the Independent Investigation Team has taken care to remain objective and impartial, whilst being mindful throughout of the devastating impact that this violent offence has had upon those most closely involved with it.

7.0 INVOLVEMENT OF THE DECEASED'S FAMILY AND PERPETRATOR

7.1 Involvement of Ms A

At the start of this investigation, Ms A was contacted by the East of England Strategic Health Authority in order to obtain her consent for the Independent Investigation Team to access her clinical records. On 14 October 2010, Ms A signed a consent form giving the Independent Investigation Team full permission to access her clinical records.

7.2 Communication with the Deceased's family

7.3 The Investigation Team Leader wrote to the Deceased's family at the outset of the Independent Investigation to explain the purpose of the Independent Investigation and provide them with a copy of the Terms of Reference. It was proposed that the team meet with the family to discuss their desired level of involvement within the Independent Investigation. The Independent Investigation Team did not receive a reply from the Deceased's family and therefore the Investigation Team Leader wrote to them again on a number of occasions.

7.4 Having heard nothing from the Deceased's family, the Investigation Team Leader made a series of telephone calls to members of the family including the Deceased's aunt and brother. The Independent Investigation Team was advised that a key member of the Deceased's family was currently suffering from ill-health. Offers to meet to discuss the Independent Investigation were not taken up.

7.5 Further attempts to engage with the Deceased's family were made throughout the Independent Investigation without success.

7.6 Communication with Ms A's family

The Investigation Team Leader met with members of Ms A's family on 13 June 2011. The Investigation Team Leader subsequently maintained contact with Ms A's mother throughout the Independent Investigation.

8.0 CHRONOLOGY

8.1 The following chronology is drawn from Ms A's school and GP records and highlights records that the Independent Investigation Team considers to be key. Entries in the records have been summarised. The chronology covers the period between 29 June 2000 and 30 September 2008.

8.2 The chronology has colour-coding to indicate where Ms A cancelled appointments (Red) and where medical or other professionals cancelled appointments (Blue).

8.3 The following is a list of people that were involved with Ms A during the period mentioned above, along with their particular role or job position.

TABLE 8.1

Initials	Job Role / Position Held
Team Leader 1	Team Leader, EIP Service
Social Worker 1	Social Worker, CMHT
Social Worker 2	Social Worker, EIP Service
Social Worker 3	Social Worker, EIP Service
Consultant 1	Consultant Psychiatrist, EIP Service
Staff Grade 1	Associate Specialist, EIP Service
Staff Grade 2	Associate Specialist, EIP Service
EIP Manager	Manager, EIP Service
Psychiatric Nurse 1	Psychiatric Nurse, EIP Service
Psychiatric Nurse 2	CPN, Crisis Assessment and Treatment Team (CATT)
Team Manager 1	Team Manager, CMHT
Community Services 1	Joint Head of Community Services, EIP Service
Service Manager 1	Service Manager, CATT
GP 1	General Practitioner

Service Administrator 1	EIP Service Administrator

Event Date	Nature of event	Details of event
29 June 2000	GP Consultation	Ms A in Year 6 at Flamstead Road Primary School. School refusal. Ms A had been allocated a place at Cheshunt School rather than St Mary's which is where her friends had obtained a place. Her GP notes state that Ms A *'needs a letter to help with the appeal to Goff's or St Mary's'*. There is also a reference to inter-personal difficulties which Ms A had with members of the teaching staff.
05 July 2000	GP Correspondence	Letter from Ms A's GP to Education Panel in support of Ms A's appeal with regard to her allocation of a place at Cheshunt School. Ms A was said to be unhappy about the allocation of a place at Cheshunt School because her friends had been allocated places at Goff's or St Mary's and she would not know anyone at Cheshunt. The letter states: *'She has become very distressed about the situation and has not actually been going into class with her schoolmates, as she is so upset. Ms A is extremely disappointed and has become very unsettled to the point of becoming rather depressed and withdrawn. If it is at all possible to allocate her a place at Goffs school, I am sure this will help'*
21 July 2000	GP Consultation	Ms A was noted to be suffering from insomnia. Ms A remained worried about allocation of school place. GP prescribed Vallergan.
16 October 2000	GP Consultation	Ms A was noted to be suffering from insomnia. Ms A still not at school and was still trying to get a place at Goff's School or St Mary's. Ms A was noted to be wanting to sleep with her parents every night. GP prescribed Trimeprazine Tartrate syrup.
05 June 2001	GP Consultation	Ms A having problems with sleeping. Ms A refusing to share a room with her sister and was continuing to sleep with her parents.
07 June 2001	GP Correspondence	Letter from Ms A's GP to Housing Department in support of an application for the family to be allocated a three bedroomed house. The letter states: '*One of the main concerns is that Ms A has had problems with sleeping over the last year or two and is unable to sleep in a room that she is supposed to share with her sister. She therefore has a tendency to stay in her parents room, which is*

Event Date	Nature of event	Details of event
		obviously causing disruption in the sleeping arrangements at home. Ms A has expressed a desire to have her own room, where she thinks she will be able to sleep without resorting to going into her parents room. She has had a lot of emotional problems over the last few years and difficulties at school also.'
26 November 2001	GP Consultation	GP consultation notes state that Ms A suspended from Cheshunt School. Ms A has been separated from friends and put in classes on her own. Ms A tends to get the blame for all problems at school. Ms A back-chats the teachers and argues non-stop with her father. Ms A sleeps in same room as her parents as she is worried that someone will come in. Ms A picks on her younger sister.
28 November 2001	GP Correspondence	Letter from Ms A's GP to CAMHS in Hoddesdon. Letter provided a detailed history which included the following: Increasing behavioural problems over past few years Suspended from school In trouble with teachers for back-chatting Argues with her father non-stop due to possible clash of personalities At the age of 12 she is still sleeping in the same room as her parents and they are unable to get her to sleep in her own room. Ms A says she is worried someone will come into her room. Ms A's behaviour is becoming increasingly oppositional and her parents and teachers are finding it difficult to deal with her.
07 December 2001	CAMHS Correspondence	CAMHS respond to referral advising GP of a 26-week waiting list.
20 June 2002	Correspondence	CAHMS: Letter to GP. Appointment offered 26 July 2002.
26 June 2002	Correspondence	CAHMS: Letter to GP. Parents cancelled appointment. Ms A removed from waiting list.
19 December 2003	School records	After-school event. Intimidation and bullying of member of staff outside school. Permanent exclusion following a number of exclusions for varied reasons including disruptive behaviour, bullying, abusive behaviour to staff and pupils.

Event Date	Nature of event	Details of event
30 January 2006	GP Consultation	Pregnant. Requested termination. Referred to Marie Stopes Clinic.
21 March 2006	Marie Stopes Clinic	Termination of pregnancy. Pregnancy dated 17 weeks. Ms A received injectable contraception and stated she would attend GP for future contraceptive advice.
11 October 2006	GP Consultation	Seen in GP's emergency clinic. Ms A complaining of insomnia, poor appetite, persistent low energy and mood. No enthusiasm. Diagnosis was that of a moderate depressive episode. Medication prescribed: fluoxetine hydrochloride capsules 20mg.
31 October 2006	GP Consultation	Ms A reviewed - remained depressed. However was feeling better and her appetite had improved. Ms A was told to continue taking her medication.
21 November 2006	GP Consultation	Ms A attended GP surgery still feeling depressed despite medication. Advised to see own GP.
01 December 2006	GP Consultation	Ms A attended GP surgery complaining of depression. Short-term diazepam prescribed. Ms A to be reviewed in 4 weeks and if no improvement, her antidepressant would be changed.
11 December 2006	GP Consultation	Fluoxetine not helping depression. Loss of appetite & poor sleep. Lives with friend as doesn't get on with father. Trying to get a job. No alcohol or smoking. Still has chesty cough with green phlegm.
25 January 2007	Consultation	Fluoxetine no help. Poor sleep. No suicidal ideas. Depressed. Medication prescribed: amitriptyline hydrochloride tablets 10mg.
21 May 2007	Consultation	Ms A attended GP surgery. Referred to GP 1 because Ms A unwilling to talk about her depression with another GP.
23 May 2007	Consultation	Ms A attended GP complaining of panic attacks and not sleeping well. Ms A wanted to postpone period on holiday. Prescribed amitriptyline hydrochloride tablets 25mg, norethisterone tablets 5mg.

Event Date	Nature of event	Details of event
12 July 2007	Correspondence	Letter from A&E: Ms A underwent a pelvic scan which revealed a pregnancy.
23 July 2007	Marie Stopes Clinic	Termination of pregnancy. Pregnancy dated 11 weeks and 4 days. Ms A received injectable contraception and stated she would attend GP for future contraceptive advice.
14 September 2007	Consultation	Ms A moved into a hostel. Ms A still sees her boyfriend. Ms A still depressed. Ms A prescribed dosulepin capsules 25mg. GP felt Ms A needed anger management. Ms A referred to Cheshunt CMHT.
24 September 2007	Correspondence	GP referral letter to Cheshunt CMHT: '*I should be most grateful for your help with this 18 year old girl. For approximately one year now she has been seen at the surgery with depression and more recently she has mentioned that she is suffering from paranoid ideas associated with angry outbursts. She has been quite physically aggressive mainly towards her boyfriend and this behaviour is exacerbated when she has had a drink of alcohol.* *She has tried various antidepressants but fluoxetine did not help and she has been taking amitriptyline. Again this is not helping her low mood. I started her on a course of dothiepin. She has a poor sleep pattern but has reasonable appetite and eats well. She denies any suicidal ideas. She is a non-smoker and does not use recreational drugs. She has also recently had a TOP* [Termination Of Pregnancy] *which may have exacerbated her depressive symptoms.* *She is becoming increasingly concerned about her paranoid ideas and thinks that when she is out people are looking at her and talking about her which makes her feel very angry. She tends to lash out either verbally or physically which has been getting her into trouble.* *She lives in a hostel. Up until a few months ago she had been living with her grandmother. She left home at a young age as she had a poor relationship with her father although she has some contact with her mother and sister.* *Her relationship with her boyfriend is suffering as a result of her mental state and behaviour. We have tried to treat her with antidepressants and seen her on several occasions to talk to her about her problems but I feel the situation is deteriorating and her mental state is becoming more unstable*.'
03 October 2007	Cheshunt CMHT	Ms A seen by Social Worker 1 at Cheshunt CMHT and referred to EIP Service. CPA and Needs assessment completed.

Event Date	Nature of event	Details of event
05 October 2007	EIP	EIP Triage undertaken. Discuss in team meeting on Monday if assessment is planned.
11 October 2007	Correspondence	Appointment letter sent by EIP Service suggesting appointment on 17 October 2007 at Ms A's home.
17 October 2007	Home Visit	Consultation with Psychiatric Nurse 1 and Staff Grade 1 at Ms A's mother's home. Ms A's presentation was that of a mild to moderate depressive episode. Anxiety and obsessional traits can be explained in that context. No clear cut psychotic features, unstable work record, self-harming and anger issues may indicate underlying personality difficulties. Ms A was accepted for care by EIP Service. Prescribed sertraline 50mg od to start with.
29 October 2007	Home Visit	Visit by Social Worker 2 and Team Leader 1 to Ms A's hostel. PANSS completed. Ms A low in mood. Ms A advised to attend GP for blood tests. Ms A reported getting into fights with strangers. Ms A reported difficulties in trusting people. Ms A had been verbally and physically abusive to boyfriend. Ms A reported long standing anger problem and that she didn't always know what she was doing when angry. Ms A reported thinking that people were talking about her. Ms A reported she spent time with children, her friends and the Deceased.
01 November 2007	Telephone	Ms A called the EIP office to rearrange meeting as she had a doctor's appointment. Further appointment made for 07 November 2007.
07 November 2007	Home Visit	Visit by Social Worker 2 and Team Leader 1 at Ms A's hostel. Ms A's friend present. Ms A discussed medication (antidepressants), reported that her main problem was wanting support with her anger; she described an incident where she had wanted to glass her boyfriend. Anger and anger management were discussed further and she stated that a previous referral for anger management was beyond her finances as she was on income support. Ms A acknowledged that anger was a long standing problem and caused difficulties for her at school and with her father. Plan: Monitor meds and mental state for next 6 weeks Consult with team re: anger management, support for anger Ms A to keep anger diary Look at structure of Ms A's day in new year when stabilised on meds
12 November	Telephone	EIP received a telephone call from Ms A to report that her GP not received letter from Staff Grade 1 regarding prescription of sertraline. Letter faxed to GP.

Event Date	Nature of event	Details of event
2007		
15 November 2007	Telephone	EIP received a telephone call from Ms A. Ms A reported starting sertraline on 14 November 2007 but was concerned that product information said no alcohol to be taken. Ms A would wait for advice from Staff Grade 2.
19 November 2007	Home Visit	Home visit by Social Worker 2 and Team Leader 1. Ms A reported that she had been taking her medication as prescribed for one week and had noticed no side effects or change in mood. Ms A was advised that the effect on mood would take 4-6 weeks. Ms A had completed anger diary as requested. Ms A given anger management worksheets and Social Worker 2 looked at Firework anger management model with Ms A, asked Ms A to continue anger diary. Discussed Ms A's anger history further. Ms A revealed that anger had always been a problem and was the reason she didn't live with parents anymore. Ms A reported being angry with teachers.
20 November 2007	Telephone	Telephone call from Ms A Appointment rescheduled for 27 November 2007 as Ms A has hospital appointment on 22 November 2007.
27 November 2007	Telephone	Ms A to inform her that Staff Grade 2 off sick today. Ms A was taking the sertraline and had not noticed any increased feelings of anxiety. Ms A had hit boyfriend this week. Appointment arranged for 03 December 2007.
07 December 2007	Home Visit	Home Visit to Ms A with Social Worker 2 and Team Leader 1. Reported taking sertraline as prescribed. Ms A was asked about her TOP. She said it was right decision but had felt pressure from boyfriend's mum. Ms A had not noticed effects aside from increased sleeping. Ms A has lost her anger diary. Ms A was continuing to get angry on daily basis and had hit boyfriend last week. Ms A took approximately 2 hours to calm down. Ms A reported that she had made attempts at using anger management techniques.
10 December 2007	Telephone	Telephone call to Ms A to inform of appointment with Staff Grade 2 on 20 December 2007. Ms A stated she was not completing anger diary as she did not want to anymore. Ms A was advised that EIP could only offer suggestions to help her.
17 December 2007	Telephone	Telephone call from Ms A cancelling appointment. Confirmed that Social Worker 2 would see her with Staff Grade 2 on 20 December 2007.

Event Date	Nature of event	Details of event
20 December 2007	Home Visit	Home visit Staff Grade 2 and Social Worker 2 to Ms A. Staff Grade 2 assessed Ms A. Paranoia stemmed from social anxiety disorder rather than psychosis and possible OCD. Sertraline increased to 200 mg per day. Prescription supplied. Possibility of side effects mentioned. Ms A asked to compile a list of checking and washing rituals. Ms A suffers from social anxiety and OCD rather than psychosis. Increase sertraline to 200 mg, with low dose of AP as back up.
02 January 2008	---	Initial care plan completed by Social Worker 2.
07 January 2008	Telephone	Text from Ms A unable to meet today as needs to go to job centre to sort out benefits. Message left on Ms A's phone suggesting further appointment.
09 January 2008	Telephone	Telephone call to Ms A - arranged to meet on 18 January 2008.
18 January 2008	Home Visit	Home visit by Social Worker 2 to Ms A. Taking sertraline as prescribed and experienced some side effects, loss of appetite and more drowsy in mornings. Anger much the same. Ms A argued with partner and hit him last week. Ms A also reported shouting at strangers.
24 January 2008	Correspondence	Letter from EIP to Housing Services to support Ms A's request for a smaller ground floor flat.
30 January 2008	Telephone	Telephoned EIP regarding her housing needs.
05 February 2008	Telephone	Telephone call to Ms A. Ms A had accepted housing offer and moving in next week. She was being supported in this by her family. Ms A reported that her medication was not having effect on OCD symptoms or anger. Ms A was advised that 3 months are required before effects are noticed. Happy to continue with medication.
08 February 2008	Telephone	Meeting with Ms A cancelled – unclear why.
22 February 2008	Home Visit	Social Worker 2 and Staff Grade 2 home visit to Ms A. Ms A moved into housing association bedsit and settled in. Family supportive of her. Ms A happy with her living situation and had met neighbours. Grandmother lives close by. Feeling reduced

Event Date	Nature of event	Details of event
		paranoia and less violent behaviour though still getting angry on very regular basis. Hand washing decreased in last week or so. Prescription given for risperidone to take alongside sertraline.
28 February 2008	Text Message	Text from Ms A to rearrange appointment.
04 March 2008	---	Ms A case entered into CPA “system”.
07 March 2008	Home Visit	Home visit to Ms A by Social Worker 2. the Deceased present. Ms A reported some improvement in anger, feels that she is getting angry less frequently, not as intense and subsides quickly. the Deceased in agreement with this assessment. Positive about changes. Some paranoia, bothered by OCD symptoms. GP has not increased sertraline, despite receiving letter from Staff Grade 2. Ms A thinking of doing apprenticeship in local nursery. Social Worker 2 sent a fax to GP requesting increase in medication.
27 March 2008	Telephone	Call from Ms A. Advice given to Ms A concerning what to say at benefits medical.
10 April 2008	Telephone	Telephone call to Ms A. Ms A reported that she was well and no concerns and was staying with family in Essex. Appointment arranged.
15 April 2008	Text Message	Text message from Ms A to cancel appointment as one of her partner’s relatives had died.
22 April 2008	---	Ms A cancelled her appointment with Staff Grade 2 and Social Worker 2 as she was attending funeral. Appointment with Social Worker 2 made for 30 April 2008.
30 April 2008	Text Message	Text from Ms A cancelling her appointment as she had been arrested in a friend’s car and had to go and see her mother and explain what had happened. Appointment rearranged for 02 May 2008.
02 May 2008	Home Visit	Home visit by Social Worker 2 to Ms A. Ms A reported that for past 2-3 weeks she has been low in mood, increased agitation, poor concentration, wanting to be on own. Feeling tearful and feeling of unease. Denied feeling suicidal or self harming. Ms A unaware of triggers. Ms A was taking

Event Date	Nature of event	Details of event
		200 mg sertraline each morning but not taking 0.5 mg risperidone as she had had difficulty getting it from her GP.
09 May 2008	Home Visit	Home visit - Staff Grade 2 and Social Worker 2. Ms A remains low in mood, energy and motivation. Ms A "paranoid". She believes people look at her and judge her. Very snappy towards boyfriend. Plan was sertraline to 200mg and risperidone 2 mg (daily). According to response – possible to increase up to 4mg after 2 weeks. If this medication will not bring an effect in 1 month, Staff Grade 2 to change AD medication. Ms A agreed to recommence risperidone 2 mg for one week then increase to 4mg in addition to sertraline. Prescription provided.
14 May 2008	Home Visit	Letter to GP from Staff Grade 2 regarding consultation with Ms A on 09 May 2008.
16 May 2008	Text Message	Text from Ms A cancelling appointment because Ms A was unwell. Unable to contact Ms A on phone.
21 May 2008	Telephone	Telephone call from Social Worker 2 to Ms A. Ms A unwell with pleurisy. Agreed to meet on 28 May 2008. Ms A has commenced 2 mg risperidone. No side effects experienced. Therefore Ms A has agreed to increase to 4 mg as planned.
09 June 2008	Text Message	Text from Ms A cancelling appointment stating that she had emergency and could not make it. Texted back offering appointment later in the week.
16 June 2008	Text Message	Text message from Ms A cancelling meeting due to family emergency. Appointment offered for 20 June 2008.
20 June 2008	Telephone	Telephone call from Ms A's friend cancelling appointment as Ms A says feeling too low to see anyone. Social Worker 2 tried to contact Ms A by phone. No answer. Message left offering appointment next week and suggesting Ms A seek help via GP/ helpline if required over weekend
24 June 2008	Home Visit	Home visit to Ms A by Social Worker 2. Ms A low in mood, low motivation, increased sleeping, decreased appetite, very anxious a lot of the time. Ms A could not identify triggers. Ms A had been like this for some time. Ms A having thoughts of suicide but Ms A clear that no intention to act

Event Date	Nature of event	Details of event
		on thoughts. Ms A did not think medication working. Becks depression inventory = 34 (severe depression). Becks anxiety inventory = 36 (high anxiety). Ms A planning to go on holiday but was not sure if she wanted to go. Ms A agreed to see Staff Grade 2 on return from holiday.
30 June 2008	Home Visit	Staff Grade 2 and Social Worker 2 met with Ms A and her mother after telephone call from Ms A's mother requesting an urgent appointment. Appointment was arranged from same day. Ms A's mother was very concerned about Ms A's mental state and called the helpline over weekend. Ms A had not gone on holiday. Ms A low in mood, reported an increase in anxiety symptoms and aggressive behaviour. She reported feeling out of control and tearful. She had thoughts of suicide but no current plans. She also stated she had self-harmed. She had had a blackout during which she had hit friends and got into a fight in the street with a stranger. She had a male voice in her head telling her to do things and laughing at her, saying that she would not get better. Ms A denied alcohol that day but had had 2 alco-pops the day before. Possibility CATT intervention discussed but not felt appropriate at that time. No psychotic symptoms present. Staff Grade 2 was of view that described symptoms of possible "epileptic equivalent – absence". Quite irritable in last weeks, among her triggers are also colours (red colour). Low in her mood, with anxiety irritability, pessimism, feeling of guilty. Risk and Needs assessment carried out. CPA Review carried out. Ms A's medication changed from sertraline to venlafaxine. Medication plan – reduce and stop sertraline over next 7 days (start 3 days 37.5 mg, 7 days 75 mg, if needs to increase to 150mg) over next 2 weeks. Discontinue risperidone and commence olanzapine 2.5 mg from today. Lorazepam prn for 2-3 weeks while venlafaxine gets into system.
02 July 2008	Telephone	Ms A reported that she was feeling a bit better. Her mood improved and her anxiety was less difficult to cope with. She had started her new medication arranged.
07 July 2008	Home Visit	Home visit Social Worker 2 and Ms A. Ms A feeling calmer and appetite had returned. She experiences low mood and daily tearfulness but not thoughts of suicide. Ms A was being supported by her mum and friends. Hearing voices inside head but less bothered by this. Ms A very drowsy today. Ms A given advice about housing transfer and holiday refund.
10 July 2008	Home Visit	Staff Grade 2 sent letter to Ms A's GP about medication change.
16 July 2008	Telephone, Text Message	Phone and text message for Ms A regarding appointment.
17 July 2008	Telephone	Phone call to Ms A no answer. Social Worker 2 called Ms A's mother, who reported that Ms A appeared to be OK but she had split up from boyfriend. Ms A appeared anxious on the phone when she spoke with her mother the previous evening.

Event Date	Nature of event	Details of event
		Telephone call to Ms A in afternoon. Ms A out with a friend today. Ms A agreed to call on 22 July 2008 to arrange to meet up during week.
23 July 2008	Telephone	Message left for Ms A regarding appointment.
28 July 2008	GP consultation	Ms A attended GP to collect prescription.
01 August 2008	---	Ms A cancelled appointment. Alternative appointment agreed.
06 - 08 August 2008	Home Visit	Home visit to Ms A possibly by Social Worker 2 and Psychiatric Nurse 2 although this is unclear. No notes of consultation. Becks anxiety inventory completed – score = 23 moderate anxiety (22-35) Becks depression inventory completed – score = 16 mild mood disturbance (11-16) LUNSERS completed (5 weeks on 75mg venlafaxine, 2.5mg olanzapine) – overall score 18
11 August 2008	Telephone	Phone call to Ms A from Psychiatric Nurse 2 to arrange home visit. Ms A stated she was busy this week as it is her birthday. Home visit arranged for 18 August 2008.
18 August 2008	Home Visit, Telephone	Home visit by Psychiatric Nurse 2. However, Ms A was not in. Ms A on mobile. Ms A stated she was in Braintree. Visit rearranged 22 August 2008.
21 August 2008	Telephone	Phone call to Ms A by Psychiatric Nurse 2. No reply on mobile. Message left.
22 August 2008	Telephone, Text Message	Phone call to Ms A. No reply. Text message sent also asking Ms A to make contact, no reply, message left on answer phone.
26 August 2008	Marie Stopes Clinic	Termination of pregnancy. Twin pregnancy dated 5 weeks and 2 days and 5 weeks and 1 day. Ms A to take contraceptive pill.

Event Date	Nature of event	Details of event
28 August 2008	Home Visit	Home visit to Ms A by Psychiatric Nurse 2. Ms A expressed feeling low in mood and angry the past 2 days, although stated feels more level today. Ms A slightly flat in mood, interacting appropriately and facially animated at times. Ms A unsure if medication is helping. Denies anxiety symptoms to be a prominent problem, but Ms A referred to fluctuations in mood. Denies auditory hallucinations since July. Psychiatric Nurse 2 discussed coping strategies for low mood with Ms A. Ms A requested increase in medication.
28 August 2008	---	Discussion between Psychiatric Nurse 2 and Staff Grade 2. Staff Grade 2 agreed to increase Ms A's venlafaxine to 150mg daily. Progress to be reviewed "next week".
04 September 2008	GP Consultation	Service user complaining of wanting to sleep all the time. Dark rings under her eyes and tiredness. Some bleeding post op. No fever. Ms A doesn't feel unwell. Denies any changes to diet or medication although I note the changes to EIP medication so GP unsure. Blood tests carried out.
05 September 2008	Home visit	Home visit to Ms A by Psychiatric Nurse 2 – Ms A not in. No answer on mobile.
10 September 2008	Home Visit	Home visit to Ms A. Ms A was at a party on Saturday night and was hit by another girl. Evidence of a black eye. Ms A drove her car to go and help her mother who had a hypoglycaemic attack. Ms A was pulled over by police for drink driving despite having 3 Bacardi and cokes. Due in court 16 September, is expecting a ban. Ms A requested letter of support from EIP. Ms A appeared euthymic, no evidence of anxiety or low mood, no agitation noted. No psychotic symptoms observed or reported. Ms A had joined a gym. EIPS notes updated.
12 September 2008	---	Care notes record change in care co-ordinator from Social Worker 2 to Psychiatric Nurse 2.
17 September 2008	Text Message	Text message received from Ms A this morning, cancelling visit as she is unwell with flu.
19 September 2008	Telephone	Telephone call to Ms A. No reply. Message left.

Event Date	**Nature of event**	Details of event
20 September 2008	---	Ms A arrested on suspicion of murder of the Deceased.

9.0 PROFILE OF HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

9.1 Hertfordshire Partnership NHS Foundation Trust ('HPFT', the 'Trust') obtained Foundation Trust status on 1 August 2007.

9.2 HPFT provides specialist Mental Health and Learning Disability services for the people of Hertfordshire. It also has services in Norfolk and North Essex. HPFT provides both in-patient care and community services, with specialist community teams for Assertive Outreach, Early Intervention in Psychosis, Crisis Intervention, and Child and Adolescent Mental Health Services (CAMHS). It employs approximately 3500 members of staff at over 100 sites.

9.3 HPFT is currently registered with no conditions and is fully compliant for all essential standards of quality and safety of service provision following a planned review by the Care Quality Commission.

9.4 HPFT organises its services into three geographical business streams:

1. Learning Disability and Forensic Services in Hertfordshire, Norfolk and Essex;
2. West Hertfordshire;
3. East and North Hertfordshire.

9.5 Community Services comprises a range of different teams working with identified service user groups. Community Services includes Child and Adolescent Mental Health Services, which in itself includes in-patient services and also the Early Intervention in Psychosis Service. The Independent Investigation Team was advised that the thinking behind this was to promote opportunities for joint working with the Adolescent Outreach Team and to facilitate the transition of service users moving from CAMHS into adult services. The Independent Investigation Team recognises that management of the EIP Service within the community directorate provides an illustration of an innovative and forward-thinking approach towards management of the EIP Service.

9.6 Each business stream is managed by two senior managers, one with a medical background at consultant level and the other with substantial health or social care management experience.

9.7 Overall, operational management of the Community Directorate rests with the Board of Directors of HPFT. However, the Independent Investigation Team understands that the Chief Operating Officer is responsible for the operational management of the services of HPFT, including both health and social care within mental health.

10.0 EARLY INTERVENTION IN PSYCHOSIS SERVICES

10.1 Adolescence and emerging adulthood are a high-risk time for developing mental disorders. In England 7,500 young people are estimated to develop an early psychosis each year. The early phase of psychosis is a critical period affecting long-term outcomes. Failure to intervene early often has significant and substantial personal costs in terms of an individual having reduced capacity to reach their social, emotional and vocational potential, as well as wider social and economic costs.

10.2 The objectives of the Early Intervention in Psychosis Service are to identify, assertively and early, people aged 14-35 years who are experiencing a first episode of psychotic illness, and follow them up in low stigma settings, maximising consistent engagement in treatment. This focus was established as necessary by evidence-based research and consumer campaigns in the 1990s, such as Rethink's Reaching People Early, which highlighted the resultant suffering and cost implications when early detection and treatment were not provided consistently at such a crucial stage.

10.3 Early Intervention in Psychosis Services were established as a result of the 'NHS Plan' ('NHS Plan: Department of Health', 2001) and were supported by new and targeted funds. The Mental Health Policy Implementation Guide (Department of Health 30 March 2001) ('the PIG') outlines the service specifications, which include the following:

- The service is accessible to 14 to 35 years old.
- It involves active monitoring of individuals at high risk of psychosis or with suspected psychosis for a minimum of 6 months.
- The maximum caseload per case manager is 15.
- The service comprises a multi-disciplinary staff mix with specialist skills/experience in work with adolescents, family intervention, low dose medication, CBT, relapse prevention and substance misuse interventions.
- The service monitors Duration of Untreated Psychosis (DUP), engagement rates, relapse rates, hospital readmission, suicide and parasuicide, education and employment functioning.

10.4 Early Intervention in Psychosis Services are often distinguishable by their cultural sensitivity to the unique needs of younger adults, their focus on families, and their attention to the impact of interrupted development and the social consequences of serious mental illness. Early Intervention in Psychosis Team members are required to be conversant with people where a diagnosis is uncertain, but help is needed.

10.5 Early Intervention Service in Psychosis in Hertfordshire (the 'EIP Service')

10.6 The EIP Service in Hertfordshire was initially established in 2005. At this time, the Independent Investigation Team was advised that the EIP Service had six members of staff.

10.7 However, shortly into the life of the EIP Service, a proposal was made to close it down which was a very demoralising experience for staff and service users alike. This was a very difficult time as service users had to be contacted in order to facilitate the transfer of their care to the relevant Community Mental Health Teams. In addition, staff who had only recently been recruited found themselves having to seek alternative positions. However, after several months and intervention by the Department of Health, the EIP Service reopened for new referrals.

10.8 The rapid expansion of the EIP Service following its re-commission led to a number of practical difficulties in 2007. These included inappropriate accommodation for the Service and a significant level of recruitment, together with a degree of uncertainty about the ongoing funding for the EIP Service.

10.9 Due to limitations in funding and with a view to minimising management costs, the Service initially operated as a county-wide service. However, the Service faced geographical challenges due to the size of the area which team members had to cover. Team members were spending large amounts of their time travelling. Therefore during the course of 2007, a decision was taken to split the Service geographically into the East and West parts of the county. The Independent Investigation Team has been advised that additional staff and skills were added to the Service as and when funding could be established.

10.10 Funding was target driven. It is understandable that the focus at management and indeed senior management level was on strategic and funding issues, which were clearly pressing and a legitimate focus. This undoubtedly had an impact upon operational services. In particular, the Independent Investigation Team was advised that this led to the EIP Service being developed on an ad-hoc basis as funding was released for specific needs. An example of the ad-hoc development of the EIP Service is the appointment of an additional consultant to the EIP Service when the case load became too large for one individual.

10.11 Initially the EIP Service was expected to receive 150 referrals a year, which would build to a total of 450 cases during the first three years in which the service operated. During the interviews conducted with the Independent Investigation Team, it became clear that management pressure was placed upon the EIP Service to achieve the number of referrals which the Service required in order to meet ongoing funding criteria.

10.12 For example, during the course of an interview with Community Services 1, the following question was asked:

'PV: *Was there any pressure that meant that some referrals would be taken within the team that weren't necessarily ones that were 100 percent those that would ordinarily, you would have wanted to be with the team?*

Community Services 1: *Well I think if I'm totally honest I wouldn't deny that…'*

10.13 The impact which this had upon the EIP Service was that a significant amount of management time was invested into securing new referrals for the Service rather than considering operational issues, including the development of robust clinical governance systems at the inception of the new services. A number of interviewees acknowledged that clinical governance has been strengthened significantly since 2007/2008 and that it is afforded a higher profile within the Service. However, it is these processes which support staff and ensure that care is planned and delivered at an acceptable standard. Key activities which are designed to ensure service user safety and deliver quality care were not in a developed form during the period of Ms A's engagement with services. This is dealt with more fully at Paragraphs 11.2, 11.13 - 11.16 and 11.21.

11.0 INTERNAL STRUCTURE OF THE EIP SERVICE

11.1 Operational Policy

11.2 At the time of the events leading up to the death of the Deceased, the EIP Service did not have in place an operational policy. This is a concern also noted in the Internal Investigation Report dated 23 January 2009. The Internal Report referred to the importance of ensuring that there was no more delay in getting the Policy ratified by HPFT and made available on the internal website operated by HPFT. The EIP Operational Policy (see Appendix **D**), was ratified on 26 August 2009 and issued in January 2010. When the Independent Investigation Team checked HPFT's external website, the Operational Policy for CMHT and other services such as Community Drug and Alcohol policies were present there although not in an accessible format. However, the EIP Operational Policy was not. The website was checked most recently as of 1 December 2011. There was a message on the HPFT's website which might explain its absence. The message states:

> *'We are currently in the process of updating our policies and procedures to ensure the latest version is available for you to download from here. This work should be completed by the end of August.'*

11.3 The Policy is written in broad terms as would be expected for a document of this nature. One of the purposes of a policy such as an operational policy is to help team members and individuals outside the immediate team, but whose work brings them into contact with the service, understand the interaction of roles and responsibilities within the Service. Its target audience is said to be *'Service users, their families and carers and professionals'*. It is disappointing therefore that the Policy is not easily accessible.

11.4 Paragraph 17 of the Policy is key as it deals with working practices, such as the requirement for all staff to participate in weekly clinical meetings. The Policy does not appear to have been reviewed in light of the 'Clinical and Practice Standards for Early Intervention in Psychosis' which was presented to CAMHS Practice Governance on 7 December 2009 and was issued in June 2010. Elements of the Standards could, in the Independent Investigation Team's opinion, be added to the Policy in an attempt to increase transparency for the stated target audience of the Policy. For example, additional information about the assessment process might be helpful for carers. At present the Policy simply states *'All clinical staff participate in an assessment schedule*.'

11.5 Paragraph 17 of the Policy also contains the following statement:

> *'What else can we include here without giving away all our most boring secrets?'*

11.6 This statement was also included in the draft version of this policy, although in the draft format it contained a typographical error which has in fact been corrected in the final version. This is an unfortunate inclusion in such a key section of a core document. Potentially, it could identify

a possible cultural issue in relation to the attitude adopted by the Service towards control systems and structures.

11.7 Structure of the Service

11.8 The draft EIP Operational Policy which was apparently in use at the time that Ms A received care from the Service and during the period when the Service was building its caseload sets out membership of the Service as follows:

'The staff team consists of:

- *1 x team leader*
- *2 x administrators*
- *1 x consultant psychiatrist*
- *2 x staff grade psychiatrists*
- *1 x consultant psychologist*
- *1 x nurse consultant*
- *1 x senior social work practitioner*
- *A range of social workers, nurses and occupational therapists at band 5, 6 and 7.'*

11.9 The final version of the EIP Operational Policy which was issued in June 2010 outlines Team Membership as:

- *'1 x senior nurse / team leader*
- *1 x combined administrator / medical secretary*
- *1 x consultant psychiatrist*
- *1 x staff grade psychiatrist*
- *A range of care co-ordinators: social workers, nurses and occupational therapists at band 5, 6 and 7.'*

11.10 They are supported by a county wide team of:

- *'1 x manager*
- *1 x consultant psychologist*
- *1 x psychology assistant*
- *1 x nurse consultant.'*

11.11 This structure demonstrates an increase in its management time by the addition of Team Leaders.

11.12 Team Manager

11.13 In its early stages, the Service experienced difficulties in recruiting a manager. At the time of the Deceased's death, the EIP Service was managed by a single Team Manager, who by 2008 was effectively responsible for around 38 members of staff. He was supported in his duties by Senior Nurses and a Nurse Consultant.

11.14 The Team is still managed by a single Team Manager. However, due to an increase in its size, that Team Manager is now supported by Team Leaders in each of the two geographical teams. Internal leadership of the Service has remained stable in that the Team Manager has been in post since the re-establishment of the Service, as have a number of the senior members of the Service.

11.15 The EIP Service Manager is a qualified social worker. His appointment as Manager of EIP was the first time that he had managed an MDT. He confirmed that the training which he received for this role was 'on the job'. During the course of his interview, the Team Manager described his view of his role in the following terms:

> *'EIP Manager: ...I've never had much of a clinical role in the team never really practiced as a social worker in the team, even though initially it was thought that I'd have a clinical component of my work that hasn't happened. Developing this service, you know putting the work into the promotional work has always been regarded as a big drive, a big effort and it's re-, it's, that's mirrored across other Early Intervention, we have a good network with our regional partners, and if the experience is mirrored there as well that case finding is deemed to be a very time-consuming exercise, so, it was no surprise that much of my time was put into that, not case-finding as in walking the streets which some teams do, but, effectively and metaphorically walking the streets of the Trust to try and find people within the Trust.'*

11.16 The Team Manger has a detailed job description with a very large remit. He is responsible for the management supervision of the Service, but not the individual supervision of any discipline other than social work within the MDT. He is also responsible for the development and implementation of systems of local audit, and for establishing quality assurance and audit processes to allow assessment of factors which might impinge upon the development of the Service.

11.17 The Team Manager does not have any clinical involvement in the case work of the EIP Service, although his job description allows for this. The PIG clearly requires the EIP Service Manager to undertake casework.

11.18 Nurse Consultant

11.19 At the inception of the Service, a Nurse Consultant was recruited to the Service in order to bring expert advice on nursing practice relating to Early Intervention Services. Whilst the Nurse Consultant has a clinical role, the post holder is also required to play a part in the development and implementation of policies and procedures across the Service, including NICE Guidelines and the CPA. In addition, the post holder is expected to actively contribute to clinical governance activities, particularly in relation to the introduction of evidence based practice. The Nurse Consultant provides professional leadership within the Service mainly in relation to the nurses within the MDT.

11.20 Team Leaders

11.21 The Service has now introduced two Team Leaders to support the Team Manager. There were no Team Leader posts at the time of Ms A's care.

11.22 Strategy Group

11.23 As it has evolved, the Service has developed a Strategy Group. This group is comprised of the Team Manager, the Team Leader for each geographical team, the Consultant Psychiatrist for each team, the Consultant Psychologist for the Service, the Nurse Consultant for the Service, the Clinical Nurse Specialist for each team and the Senior Practitioner for the East team. Meetings take place on a monthly basis. The Strategy Group does not have a written set of terms of reference. It is understood by all members of the group, however, that it is responsible for all strategic planning, initiatives or reviews of existing practice-based strategy that is the responsibility of the Service to determine or deliver.

11.24 The Independent Investigation Team understands that terms of reference are currently being drawn up for this group.

11.25 Supervision Procedures

11.26 Paragraph 17 of the EIP Operational Policy states:

> *'All staff participate in regular individual professional and managerial supervision.'*

11.27 The HPFT Supervision Policy (see Appendix **E**), dated July 2008, states at Paragraph 1.3:

> *'The Trust believes that effective supervision contributes to job satisfaction, personal development and the provision of a high quality service. Supervision is the opportunity and requirement for staff to receive guidance and support. It also enables staff to reflect on how they carry out their tasks and activities within their role and other aspects of their working lives. Supervision is a fundamental part of Practice Governance.'*

11.28 Management supervision is defined as:

> *'Management supervision is task oriented, with a formal service led agenda. Management supervision is a regular meeting with the line manager (or other nominated manager) in order to discuss*
> - *operational and management issues relating to the supervisee's role including prioritising work*
> - *main tasks*
> - *required performance standards*
> - *training needs*
> - *personal development'.*

11.29 Clinical supervision is defined as:

> *'Clinical supervision provides the opportunity for health and social care staff to:*

- *Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention*
- *Reflect on and review their clinical practice*
- *change or modify their practice*
- *Develop clinical skills*
- *Review professional standards and how any changes impact on practice*
- *Key clinical issues that are impacting on practice'.*

11.30 During the course of his interview, the Team Manager was asked about the supervision procedures which were in place in EIP. He was able to advise the Independent Investigation Team that new procedures had recently been introduced in order to strengthen the clinical supervision process. In the two months prior to his interview, the Team Manager stated that the following documents had been introduced to the EIP Service:

1. Supervision Record Form
2. Pro Forma Supervision Record Form.

11.31 In addition, a supervision checklist and guidance is now available to EIP Service members (see Appendix **F**). Supervision within the EIP Service is considered in more detail at Section 19, Paragraphs 19.1 – 19.42.

12.0 SOCIAL AND MEDICAL BACKGROUND INFORMATION

12.1 The Independent Investigation Team had access to a number of records and documents, which those treating Ms A in the EIP Service and CMHT would not have had access to unless they had asked for them, or alternatively had sought this information from Ms A's carers or other individuals connected with her on a professional basis. These documents included Ms A's General Practitioner records, school records and records obtained from Marie Stopes International, which is an organisation dealing with all aspects of women's sexual health, including the provision of termination of pregnancy services.

12.2 The information contained in these documents is highly relevant to the diagnostic process which was undertaken in relation to Ms A, as it contains many diagnostic clues.

12.3 General Practitioner Records

12.4 The Independent Investigation Team had access to a full set of Ms A's GP notes. Neither team in the criminal proceedings, nor the EIP Service, had access to this valuable resource.

12.5 A striking feature of Ms A's records is the number of consultations which Ms A had with her GP prior to her leaving the family home in 2005. The following table shows the number of attendances which Ms A made to her GP between 1999 and 2008.

TABLE 12.1

Year	Age at attendances	Number of attendances
1999	9	5
2000	10	14
2001	11	10
2002	12	13
2003	13	7
2004	14	13
2005	15	20
2006	16	25
2007	17	13
2008	18	9

12.6 Ms A was an asthma sufferer and had had her tonsils removed. She also had repeated urinary tract infections. In addition, Ms A appears to have experienced a number of problems

with conditions such as insomnia, cystitis and dysuria from a very early age. These problems seem to occur at or around the same time that she was experiencing problems at school.

12.7 However, it is clear that notwithstanding these conditions, Ms A was a very regular attendee at her GP surgery and appears to have sought help on a regular basis both for health issues and for assistance with social issues such as housing and in relation to her schooling. These issues are referred to more fully in the chronology prepared by the Independent Investigation Team.

12.8 In addition, Ms A's notes indicate that she was the subject of a referral to the Child and Adolescent Mental Health Services in Hoddesdon run by HPFT on 7 June 2001 when Ms A was 12 and was experiencing behavioural difficulties, which resulted in a suspension from school. Unfortunately, at this time CAMHS were experiencing staff shortages and a high number of referrals and accordingly Ms A was not allocated an appointment until 26 July 2001. For reasons which are not clear, Ms A's parents declined this appointment and Ms A was removed from CAMHS's waiting list.

12.9 School Records

12.10 During the course of the Independent Investigation, details of Ms A's educational background were obtained from Cheshunt School. Members of the Independent Investigation Team did not interview individuals connected with Ms A's education. The information obtained was in the form of a log of disciplinary incidents involving Ms A and a report supporting the decision to permanently exclude Ms A from Cheshunt School on 19 December 2003.

12.11 The information which the Independent Investigation Team obtained shows that Ms A left Flamstead End Junior Primary School in Cheshunt without having met National Curriculum Key Stage 2 targets.

12.12 Ms A attended Cheshunt School for her secondary education. Ms A and her parents had been unhappy about Ms A being allocated a place at Cheshunt School and had initiated an appeal process, which was supported by the family GP but was ultimately unsuccessful. The basis for Ms A's unhappiness was that her friends had gained places to other nearby schools. Ms A's parents sought support from their GP in their unsuccessful attempts to influence the allocation of a place to Cheshunt School to Ms A. The GP consultations relating to Ms A's schooling are outlined in the Chronology prepared by the Independent Investigation Team.

12.13 Due to her concerns about the allocation of a place at Cheshunt School, Ms A did not commence her secondary education promptly at the beginning of Year 7. According to records provided by Cheshunt School, Ms A commenced her education at Cheshunt School on 17 October 2000. She was permanently excluded from the school on 19 December 2003. During her time at Cheshunt School, she had a troubled disciplinary record.

12.14 Upon her arrival at Cheshunt School, an integration policy was instigated to help Ms A settle into the school, following her initial reluctance to accept a place. Ms A's behaviour in Year 7 was often inappropriate, with a number of instances of disobedience and disruptive behaviour being reported.

12.15 Between 13 September 2001 and 16 July 2002 when she was a pupil in Year 8 (age 13), Ms A received 23 'Red Cards' in relation to her behaviour. The behaviour that incurred a 'Red Card' included: class disruption, foul and abusive language and defiance of staff instructions. There were also two instances of fighting with other pupils (19 November 2001 and 14 January 2002).

12.16 Ms A's behaviour deteriorated significantly throughout Year 9 (age 14) and she received a number of fixed term exclusions, in addition to other disciplinary sanctions for behaviour which included abusive conduct towards teachers and pupils, violence and bullying of fellow pupils, swearing and use of inappropriate racial and sexual comments.

12.17 Unfortunately, Ms A's behaviour continued to deteriorate in Year 10 (age 15). A number of fixed exclusions were incurred before her permanent exclusion on 19 December 2003. During this period she received pastoral support and it is clear that the school tried a variety of techniques and strategies in an attempt to modify Ms A's behaviour.

12.18 The Headmaster of Cheshunt School has given an account of the final incident which led to Ms A's exclusion from Cheshunt School as follows:

> *'On the 15th December Ms A and a small group of students from another school accosted Mr M (Maths teacher), just outside of School. Ms A blocked Mr M's way across the A10 footbridge and despite requests take the pack off in order to make her let go. Mr M was then subject to a tirade of abuse and hurling of sweets from Ms A and her friends. When Mr D interviewed Ms A regarding this Ms A failed to see she had done anything only one there and that she was not responsible for the actions other friends.'*

12.19 Following her exclusion from Cheshunt School, Ms A completed her education at the Lea Valley Education Support Centre. The Independent Investigation Team contacted the Lea Valley Education Support Centre, now known as the Rivers Education Support Centre, which caters for Years 7 to 11 who have been permanently excluded from schools within Hertfordshire. They were not able to provide any information regarding Ms A as their records were unavailable. However, it was confirmed that Ms A had attended the centre erratically and continued to experience behavioural difficulties.

12.20 Termination of Pregnancy

12.21 Ms A has undergone three terminations of pregnancy. All three terminations were conducted under the care of Marie Stopes International ('MSI') in Essex. MSI hold a contract with

Hertfordshire PCT to provide abortion services. Ms A underwent termination of pregnancy on the following dates:

- 21 March 2006 (17 weeks)
- 23 July 2007 (11 weeks and 4 days)
- 26 August 2008 (5 weeks and 1 day and 5 weeks and 2 days).

12.22 The issue of contraception was raised with Ms A following each termination. On the first two occasions she opted for injectable contraception and stated she would attend her GP for her future contraceptive needs. There is no record in Ms A's notes that she attended her GP for contraceptive advice during the period between 21 March 2006 and 23 July 2007. On the third occasion she opted for the contraceptive pill, which was to be supplied by MSI.

12.23 On all three occasions, the 'Counselling Notes' section of Ms A's MSI records has been left blank.

12.24 It should be noted that Ms A's GP letter of referral to Cheshunt CMHT dated 24 September 2007 made reference to only one termination of pregnancy when in fact Ms A had undergone two terminations of pregnancy by this date.

12.25 Abuse

12.26 Abuse suffered in childhood can constitute a predictor of mental health problems in later life. Equally, those who have been the subject of abuse may develop coping strategies which are maladaptive and can impact adversely on psychological adjustment.

12.27 It is often very difficult for those who have been the subject of abuse to discuss the abuse or seek help, particularly if they have tried to talk about the issue to friends, family or professionals and have not had a response that helped. This can affect how these individuals interact with professionals involved in their care in later life and can cause difficulties in the diagnostic process.

12.28 Ms A confirmed a positive history of being physically abused by a male relative to both the Defence and Prosecution Psychiatrists during the course of the criminal proceedings against her. Ms A stated that they had hit her but repeatedly denied any sexual abuse.

12.29 Key Points

It is clear that Ms A experienced a disturbed childhood and experienced difficulties in her transition into adult life. In summary, the following features would be expected to be of interest to those involved in her psychiatric care:

1. Ms A's difficulties with anger were long standing.
2. A troubled school record with significant disciplinary problems leading to eventual exclusion. Difficulties in relationships with other pupils and teachers.

3. A referral to CAMHS at age 12 which was not pursued by her family, possibly as a result of a long wait prior to an appointment being offered.
4. Refusal to sleep in her room and persistent sleeping in her parent's room.
5. Difficulties in inter-personal relationships within the family including those with her father and sister.
6. Two terminations of pregnancy before the age of 18.

From an early age Ms A and her family demonstrated a significant pattern of help-seeking behaviour towards their GP, who provided the family with significant practical support in relation to a number of key issues. The nature of this reliance, particularly in relation to housing and schooling issues, indicates a reliance and acceptance on an external locus of control by Ms A and her family.

13.0 DIAGNOSIS

13.1 Diagnosis by EIP Psychiatrists

13.2 Ms A received care from the Service between 17 October 2007 and 20 September 2008. She was initially seen by Staff Grade 1, a psychiatrist, and Psychiatric Nurse 1. She was allocated an appointment within a week of referral by the CMHT, after an assessment by the CMHT, and the actual appointment took place within 2 weeks of the initial referral, which constitutes a good standard of care delivery. Her appointment was to take place at Ms A's home, which also constitutes good practice.

13.3 During the course of her care Ms A was also treated by Staff Grade 2, a psychiatrist. She had two care co-ordinators; Social Worker 2, a newly qualified social worker and Psychiatric Nurse 2, a Psychiatric Nurse of Band 8. Team Leader 1 was responsible for Social Worker 2's supervision throughout Ms A's care. Team Leader 1 is a senior social worker.

13.4 The diagnoses reached by Ms A's clinicians were as follows:

TABLE 13.1

Date	Clinician	Diagnosis	Differential Diagnosis	Recorded Symptoms
24 September 2007	GP 1	Depression		Depression Paranoid ideas Angry out bursts Physically aggressive Poor sleep pattern Good appetite Denies suicide TOP
17 October 2007	Staff Grade 1	Moderate depressive episode F32.1	Possible traits of personality difficulties	Depressed – low in mood Increased irritability Strained relationships Biological functions affected Not enjoying going out Cut wrists Denies suicide Agoraphobic Anxious Compulsive rituals Feeling paranoid
20 December 2007	Staff Grade 2	Moderate depressive episode F32.1	Obsessive compulsive disorder, Social anxiety	Anger issues Social anxiety Mood low to moderate Absence of psychotic symptoms
22 February 2008	Staff Grade 2	Depressive episode F32		None noted
9 May 2008	Staff Grade 2	Recurrent depressive disorder F33	Obsessive compulsive disorder, Social phobia	Low energy and motivation Tense Acts in an aggressive way Lost weight poor appetite Sleeps too much Feels paranoid when out Snappy with boyfriend

30 June 2008	Staff Grade 2	Recurrent depressive disorder F33	Obsessive compulsive disorder, Social phobia	Build up of frustration leading to a black out whereby she was hitting people Paranoid – got into altercation in street Male voice in head telling her she will not get better Symptoms of epileptic equivalent
28 August 2008	Psychiatric Nurse 2 /Staff Grade 2	Recurrent depressive disorder F33	Obsessive compulsive disorder, Social phobia	

13.5 Diagnostic Process

13.6 A significant feature of EIP Services which has made this type of service so successful in the care of younger adults is their ability to tolerate diagnostic uncertainty while addressing psychosocial problems.

13.7 Ms A was referred to EIP through the CMHT route. There were some problems with her GP's letter of referral. It did not contain all the information that it might, such as a failure to include the fact that Ms A by this stage had experienced two terminations of pregnancy and not one. It also failed to contain details of her schooling difficulties. However, it did highlight a number of areas where Ms A was experiencing difficulties and which would ordinarily have provided a target for further investigation by the EIP Service.

13.8 These areas were as follows:

1. Ms A's difficulties had persisted for a period of about one year.
2. Ms A had recently begun to suffer from paranoid ideas associated with angry outbursts.
3. Her paranoid ideas made her think people are talking about her, which led to her lashing out physically or verbally.
4. Ms A was physically aggressive particularly towards her boyfriend – a behaviour which was exacerbated by alcohol.
5. She had had a recent termination of pregnancy which exacerbated her depressive symptoms.
6. Inter-personal relationships within Ms A's family unit.
7. Ms A denied the use of recreational drugs.
8. Ms A had tried various antidepressants.

13.9 The Independent Investigation Team performed an analysis of Ms A's records maintained by the EIP Service to assess how these initial themes have developed during the course of Ms A's care.

13.10 Anger

13.11 Ms A's GP highlighted in her letter of referral that Ms A had suffered angry outbursts associated with paranoia. The manner in which Ms A's anger was considered throughout her care in EIP is set out in the table below:

TABLE 13.2

Date	Clinician	Comment
3 October 2007	Social Worker 2	Ms A described herself as a sociable and outgoing person but has a long standing difficulty in controlling her anger. Ms A described an 'angry streak' whereby she doesn't know what angers her. Ms A declined the offer of referral to MIND for anger management counselling.
17 October 2007	Staff Grade 1	Ms A had a longstanding difficulty in controlling her anger.
29 October 2007	Social Worker 2	Ms A reports that she gets into arguments with strangers. She reported that she had a fight with a stranger about 3-4 weeks ago.
7 November 2007	Social Worker 2/Team Leader 1	Ms A reports that the main issue she wanted support with is her anger; Ms A had been arguing and fighting with her boyfriend. Ms A stated she had always been angry; She reported she was not aware of becoming angry or the build up and that she became angry very quickly. Ms A was told that Social Worker 2 would consult with team to see what support could be offered. Ms A was given an anger diary to complete. Ms A had been offered anger management counselling but she could not afford this.
19 November 2007	Social Worker 2/Team Leader 1	Ms A had completed her anger diary, twice per day for about two hours each time. Ms A says she thinks she has always been angry. Social Worker 2 looked at Firework model of anger with Ms A and provided her with worksheets on anger management. Ms A reported that she had been angry with teachers at school.
7 December 2007	Social Worker 2/ Team Leader 1	Ms A had lost her anger diary. Ms A was continuing to get angry on a daily basis. Ms A has no control over her anger and had hit her boyfriend in the past week. She had been unsuccessful in using calming techniques. Ms A's pattern of anger is that she reaches a peak of anger very quickly and then stays that way for about 2 hours. Ms A given encouragement to keep trying with techniques she had been shown.
10 December 2007	Social Worker 2	Ms A not completing her anger diary as she did not want to any more. Social Worker 2 advised that team could only offer suggestions as to what might help with her anger.
20 December 2007	Social Worker 2/ Staff Grade 2	Anger issues were discussed along with social anxiety problems.
18 January 2008	Social Worker 2	Ms A reports she is taking sertraline. Ms A reported that her anger was much the same. She had continued to argue with her partner and hit him last week.
5 February 2008	Social Worker 2	Ms A reported that medication did not seem to have an effect on OCD symptoms or anger.
7 March 2008	Social Worker 2	Ms A reported some improvement in anger and it was noted that she got angry less frequently.
30 June 2008	Social Worker 2	Ms A was noted to feel generally angry but finds it difficult to identify triggers when she "blows up" in anger, suddenly becomes very angry and feels out of control. This can happen several times a day and takes up to 2 hours to calm down. Ms A also described herself as acting impulsively.

13.12 It is clear from Ms A's records that even at an early stage, Ms A stated that her anger issues were longstanding and that this was the main issue with which Ms A wanted help. Attempts to deal with Ms A's anger were made, for example on 19 November 2007 Social Worker 2 discussed the Firework model of anger management with Ms A. On 10 December 2007, Ms A advised Social Worker 2 that she was not keeping her anger diary any longer. Social Worker 2 advised that EIP could only offer suggestions as to what might help with her anger. Ms A's notes do not make reference to Ms A being unamenable to reflective psychological work nor to any future attempts to engage her in such work. Significantly, there is no mention of the possibility of CBT or indeed DBT as a further possible option in relation to anger, and no referral was made to a psychologist at any time.

13.13 Aggression

13.14 GP 1's initial letter of referral highlighted that Ms A was physically aggressive, particularly towards her boyfriend. As Ms A's care with the EIP Service progressed, the following picture of violent and aggressive behaviour was documented.

TABLE 13.3

Date	**Clinician**	**Comment**	Did Aggression Involve the Deceased?
3 October 2007	Social Worker 1	Ms A becomes both verbally and physically aggressive towards her partner and others. Ms A has no significant reasons as to why she becomes aggressive. Ms A does not feel this is a huge issue. Ms A has hit her boyfriend over the head with a broken bottle during the course of an argument. She has also used teeth and fists in arguments with him. Ms A describes wanting to attack someone if she believes them to have upset her or if she were in a fight, Ms A wishes that individual were dead.	Yes
29 October 2007	Social Worker 2/Team Leader 1	Ms A reported that she had had a fight with a stranger one week ago. She also reported being verbally and physically abusive to her boyfriend in that she bit and hit him in the past week.	Yes
7 November 2007	Social Worker 2	Ms A said she had been arguing with her boyfriend. He had threatened to leave her because of it, which she didn't want. Ms A also reported that she had been asked to leave a night club recently because of fighting with her boyfriend. Had they not left the club Ms A thinks she may have glassed him. Ms A appeared to be motivated to work on changing her behaviour.	Yes
27 November 2007	Social Worker 2	Ms A had hit her boyfriend this week but could not identify a trigger for this.	Yes
7 December 2007	Social Worker 2	Ms A hit her boyfriend during week.	Yes
18 January 2008	Social Worker 2	Ms A continues to argue with her boyfriend and hit him last week. Ms A also reported shouting at strangers.	Yes
22 February 2008	Social Worker 2	Ms A reported feeling less paranoid and less violent behaviour although still very angry.	No

2 May 2008	Social Worker 2	Ms A reported that she did not want to go out for fear of getting herself into trouble as she does not know what might happen.	No
30 June 2008	Social Worker 2/ Staff Grade 2	Ms A describes feeling out of control, tension and numbness, tearfulness and aggression and irritability. Ms A reported hitting family members.	No
11 August 2008	Psychiatric Nurse 2	Ms A in a fight with another girl on Saturday night.	No
28 August 2008	Psychiatric Nurse 2	Ms A has been low in mood and angry. Coping strategies for low mood discussed.	No

13.15 It is clear that throughout the course of her care Ms A made a number of reports of violent or aggressive behaviour, although latterly this was not aimed at her boyfriend.

13.16 Termination

TABLE 13.4

Date	Clinician	Comment
3 October 2007	Social Worker 1	Ms A has had a termination of pregnancy.
17 October 2007	Staff Grade 1	Ms A felt her termination was the last straw in relation to a number of other significant problems. As a result Ms A has felt under pressure and has felt increasingly depressed.
7 December 2007	Social Worker 2/Team Leader 1	Ms A was asked about her termination earlier that year. Ms A reported that she felt it was the right decision, although she had felt some pressure from her boyfriend's mum. Ms A said that she felt she was coping well and did not feel that she needed any support with this.
30 June 2008	Social Worker 2	Ms A had a termination of pregnancy in July 2007.

13.17 The above table sets out the occasions when termination of pregnancy is mentioned in Ms A's EIP records. The records reveal little information about how this issue was explored or developed with Ms A, other than to report that Ms A did not feel that she required any support. However, GP 1's letter of referral states that Ms A's termination was causing an exacerbation of her depressive symptoms.

13.18 Ms A's history of terminations may have revealed some key information which was relevant to her care and possible diagnosis. The fact that Ms A had in fact had two terminations at the point of her referral to EIP could have indicated an appetite for risk taking behaviour, inter-personal issues or indeed a reluctance to comply with medication. It may also potentially have given an insight into Ms A's relationship with her father, who is Maltese and Catholic.

13.19 Interpersonal Relationships

13.20 The interpersonal framework in which an individual grows up often provides some key information which can be fed into the diagnostic process. Ms A admitted during the course of her criminal proceedings that she had been physically abused by a male relative but she repeatedly denied any sexual abuse. Ms A left the family home at 16 and went to live with her maternal grandmother and then into a hostel.

13.21 At her initial meeting with Ms A, Social Worker 1 captured some very important information about Ms A's interpersonal relationships which warranted further exploration once a therapeutic relationship had been established with the team responsible for her clinical care or indeed with her care co-ordinator.

13.22 The table below sets out how the poor relationship which Ms A experienced with her father during the course of her care was developed by the EIP Service.

TABLE 13.5

Date	Clinician	Extract from Notes
3 October 2007	Social Worker 1	Ms A's relationship with her family is volatile whereby she does not have contact with her father. Ms A feels she has always had to compete for affection from her father and believes that he and her mother love Ms A's sister more. Ms A does talk with her mother and has little contact with the sister. When probing further into the dynamics of the family, Ms A was very clear that she gave me all information presented and that there was nothing significant that happened to cause the family rift. Ms A's childhood was chaotic whereby during primary school she ran out and described her father carrying her or grabbing her arm to return to school. It is alleged by Ms A that a bystander reported the incident to the CSF. Ms A disclosed that she did not go to school from the end of Year 6 until mid-Year 7. Ms A described her not wanting to go to school was as a result of not sleeping at home as she imagined a man standing in her room and was too frightened to sleep.
17 October 2007	Staff Grade 1	Ms A denied physical or sexual abuse.
7 November 2007	Social Worker 2	Ms A reported that her Mum also told her that she became very angry and this was a large factor in Ms A not being able to live with her parents anymore. Ms A sees her Mum sometimes but not her Dad, with her Mum seeing her without her Dad knowing.
19 November 2007	Social Worker 2/Team Leader 1	Ms A said that her anger was the reason that she did not live with her parents and now had no contact with her Dad.
30 June 2008	Social Worker 2	Ms A also said that in the past week she had a male voice inside her head telling her to do things and laughing at her and saying that she won't get better. Ms A reported that she was trying to ignore voice.

13.23 Having flagged the difficulty in her relationship with her father little appears to have been done to explore this key relationship any further. It is reported that Ms A was angry with her father. However, the reason for that anger does not appear to have been established, nor was the nature of this relationship established.

13.24 Ms A has repeatedly denied sexual abuse. However, in the context of interpersonal relationships, she reports the presence of a male voice in her head telling her to do things and saying that she would not get better. In her CPA Needs Assessment, Ms A describes a poor sleep pattern in childhood due to the fear of a man standing in her room. This is an unusual incident for Ms A to describe. It is disappointing, therefore, that steps were not been taken to understand more about it.

13.25 There is no evidence that these issues were explored with Ms A. Victims of abuse and indeed sexual abuse often report hearing the voice of their abuser and the Independent Investigation Team believes that this issue should have been a target for further investigation. Ms A's mother or sister may have had vital information about this relationship or indeed Ms A's GP. However, no inquiries appear to have been made. At no stage in Ms A's care does family therapy appear to have been considered.

13.26 Alcohol

13.27 In her initial letter of referral dated 24 August 2007, GP 1 reported that Ms A had:

> *'Been quite physically aggressive mainly towards her boyfriend and this behaviour is exacerbated when she has had a drink of alcohol.'*

13.28 Alcohol is mentioned in Ms A's GP records. However, it is the first time that Ms A appears to have stated that she consumed alcohol. For example, on 11 October 2006 (age 17), Ms A reported her alcohol consumption as being 0 units a week during the course of a routine health check. A liver function test was carried out on 3 August 2005 (age 15), apparently in response to a complaint that Ms A had '*felt weak and tired since Saturday. Mum thinks she might be anaemic*.' This was reported on as normal on 3 August 2005.

13.29 During the course of the criminal investigation, it became clear that Ms A had engaged in often heavy drinking prior to the death of the Deceased. Ms A's blood alcohol upon arrest for the murder of the Deceased was 175mg%. This equates to being just over twice the legal limit for driving. Judge Michael Baker QC told Ms A when sentencing her that:

> *'You have been considerably responsible for your actions in which drink and drugs played a very large part.'*

13.30 Following Ms A's arrest and imprisonment, the Independent Investigation Team has been advised that Ms A has undergone treatment for alcohol addiction.

13.31 The Independent Investigation Team has not had the benefit of interviewing Ms A. However, we have had access to the report of the Prosecution's Psychiatric Expert, Dr P Wood, dated 20 August 2009. During the course of discussions with Dr Wood, Ms A confirmed that she had started drinking at the age of about 13 and would drink 22 units of alcohol a day. Ms A also stated that she drank to stop her worrying about her troubles. She acknowledged that when she drank she became violent, angry and wound up. Ms A also confirmed to Dr Wood

that she took drugs orally. She identified cocaine and amphetamines. She would also use amphetamines when out clubbing. Ms A explained to Dr Wood that when she took amphetamines she would feel vaguely paranoid in attitude and described it as feeling that others were looking at her in a particular way or getting at her in some way.

13.32 The Independent Investigation Team has been very aware throughout the course of this investigation to try and minimise the detrimental effects of hindsight bias in its investigations. Ms A had been drinking the day that the Deceased died and the Judge clearly believed that alcohol played a major part in his death. With the benefit of hindsight, it is easy to say that alcohol played a major factor in the Deceased's death.

13.33 The Independent Investigation Team has tried to negate the effect of hindsight bias by assessing this key issue not on the basis of the part that alcohol played in the Deceased's death, but the role that it played in Ms A's treatment and the process by which its impact was assessed.

13.34 Development of Issue of Alcohol in EIP

13.35 The table below sets out the occasions in which alcohol is mentioned in Ms A's EIP records.

TABLE 13.6

Date	Clinician	Comment
24 September 2007	GP 1	Ms A has been quite physically aggressive mainly towards her boyfriend. This behaviour is exacerbated when she has had a drink of alcohol.
03 October 2007	Social Worker 1	CPA needs assessment. Ms A was given a caution by the police for stealing alcohol at the age of 16. Standard risk assessment. Ms A tends to binge drink over the weekend. Service User states she drinks 1 bottle of wine and 4 Jack Daniels and coke or Vodka and coke. Ms A does not feel she has any alcohol issues and prefers to drink to help her be around friends and to forget about her anger issues. Becomes more angry at time of drinking. Does not wish to stop drinking. EIP Triage Team: Ms A has a caution for stealing alcohol aged 16.
17 October 2007	Staff Grade 1/Psychiatric Nurse 1	Ms A drinks alcohol once a week with the maximum intake of two bottles of wine (14 units) or spirit (1/4 of a bottle). She denied using illicit drugs.
15 November 2007	Social Worker 2	Ms A telephoned Social Worker 2. Ms A stated she had started sertraline. Ms A was concerned that product info said no alcohol to be taken, said this would be difficult in the lead up to Christmas. Ms A she would not be drinking that weekend and would await advice from Staff Grade 2.
19 November 2007	Social Worker 2/Team Leader 1	Ms A happy to discuss concerns about alcohol and her medication with Staff Grade 2.
10 September 2008	Psychiatric Nurse 2	Ms A arrested for drink driving. Ms A expecting a ban.
30 June 2008	Social Worker 2/Staff Grade 2	Ms A had what she describes as a "blackout" on 26 June 2008 when she was out of control but was told afterwards she was hitting family members. She had an altercation with stranger in the street. She reported that she had not had any alcohol on this day but had 2 alcopops

		the day before.

13.36 During the course of the interviews with those responsible for delivering Ms A's care, it was clear that local services such as the Community Drug and Alcohol Team (CDAT) were in place for the assessment and treatment of substance misuse. All those individuals interviewed were aware that they could have sought advice from these specialised services regarding treatment options or difficulties in service user engagement without the need for a formal referral.

13.37 Key Points

There were a significant number of diagnostic clues which could have assisted the EIP Service to reach an accurate and relatively speedy diagnosis, in order to implement a care package which addressed Ms A's needs.

These clues were not systematically followed and developed, resulting in a significant number of missed opportunities, the most clinically-significant being the nature of Ms A's use of alcohol and her longstanding anger issues as demonstrated by her school records and difficulties in her personal relationships.

Had Ms A's case had greater exposure to MDT working and had been explored in greater detail in supervision, this may not have occurred.

School History

13.38 GP 1's letter of referral to Cheshunt CMHT did not include any details of Ms A's behavioural issues at school. This information could potentially have been helpful for Ms A's clinicians.

13.39 It is very easy in hindsight to point to the information contained in Ms A's school records as being in some way predictive of her future conduct. Ms A is noted by the Prosecution Psychiatrist to not having been forthcoming about the reasons behind her school exclusion, despite apparent openness in other areas. However, information about schooling contributes to an understanding of personality development.

13.40 Ms A was a young adult when she sought help for her problems. It is relatively common practice for CAMHS to actively seek information concerning a child or adolescent in their care as it provides valuable diagnostic information. This practice occurs less frequently in adult mental health services. However, the EIP Service is a service dealing with younger adults and indeed Ms A was 18 at the time of her initial referral. Therefore, there might have been some advantages in obtaining these records.

13.41 Throughout Ms A's care, the following information was elicited about her schooling and its troubled history.

TABLE 13.7

Date	Clinician	Comment
3 October 2007	Social Worker 1	Ms A's childhood was chaotic whereby during primary school she ran out and described her father carrying her or grabbing her arm to return to school. It is alleged by Ms A that a bystander reported the incident to CSF. Ms A disclosed she did not go to school from the end of Year 6 until mid Year 7. Ms A described her not wanting to go to school was as a result of not sleeping at home as she imagined a man standing in her room and was too frightened to sleep.
17 October 2007	Staff Grade 1	Aged 10 she was expelled from school for anti social behaviour (Ms A found it difficult to elaborate on this). She left school with no qualifications. There is a history of school refusal as a child (aged 7). The welfare officer was involved in her case but it is not clear whether she was seen by a child psychiatrist/psychologist.
7 November 2007	Social Worker 2	Ms A identified her anger being a major factor in her being excluded from school Year 10 onwards. Ms A also reported that she had had some anger management support whilst at school but she had not found it very useful..
4 March 2008	Social Worker 2	Ms A went to a different school to some of her friends which she was unhappy about and both her and her mum report that Ms A's behaviour was difficult for her school to manage
30 June 2008	Social Worker 2	Ms A and her mum report that Ms A was expelled from secondary school before taking her GCSE's due to history of impulsive behaviour at school e.g. walking out of class, shouting at teachers etc.

13.42 Key Points

Ms A's troubled school history reveals a number of key diagnostic clues. In particular, it confirms that Ms A's anger issues were longstanding and that Ms A's interpersonal relationship with her father was

a difficult area for her. However, there is little evidence in Ms A's notes which suggests that these issues were explored.

14.0 DIAGNOSTIC APPROACH

14.1 Published Guidelines relating to Ms A's care

14.2 NICE Guidance

14.3 NICE has issued guidance in relation to depression entitled 'Depression: the treatment and management of depression in adults' (a partial update of NICE Clinical Guideline 23 which was issued in December 2004) ('Clinical Guideline 90') in October 2009. The references in this report to Clinical Guideline 90 refer only to the guidance which was in force when Ms A received treatment and not to guidance which was subsequently amended.

14.4 The Clinical Guideline 90 covers the care of people with depression by their GP or other healthcare professionals, whether they receive treatment in or out of hospital, together with the information they can expect to receive about their problem and its treatment including psychological therapies and drug treatment. Clinical Guidance 90 looks at depression in people aged 18 years and older, and covers mild to severe depression.

14.5 NICE Clinical Guideline 22 (amended) 'Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care' ('Clinical Guideline 22') was issued in April 2007. This document deals provides full guidance on the management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.

14.6 NICE Clinical Guideline 31 entitled 'Obsessive-Compulsive Disorder: Core Interventions In The Treatment Of Obsessive-Compulsive Disorder And Body Dysmorphic Disorder' was published in November 2005.

14.7 Compliance with NICE guidance is the focus of Criterion 5.8 of the NHSLA Risk Management Standards. This requires organisations to have in place approved documentation which describes the process for ensuring that agreed best practice, as defined by NICE, is taken into account in the delivery of clinical services. In addition, the NHSLA will look to see whether the processes set down in policies have been implemented and monitored. In the event that deficiencies have been highlighted, the NHSLA will look to see whether action plans have been developed and changes implemented.

14.8 HPFT currently have in place the policy 'NICE Guidance & Any Other National Agreed Guidelines Implementation Process' which was introduced after 20 September 2008.

14.9 In an additional helpful summary for staff which was revised December 2010, HPFT makes it clear that:

> *'In their own practice staff are expected to use NICE guidelines as the over-riding (but not the only) source of evidence of their clinical effectiveness*

In undertaking practice audit or other clinical effectiveness projects staff are encouraged to use NICE guidelines as a key source of clinical standards.'

14.10 British National Formulary Guidance ('BNF')

The BNF is a joint publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain. The BNF includes key information on the selection, prescribing, dispensing and administration of medicines. Information on drugs is drawn from manufacturers' literature, UK Health Departments, regulatory bodies etc. The BNF also takes account of national guidelines, best practice and emerging safety concerns.

14.11 Compliance with NICE Guidance and BNF

14.12 While guidelines inform clinical practice, they do not dictate it and doctors can still exercise clinical judgment. Each individual service user and the specific scenario must be considered on a case-by-case basis with all clinical factors being taken into account.

14.13 However, doctors have a duty to be *'familiar with relevant guidelines and developments that affect [their] work'* (Paragraph 12, Good Medical Practice) such as NICE guidelines, as well as any local guidance with respect to a particular procedure or treatment. Importantly, they can depart from guidance in specific situations when they consider it to be in the service user's best interests to do so.

14.14 In a document entitled 'The legal context of NICE Guidance', NICE itself explained in 2004 that:

'Once NICE guidance is published, health professionals are expected to take it fully into account when exercising their clinical judgment. However NICE guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual service user in consultation with the service user and/or their guardian/carer. As with all clinical decisions, the clinician must be prepared to explain and justify their decisions and actions, especially if there is a departure from guidelines produced by a nationally recognised body.'

14.15 Key Points

HPFT has in place a detailed policy relating to the implementation of NICE Guidelines. The importance of guidance such as that published by NICE is recognised by the NHSLA. HPFT staff are actively encouraged to adopt NICE Guidelines in relation to the care which they promote.

15.0 DIAGNOSTIC PROCESSES

15.1 The NHS has experienced a number of high profile investigations into care delivery across a number of specialties. Each investigation has demonstrated individual clinical failings of one kind or another. However, these investigations have also demonstrated fundamental flaws in the way care was organised within NHS organisations. Organisations where failures occur may lack management systems relating to incident reporting and performance management. In addition there may be evidence of poor collaboration between managers and clinicians and a lack of coherent clinical leadership.

15.2 The Department of Health stated in its Report entitled 'An Organisation With a Memory':

> *'Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety net to mitigate its consequences.'*

15.3 At the outset of this review of Ms A's diagnosis and treatment, the Independent Investigation Team wishes to make it clear that, whilst the Independent Investigation Team has concentrated upon the actions of individual clinicians, this is not an attempt to introduce a "blame culture" into its analysis of Ms A's care. The reason that the actions of those individuals are relevant is not in order that their overall clinical competency should be called into question, but rather to provide a focal point for consideration of how the organisation supported their actions in an attempt to ensure the quality of care delivered to service users.

15.4 The Independent Investigation Team has spent some time analysing the diagnostic approach which Staff Grade 2 has adopted in relation to Ms A. It has done this not in an attempt to ascribe blame to Staff Grade 2 for any purported failings. The Independent Investigation Team recognises that its review has concentrated on only one case, which is insufficient to draw any firm conclusions about Staff Grade 2's overall competence and capability.

15.5 The Independent Investigation Team's focus is instead to evaluate how Ms A's care was delivered in systemic terms and how the clinical governance regime in operation at the time dealt with her presentation.

15.6 Ms A's care highlights a number of issues in the diagnostic process applied to her care. These issues are as follows:

1. Lack of clarity in the diagnostic process;
2. Failure to review in multi-disciplinary setting;
3. Failure to apply Reflective Practice;
4. Failure to recognise difference between observed and reported mental state;
5. Failure to use motivational interviewing.

15.7 Failure to adopt a Structured Approach in the Diagnostic Process

15.8 The EIP Service is a specialised team which deals with psychosis. Ms A's referral by her GP was in relation to depression with paranoid ideas associated with outbursts of anger. In Staff Grade 1's initial view Ms A's presentation was of a depressive episode, or possibly an emerging personality disorder. A core principle of EIP Services is that they can tolerate diagnostic uncertainty. However, that does not obviate the need to attempt to reach a diagnosis.

15.9 The Independent Investigation Team could find no detailed evidence of the exact nature of the diagnostic process relating to Ms A. Decisions appear to have been made on an ad-hoc basis. Ms A's diagnosis appeared uncertain at times. The Independent Investigation Team is of the view that there would have been significant value in exploring Ms A's past history further as information such as her schooling, terminations, inter-personal relationships, etc., would have provided vital diagnostic clues and had been highlighted by Ms A herself. Equally no goals were set for Ms A or benchmarks identified to assess her progress. There have been no real attempts made to examine features of her presentation systematically. This has led to the diagnostic process appearing somewhat unclear.

15.10 Throughout Ms A's care, her diagnosis was primarily that of depression. NICE Clinical Guideline 23 (as amended) was in force throughout Ms A's care. Clinical Guideline 23 is very specific and shares the learning from many practitioners as to how the treatment of depression might be carried out.

15.11 The Independent Investigation Team could find no clearly documented evidence of compliance with this guideline in relation to Ms A's care. This is a matter of considerable concern to the Independent Investigation Team.

15.12 The failure on the part of a number of professionals to explore information or to appreciate its clinical importance can be looked at individually or systematically.

15.13 Even during the course of the interviews conducted with clinicians, it was not clear what process or strategy had been adopted to consider the information about Ms A which the EIP Service had access to. For example, when asked about the continuing diagnosis of depression which had been coded as 'Recurrent Depression', Staff Grade 2 responded in the following terms:

'DW:	*You have now put a diagnostic coding of a recurrent depressive disorder. Was she not in the same episode that you were treating her for? I am just wondering why that coding came in. I mean it's a long time back now.*
Staff Grade 2:	*I don't know. I probably somewhere recognised that there was more than one episode but maybe she was symptomless or just got a mild and insignificant clinical score, something like that, yes,*

and it was already quite a long time she was in this depression, I really don't recall any changes in diagnosis.'

15.14 Systemically, the Independent Investigation Team is concerned that this information did not form part of a structured diagnostic process involving the MDT, or a planned CPA review. The CPA process is dealt with more fully in Section 20 and the MDT approach at Paragraphs 19.47 – 19.52.

15.15 Failure to review Ms A in a Multi-Disciplinary Setting

15.16 Ms A's presentation was not straight-forward, even in relation to a diagnosis of depression. In the opinion of the Independent Investigation Team, her case would have benefited from discussion in supervision or indeed at a MDT meeting. No evidence has been produced to the Independent Investigation Team that this happened. Difficulties with the MDT meeting and supervision are discussed more fully in Section 19. The lack of multi-disciplinary review of Ms A's progress has not been substituted for by any other review process and has adversely impacted upon the delivery of her care.

15.17 Failure to apply Reflective Practice

15.18 Many features of Ms A's presentation which were clear from an early stage were diagnostically significant, but were not necessarily a feature of depression. However, depression appears to have been the primary diagnosis which was actively pursued. The EIP Service gave consideration to OCD and changed their treatment strategy as a result for a time. Information concerning Ms A's interpersonal relationships, her longstanding anger issues, her relationship with alcohol, etc. could, had they been a target for investigation and consideration, have pointed those responsible for delivering Ms A's care in a different direction. These other factors do not appear to have featured in the diagnostic process.

15.19 The Independent Investigation Team is concerned about the apparent failure to keep Ms A's symptomatology under review, particularly when medication was changed because of lack of response or perceived benefit. At no stage have the reasons behind Ms A's lack of improvement in relation to her depressive symptoms been questioned. In addition, the Independent Investigation Team is concerned that features of Ms A's presentation were misunderstood in this context. In particular, the Independent Investigation Team is concerned that in relation to the issue of anger, the fact that Ms A gave a history of anger which pre-dated the depression was not re-visited when Ms A failed to improve.

15.20 There is no evidence that reflective practice, which is an important facet of modern psychiatry, was applied in relation to Ms A. When symptoms do not respond as expected, it is worth starting afresh with the history and considering alternative diagnoses systematically. The Independent Investigation Team could not find any documented evidence of this happening at any stage in Ms A's care.

15.21 Observed Mental State versus Reported Mental State

15.22 A further concern for the Independent Investigation Team is the failure by those treating Ms A to recognise a disparity in the information which Ms A gave about herself and her background and the manner in which she presented at consultations. Throughout the Independent Investigation, the EIP Service commented upon Ms A as being a quiet and polite person. However, the information that she was giving the EIP Service, such as in reporting the incident where she had hit her boyfriend over the head with a broken bottle, does not fit with that assessment. The difference between her observed mental state and her reported mental state should have led to further investigation or review of diagnosis. There is no evidence in Ms A's records that this occurred.

15.23 Motivational Interviewing

15.24 It is clear from the records that Ms A was prepared at a very early stage in her contact with mental health services to give sensitive information about her life and history to individuals such as Social Worker 1. Motivational interviewing techniques do not appear to have been used to explore key areas of Ms A's life, such as alcohol, which could have provided further clues to diagnosis or information to help address Ms A's treatment needs.

15.25 Key Points

A structured approach was not taken towards diagnosis of Ms A's difficulties.

There was no evidence of any of the following features of good practice in the diagnostic process which was applied to Ms A:

A systematic evaluation of all of the symptoms with which Ms A presented, together with the information which was known about Ms A, did not occur.

There was a failure to comprehensively or systematically review Ms A's care in a multi-disciplinary setting.

There was an apparent failure to apply reflective practice, to evaluate Ms A's progress and its impact upon the appropriateness of her treatment plan.

There was a marked difference between Ms A's observed mental state and her reported mental state. This was never recognised as an issue and investigated.

Motivational interviewing techniques do not appear to have been utilised to help uncover vital information which was necessary to help reach an informed diagnosis.

15.26 Impact of Lack of Structured Diagnostic Process

15.27 As has already been stated, Ms A's diagnosis remained one of depression throughout her care under the EIP Service. This was in fact a period in excess of ten months. Had a more structured approach towards diagnosis been taken, involving the elements set out at Section 13, then the Independent Investigation Team is of the view that a diagnosis which addressed all of Ms A's needs could have been reached at an earlier stage. A significant issue which failed to be recognised and which was a factor in the Deceased's death was Ms A's use of alcohol.

15.28 Ms A mentioned her use of alcohol at an early stage in her contact with the EIP Service.

15.29 Staff Grade 1 discussed the issue of alcohol with Ms A at her only consultation with her on 17 October 2007. During the course of her interview, Staff Grade 1 was asked about the impact which alcohol might have had on Ms A. She stated:

> *'Staff Grade 1: … we talked a lot about psychological education, about alcohol and impact on mental state and, you know, how it could exacerbate with everything, anger, her mental health, but I don't think she actually recognised that as a problem, and also she did deny using drugs for a while so I understand that she had been using lots and lots of drugs which we never knew about, you know, she said no I didn't use any drugs, never touched them, so there's a bit of denial of that, you know, a kind of fear that she's been using you know.'*

15.30 During the course of the Internal Investigation undertaken by HPFT, Staff Grade 1 confirmed that because Ms A reported a level of alcohol which she understood was within the recommended weekly limit as she understood it, she did not consider Ms A's drinking to be problematic.

15.31 However, even at an early stage in Ms A's care, Ms A had revealed information, which should have been a target for further investigation. For example, Ms A had admitted to being a substantial binge drinker, drinking 20 units of alcohol at a session, at a relatively young age. Her account of what she drank was unreliable in that she told Social Worker 1 she drank approximately 14 units at a time and Staff Grade 1, 20 units. She had a caution for stealing alcohol and she admitted that she used alcohol as a tool to relieve anxiety in social situations and drinking to forget. Significantly, she highlighted for the EIP Service a link between alcohol and her levels of aggression.

15.32 However, there is no evidence that further assessments were carried out, which was a significant missed opportunity. The reason for this appears to be that the EIP Service was of the view that Ms A did not consider her alcohol intake an issue and did not want to reduce her levels of drinking.

15.33 Staff Grade 2 was asked about the potential impact alcohol could have had upon Ms A's problems. Her response was as follows:

> *Staff Grade 2:* *…we discussed her alcohol. She said that she binges alcohol mostly during the week-ends when she wants to socialise and she is, it is a coping strategy. I think that Ms A knew very well that it is not allowed when she is on her psychiatric medication and she was advised many times on not drinking of course, by myself and also by Staff Grade 1 at the beginning, and Social Worker 2 repeatedly said it. Ms A never admitted to us that she was taking any illicit drugs or any other drugs.*
> *…we recognised it as a trigger factor of her anger, but I don't feel that Ms A was in that time in the place that she really wanted to stop drinking completely.'*

15.34 Social Worker 2 was also asked about the amount Ms A drank and her ability to obtain alcohol. Her response was as follows:

> *'Social Worker 2:* *I mean she was talking about having very low income, so when she said this is what I drink, you know, I took her at face value.'*

15.35 Social Worker 2 was also asked whether she considered the variance in Ms A's mood to be potentially related to alcohol.

> *'Social Worker 2:* *I guess it could, yeah, I think she was very changeable over the few months and that was one of the difficulties really with her that she, you know, very much, when we first started working with her there was the worry about the low mood and the anger obviously was really very much pertinent for the first couple of months and then it was, it seemed that that maybe diminished and then there was OCD, and anxiety and then, you know, she flipped around quite a bit and maybe that was connected to the alcohol use, and I think from, who knows whether it's true, but kind of from after the event her Mum was talking to me about she, unbeknown to me and to her that she was using lots of other drugs and that could make sense in terms of things being a bit all over the place.'*

15.36 On 11 September 2008, a note in Ms A's records compiled by Psychiatric Nurse 2 refers to an incident involving Ms A, her involvement in a fight and her subsequent arrest for drink driving. Details of this consultation are set out in the Chronology prepared by members of the Independent Investigation Team. This was only the second occasion upon which Psychiatric Nurse 2 had met Ms A. In interview, Psychiatric Nurse 2 was asked, whether this event raised any concerns about risk. Her response was as follows:

> *'Psychiatric Nurse 2:* *Well it raised the issue, yes of, one that her behaviour was, seemed quite chaotic and two, as it would do for anyone to be drink driving, carelessness.*
> *PV:* *Did it raise any issue for you in terms of her drinking behaviour?*

Psychiatric Nurse 2: I'd known from previous that it was previously recorded that she was a binge drinker, recreational drinker and seemed in pattern with that really, and that she'd got into a fight with another girl.'

15.37 In fact, this incident failed to elicit a response from the EIP Service in terms of Ms A's behaviour save that a letter was written to the Court in support of Ms A's defence to the drink driving charge. Instead of Ms A being required to address her issues she was instead provided with practical assistance which took the responsibility to do so away from her.

15.38 The incident was not raised as a 'hot spot' within the MDT structure. It did not prompt a CPA Review or a risk assessment, despite it being a potential diagnostic clue to Ms A's presentation which should have received further investigation, involving third parties such as Ms A's carers if necessary. The MDT structure operated by the EIP Service and the CPA process are dealt with more fully at Paragraphs 11.7 – 11.24, 19.45 – 54 and Section 20.

15.39 Ms A also highlighted to the EIP Service the importance of alcohol to her in that she expressly queried with her care co-ordinator whether she could take alcohol with her medication. This could have indicated a potential prioritisation of alcohol over her treatment which would be a matter of concern and again highlighted a need for further exploration with Ms A. Social Worker 2 in interview was asked about whether this raised any concerns:

'Social Worker 2: I thought actually it was quite sensible to be honest, I thought Christmas was coming up she is wanting to take this medication that she was thinking about you know if I am going to have some drinks what is going to happen, I think we work with a lot of young people that wouldn't give a monkeys to be honest so I think that was quite a helpful useful thing for her to ask.'

15.40 Social Worker 2 was asked about her understanding of the assessment of the impact which alcohol had on Ms A's presentation:

'Social Worker 2: I think we were aware that that was the situation with her, she didn't deny it, she didn't you know, this is what I do at the weekend, and this is what happens, she didn't think it was a significant issue and didn't want to kind of work to reducing it.'

15.41 The impression which the Independent Investigation Team gained from the interviews which were conducted with the EIP Service was that Ms A, during the course of her treatment, did not realise or accept that there was a problem with her drinking and it was she who then dictated its inclusion in her care. The Independent Investigation Team is also of the view that there was a lack of an inquisitive approach concerning alcohol or other substance misuse issues on the part of those responsible for her care. The Independent Investigation Team is of the view that the information which Ms A imparted throughout her care should have led to an increase in suspicion concerning the risk which alcohol would have had on her presentation.

15.42 Denial of a drinking problem can be symptomatic of a problem involving alcohol. Alcoholic clients tend to be evasive when questioned about their drinking and it may be difficult to recognise that alcohol is aggravating or even causing the problems that they are presenting. However, whilst Ms A was evasive about the amount which she was drinking, she was in fact clear about the impact which it had on her problems.

15.43 Alcohol has a depressant effect, particularly binge drinking. Around a third of young suicides have drunk alcohol before their death and increased drinking may have been to blame for rising rates of teenage male suicide. There is a connection between depression and alcohol, and both self-harm and suicide are much commoner in people with alcohol problems. Alcohol can create and exacerbate relationship problems. Further, alcohol can increase impulsivity.

15.44 Despite the fact that Ms A expressed the view that her drinking was not a matter of concern for her, it was in fact problematic. As she herself conceded, it had an impact upon her personal relationships and levels of aggression for which she had sought help. The Independent Investigation Team notes the absence of any planned approach to steps that should have been put in place to work with her, to allow her an insight into this key area of her life. In particular, no attempts were made to monitor Ms A's use of alcohol, nor does it appear that any efforts were made to engage her in alcohol or substance use assessment.

15.45 Instead, the EIP Service appears to have put the issue of alcohol to one side whilst they focused upon other issues which in fact could have been a feature of Ms A's use of alcohol. Indeed, even when they were told by Ms A that she intended to take alcohol with her antidepressant medication, she was congratulated for asking questions rather than any assessment being made of the nature of her drinking or the issue of potential non-compliance being considered. Equally, when Ms A was arrested for drink-driving, the EIP response was to provide her with a letter to assist her in the resultant court proceedings, rather than seeking to re-evaluate the situation with regard to her drinking.

15.46 When alcohol and medication are combined, symptoms may be exacerbated. In particular, alcohol can worsen depressive symptoms. Drinking can counteract the benefits of medication, making symptoms more difficult to treat. In addition, side effects may be worse if alcohol is taken. Indeed, NICE Guideline 90 suggests that in cases where alcohol is a feature, pre-treatment counselling may be advisable before any form of medication is commenced. There is no indication in Ms A's notes that Staff Grade 2 took the potential effect of binge drinking into account when undertaking her reviews of Ms A's medication (see Paragraphs 17.22 - 17.69).

15.47 Diagnostically, the presence of alcohol makes identification of mental illness or personality disorder more difficult and treatment more problematic. Risk assessment also becomes considerably trickier. There is no evidence in Ms A's records of a planned approach to Ms A's use of alcohol in order to assess its impact upon her presentation and facilitate her

acceptance in its potential role in her problems. The Independent Investigation Team is concerned that the EIP Service did not properly assess the role of alcohol in Ms A's care and take sufficient steps to develop an appropriate treatment strategy.

15.48 The EIP Service missed a number of opportunities to open up discussions about alcohol with Ms A. With proper care planning and or referral to 'hot spot', it may be that those caring for Ms A might have been able to gain a different perspective upon the information which was available at the time with regard to Ms A's use of alcohol.

15.49 Recommendations to Improve Patient Safety

Patient safety was compromised in this case by a failure to adopt a structured approach towards diagnosis. This could have been mitigated by a robust supervision process or equally by discussion in a MDT meeting.
The EIP Service has strengthened its supervision and MDT processes since this incident and has produced clinical and practice standards for Early Intervention in Psychosis. However, the Independent Investigation Team is of the view that these systems should be the subject of regular audit to ensure that the improvements which have been made have been implemented and that they are effective.

15.50 Key Points

Ms A had a caution for stealing alcohol which was known to the EIP Service.
Ms A was clear at an early stage of her relationship with the EIP Service that she was a binge drinker, drinking in excess of 20 units at a time.
Ms A made it clear to the Service that the consumption of alcohol was important to her as she queried whether she could take alcohol and her medication together.
Ms A stated at the outset of her care that alcohol increased her levels of violence.
Despite these factors being known to the Service, the impact of alcohol was not considered diagnostically in relation to Ms A's complains of low mood or indeed any of the other symptoms which she reported including aggression. This is a matter of significant concern. Notwithstanding Ms A's reluctance to discuss this issue, the EIP Service should have taken steps to clarify the impact of alcohol on Ms A's presentation.

15.51 Diagnostic Rating Scales

15.52 During the course of Ms A's care, the EIP Service utilised a number of rating scales. Scales are helpful in confirming a clinical opinion but are not in themselves a diagnostic tool. However, their use demonstrates a desire on behalf of the team responsible for Ms A's care to attempt to monitor her progress.

15.53 The Following rating scales were applied:

1. PANSS
2. HoNOS
3. Beck Anxiety Inventory
4. Beck Depression Inventory
5. Y-BOCS.

15.54 PANSS

15.55 The Positive and Negative Syndrome Scale (PANSS) is a scale used for measuring symptom reduction of schizophrenia service users. It is also widely used in the study of psychosis. It is not generally used in the care of individuals thought to be suffering from depression. Staff Grade 1 asked that Ms A complete a PANNS questionnaire on 17 October 2007 as was standard practice for new patients within the EIPS Service at the time.

15.56 Ms A's results indicate that she was not achieving any scores which would indicate psychosis. Consequently, even at a very early stage in the diagnostic process, Ms A's presentation was not straightforward, indicating a need for reflective practice.

15.57 HoNOS Health of the Nation Outcome Scales

15.58 HoNOS is a scale on which service users with mental illness are rated by clinical staff. If ratings show a difference over a period of time, then that might mean that the service user's health or social status has changed.

15.59 Ms A underwent HoNOS on 7 December 2007 and again on 1 July 2008. The differences in the scores obtained on each occasion tend to show that her condition was deteriorating despite having received treatment.

15.60 Beck Anxiety Inventory

15.61 The Beck Anxiety Inventory (BAI) is a 21-question multiple-choice self-report inventory that is used for measuring the severity of an individual's anxiety.

15.62 Ms A completed two Beck Anxiety Inventories. The first was on 24 June 2008 when the result was a score of 36, indicating severe anxiety. This appears to have been carried out by Social Worker 2 and was not in response to a request by a clinician. The second was undertaken on 6 August 2008, where the result was a score of 23, indicating moderate anxiety.

15.63 These scores further complicate the picture presented by Ms A, because it shows an improvement in her levels of anxiety.

15.64 Beck Depression Inventory

15.65 The Beck Depression Inventory (BDI, BDI-II) is a 21-question multiple-choice self-report inventory, for measuring the severity of depression.

15.66 Ms A completed a Beck Depression Inventory on 24 June 2008. She obtained a score of 34, indicating severe depression.

15.67 Yale Brown Obsessive Compulsive Scale (Y-BOCS)

15.68 A cause for concern is that Staff Grade 2 asked for Y-BOCS to be carried out. The Yale Brown Obsessive Compulsive Scale (Y-BOCS) is a measurement tool for OCD. Despite having requested this test on 20 December 2007, it was never carried out or the results recorded in the records. This is not good practice.

15.69 Key Points

The EIP Service demonstrated a willingness to include the use of rating scales in their care of Ms A. This is an element of good practice.
However, the result of these tests did not become a part of the diagnostic evaluation or indeed re-evaluation of Ms A. Therefore the benefit of undertaking these tasks was lost.
The concern of the Independent Investigation Team is that the results of the tests which were carried out added to the complexity of Ms A's presentation and did not add clarity. This lack of clarity did not initiate a review of Ms A's care.

16.0 CARE GIVEN BY MS A'S GENERAL PRACTITIONERS

16.1 Ms A was born on 15 August 1989. Therefore, until 15 August 2007 when she reached 18, children and young adult protocols applied to her treatment.

16.2 NICE issued guidance in September 2005 entitled 'Depression in children and young people: identification and management in primary, community and secondary care' ('Clinical Guideline 28'). The Guidance deals with the prescription of antidepressants in young adults. As of 15 September 2007, there were no antidepressant drugs that held UK Marketing Authorisation for the treatment of depression in children and young people (under 18 years). A key issue to the failure to obtain authorisation is the risk of suicide-related behaviour and hostility in young people who are prescribed such medications.

16.3 Clinical Guideline 28 gives clinicians the following guidance about the use of antidepressants in young adults and attempts to balance the risks of such medication being prescribed with the benefits which can be achieved.

> *'1.6.1.2 Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], inter-personal therapy or shorter-term family therapy); it is suggested that this should be of at least 3 months' duration.'*

16.4 Further, it states:

> *'1.6.4 How to use antidepressants in children and young people*
> *All antidepressant drugs have significant risks when given to children and young people with depression and, with the exception of fluoxetine, there is little evidence that they are effective in this context. Although fluoxetine can cause significant adverse drug reactions, it is safer when combined with psychological therapies….'*

16.5 The following guidance outlines how fluoxetine should be used, and suggests possible alternatives in the event that fluoxetine is ineffective or not tolerated because of side effects:

> *'1.6.4.3 When an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks.'*
>
> *'1.6.4.5 a child or young person prescribed an antidepressant should be closely monitored for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment, by the prescribing doctor and the healthcare professional delivering the psychological therapy….'*
>
> *'1.6.4.6 When fluoxetine is prescribed for a child or young person with depression, the starting dose should be 10mg daily. This can be increased to 20mg daily after 1 week if clinically necessary, although lower doses should be considered in children of lower body weight. There is little evidence regarding the effectiveness of doses higher than 20mg daily. However, higher doses may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority.'*

'1.6.4.9 If treatment with fluoxetine is unsuccessful or is not tolerated because of side effects, consideration should be given to the use of another antidepressant. In this case sertraline or citalopram are the recommended second-line treatments.'

'1.6.4.14 Tricyclic antidepressants should not be used for the treatment of depression in children and young people.'

16.6 Ms A was seen by her General Practitioners on the following occasions in relation to depression prior to her reaching her eighteenth birthday:

TABLE 16.1

Date	Symptom	Drug	Dose
11 October 2006	depression – moderate depressive episode	Fluoxetine hydrochloride	20mg
31 October 2006	depression	Fluoxetine hydrochloride	20mg
21 November 2006	ent problems. Depressed on medication. Sleep and appetite problems (referred by Practice Nurse to GP)	none	None
01 December 2006	depression – sleep is a problem	Diazepam	5mg
11 December 2006	depression – fluoxetine not helping poor appetite and sleep	fluoxetine	not stated
25 January 2007	depression	Amitriptyline hydrochloride	10mg
26 February 2007	chronic sinusitis anger problems refer drop in centre	amitriptyline	not stated
23 May 2007	panic attacks	Amitriptyline hydrochloride	25mg
14 September 2007	paranoid and aggressive	Dosulepin	25mg

16.7 The BNF published in September 2008 states in relation to tricyclic antidepressants such as amitriptyline hydrochloride and dosulepin hydrochloride:

'Children and adolescents
Evidence of the efficacy of tricyclic antidepressants for depression in children has not been established.'

16.8 It goes on to confirm the advice given in Clinical Guideline 28 in relation to the use of fluoxetine and the need to monitor adolescents in relation to the risk of self-harm and suicide.

16.9 There are a number of elements of good practice in the primary care which Ms A received from her General Practitioners. For example, it is clear that Ms A was able to establish a good relationship with GP 1 who involved her mother in the consultations which Ms A attended. Her GP's also discussed a number of social issues with Ms A. An attempt was made to encourage Ms A to contact a local drop in centre for adolescents. This centre provides counselling services. Ms A was given the clinic's telephone number by her GP. Ms A's GP also reports

discussions with Ms A concerning her symptoms and problems. However, these discussions are not documented in Ms A's records.

16.10 However, the Independent Investigation Team is concerned that a key element of Clinical Guideline 28 was not followed, in that no watchful waiting periods were applied whilst other approaches were being trialled. Even at this early stage in her treatment Ms A was given a subtle message which was later repeated and re-emphasised by the care that she received that there was a solution to her difficulties in the form of medication. Therefore, putting it more bluntly, the right pill could cure her and make her 'better'. Ms A was not required to address the issues which could have given rise to her symptomatology even at an early stage.

16.11 In addition, the Independent Investigation Team has a number of concerns about the medication which was prescribed:

16.12 Fluoxetine was an appropriate choice of antidepressant for a young person. However, the Independent Investigation Team noted that an initial dosage of 20mg was prescribed which the BNF recommends for adults with 'major depression' rather than 10mg recommended by NICE. The reason for this clinical decision is not documented. Ms A was noted to have moderate depression. Further, the dose for children and young adults is 10mg initially, to be increased to 20mg and to be discontinued within 9 weeks if no improvement.

16.13 Whilst Ms A was first monitored after the first 2 weeks of the prescription of fluoxetine, she remained on this medication without improvement for a period in excess of 9 weeks without a formal review structure being in place such as that recommended by NICE. A review of her medication did however take place at around three weeks of commencing treatment. It should be noted that during this period, Ms A did attend her General Practitioners regularly with a number of other conditions and therefore was being seen by clinicians. Ms A's GP's have advised the Independent Investigation Team that Ms A would have been told to return to the GP practice every 2-4 weeks for review of her medication and mental state. There is no record in Ms A's notes that she received this advice. However, there is evidence in the notes that Ms A's depression was discussed at irregular intervals. At no stage is it documented that Ms A and her GPs discussed the risks and benefits of each medication, the risks and side effects attached, or potential benefits with her. Without such information being documented in Ms A's records, it cannot be said with certainty that Ms A received this advice.

16.14 Ms A was prescribed Amitriptyline between 25 January 2007 and 23 May 2007. Clinical Guideline 28 expressly states that tricyclic antidepressants should not be used for the treatment of depression in children and young people. Amitriptyline is a tricyclic antidepressant. In addition, the BNF does not recommend this drug for the treatment of depression. However, if depression is being treated then an initial dose of 30mg - 75mg daily is suggested for adolescents which can be increased to 150mg - 200mg. It appears, therefore, that Ms A did not receive an appropriate dose as she was prescribed a daily dose

of 10mg and 25mg in order to address her sleeplessness. The Independent Investigation Team has concerns about the prescription of this drug to a young person because, whilst it is not contraindicated, it is not best practice. (It is also concerned about the dosage administered which does not follow guidance set out in the BNF current at that time for depression). Indeed the good practice to note is the counselling which was undertaken, '*appropriate counselling in focus.*'

16.15 Dosulepin is also a tricyclic antidepressant. The BNF states that it is not recommended in children. When Ms A was prescribed this drug initially, it was the day before her 18th birthday. A greater concern for the Independent Investigation Team is consequently dosage levels. The BNF suggests an initial dose of 75mg. Ms A was prescribed 25mg, which is sub-therapeutic for depression.

16.16 Key Points

The care which Ms A received from her General Practitioners was not in accordance with NICE guidelines relating to *'Depression in Children and Young People: Identification and Management in Primary Community and Secondary Care'*, due to:

1. Use of a tricyclic antidepressant in a young adult.
2. Dosages of fluoxetine outside guidelines.
3. Poor review whilst on antidepressants.

17.0 RECORDING OF THE MEDICATION DISPENSED TO MS A

17.1 The Independent Investigation Team has given detailed consideration to the pharmaceutical approach adopted in Ms A's case because it represents the greatest element of the care given.

17.2 During the course of this investigation, the Independent Investigation Team has been hampered by a lack of clarity in relation to the medication which was prescribed to Ms A. The Independent Investigation Team understands from the interviews which were carried out that the EIP Service did provide clients with medication. There are no drug charts in the EIP Service notes, and few records of any medication being issued by the EIP Service in the care notes, such as a scan of the prescriptions which were issued to Ms A. Without such a written record in the notes, it becomes unclear at times as to where Ms A was obtaining her medication from, if at all.

17.3 This problem is exacerbated by the fact that Ms A's GP notes also do not record whether a prescription was issued. For example, only five prescriptions were entered into Ms A's General Practitioner records throughout the period when Ms A was receiving care from the EIP Service.

17.4 These prescriptions were as follows:

TABLE 17.1

Date	Drug	Dose	Number of tablets
18 October 2007	Dosulepin*	25mg 1 n	28
08 February 2008	Sertraline Hydrochloride Tablets	50mg 1 d	28
10 April 2008	Sertraline Hydrochloride Tablets	100mg 2 d	2 x 28
27 August 2008	Olanzapine	2.5mg nocte	28
27 August 2008	Venlafaxine M/R Capsules	75mg bd	2 x 28

**prescribed by GP*

17.5 This lack of clarity makes it difficult to assess whether Ms A was regularly obtaining her medication, which in turn may have had an impact upon her treatment regime. For example, according to her GP records, it appears that between 10 April 2008 and 27 August 2008, only one prescription for sertraline was prescribed despite the drug regime recommended by Staff Grade 2 set out at Paragraphs 17.22 – 17.69 below.

17.6 Recommendations to Improve Patient Safety

EIP may wish to consider reviewing their policies and procedures regarding the recording of medication and/or prescriptions in order to ensure that a full record of the medication dispensed is maintained.
The EIP Service should scan or otherwise record copies of prescriptions issued to service users in the service user's records.

17.7 Key Points

There is a lack of clarity in the recording of the medication prescribed to Ms A by the EIP Service.

17.8 Condition for which Ms A was being treated

17.9 During the course of her treatment Ms A was diagnosed as suffering from depression. It is against this background that an analysis of the medication prescribed to her has been considered.

TABLE 17.2

Date	Clinician	Diagnosis	Differential Diagnosis
24 September 2007	GP 1	Depression	
17 October 2007	Staff Grade 1	Moderate depressive episode F32.1	Possible traits of personality difficulties
20 December 2007	Staff Grade 2	Moderate depressive episode F32.1	Obsessive compulsive disorder Social phobia
22 February 2008	Staff Grade 2	Depressive episode F32	
9 May 2008	Staff Grade 2	Recurrent depressive disorder F33	Obsessive compulsive disorder Social phobia
30 June 2008	Staff Grade 2	Recurrent depressive disorder F33	Obsessive compulsive disorder Social phobia
28 August 2008	Staff Grade 2 (W AL)	Recurrent depressive disorder F33	Obsessive compulsive disorder Social phobia

17.10 Ms A was initially commenced on a 50mg dose of sertraline, an SSRI, by Staff Grade 1 on 17 October 2007. It is clear that Staff Grade 1 was aware of and took into account Clinical Guideline 90 in considering Ms A's needs. Indeed it is also clear that Staff Grade 1 reviewed

the medication previously prescribed by Ms A's General Practitioners. A note of her consultation with Ms A on 17 October 2007 states:

> *'I believe that she has not, yet, had an adequate trial of antidepressant medication (highest tolerated BNF limit), I therefore suggest that we start her on an antidepressant medication, and as per the NICE guideline SSRIs should be our first choice……she will be reviewed again by my colleague Dr P in three weeks time, with the view to reviewing her mental state and to increase her antidepressant medication gradually to the maximum tolerated limit.'*

17.11 This represents an example of good practice for the treatment of depression. Staff Grade 1 has taken into account Clinical Guideline 90, which supersedes Clinical Guideline 23, has noted the medication and dosages previously dispensed, and has prescribed sertraline in accordance with guidance set out in the BNF at that time. This states:

> *'Dose Depressive illness, initially 50mg daily increased if necessary by increments of 50mg over several weeks to max 200mg daily usual maintenance dose 50mg daily.'*

17.12 Staff Grade 1 wrote to GP 1 on 24 October 2007. This letter included details of the medication which she believed Ms A required and asked Ms A's GP to prescribe it. Unfortunately, this letter does not appear to have reached Ms A's GP. It was therefore faxed to Ms A's GP on 12 November 2007 by Social Worker 2. It appears from the notes that Ms A therefore started sertraline on 14 November 2007.

17.13 Monitoring of Ms A's response to Sertraline

17.14 During the period between Ms A commencing sertraline on 14 November 2007 and her first consultation with Staff Grade 2 on 20 December 2007, Ms A does not appear to have been monitored by the medical team. She was however being monitored by Social Worker 2 her care co-ordinator. Whilst it could be argued that the whole MDT had responsibility toward this monitoring, the care plans were not specific in this regard.

17.15 Staff Grade 1 had asked for Ms A to be seen by Staff Grade 2 three weeks after commencing sertraline. This is outside the review period recommended by Clinical Guideline 90, which is 2 weeks for people who are considered to be a suicide risk (see Paragraphs 1.5.2.6 and 1.5.2.7 of Clinical Guideline 90).

17.16 In any event, this requirement does not appear to have been applied following Social Worker 2's fax of 12 November 2007 as Ms A was in fact not seen by Staff Grade 2 until 20 December 2007. The Independent Investigation Team notes that this delay was due to a number of cancelled appointments. The reasons for the cancellations varied and included cancellations by Ms A but were also due to illness on the part of Staff Grade 2.

17.17 However, it should be noted that on 19 November 2007 it was reported by Social Worker 2 and Team Leader 1 that:

'Ms A reported that she was taking meds as prescribed for one week and had noticed no side effects and no changes in mood.'

17.18 Further on 27 November 2007, during the course of a telephone call with Social Worker 2:

'Ms A said that she was taking the sertraline and had not noticed any increased feelings of anxiety.'

17.19 On 7 December 2007, Social Worker 2 undertook a home visit with Ms A. It is noted in the records that:

'Ms A reported that she was taking sertraline as prescribed but not noticed any side effects aside from increased sleeping.'

17.20 Whilst it is not an uncommon practice for non-medically qualified care co-ordinators to monitor a service user's response to medication including the potential side effects, it does not constitute good or best practice. Social Worker 2 does not hold any medical qualifications and was inexperienced at this early stage in her career. Her notes record the fact that Ms A was not experiencing any side effects. However, the Independent Investigation Team are concerned that Social Worker 2 was not fully equipped to make such a judgment. A failure to monitor may put service users at risk, particularly when a young adult is involved.

17.21 Increase in Dose of Sertraline

17.22 On 20 December 2007, Staff Grade 2 saw Ms A for the first time. By this stage Ms A had been taking sertraline at a dose of 50mg for a period of 5 weeks according to her records. Whilst there appears to have been an intention to increase the dosage of sertraline on the part of Staff Grade 1, no detailed plan to do so had been formulated. The note of this consultation is brief. In relation to medication the entry states:

'….it is likely that Ms A suffer with social anxiety and obsessive compulsive syndrome probably OCD) rather than psychosis …….to increase sertraline to 200mg. Low dose of AP as a back up. Next appointment 2 week in February.'

17.23 The letter advising Ms A's GP of this change in her medication is dated 22 January 2008. It should be noted that the letter refers to sertraline alone. There is no mention of the low dose of 'AP' referred to in Ms A's notes.

17.24 In interview, Staff Grade 2 was asked about her decision to increase Ms A's dose of sertraline. She stated:

'Staff Grade 1 prescribed sertraline and she advised that we can increase it up to the upper recommended levels, which I did on this occasion.'

17.25 Clinical Guideline 90 states:

'1.5.2.11 If response is absent or minimal after 3 to 4 weeks of treatment with a therapeutic dose of an antidepressant, increase the level of support (for example, by weekly face-to-face or telephone contact) and consider:

- *increasing the dose in line with the SPC if there are no significant side effects or*
- *Switching to another antidepressant as described in section 1.8 if there are side effects or if the person prefers.'*

17.26 The BNF suggests the following:

'Depressive illness, initially 50mg daily increased if necessary by increments of 50mg over several weeks to max 200mg daily usual maintenance dose 50mg daily
Obsessive compulsive disorder initially 50mg daily increased if necessary in steps of 50mg over several weeks' usual dose range 50 – 200mg daily.'

17.27 The Independent Investigation Team recognises that Ms A had not had experienced any significant side effects of sertraline at this stage. However, it remains concerned about the increase in dose of sertraline from 50 mg to 200 mg without any intermediate prescribing level being undertaken, any formal monitoring plan being put in place, or indeed increased support being put in place as suggested in Clinical Guideline 90. In addition, the notes do not give any direction as to who would enact the increase of sertraline or how it was to be achieved in practical terms. The planning and communication process which has been applied is poor in this instance.

17.28 At this stage Ms A was still a young adult, being aged 18. Ms A's records confirm that it was not until 9 January 2008, some three weeks later, after commencing an increased dose of sertraline, that Social Worker 2 spoke to Ms A and who reported that she was well and had had no side effects of the medication apart from a complaint of loss of appetite. Indeed it appears that it was not Staff Grade 2's intention to see Ms A for a period of approximately 7-8 weeks following the increase in sertraline to the maximum dose. In addition, her GP would not have been aware of the increase in her medication for approximately 4 weeks following the increase in dosage, due to the delay in a letter being written following the consultation.

17.29 During the period between 20 December 2007 and 22 February 2008, when Staff Grade 2 next saw Ms A, the issue of sertraline was discussed with Social Worker 2 on three occasions on 9 January 2008 and 18 January 2008, when Ms A complained of loss of appetite and drowsiness, and 5 February 2008 when Ms A reported that she did not feel that the medication was working. The notes are clear that Ms A was taking an increased dose of sertraline.

17.30 Medication Change 22 February 2008

17.31 On 22 February 2008, Social Worker 2 and Staff Grade 2 met with Ms A. Ms A reported less paranoia and less violent behaviour but said she was still getting angry. She also reported decreased hand washing. It is not entirely clear from Ms A's notes what Ms A was being treated for at this point.

17.32 On this occasion Staff Grade 2 augmented sertraline with risperidone. Staff Grade 2 did not make an entry in the notes in respect of this consultation; the note was made by Social Worker 2. The note does not contain an explanation for the change in medication. Equally, the letter sent to Ms A's GP following this consultation, which is dated 7 March 2008 and which was signed by Social Worker 2 on behalf of Staff Grade 2, gives no clinical information or explanation for the change in medication. It does confirm that the diagnosis remained that of depression.

17.33 Risperidone did not hold a UK marketing authorisation for any condition other than acute/chronic psychoses and mania in 2008. By prescribing risperidone in this manner, Staff Grade 2 was not following any UK protocol or guidance for aggression or OCD. Consequently, if it was being used for the treatment of aggression, anxiety, or OCD then this issue should have been brought to Ms A's attention and a record made of her consent to the use of this drug made in the records in order to confirm that the service user had given an informed consent to the potential risk of increased side effects.

17.34 Clinical Guideline 90 does allow for risperidone to be prescribed to individuals suffering from depression in certain circumstances. However, from discussions at interview and in light of the poor record maintained of this consultation, the Independent Investigation Team was not able to confidently determine what Staff Grade 2 was treating with the prescription of risperidone. In interview, Staff Grade 2 was asked what the thinking behind the prescription of risperidone was:

> *'Staff Grade 2: There were a few thoughts about it. I had personal experience at a lower dose of antipsychotic can manage some other symptoms or some aggressive behaviour. Also, she was anxious and there are some OCD traits as well which also can be improved but the main thought behind it was to manage somehow these aggressive symptoms that she reported.'*

17.35 Later she stated:

> *'Staff Grade 2: I just, from my own experience I know that first of all anxiety and depressive symptoms responded have a prolonged response to the antidepressant treatment and I also always found that there is some personality issue in the background which, from my opinion, the change in the antidepressant as often as with a simple depressive illness is not good because they are responding really, they respond are prolonged as well. So I had it in my mind, I thought I might also change it later. I just wanted to give her a proper trial of the highest dose of sertraline augmented with antipsychotic.'*

17.36 Social Worker 2's note of this consultation states:

'PX given for respierdone to take alongside sertraline. Staff Grade 2 left Ms A questionnaire to fill in re OCD symptoms and will meet again in about 3 weeks to discuss and analyse.'

17.37 Social Worker 2's note of this consultation does not document the rationale behind the prescription of risperidone and sertraline, nor does it make reference to any discussions with Ms A about the clinical decisions surrounding the change of her medications and the possibility of side effects. Such a conversation may have taken place but without a record of it being contained in the records it is difficult to say that this was done. There was no plan for monitoring Ms A whilst on antipsychotic medication. This constitutes poor practice in recording and prescribing and also potentially places a colleague in a difficult situation.

17.38 Medication Change 8 February 2008

17.39 On 8 February 2008, a prescription for sertraline was issued to Ms A by her GP surgery. The prescription issued was for *'sertraline hydrochloride tablets 50mg 1 d 28 tablet'*, which was not the dosage requested by Staff Grade 2.

17.40 This error does not appear to have come to the attention of EIP Service until 7 March 2008, during the course of a home visit made by Social Worker 2 to Ms A. It is not clear why this error was not identified earlier at Staff Grade 2's review of Ms A and her medication on 22 February 2008. The prescription of a lower dose of medication could potentially have affected any decisions about medication and its effectiveness. It is also not clear from the records how the error came to light on 7 March 2008, but it did result in a letter being faxed to Ms A's GP. Staff Grade 2 had not at this time sent a letter to Ms A's GP regarding the prescription of risperidone on 22 February 2008. The letter does not refer to the GP's prescription error nor does it attempt to clarify what medication had been prescribed to Ms A, in what dosage and when.

17.41 It is a matter of concern to the Independent Investigation Team that this error does not appear to have come to light during the course of Staff Grade 2's consultation with Ms A on 22 February 2008.

17.42 Medication Change 10 April 2008

17.43 On 10 April 2008, a prescription of sertraline 100mg, 2 tablets to be taken daily, 2 packs of 28 tablets to be dispensed, was issued to Ms A by her General Practitioner. A prescription for risperidone was not issued. As no consultation with Ms A took place on this occasion, it is not clear why this medication was prescribed.

17.44 Medication Change 2 May 2008

17.45 During the course of a visit from Social Worker 2, Ms A was noted to be taking 200mg of sertraline each morning but was not taking any risperidone as she had experienced difficulty in obtaining it from her GP. Social Worker 2 arranged for Ms A to be seen by Staff Grade 2.

17.46 Medication Change 9 May 2008

17.47 At this time, Ms A was not taking risperidone and had not done so since 22 February 2008 when she received a prescription from Staff Grade 2 at a dose of 500mcg. It is not clear what period this prescription covered. No prescriptions of risperidone are recorded as having been issued by Ms A's General Practitioner.

17.48 At a consultation on 9 May 2008, Staff Grade 2 decided to recommence risperidone at an increased dose. Ms A was stated to be low in mood and energy but no other information about her condition is included in her notes, which were again written by Social Worker 2 and not Staff Grade 2. She was asked about this decision in interview and said:

> *'DW:* *…and then you actually increased the risperidone to 2mg and then 4mg thereafter.*
>
> *Staff Grade 2:* *My reasons for that were similar as I said. I wanted, as she responded very well on a small dose of risperidone, I was always aware of this and this aggressive problem and I used to work with young women with borderline impulsive traits in the past and I had a good experience with risperidone…'.*

17.49 Borderline Personality Disorder is a diagnosis which does not appear to have been considered by Staff Grade 2 previously. Her rationale for thinking that she was now treating Ms A in respect of a personality disorder is not outlined or indeed referred to in Ms A's notes or the letter sent to Ms A's GP concerning this consultation on 14 May 2008. Indeed, this letter states that the diagnosis was that of a 'Recurrent depressive disorder F33' with differential diagnoses of obsessive compulsive disorder and social phobia. The note of the consultation with Ms A on 9 May 2008 is particularly succinct and was compiled by Social Worker 2. Staff Grade 2's letter dated 14 May 2008 indicates that if the new medication regime did not bring effect in one month then Staff Grade 2 would change 'AD' medication.

17.50 The quick reference to NICE Guidance on borderline personality disorder published in January 2009 ('Clinical Guideline 78') states at Page 13:

> *'The role of drug treatment*
> *Do not use:*
> - *drug treatment specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms)*
> - *antipsychotic drugs for the medium-and long term treatment of borderline personality disorder.'*

The Independent Investigation Team recognises that, whilst NICE had not published guidelines in relation to borderline personality disorder at the time of Ms A's care, there was a substantial body of expert knowledge and literature that indicated the need for a more

sophisticated psychotherapeutic approach rather than reliance on psychopharmacology alone.

17.51 If Staff Grade 2 was continuing to treat Ms A for depression at this stage, then the change in risperidone was a reasonable proposal. However, once again, it is unclear from the notes and indeed from Staff Grade 2's responses in interview what was actually being treated. It is equally not possible to comment upon the appropriateness of the dosage of risperidone due to the uncertainty of what Ms A was being treated for at this stage.

17.52 Medication Change 21 May 2008

17.53 Social Worker 2 contacted Ms A by telephone and confirmed that Ms A was not experiencing any side effects and it was agreed therefore that she would increase her dose of risperidone to 4mg.

17.54 By this stage of her care, Ms A was receiving a number of medications. The Independent Investigation Team is concerned that potentially complex reactions between various drugs could be causing side effects, some of which are rare, but in extremis could be potentially fatal. In these circumstances, it is not best practice to charge a non-medically qualified individual with the responsibility of assessing side effects.

17.55 Medication Change 30 June 2008

17.56 Staff Grade 2 made further changes to Ms A's medication on 30 June 2008. She changed Ms A's antidepressant from sertraline to venlafaxine. Risperidone was discontinued and replaced with olanzapine. Lorazepam was also prescribed.

17.57 The changes in medication were to take place as follows:

- Sertraline - reduce and stop over next 7 days.
- Venlafaxine - start 3 days 37.5mg, 7 days 75mg and assess if needs to increase to 150mg over next 2 weeks.
- Risperidone – stop.
- Olanzapine - 2.5mg to commence immediately.
- Lorazepam prn - taken as needed, to be taken for 2-3 weeks.
- A daily medication chart was drawn up for Ms A.

17.58 It is not clear why Staff Grade 2 chose to augment venlafaxine with olanzapine. The choice of drugs would suggest that it was related to OCD symptoms, but that is not recorded in the records. In the event that this is what Staff Grade 2 was attempting to do, then best practice for OCD would be to attempt an alternative SSRI prescription before augmenting the SSRI with an antipsychotic.

17.59 Staff Grade 2's notes suggest that the change in medication from sertraline to venlafaxine was as a result of the description by Ms A of possible *'epileptic equivalent – absence'*. The BNF makes it clear that SSRI's should be used with caution in service users with epilepsy and should be discontinued if convulsions develop. This makes venlafaxine an unusual choice. The BNF also states in relation to venlafaxine that it should be used with caution in individuals with a history of epilepsy.

17.60 The BNF also states that in relation to withdrawal of an SSRI:

'...the dose should be tapered over a few weeks to avoid these effects.'

17.61 Whilst it is recorded that Ms A was to reduce her sertraline over a period of 7 days, the actual plan for that reduction from what is the BNF maximum recommended dose is not recorded in Ms A's notes or in any correspondence with her General Practitioner. The advice given is *'reduce and stop over next 7 days'*.

17.62 Staff Grade 2 was asked in interview about the changes to Ms A's medication on 30 June 2008. Her response is set out below:

'Staff Grade 2:	*I thought that the trial with sertraline was over and it didn't show much effect. She always reported with anger outbursts and she also was very low in the mood when I saw her on that day, so I thought it was a logical step to go for the second choice antidepressant after she had already two SSRIs plus two tricyclic antidepressants in the past, and I also, I think that, I am not very sure about it, but I think that she stopped her risperidone or she said that it didn't work so I used another antipsychotic to augment this. I replaced actually risperidone with olanzapine. The reason for that was also these anger outbursts but also she mentioned during this interview that she had a male voice inside her head telling her to do things and laughing at her, so it, might be one of significant symptoms of psychosis but can also be included in depression but all the other symptoms of depression did not show in severity, you know. It wasn't severe episode of depression with depressive thought like psychotic symptoms, so I thought that for her, because of the symptoms and because of the previous good response of the psychotic medication that olanzapine would help together with venlafaxine.*
DW:	*Alright, so the change from risperidone to olanzapine was because she didn't feel that the risperidone worked?*
Staff Grade 2:	*Yes.*
DW:	*Okay, and again, the olanzapine was prescribed predominantly for managing anger?*
Staff Grade 2:	*Yes.'*

17.63 The BNF states that venlafaxine is indicated for '*major depression, generalised anxiety disorder'*. The recommended dosage for its prescription is as follows:

'Depression ADULT over 18 years, initially 75mg daily in 2 divided doses increased if necessary after at least 3-4 weeks to 150mg daily in 2 divided doses
'In relation to generalised anxiety disorder and social anxiety disorder venlafaxine is recommended with a dose of 75mg once a day.'

17.64 The Independent Investigation Team is also concerned about the monitoring following this change. Young adults such as Ms A who are prescribed antidepressants such as venlafaxine are at a greater risk of suicide than those not taking such medication. Staff Grade 2 recommended that Social Worker 2 see Ms A on a weekly basis following the prescription of venlafaxine. She was also to receive a weekly telephone call. Once again monitoring was to be carried out by a non-medically qualified individual which is a matter of concern given the nature and dose of the drugs prescribed.

17.65 Medication Change - Period between 30 June 2008 and 28 August 2008

17.66 During this period Social Worker 2 maintained sporadic telephone contact with Ms A. Ms A's lack of engagement is discussed in more detail in Paragraphs 17.16 and 18.14 – 15.

17.67 Ms A was noted to be complaining of drowsiness on 7 July 2008. Social Worker 2 had a conversation with Staff Grade 2 about this on 10 July 2008 and it was decided to maintain Ms A on a dose of 75mg of venlafaxine because of the drowsiness.

17.68 On 28 August 2008, Ms A was visited by Psychiatric Nurse 2 at home. Ms A asked about increasing her medication to 150mg of venlafaxine. Psychiatric Nurse 2 agreed to discuss this with Staff Grade 2 which she did later that day. Staff Grade 2 agreed that the venlafaxine should be increased to 150mg to be taken in divided doses of 75mg BD. If this did not suit Ms A then a slow release tablet or prescription of 112.5mg was to be considered. Ms A was to be reviewed in a week.

17.69 Venlafaxine is a second line treatment. It is dangerous in overdose. This factor, combined with potential drug interactions due to the multiple medications Ms A was being prescribed at this time, makes the failure by a medically qualified clinician to review Ms A difficult to understand.

17.70 Recommendations to Improve Patient Safety

The EIP Service should take steps to ensure that, when a clinician wishes to prescribe a drug which is unlicensed for the condition for which it is prescribed, the service user's express consent is obtained concerning the increased risk of side effects.
The EIP Service should review and strengthen its procedures relating to the monitoring of medication side effects.
The EIP Service may wish to review its procedures relating to the monitoring of antidepressants in young people both in relation to ensuring that a review is undertaken following a request from a doctor and also in relation to how that review is undertaken, in what circumstances and by whom.

The EIP Service may wish to review its procedures relating to the consent process attached to the prescription of medications which are prescribed outside the guidance produced by NICE and recommendations made in the BNF.

17.71 Key Points

Medication prescribed to Ms A did not comply with NICE Guidelines or BNF recommendations, in terms of choice of drug and dosage.

Drugs were prescribed to Ms A which were unlicensed in relation to the condition they were being used to treat. In these circumstances Ms A's consent should have been obtained and recorded in the records. This does not appear to have been done.

The monitoring of drug side effects and interactions was not planned. Monitoring was conducted by Social Worker 2, a social worker and not a qualified medical practitioner. Drugs such as venlafaxine are associated with an increased suicide risk in young adults. A large dose was prescribed for Ms A and Social Worker 2 was charged with her monitoring.

Changes to medication were made on an ad-hoc basis. There are examples of an antipsychotic being changed at the same time as an antidepressant making it difficult to determine which change was effective.

18.0 PSYCHOTHERAPEUTIC INTERVENTIONS

18.1 The National Institute of Health and Clinical Excellence (NICE) has recognised the contribution that psychotherapeutic treatments can make to the care of people with a wide range of debilitating mental and physical illnesses and the importance of initiatives such as the Improving Access to Psychological Therapies (IAPT) programme (CSIP, 2007). NICE Guideline 23 (as amended), relating to depression and NICE Guideline 113 (2.4.1 and 2.4.3), relating to anxiety, actively encourage the use of CBT as does NICE Guideline 31 (2.3.1.2), which deals with OCD.

18.2 Psychological therapies encompass a broad range of interventions, including talking therapies, which follow different theoretical models, e.g. cognitive-behavioural, as well as different forms of delivery, for example individual, group and family treatments. The EIP Policy Implementation Guide is explicit in saying that psychological therapies are an expected aspect of EIP services. CBT '*as appropriate*' and '*psychoeducation, family therapy and support*' are noted.

18.3 The value of psychological therapies is that whilst they can reduce symptoms, just as medication can, they can also lead to other valuable outcomes, such as helping people to make lasting changes in their lifestyle and approach to the self-management of their mental health difficulty, and to improve their ability to develop and sustain relationships. Essentially, they have the potential to provide a sustained recovery which medication alone cannot always achieve and which in some instances may only provide a quick fix.

18.4 Availability of Psychological Therapies

18.5 During the course of the interviews conducted with the EIP Service, questions were asked about consideration of whether psychological therapies would be of assistance to Ms A. The records make no reference to the consideration of talking therapies despite their inclusion in NICE Guidelines. Members of the EIP service have stated that they attempted to use psychologically informed strategies with Ms A, however no formal referral to specialist therapists was made nor opinions sought. During the course of the interviews the Independent Investigation Team was advised that a psychologist has now been appointed to the EIP Service.

18.6 Staff Grade 2 was asked if CBT was undertaken with Ms A. Her response was that Social Worker 2 would undertake anger management with Ms A. However, Staff Grade 2 confirmed that she did not establish a CBT regime. Staff Grade 2 confirmed however that she did use 'elements of CBT' with Ms A. She later stated that providing systematic structured CBT psychotherapy was not part of her job description at the time.

18.7 During the course of the interviews some confusion became clear regarding Staff Grade 2's qualifications in CBT. Consultant 1, who himself confirmed that he held CBT qualifications

and was responsible for Staff Grade 2's supervision, was of the view that Staff Grade 2 had in fact formal qualifications in CBT. Social Worker 2 was of a similar understanding. When both these individuals were asked about why Staff Grade 2 did not undertake CBT with Ms A herself their response was that she was required to focus on her medical role first. Social Worker 2 went on to say:

> *'Social Worker 2:* *I think within the team that her, she was asked to have a more sort of psychiatry role so looking at diagnosis and medication and that kind of thing rather than doing specific ongoing sessions around CBT because other people in the team trained in CBT, so she would, within her sessions, will talk to people kind of thinking about kind of appraising what's going on and looking at kind of evidence for this, you know, so talking to people in a way that's kind of using the CBT model but she wouldn't be offering people kind of ten sessions of CBT.'*

18.8 Social Worker 2 also confirmed in interview that she had been able to undertake CBT with Ms A using basic CBT techniques. This is not evidenced in Ms A's notes. In interview, Social Worker 2 explained how this came about:

> *'Social Worker 2:* *With Staff Grade 2, we were talking about her medication, about her kind of diagnosis about treatment and stuff. Staff Grade 2 got this training in CBT as well so kind of just looking where to go with her.*
>
> *JH:* *Did she ever ask you to do CBT on this lady?*
>
> *Social Worker 2:* *I think Staff Grade 2 was you know aware of the plan to try to look at some anxiety management, which would be in a CBT kind of format as the anger work, so that would be, you know that is the way we would have done it.*
>
> *JH:* *And do you have any formal qualifications in CBT?*
>
> *Social Worker 2:* *I've done a University module in it, so a 30 point module'.*

18.9 The Independent Investigation Team could find no reference to a planned structured approach to CBT or any other psychological therapies recorded in Ms A's notes. Many important psychotherapeutic interventions are provided as components of a holistic care package, with comprehensive care plans, including physical and social treatments. Often the quality of such interventions is dependent on an organisation's ability to deliver these care packages in ways that ensure the components reinforce, rather than work against one another. It is crucial to have a common, psychologically-informed framework that allows each individual's needs and strengths to be understood, and an overall care plan to be formulated. There is no evidence in Ms A's notes that this planning process was undertaken to determine the correct 'package' of psychological therapy and how this was to be delivered alongside Ms A's medication.

18.10 There is reference to discussions surrounding anger management, e.g. the Firework model. However, this appears to have been discontinued on 10 December 2007 when Ms A advised the EIP Service that she no longer wanted to maintain her anger diary. This presented an

opportunity for reflective practice for the EIP Service. However, no review was undertaken and therefore the reason for Ms A's failure to engage with this therapy was never determined in order to see whether it has any significance diagnostically. The EIP Service also failed to implement an active strategy to support her to a point where she was prepared to recommence therapy. Psychological therapies are not specifically mentioned in Ms A's notes after this point, despite periods in her care where medication on its own did not appear to be providing Ms A with any benefit.

18.11 Ms A's Failure to Engage

18.12 During the course of the interviews with staff, it was mentioned that Ms A was difficult to engage with as she had not attended a significant number of appointments with the team. The fact of Ms A's non-attendance is confirmed by the notes which have been maintained.

18.13 However, the Independent Investigation Team notes that Ms A's failure to attend appointments was not fully investigated by the EIP Service. Equally, Ms A's failure to accept referral for talking therapies in the past appears to have precluded her from referral by the EIP Service for specialist psychotherapy interventions. Instead a medication route was adopted until the transfer of Ms A's care co-ordination to Psychiatric Nurse 2, the purpose of which was apparently to allow Ms A to undergo anxiety management therapy, although this is not documented at any point in Ms A's notes.

18.14 Ms A has been described as difficult to engage. However, the Independent Investigation Team notes that Ms A demonstrated an ability early on in her care to disclose often very sensitive and personal information about herself to individuals who she has had a very transient clinical relationship with, for example Social Worker 1. There is a conflict between this behaviour and Ms A's failure to attend appointments with the EIP Service. When the Independent Investigation Team looked at the notes relating to Ms A's cancelled appointments, a pattern emerges. Ms A did not, until the later stages of her care when Psychiatric Nurse 2 was her care co-ordinator, simply fail to attend appointments. She in fact made the effort to telephone or send telephone SMS messages to the team, to provide an explanation and then reschedule the appointments. This behaviour was interpreted by the team as being suggestive of Ms A only contacting the team when she needed or wanted something, such as a letter for a benefits agency. Although her case was kept open there was not an assertive and sustained attempt to improve Ms A's engagements. The Independent Investigation gained the impression that this behaviour in some way 'coloured' how the team approached Ms A's care, as perhaps they believed that Ms A was effectively turning down their efforts to help her.

18.15 However, the Independent Investigation Team believes that this behaviour may in fact have been a presentation of her difficulties which warranted further investigation. Had a more extensive history been taken or a review of Ms A's pattern of non-engagement been

undertaken, then perhaps some further explanation could have been found which would have shed light on this aspect of her difficulties.

18.16 Instead of working with Ms A to identify any reasons which could encourage her to respond to the offer of psychological therapy or indeed to attend appointments with the EIP Service, no real action was taken other than to satisfy Ms A's requests for practical help and to provide her with medication without properly assessing whether medication better fitted her needs long-term. This followed a pattern adopted by Ms A's GP's who were also very helpful to Ms A in providing practical help and if requested, medication to deal with her problems. This approach perpetuated the idea that Ms A did not need to take responsibility for her own situation and learn to develop her own internal strategies to help her cope with her difficulties. Paradoxically, this would have provided her with a more long-lasting solution.

18.17 Team members inevitably bring in to their work ordinary human feelings, images and prejudices, both conscious and unconscious. Whilst this cannot be avoided, this needs to be thought about within teams and in sensitive supervision. It is important to recognise negative as well as positive feelings. Psychotherapeutic techniques help teams deal more positively with individuals, such as Ms A, who do present a challenge to the therapeutic relationship by exhibiting behavioural characteristics within that relationship which are damaging or negative.

18.18 There are a number of psychological therapies which could potentially have provided Ms A with significant benefit, such as CBT and family therapy. There were a number of missed opportunities for engagement with family and friends. Such opportunities would have afforded the team collateral information for their assessment and risk assessment as well as strengthening the therapeutic alliance. However, for the reasons set out above, these were not offered to Ms A. This is a significant missed opportunity in relation to Ms A's care.

18.19 Referral to a Psychologist

18.20 Staff Grade 2 was asked whether Ms A could have been referred for psychotherapy at this time. Staff Grade 2 confirmed that this would have been an option but in their view, because Ms A had already declined therapies in the past and had a poor engagement record with them, it was best that Ms A commence anxiety work with Social Worker 2 and then when Ms A was in a position to recognise her triggers she could be referred at that point. At this point referral would have been out with the EIP Service. In any event there is no evidence in Ms A's notes of consideration or re-consideration at any stage of a referral being made for psychotherapy.

18.21 Improvements in Patient Safety

18.22 The EIP Service now has a psychologist who forms part of the MDT. This represents a significant strengthening in the skills resource of the Service, particularly in light of the fact that a number of EIP Services do not have a psychologist on their team.

18.23 Recommendations to Improve Patient Safety

The Clinical Standards should be revised to include a process for referral of service users for psychological review and assessment.

18.24 Key Points

The care that was delivered to Ms A did not include the structured provision of psychological therapies despite their use being indicated in various NICE Guidelines.
In particular, a plan was not formulated to identify which psychological therapies would assist Ms A and provide her with tools to lead her towards a sustained recovery.
Ms A was allowed to disengage from the possibility of psychological therapies without proper attempts having been made to identify the reasons for her non-engagement.

19.0 CLINICAL GOVERNANCE STRUCTURES

19.1 Supervision

19.2 Clinical and professional supervision in the NHS was introduced as a way of using reflective practice and shared experiences as a part of continuing professional development.

19.3 Supervision is a cornerstone of clinical governance because it seeks to promote and engender the following:

- Quality improvement;
- Risk management and performance management; and
- Systems of accountability and responsibility.

19.4 Crucially, it provides a structured approach to deeper reflection on clinical practice. This can lead to improvements in practice and client care, and contribute to clinical risk management.

19.5 In 2005, HPFT published a Staff Supervision Policy Statement. This document contains the following statement:

> *'The Trust believes that effective supervision contributes to job satisfaction, personal development and the provision of a high quality service. Supervision is the opportunity and requirement for staff to receive guidance and support. It also enables staff to reflect on how they carry out their tasks and activities within their role and other aspects of their working lives. Supervision is a fundamental part of Practice Governance.'*

19.6 Supervision Log

19.7 As part of the Independent Investigation, copies of the EIP Supervision Logs ('the Log') were requested. These were provided from the date that the log appears to have been incepted, which was on or around 28 June 2010 until August 2011, when the Log was requested by the Independent Investigation Team.

19.8 The Log shows that clinical supervision has not been recorded in respect of a number of individuals across a number of specialties. Notably, there is no supervision recorded in respect of any of the following professionals:

- Nurse Consultant
- Medical Team — all levels.

19.9 Within specialties that are recorded on the Supervision Log, not all members of the specialty have had details of their supervision meetings recorded. This applies to the following categories of individual:

- Clinical nurse specialists
- Social workers

- Occupational therapists.

19.10 There may be reasons for this, such as individuals leaving the EIP Service or individuals being temporary members of the EIP Service. However, for a control system to work, it must be a complete record, even in a multi-disciplinary setting where supervision may in fact be taking place by individuals who are not part of the EIP Service.

19.11 A further concern is that the Log shows that supervision is not carried out at regular intervals. It is not possible to say whether the supervision intervals applicable to each member of the team have been complied with because these do not appear in the log, which is a control weakness of the logs. Consequently, it is not possible to determine whether the HPFT Supervision Policy is being complied with, because the Supervision Policy states at Paragraph 6.2:

> *'The frequency of clinical and/or professional supervision will depend on the context and requirements of the role and any minimum requirements laid down by the professional bodies. Frequency levels should be agreed by supervisee, line manager and clinical and/or professional supervisor.'*

19.12 For example, Social Worker 2 had only three recorded supervision meetings throughout the thirteen month period of the Log. Meetings took place in June 2010, December 2010 and August 2011. Team Leader 1 had two meetings in respect of his supervision. The first meeting was in October 2010 and the second in December 2010. A meeting in March 2011 was cancelled.

19.13 During the course of his interview, the EIP Service Manager was asked about the supervision periods which were applicable in EIP:

> *'JH:* *And the supervision periods that apply with, throughout the department, do they vary as well, or do they, was it, monthly, weekly, what was the criteria,*
> *EIP Manager:* *Within our service we've always aimed for monthly,*
> *JH:* *Always monthly.*
> *EIP Manager:* *As a minimum.*
> *JH:* *Right.*
> *EIP Manager:* *Barring exceptions where the supervision get postponed or cancelled due to clinical priorities but the target has been the minimum of monthly and many people will have supervision more frequently than that depending on their experience and perceived performance and the capacity and skills.'*

19.14 The EIP Operational Policy states at Paragraph 22:

> *'There is regular supervision for staff, in accordance with the Trust's policy. All staff receive professional supervision given by a more senior member of staff. Sessions are recorded, are held at least monthly, and offer an opportunity to focus upon professional role, workload and professional practice. When a supervisor is from a different*

profession the supervisee will have an identified person from the same profession from whom to seek further clinical advice when / if this is required.'

19.15 The Log does not demonstrate compliance with this statement. EIP Manager conceded during the course of his interview that the Supervision Logs were not audited.

19.16 The Independent Investigation Team also noted that the Log shows a difference in the amount of supervision which is undertaken between the two teams. Staff members in the West Team appear to receive a greater level of supervision than in the East Team in all specialties.

19.17 Clinical Supervision Meetings

19.18 Clinical supervision provides a forum for discussion of work issues within a clinical and/or professional supervision context. They also provide the opportunity to reflect on practice and relationships and to learn, implement and evaluate outcomes based on that reflection.

19.19 The HPFT Statement upon supervision makes it clear who holds responsibility in the supervision process:

'Responsibility for supervision
Professional Leads, Directors and Senior Managers are responsible for the implementation of this policy.
Line managers are responsible for ensuring that appropriate supervision arrangements are made for each member of their staff.
Both supervisors and individual staff have a responsibility to ensure appropriate supervision takes place. Engaging in both management supervision and, where appropriate to job role, clinical and/or professional supervision, are a part of the individual's contract of employment with the Trust.'

19.20 Supervision Attached to Ms A's care

19.21 The supervision tree which worked within the EIP Service when Ms A was undergoing care and, indeed, which remains a feature of the EIP Service, is that members of each individual profession within the MDT are supervised by a member of their own individual profession. Therefore, social workers supervise social workers, nurses supervise nurses, clinicians are supervised by clinicians, etc.

19.22 During the course of the Independent Investigation, the Independent Investigation Team interviewed the staff most closely connected with Ms A's care. Social Worker 2 was a newly qualified social worker who was in her first job following qualification. She was supervised by Team Leader 1, an original member of the EIP Service and a very experienced social worker. Staff Grade 1 and Staff Grade 2, who both remained Staff Grade doctors throughout the course of their involvement in Ms A's care, were supervised by Consultant 1, a consultant psychiatrist. Psychiatric Nurse 2 was supervised by Psychiatric Nurse 1, a senior member of the EIP Management Team. Team Leader 1 was supervised by EIP Manager.

19.23 The Independent Investigation Team was pleased to note that team members were generally happy with the level of supervision which they received. Social Worker 2 in particular felt that she received good support in light of her lack of practical experience in an EIP Service. Equally, the Independent Team noted that supervisors had received training in supervision which is good practice.

19.24 Supervision Records

19.25 Social Worker 2 provided the Independent Investigation Team with records of her supervision meetings with Team Leader 1. Ms A was mentioned at those meetings in the following terms:

TABLE 19.1

Date	Mention of Ms A
18 October 2007	Not mentioned
25 October 2007	Ms A; Social Worker 2 now case co-ord. Social Worker 2 and Team Leader 1 to visit 26/10/07 and complete PANSS
02 November 2007	Ms A: Social Worker 2 now case co-ord. Social Worker 2 and Team Leader 1 to visit 07/11/07. Session: explain to Ms A that Team Leader 1 there for first few meetings for assessment and then just Social Worker 2, explore what support/help Ms A thinks she will find helpful, find out how last couple of weeks have been, medication, mood etc.
12 November 2007	Ms A: ?meds prescribed — symptoms seem to be more psychotic features then depressive. Need to check out with Staff Grade 2. Do thumbnail sketch of life -10 mins Sessions with Ms A re anger: suggest she keeps diary of anger and reflect on this, explain this means going over thoughts and how these effect behaviour. Explore where boundary-less thinking from and check awareness of consequences of behaviour: Thoughts-behaviour-consequences. People who don't think this through usually end up in prison, hospital, injury... How can we help you? Think about triggers, warning signs, how do you calm down/can you calm down?
06 December 2007	Ms A: ?meds prescribed — symptoms seem to be more psychotic features then depressive. Staff Grade 2 to see when back at work. Social Worker 2 to see on own on 17/12
11 January 2008	Ms A not mentioned
20 March 2008	Ms A not mentioned
11 June 2008	Case load Getting down to 12 so can do CDW work 0.25 post. Who to hand over? Ms A — hard to engage as cancels lots of appointments and lots of different presentations (anger, low mood, OCD type symptoms, paranoia). May pass to Psychiatric Nurse 2.
22 July 2008	No mention of Ms A.

19.26 On 20 March 2008, Social Worker 2's supervision records stated in relation to carer's assessments:

'Carer's assessment — doing some for team — time consuming. Not clear if able to do assessment's on own client's carers due to loss of independence.'

19.27 HPFT were also asked to provide copies of Staff Grade 2's supervision records. HPFT's response was:

'They could not provide Staff Grade 2's supervision records although they said the Doctors would have used Care notes to record certain aspects and outcomes of their supervision and case strategies, though it wont be straight forward to separate these entries out from the other entries as they will be integral.'

19.28 Supervision Records

'11.5.1 It is the responsibility of the supervisor whether management or clinical and/or professional supervision to keep clear, accurate and up-to-date records of all discussion using an appropriate record forms. (See Appendices 3a, 3b, 3c). The supervisor is responsible for providing the supervisee with a copy and the two parties should agree the content and sign.'

19.29 In the absence of Staff Grade 2's supervision records, it is not possible to judge the nature and quality of the clinical supervision which was applied to Ms A's case. A review of Ms A's notes does not indicate any supervisory input by Consultant 1. This is a significant cause for concern which represents poor practice and indeed a breach of HPFT policy.

19.30 It is also a concern that the last time that Ms A's care appears to have been discussed in supervision by Social Worker 2 and Team Leader 1 is on 6 December 2007. A discussion on 11 June 2008 purely relates to the transfer of her care co-ordination to Psychiatric Nurse 2. The Independent Investigation Team believes that the supervision notes maintained by Team Leader 1/Social Worker 2 are of a poor quality. For example, abbreviations have been used which are unclear, for example in an entry dated 11 June 2008, it is unclear what 'CDW' means.

19.31 The Independent Investigation Team is also concerned about the lack of clarity of purpose which the supervision process has with the EIP Service. This is demonstrated by a comment made in Social Worker 2 /Team Leader 1's notes of her initial supervision meeting. This note states:

'Supervision time can be used flexible depending on Social Worker 2's Team Leader 1's needs e.g. can be run through of cases, discussion re practice/theory or to look at pressing issues. Can also be used in other ways as agreed by Social Worker 2 /Team Leader 1. Supervision to be positive experience with emphasis on positive action — end on a good note!'

19.32 It is disappointing that clinical governance and improvement in patient care do not feature in this assessment of what supervision can be used for.

19.33 The two styles of supervisory approach between Consultant 1/Staff Grade 2 and Social Worker 2/Team Leader 1 illustrate a significant lack of consistency of approach within the EIP Service.

19.34 Development of Supervision in EIP

19.35 It is clear from the information given to the Independent Investigation Team by interviewees that the supervisory system in place at the time of Ms A's care was developed on an ad-hoc basis. The Independent Investigation Team understands that the Service was undergoing significant development and growth at around the time Ms A was cared for. However, supervision is a key plank in clinical governance and has a dual role of supporting staff and maintaining standards of care.

19.36 At the time of Ms A's care, a formal supervisory structure which applied universally to team members had not been adopted. The manner and interval in which supervision occurred depended upon the individual supervisor. There were no systems within the EIP Service which were capable of highlighting issues with supervision, such as lack of regularity of meetings, failure to discuss cases or a failure to record discussions.

19.37 The inclusion of a case in the supervisory process was dictated by the supervisee. This meant that cases which were considered pressing in the view of the supervisee would be allocated more time. The risk with this approach is that cases which were not a cause for concern for the individual supervisee may not be highlighted for in-depth discussion and could potentially fall beneath the radar.

19.38 The threat to clinical governance which this lack of formality provides is best illustrated by the inconsistency in how supervision was recorded by each supervisor. The Independent Investigation Team was advised that each supervisor retained notes in a different manner. Some made handwritten notes, some made electronic notes and some used a combination of the two. The manner in which the notes were stored also varied enormously. What is clear from this lack of consistency is the threat to patient care. The discussions in supervision meetings are central to continuity of care and should form part of the service user record which is accessible to all.

19.39 In the opinion of the Independent Investigation Team, the sub-optimal supervision process was a very significant gap in the clinical governance regime operated by the EIP Service.

19.40 Improvements in the Supervisory Process

19.41 The Independent Investigation Team was advised that, following a number of complaints received by the EIP Service, the team developed a set of standards which form the basis of the clinical governance structure operated by the EIP Service. These standards are set out in a document entitled 'Clinical and Practice Standards for Early Intervention in Psychosis' ('the Standards'), which was issued in June 2010. The Standards have been agreed by the

Strategy Group for EIP Practice and were presented to CAMHS Practice Governance on 7 December 2009.

19.42 Practice Standards presents evidence of the EIP Service seeking to formalise the supervision process which it operates. It is clear that the supervision regime has been developed positively following Ms A's case. For example, decisions and recommendations from supervision are now recorded in Care Notes.

19.43 Recommendations to Improve Patient Safety

The Clinical Standards introduced by the EIP Service constitute a positive step forward in terms of improving its own control structure and processes. The EIP Service should consider the introduction of *'Practice Guidance Notes'*, setting out what is required by each element of the Standards to ensure consistency of implementation of the Standards across the service.

There are different models of clinical supervision that reflect the differing professional training and expectations, work contexts and needs of team members. The Standards are silent as to how supervision is to be carried out in practical terms to ensure that a consistent standard is applied across the MDT. The Independent Investigation Team understands from interviewing team members that there has been a great deal of discussion within the team but no consensus reached due to differences in professional attitudes towards supervisory practice. This failure to reach a consensus and adopt a consistent stance is a significant threat to the clinical governance framework operated by the EIP Service.

The Standards do not incorporate any 'failsafe' procedures. The Standards assume that they will be implemented by team members. The Standards are not designed to mitigate the effect of a team member failing to comply with the Standard in order to protect the object of supervision which is stated to be the 'quality of recovery outcomes for EIP clients'. Significantly, if a social worker failed to bring a case to supervision for 3 months, for example because of work load pressure, there is nothing to catch that omission and ensure that that client's case is brought into the supervision process.

The Independent Team were concerned about responses which it received concerning how compliance with the Standards is achieved. For example, questions were asked about checking that care co-ordinators were entering supervisory records into Care Notes. No audit has been undertaken of this and so it is not clear whether compliance with the Standards is being achieved. Given the importance of the Standards to the clinical governance structure of the EIP, it is a matter of concern that an audit cycle has not been implemented to assess the level of compliance with its objectives.

The Standards were due to be reviewed in June 2011. To date this review has not taken place. This is disappointing, given that an opportunity has been missed to evaluate what has gone well with the

introduction of the Standards and what has not gone as well with a view to making improvements in the provision of care.

The Standards are silent as to the responsibilities of supervisor and supervisee. For example, it is not clear whose responsibility it is to ensure that supervision takes place on a 3-monthly basis. There is some clarity upon the practicalities of supervision in the HPFT Statement on Supervision, but there may be merit in this aspect of the Standards being reviewed in order to ensure clarity for staff in EIP. The Standards do not address the issue of client confidentiality in the supervision process.

19.44 Key Points

The supervision regime in place during Ms A's care was not robust. Significant changes have been made to that system.

19.45 Multi-Disciplinary Meetings

19.46 Individuals experiencing psychosis or other mental health issues present in a number of different ways and are shaped by a complex pattern of social, physical and so-called psychological factors.

19.47 This can cause difficulty in the clinical decision-making process. Experienced clinicians rely on a wide array of patient behaviours, characteristics and values in deciding management. This may not be as easy for more junior members of the team. Multi-disciplinary team working provides the skill range to meet the increasingly complex needs of service users who require the decision-making skills of different professionals in order to enhance the provision of care. The value of this process is recognised in a number of Clinical Guidelines prepared by NICE, such as that relating to anxiety, a condition which can be associated with psychosis where referral of cases for MDT discussions is actively encouraged.

19.48 The EIP Service has a weekly MDT meeting. Paragraph 9 of the EIP draft Operational Policy makes it clear that:

> *'A weekly multi-disciplinary clinical meeting is held in each team to discuss referrals, assessments, allocation and on going care and recovery issues.'*

19.49 Further, at Paragraph 17 in Working Practices, the draft policy states:

> *'All staff participate in weekly clinical meetings and a Monday morning planning meeting.*
> *All staff participate in regular individual professional and managerial supervision.'*

19.50 The EIP Operational Policy was only in draft format at the time of Ms A's care. During the course of the interviews, members of the EIP Service confirmed that MDT meetings did take place and had a good level of attendance. There was a general level of agreement amongst

interviewees that as the EIP Service developed, the style of the weekly MDT meeting had changed and become more structured.

19.51 As part of its investigations, the Independent Investigation Team requested a copy of the minutes of the MDT meetings at which Ms A's case was discussed. HPFT confirmed that Ms A did not appear in the minutes of any MDT meeting during the course of her care by EIP.

19.52 This is a major cause for concern. Multi-disciplinary team working is central to the EIP ethos. Due to the complexities in the presentation of early stage psychosis, exposure to the knowledge and skill set of a range of professionals ensures that service users are afforded the most appropriate care package to suit their needs and provides a bio-psychosocial assessment. This is particularly valuable when the individuals who are most immediately involved in the delivery care of are at an early stage in their careers, as MDT working provides an excellent training experience.

19.53 Ms A's presentation was described as complex in her records and in Social Worker 2's supervision notes. Her diagnosis was at times unclear and she was not making progress despite having been under the care of the EIP Service for a significant period. In these circumstances, her care could have benefited from a review in the EIP Service MDT meeting. The Independent Investigation Team notes that the Clinical Standards which have now been developed by the EIP Service require a care co-ordinator to refer a case to the MDT meeting for individuals 'who have not made a full psychosocial recovery after prolonged EIPS input (minimum 3 monthly professional review)'. This is a significant improvement in service delivery for individuals such as Ms A whose presentation is complex and whose diagnosis might be uncertain.

19.54 The Clinical and Practice Standards for Early Intervention in Psychosis were ratified by CAMHS Practice Governance on 7 December 2009. They were issued in June 2010. The Standards have not been reviewed since their inception, nor has an audit been undertaken to ensure that they are working in practice.

19.55 Recommendations to Improve Patient Safety

The Independent Investigation Team is of the view that an audit should be undertaken to review the effectiveness of the introduction of the Standards and specifically to ensure that cases are now being referred to MDT Meetings, in accordance with the terms of the Standards.

19.56 Key Points

Ms A's case was not discussed in the EIP Service MDT Meetings throughout the course of her care. This is a significant cause for concern given the complexities of Ms A's presentation.

The EIP Service has introduced Clinical and Practice Standards for Early Intervention in Psychosis since Ms A received care by the Service. These standards seek to ensure that service users now receive consideration by the MDT.

19.57 Hot Spots

19.58 The EIP Service maintains a slot for the discussion of cases which are a cause for concern at its weekly MDT meeting. These cases are known as 'hot spots' within the Service. This constitutes an example of good practice within the EIP Service.

19.59 However, the criteria for what constitutes a 'hot spot' has not been written down, either during the period of Ms A's care or indeed subsequently. Senior members of the EIP Service were asked about this in interview.

'PV: Was it clear what would make a hot spot?
Psychiatric Nurse 1: Yeah yeah, it is quite clear. So if there's anybody that you are concerned about as a Care Co-co-ordinator, so somebody that you think might be becoming unwell or they're immediate risks to other people. …
Psychiatric Nurse 1: Or somebody that you want to, you know, so those are extremely clear so people understand and the threshold is actually quite low so if you see that so-and-so has stopped their medication and you are worried that they might becoming unwell again you, that person needs to go in hospital
PV: So, so it's clear that there is a place on the agenda at every meeting which is hot spot, that is for, so that somebody, a Care Co-ordinator or other clinician can communicate to the rest of the team where there are increase risks involved.
Psychiatric Nurse 1: Yeah, yeah so that includes disengagement.
PV: Yeah,
Psychiatric Nurse 1: Stopping all medication,
PV: Violence and,
Psychiatric Nurse 1: Violence,
PV: Crimes,
Psychiatric Nurse 1: Crime, so somebody was arrested at the weekend, you know.
JH: So where are those criteria for hot spot written down?
Psychiatric Nurse 1: We haven't written them down [laughter], but they're known to people….'

19.60 The effectiveness of the 'hot spot' facility can only be exploited to its full potential if all team members have a clear idea of its role and position in the delivery of care and clinical governance of the Service. If criteria are not written down in a place and format which is easy for team members to access, then there is a risk that the 'hot spot' system will not function properly because team members do not understand what it can be used for.

19.61 During her interview, Social Worker 2 was asked to outline what her understanding of what a hot spot was:

'Social Worker 2: *That was a point in a meeting where people would talk about people on a case that they were worried about for, that they were becoming accurately unwell perhaps or that they maybe had other kind of issues that were really kind of important, so housing or things like that, usually about mental health, kind of acute mental health kind of situations, but not always, so now we talk about forensic things or court cases child protection, that kind of thing, but just it was a time to make other people aware, so if you weren't in the office and a call came in, or you know, people needed to know anything they know about that person.'*

19.62 Psychiatric Nurse 2's response to the same question was as follows:

'Psychiatric Nurse 2: *OK, let me think back, people, clients who were considered to be hot spots so to speak would be for example, clients who were disengaging from the team, not taking medication, non compliance, where mental health act assessments were possibly being considered.'*

19.63 When Social Worker 2 was asked about whether Ms A made it to 'hot spot', her response was:

'Social Worker 2: *Yeah, she wasn't a hot spot. I suspect a lot of people in the team would have never have heard of her. She wasn't one of the kind of notorious at all if that's what your,*

JH: *Well that's one of the things that I wanted to ask. We've asked for the minutes of the team meetings. She's not discussed once. Is that because she wasn't minuted or is that because she wasn't discussed once?*

Social Worker 2: *I think that once she's allocated and she wasn't you know classed as someone that was really high kind of risk to be honest, you know I think she was one of the ones that was bubbling along you know we have a lot of kind of people that are doing all sorts of different things and kind of causing all sorts of different issues.*

PV: *She wasn't in that threshold?*

Social Worker 2: *Yeah.*

PV: *What would you have done to have reached you know that sort of,*

Social Worker 2: *I guess she would have to have been acutely psychotic, you may be disengaging with the team, disengaging from your meds, in trouble with the police, risk of homelessness, those kinds of things so you know I think people that are kind of bubbling along kind of up and down like that that she wouldn't, you know she was being dealt with in supervision and kind of outside.'*

19.64 It is sometimes helpful when considering the effectiveness of a control system to look at it from the perspective of a locum who has not worked in that location before. Such individuals pose an increased challenge to clinical governance, simply because of their lack of familiarity with the organisation. This question was put to Psychiatric Nurse 1:

'JH: *Again, a locum coming in, how will a locum know what a hot spot is?*

Psychiatric Nurse 1: Hmm. They wouldn't, not, we don't know if we, we'd have to explain it to them yeah, but we haven't got any criteria, yet. We do have a criteria, but we haven't got it written down as you know.'

19.65 When the Locum Pack for the Service was checked, only the following information appears in respect of the team meeting:

'3.1 Team meetings
These are held on Tuesday morning, and run from 10am until 12pm. Agendas for them, to which you can add, are on the white board in main office. Business, casework and teamwork issues are raised and discussed here.'

19.66 No other guidance is produced for locums or new members of staff as to how these meetings operate or how a 'hot spot' could be utilised. In addition, the Locum Pack produced to the Independent Investigation Team does not specifically contain the Clinical Standards, which is a cause for concern.

19.67 The idea of a 'hot spot' is a good one. It allows speedy consideration of cases which are causing concern. It brings a wealth of experience and a different perspective on care which can deliver benefits for individual service users. However, if there is no consensus or source material as to how to access a 'hot spot' on behalf of a service user, then the effectiveness of the 'hot spot' system is compromised. This risk is highlighted in Ms A's care.

19.68 Ms A had a caution for stealing alcohol, had admitted to binge drinking and described herself as being more aggressive when she had taken alcohol. She was then arrested for drink driving on or around 11 September 2008. This was a significant event in relation to this young person and her risk profile. A conviction for drink driving is a significant indicator of possible alcohol misuse.

19.69 When asked about this arrest and whether that would have been an issue which would have been discussed as a 'hot spot', Psychiatric Nurse 2 responded as follows:

'Psychiatric Nurse 2: To be honest, at the time I, whether that it was my oversight or not but I probably wouldn't have thought of that as being sort of on a par with other things that we were taking to the, or identifying as hot spots, you know, yes it was a chaotic behavior and it was I suppose now an indication of how problematic and dangerous her behavior could become, after consuming alcohol, I don't know, was something we thought that we were or that I thought you know, we were sort of on top of and at that point in time I wasn't sort of concerned that she was acutely unwell or that her mental state was deteriorating, I didn't see any sign that I thought I need to put in more intervention now because this is an indication that she either becoming more depressed or psychotic, although I never saw her when she was psychotic, so no, I'll be honest about that, I didn't.'

19.70 It is clear that both Social Worker 2 and Psychiatric Nurse 2 reached judgments upon what was appropriate for 'hot spot' by reference to the type of issues their colleagues were bringing which, as it is an EIP Service, were mainly related to psychosis.

19.71 In relation to 'Risk Assessments and Care Plans' the Standards state:

> *'Clients posing serious risks discussed as hot spots in MDT meetings. If there any doubts or concerns regarding abuse of persons who are not capable of caring for themselves SAFA procedures must be discussed with the relevant manager.'*

19.72 This is the only stage at which the 'hot spot' is specifically mentioned in the Standards. Psychiatric Nurse 1 was asked why 'hot spots' appeared in the risk assessment section of the Standards:

> *'Psychiatric Nurse 1: We've put them within the risk assessment, 'cause they are a risk issue…*
> *JH:… Mainly around risk, but if it's something that's outside risk, what happens to the outside?*
> *Psychiatric Nurse 1: We have clinical discussions.'*

19.73 This would appear to confirm the view of Social Worker 2 and Psychiatric Nurse 2 that behaviour had to involve risk to warrant a mention as a 'hot spot'. If there was any other concern, then the mechanism is to take the service user to a clinical review, which may not be the best option for the service user as it denies them the benefits of full MDT consideration. Equally, risk in this context is required to be 'serious'. This represents a missed opportunity for the cases which may pose a challenge for reasons other than risk, as these cases would not necessarily be brought into 'hot spot' and therefore could miss MDT review.

19.74 Ms A's diagnosis was uncertain. 'Watch and wait' is a recognised and appropriate strategy in relation to the assessment of early psychosis. However, that process has to be carefully and indeed actively managed. Some service users for whom a 'watch and wait' strategy has been adopted will ultimately be found to be developing other conditions, co-morbidities or may in fact recover from their difficulties.

19.75 It is this group of service users for which MDT discussion and review can provide the greatest benefit. The clinical governance system which existed at the time of Ms A's care did not provide an opportunity for referral to 'hot spot' of this category of service user who experiences an event which whilst not constituting a 'serious risk' is nonetheless significant in relation to their presentation and would therefore benefit from MDT discussion.

19.76 Recommendations to Improve Patient Safety

The EIP Service should consider and produce guidance for staff as to the use of the 'hot spot' facility in order to maximise its benefit.

19.77 Key Points

The ‘hot spot’ facility within the MDT Meeting is an innovative approach to allow cases which were a cause for concern to be discussed by the MDT.

Ms A did not reach ‘hot spot’ because her conduct, which included a conviction for drink driving, was not felt to merit referral when compared to other individuals being discussed in ‘hot spot’ at that time.

The ‘hot spot’ facility is not being fully exploited due to a potential lack of clarity as to what constitutes a ‘hot spot’.

20.0 CARE PROGRAMME APPROACH

20.1 Background

20.2 Since the publication of the Mental Health National Service Framework in 1999, mental health policies have increasingly focused on personalisation through an emphasis on meeting the wider needs of those with mental illness, addressing inequalities, tackling the problems of social inclusion, and promoting positive crisis, contingency and risk management practices.

20.3 The CPA is at the centre of this focus, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what can be complex systems of care. Put simply, the CPA is a straight forward term for describing the process of how mental health services assess user's needs (including assessment of risk), plan ways to meet those needs, and check that the identified needs are being met.

20.4 The CPA is both a management tool and a system for engaging with people. Its primary function is to minimise the possibility of service users losing contact with services and maximise the effect of any therapeutic intervention.

20.5 Key Features of the CPA

20.6 Key features of the CPA in practice are as follows:

- The appointment of a key worker to coordinate care, ensure that there is a care plan and ensure that reviews are conducted at stipulated intervals not longer than six months between each review,
- An inter-professional collaborative approach to care,
- Conducted in consultation with users and carers.

20.7 The aims of the CPA can be summarised as follows:

- To focus care on the needs of those with the most severe illness,
- To ensure continuity of care (across time and place),
- To ensure good communication and joined up working between agencies,
- To involve Mental Health Service Users in making decisions about their care,
- To involve carers in the process.

20.8 Trust Policy

20.9 HPFT had an 'Integrated Care Programme Approach and Care Management Policy' ('the CPA Policy') (see Appendix **G**) in place throughout the course of Ms A's treatment. This policy was issued in July 2007 and was due for review in March 2008. It is applicable to services provided by the CMHT and the EIP Service.

20.10 The CPA Policy states clearly at Paragraph 21:

'CPA is a system of care which spans all areas of service provision. It is not intended as an additional layer of bureaucracy that overlays or stifles clinical practice. It is the very building block of integrated care and has the service user at its centre.
'The Trust's CPA framework reflects what most clinical teams undertake routinely and accept as good clinical practice.'

20.11 The Independent Investigation Team would concur with the description of the CPA system of care which is outlined in HPFT's CPA Policy. Instead of focusing upon whether the 'procedural requirements' of the CPA system have been complied with, the Independent Investigation Team has instead focused upon whether the aims of the CPA as set out above have been addressed in relation to Ms A's care, rather than an assessment of the paper trail which supports that care.

20.12 Accordingly, in considering whether there is any learning to be taken from the application of the CPA in Ms A's case, the Independent Investigation Team focused upon an assessment of the organisation of Ms A's care and Ms A's involvement in that process in order to assess whether her needs were at the heart of the care which was delivered.

20.13 Entry into CPA

20.14 The CPA Policy states:

'CPA is applicable once a service user has been assessed and accepted by the specialist mental health service. It follows that the level of CPA, the allocation of a Care Co-ordinator and development of a care plan must occur at that stage.

Managers of local teams and services must ensure that all service users accepted for services are in receipt of the full CPA requirements….

The responsibility for ensuring the effective and timely entry of service users into the CPA process rests with the respective Team Manager.'

20.15 Ms A was not accepted by Cheshunt CMHT for care but was referred on to the EIP Service. According to the CPA Policy therefore, responsibility for initiation of the CPA process rested with the EIP Service.

20.16 The Independent Investigation Team has noted that when the EIP Service accepted the referral from Cheshunt CMHT concerning Ms A, she was initially assessed on 17 October 2007, by a Nurse Consultant and a Psychiatrist at Ms A's mother's house. In interview, Staff Grade 1 confirmed that Ms A's mother was present. In effect this approach fits the CPA model in that it adopts an inter-professional collaborative approach towards care. In addition, Ms A was seen promptly, although this has to be balanced with the fact that the individuals who saw her would not play an ongoing role in Ms A's care due to the geographical split in the EIP Service's case load. However, Ms A was accepted for care and an initial plan was prepared with regard to her clinical care.

20.17 In these circumstances, and in the absence of a care co-ordinator being assigned to Ms A, it is perhaps understandable that a plan for Ms A's care was not drawn up at this first contact with Ms A. However, an opportunity was missed given the presence of Ms A's mother to develop a collaborative plan with Ms A and a carer for Ms A's future care.

20.18 Ms A was seen by her care co-ordinator and her supervisor for the first time on 29 October 2007. At this point it would have been possible to have initiated the formal CPA process including completion of the relevant paper work and initiating the plan of care.

20.19 In fact, given the arrival of Social Worker 2 into Ms A's 'world' so to speak, and in light of the supportive environment which had been created for Social Worker 2 in that her supervisor was present, a structured review of Ms A's care at this initial stage might have helped build therapeutic alliances. Whilst a discussion of Ms A's presenting symptoms is recorded in the notes, there is no information about what Ms A's expectations of care were, nor was identification of what that Ms A wished to achieve from her involvement with mental health services. Equally, there is no explanation of how Ms A's care was to be delivered, either for Ms A's benefit or indeed other practitioners in the EIP Service.

20.20 Similarly, when Ms A was next seen by Social Worker 2 and Team Leader 1 at her hostel on 7 November 2007, a further opportunity was missed when a friend of Ms A's was present at the consultation, but was not engaged in a discussion about Ms A's difficulties. Once again, there is nothing in the records which suggest that Ms A or her friend was given an opportunity to have an input into how the care with which she was to be provided would meet her needs as she saw them.

20.21 However, following Ms A's first consultation with Staff Grade 2 on 20 December 2007, Social Worker 2 does appear to have sketched out an initial care plan. The plan is dated 2 January 2008. There is no indication that Ms A was provided with a copy of this plan as the signature box has been left blank in the copy set of records which were provided to the Independent Investigation Team. Equally, it is not clear what her involvement in its preparation was.

20.22 The Care Plan is not comprehensive in nature and the Independent Investigation Team has some concerns about it. Firstly, there is no evidence as to how it was prepared. Its preparation is not mentioned in Ms A's clinical records and as a result, the Independent Investigation Team would query whether it was the result of a collaborative approach involving for example Staff Grade 2 and Ms A or indeed Social Worker 2's supervisor, given this early stage in Social Worker 2's career in EIP Services.

20.23 Secondly, the content of the plan is poorly constructed. The plan does not appear to relate in any way to the CPA Needs Assessment prepared by Social Worker 1, nor does it address the areas of risk highlighted in Ms A's risk assessment which was also prepared by Social Worker 1. For example, one element of the plan is stated as '*Monitor mental state'*. The plan is silent as to how this is to be implemented or monitored and by whom. There are a number of key

targets of the CPA process which have been omitted from the plan. For example, the issue of how to address Ms A's binge drinking and her response to that potential problem is not addressed. Ms A's anger problems are omitted as is the risk of violence to the Deceased and other individuals which Ms A had identified at the commencement of her care. In addition, it is not clear to the Independent Investigation Team what is required by certain aspects of the plan. For example, an element in the care plan is *'Discuss and educate client re: positive coping mechanisms*'.

20.24 It is possible for care to be delivered in accordance with the CPA model despite a lack of CPA documentation being completed. However, in light of the disconnect highlighted in Paragraphs 20.19 - 20.23 above, it is difficult for the Independent Investigation Team to conclude that the aims and objectives of the CPA were met in relation to the planning of Ms A's care in the initial stages of her presentation.

20.25 Ms A was formally added to the CPA process by Social Worker 2 on 4 March 2008 when Social Worker 2 completed CPA 1 (Part B) and CPA (Part B). The date on CPA 1 (Part A) is 5 November 2007 and CPA (Part B) is dated 17 October 2007. The information contained in the documents is correct as at that time. However, the electronic record clearly states that the documents were in fact created on 4 March 2008. Given that Ms A's presentation had moved on by this point, the Independent Investigation Team believes that it was not best practice to fail to record the fact that the documents were written on 4 March 2008 as opposed to 5 November 2007 and 17 October 2007 when the information in the document would have been more accurate. A simple note acknowledging the delay would have been more appropriate.

20.26 Notwithstanding the potential professional conduct issues which could arise as a result of creating a document such as that dated 4 March 2008, its construction in this manner denied Ms A a further opportunity to have her needs assessed and the delivery of her care reviewed accordingly. Unfortunately, this did not happen and the ethos of the CPA approach appears to have been abandoned in substitution for a bureaucratic exercise which did not enhance the delivery of Ms A's care.

20.27 Lack of planning in Ms A's case has been a significant concern throughout Ms A's care. The Independent Investigation Team is concerned that even when Trust Policy in the form of adherence to the CPA process requires a planning exercise to be performed, this was not done effectively.

20.28 Level of CPA

20.29 The CPA Policy states at Paragraph 11 that:

> *'CPA is a tiered approach to care intended to meet different levels of need. There are two levels of CPA – Standard and Enhanced.*

The CPA levels reflect the complexity of the Mental Health needs and risks that need to be managed. They therefore also reflect the amount and range of services required to meet those needs. Service users may transfer from one level of CPA to another based upon their needs and requirements.'

20.30 The CPA Policy goes on to set out the characteristics for the respective levels.

20.31 Ms A was managed throughout her care on the standard level of care. The Internal Investigation Team agreed with this approach given the relatively straight forward care plan. However, the Independent Investigation Team would seek to question whether the intention of the CPA Policy was that it was the nature of the care to be delivered that dictates the level of CPA. The CPA Policy is drafted in terms that require practitioners to look at the characteristics of the service user in order to allocate a CPA level. The Independent Investigation Team takes the view that in allowing the delivery of the care plan to dictate the level of care, the aim of the CPA process is defeated.

20.32 The CPA Policy states that the characteristics of service users on the enhanced level of CPA should include at least one of the following:

- They are only willing to co-operate with one professional or agency but have multiple care needs,
- They may be in contact with a number of agencies (including the criminal justice system),
- They are likely to require frequent and intensive interventions, perhaps with medication management,
- They are 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 because of their mental health problems,
- They are more likely to disengage from services or not comply with treatment,
- They have multiple care needs which require multi-disciplinary or interagency co-ordination.

20.33 When Ms A was seen by Social Worker 1 on 3 October 2007, Social Worker 1 noted the following features of Ms A's presentation on her CPA Needs Assessment which could have indicated that she could have been placed upon an enhanced CPA level:

- She was not prepared to engage with services such as CRUISE (bereavement) and MIND (anger management), despite the possible benefit to her of these services.
- She had multiple care needs, given the significant level of binge drinking which she reported.

20.34 Given these features on presentation, Ms A could have been assessed as requiring an enhanced CPA level. Had Ms A been assessed as requiring enhanced CPA, the CPA Policy allows for a multi-disciplinary team meeting to be held to discuss and plan her needs. In

addition, she would have undergone an 'enhanced' risk assessment process as opposed to a 'standard' risk assessment process, which might have been of benefit in that more than one individual would have been involved in the process which may have allowed a better understanding of her needs.

20.35 Notwithstanding the designation of Ms A to the standard level of CPA, it would have been open to those responsible for delivering Ms A's care to use elements of the enhanced level of care such as the 'enhanced' risk assessment to develop strategies relating to Ms A's care. If used effectively, the CPA process can be adapted in terms of process in order to best suit the needs of the individual who is the subject of care. However, in order to do this, there must be recognition of CPA as a mechanism of care planning in order to meet the needs of individuals as opposed to it being a bureaucratic process which impedes or adds to practitioners workloads.

20.36 In practice, Ms A did receive elements of multi-disciplinary practice, despite being assessed for a standard CPA which is to be commended. However, a formal enhanced CPA meeting at the outset of her care or indeed whilst it was ongoing would potentially have given the MDT an opportunity to plan Ms A's care from their different perspectives and then to consider how that care should be delivered in order to match her needs at the time. In practice in Ms A's case, care planning was largely left to a single individual, leading to the aims of the CPA not being met and Ms A receiving a poorer standard of care as a result.

20.37 Involvement of Carers

20.38 A key element of the CPA is collaboration between service users, their carers and the professional responsible for the delivery of care. The CPA encourages service users to be involved in the identification of their needs and the formulation of the plan which seeks to address those needs. In addition, the CPA recognises the importance of carers in supporting the delivery of care.

20.39 Throughout Ms A's care, she attended consultations with a number of individuals whom it might have been possible to consider establishing as Ms A's carer.

20.40 In the initial stages of her relationship with the Service, Ms A attended a consultation with Social Worker 2 and Team Leader 1 on 7 November 2007 with a friend who is not named. Throughout Ms A's notes there is reference to a friend whose children Ms A takes care of. The Independent Investigation Team believes that Ms A's friend may also have been a cousin of the Deceased's. It is also believed that she was named as Ms A's next of kin in relation to the TOP's which Ms A underwent and made telephone calls to the EIP Service cancelling consultations on Ms A's behalf. The Independent Investigation Team believes that these references are in fact to the same individual.

20.41 It is clear that, by the time in which Ms A moved into her own flat following her stay at the hostel, her family were very much a part of her life. Indeed, it is recorded in Ms A's notes on 5 February 2008 that her 'Family are supporting Ms A to decorate flat and move in'. On 30 June 2008, when Ms A appeared to suffer a crisis, her mother contacted the Service and was with Ms A at her meeting with Staff Grade 2 and Social Worker 2.

20.42 Equally, it was clear that Ms A was in significant contact with the Deceased, who was the subject of much of her violence. The Deceased attended a consultation with Ms A on 7 March 2008.

20.43 It does not appear at any stage that any of these individuals were considered as potential carers for Ms A despite Ms A's mother attending meetings with the Service on two occasions. This constitutes a string of missed opportunities and does not accord with the ethos of the CPA, which is to include carers as well as service users in the care given. The views of members of Ms A's social and family network about her needs, including the impact her problems were having on members of her social and family network, were of vital importance diagnostically, given Ms A's failure to improve despite treatment and also her failure to attend consultations with the Service.

20.44 There is no evidence in Ms A's notes that any discussions were had with Ms A about possible carers. The individuals who were referred to by Ms A or attended consultations with her could have had significant information about Ms A which was relevant to her presentation. Such opportunities to meet with these key individuals in Ms A's life would have afforded the team collateral information for their assessments and risk assessment as well as potentially strengthening the therapeutic alliance.

20.45 It should be noted that Ms A's mother was involved in a CP3 CPA meeting with Social Worker 2, Staff Grade 2 and Ms A on 30 June 2008. This is an example of good practice in that it constituted a gathering of key individuals in Ms A's care. According to HPFT Policy, Form CP4 - Standard Care Plan should be utilised to summarise the care plan for standard CPA. However, in this instance Form CP3 was used, despite being normally used for summarising the outcome of an enhanced CPA Review meeting. The form makes it clear however, that Ms A remained on the standard level of care despite receiving a multi-disciplinary review, which is a feature of an enhanced level of care. The Independent Investigation Team recognises this as an illustration of a flexible use of the CPA process in Ms A's care, which is to be commended.

20.46 However, in the opinion of the Independent Investigation Team, the plan which was developed as a result of this meeting is vague and does not identify Ms A's needs as set out in a CPA Needs Assessment which was undertaken on 1 July 2008. Equally, it does not appear that this meeting was used as an opportunity to re-evaluate where Ms A had reached in relation to the issues, which caused her to seek help from Cheshunt CMHT in the first place

with a view to moving her care forward. For example, Staff Grade 2's future actions in relation to Ms A's care are:

> *'To offer Ms A regular appointments to assess and monitor mental health, response to medication, diagnosis etc. To keep GP informed of this and to request tests as necessary.'*

20.47 Equally, Social Worker 2's actions are to:

> *'To meet with Ms A once per week in order for response to medication and side effects to be monitored, to assess and monitor mental health, to record of Ms A's weight and hip/waist measurements and to look at coping strategies and structuring day. Social Worker 2 to support Ms A to go on housing transfer list.'*

20.48 Paragraph 13.1 of the HPFT CPA Policy sets out the requirements which relate to the formulation of a care plan, which include the fact that the care plan should be devised and written with the optimal involvement of the service user, using the service user's preferred form of words where possible. In addition, the care plan must:

- Identify the interventions and anticipated outcomes;
- Record all the actions necessary to achieve the goals;
- Set out estimated timescales by which outcomes or goals will be achieved or reviewed;
- Describe the contributions of all agencies involved;
- Include a contingency plan;
- Be understandable and meaningful to the service user;
- Be agreed by the service user and signed by them (the electronic service user record may not be signed); and
- Be signed by a representative of the Clinical Team.

20.49 In the opinion of the Independent Investigation Team, these requirements are not satisfied by the care plan which was produced following the meeting of 30 June 2008.

20.50 The initial CPA Needs Assessment and Standard Risk Assessments were completed by Social Worker 1 on 5 and 7 October 2007. Social Worker 2 used these documents to construct the CPA Needs Assessment and Standard Risk Assessments which are dated 1 July 2008 and 2 July 2008. No needs assessments or risk assessments were conducted in the intervening period.

20.51 The HPFT CPA Policy states in relation to care plan review that:

> *'There is no predetermined frequency for a review meeting as this is determined by the needs of the service user. However all service users on Standard and Enhanced CPA should have a minimum of one review per year.*
> *The purpose of a CPA review is therefore:*
> - *To review the working of the care plan and risk management plan*
> - *To revise the care plan and risk assessment as necessary'.*

20.52 There were a number of events in Ms A's life which the Independent Investigation Team believes would have warranted a review either at the time that they occurred or indeed at the meeting on 30 June 2008:

- Changes in Ms A's medication and her perceived lack of response to that medication;
- Ms A moved from a hostel to her own flat;
- A pattern of non-engagement had emerged; and
- Repeated reports of violence towards the Deceased.

20.53 These issues do not appear to have been considered in detail in relation to whether current service delivery addressed these issues. Without a structured review of care at a CPA meeting which leads to measurable outcomes, targets and goals, the CPA process is in danger of becoming a bureaucratic exercise. The actions identified in the CP3 meeting note all relate to care delivery pathway without an assessment of Ms A's needs having been undertaken, or a decision having been taken upon what her care was seeking to achieve.

20.54 HPFT have adopted a Carers' Assessment Practice Guide which was originally drafted in December 2006. It was revised on 2 September 2010. The definition of Carer in this policy is as follows:

> *'A carer is someone who provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability….'* (Princess Royal Trust, and Luke Clements Carers and their Rights 3rd Edition, Page 15, Paragraph 3.22).

20.55 Whilst this is a comprehensive definition, the Deceased and other individuals such as Ms A's mother could have fallen foul of it despite being a carer in the sense of the definition. The definition requires the service user to be unable to manage without the help of the carer. It is not clear whether this is a physical reliance or an emotional reliance. This is a high threshold in the case of a young adult who is in contact with their family and network of friends.

20.56 The PIG provides a wider definition of carer which encompasses the ethos of EIP, which is to provide a new type of service that seeks to preserve normality for those who are potentially affected by an emerging psychosis. The PIG makes it clear that the service user's friends and family can be considered as carers. There is no requirement of dependence attached to designation as a carer.

20.57 The EIP Service Operational Policy states that carers can include family and friends but does not provide a definition to assist team members.

20.58 A further possible safeguarding issue, which was not recognised in Ms A's case which is a cause for concern, is in relation to safeguarding children.

20.59 Recommendations to Improve Patient Safety

The Independent Investigation Team believes that care planning could be improved by a slot being made available at the weekly MDT Meeting to allow for discussion of more complex care planning and ongoing planning issues.

The documentation surrounding care planning should be reviewed to make it easier for care co-ordinators to structure care into its key elements.

The quality of care planning should feature in the clinical audit cycle of the EIP Service.

20.60 Key Points

The ethos of the CPA was not adhered to in Ms A's care.

Ms A's care was not the subject of collaborative working between Ms A and those delivering her care. Ms A's needs do not appear to have been put at the centre of care delivery. Opportunities to discuss Ms A's difficulties with friends and carers were missed.

Ms A's care plan was not properly structured. It is not clear how it was envisaged care would be delivered or indeed its success functioned. Whilst issues such as Ms A's violence were highlighted, a plan to address that violence was not constructed.

Ms A could have been assessed as enhanced CPA level. However, she was maintained on the standard level of care. Ms A would have benefitted from the multi-disciplinary input into the planning of her care which enhanced CPA could have given her.

Ms A's care appears to have been planned by one individual which does not adhere to the ethos of the CPA. Ms A's care was not planned or delivered with the collaboration of Ms A's carers and friends.

Ms A's care plan was not kept under review despite her changing circumstances either formally or informally.

20.61 Fair Access to Care

20.62 There is a requirement to ensure that the 'Fair Access to Care Services in Hertfordshire' eligibility framework is used to determine the eligibility of adults referred for social care. The Internal Investigation Team made recommendations concerning Ms A's failure to be assessed as being eligible for social care. The Independent Investigation Team would repeat this concern.

20.63 The Independent Investigation Team notes that, in accordance with the Internal Investigation Team's recommendation, staff have been given further training in this area.

20.64 Risk Assessment

20.65 Effective and good quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgment to be made identifying whether the service user is at risk of harming themselves and/or others, or of being harmed themselves.

20.66 The assessment, documenting and management of risk is an essential component of all clinical assessments undertaken by members of HPFT health and social care staff. Risk assessment and CPA procedures are intrinsically linked. A thorough risk assessment coupled with a needs assessment will assist the assessor in determining the most appropriate level of CPA for an individual service user.

20.67 The assessment and management of risk should be a multi-disciplinary process which must include, where possible and appropriate, the service user and their carer(s). This is because engagement and compliance are more likely if individuals have been given an opportunity to buy into the process. Decisions and judgments should be shared amongst clinical colleagues and documented clearly.

20.68 An assessment of risk will form part of a needs assessment. There are only two completed formal risk assessments within Ms A's notes. The first is dated 5 October 2007 and was completed by Social Worker 1 of Cheshunt CMHT, and the second is dated 2 July 2008. The Independent Investigation Team does not regard risk management as a formal process which should only be undertaken when required by the CPA process. In order to work effectively, it can be undertaken informally as soon as new information comes to light. A record placed in the service user's notes would suffice as evidence that this had been done.

20.69 The impression which the Independent Investigation Team reached is that these documents were not regarded as being an integral part of Ms A's care. They appear to have been created as part of a process but once created played little part in Ms A's care.

20.70 At no stage in Ms A's care does a methodical or comprehensive approach appear to have been adopted in relation to the consideration of risk.

20.71 A significant risk factor was the violence which Ms A had exhibited to the Deceased and the circumstances in which it occurred. This is an issue which was dealt with in the Internal Investigation Report. The authors of that report recognised that greater consideration should have been given to the violence towards the Deceased.

20.72 However, Ms A exhibited other risk factors which do not appear to have been explored. Ms A was violent to individuals other than the Deceased, for example she was said to have hit family members on or around 30 June 2008.

20.73 In addition, a significant risk was posed by the diagnostic uncertainty which was attached to Ms A. The risk attached to an individual who displays characteristics of a personality disorder with maladaptive behaviours potentially poses a greater risk than an individual with depression.

20.74 However, the somewhat unstructured approach taken by the EIP Service in relation to Ms A's risk assessment is perhaps best illustrated by two entries in her records.

20.75 On 30 April 2008, Ms A cancelled an appointment because she had been arrested in a friend's car and had to go and explain what had happened to her mother. The reasons for this arrest were not identified at any stage, nor was Ms A's mother asked about the incident.

20.76 Ms A was arrested for drink driving on 11 September 2008. The EIP Service's response to this event was to provide a letter of support for Ms A to assist her in the subsequent court proceedings. It did not however trigger a risk review despite the fact that it is a significant event in relation to Ms A's presentation involving the combination of alcohol and risk taking behaviour. Ms A had a previous caution for stealing alcohol and had admitted to being a binge drinker. However, this was never subjected to risk review. A further possible safeguarding issue, which was not recognised in Ms A's case which is a cause for concern, is in relation to safeguarding children.

20.77 In the opinion of the Independent Investigation Team, both these incidents illustrate a very poor approach towards the identification of risk.

20.78 The above paragraphs deal with the assessment of risk with regard to others. However, Ms A herself was exposed to risk issues. Self-harm was not pursued nor was non-engagement, which of itself is a risk. Equally, because her relationship with the Deceased was not explored, the Deceased was not considered a risk. However, no assessment was made of the Deceased's response to violence. In clinical notes dated 7 November 2007, the following entry is suggestive that the Deceased may react violently to Ms A's violence:

> *'Ms A said she had been arguing and fighting with boyfriend and that he had said if she did not stop that he would leave her / retaliate violently – neither of which Ms A wanted.'*

20.79 The EIP Service has taken steps to address and strengthen risk management in the Clinical Standards. It is explicitly stated that risk assessments and care plans should be '*Updated every 6 months or when clients' client's situation changes, e.g. when there is a change in medication or new concerns about adherence to treatment or at the CPA meeting or when HoNOS is reviewed'*, which is simply a restatement of CPA. Risk plans and care plans now have to be discussed at in supervision.

20.80 Recommendations to Improve Patient Safety

The Independent Investigation Team believes that care planning could be improved by a slot being made available at the weekly MDT Meeting to allow for discussion of more complex care planning and ongoing planning issues.

The documentation surrounding care planning should be reviewed to make it easier for care co-ordinators to structure care into its key elements.

The quality of care planning should feature in the clinical audit cycle of the EIP Service.

20.81 Key Points

Risk Management was not pursued in Ms A's case in a structured manner. Risks which she posed were identified but there was no real plan to tackle the issues which then arose. The risks to which Ms A herself was exposed were not fully explored.

The EIP Service has introduced the Clinical Standards which strengthen the EIP Service Risk Management framework.

20.82 Care Co-ordinator

20.83 The Care Co-ordinator's role is set out in the 'Care Co-ordination Policy (Incorporating the Care Programme Approach)', at Paragraph 6.2. It states that the role of the Care Co-ordinator is to be:

> *'...responsible for keeping in close contact with the service user and for advising other members of the care team of changes in the circumstances of the service user which might require review or modification of the care plan and the risk assessment/management plan.'*

20.84 Social Worker 2 and Ms A appear to have developed a good relationship. Social Worker 2 provided Ms A with a great practical support. She was attentive to Ms A's needs and made significant efforts to arrange and rearrange appointments with Ms A. She was persistent and assertive in her attempts to maintain the relationship between Ms A and the EIP Service. Social Worker 2 did well to establish a good relationship with Ms A given Ms A's reported difficulties with others. However, the degree to which she managed to put this to therapeutic benefit is in doubt as a result of the lack of information which was established about Ms A in light of clues which Ms A provided. However, it should be remembered that Social Worker 2 was at an early stage in her career when she was responsible for Ms A's care. The Independent Investigation Team believes that she would have benefited from more regular and structured supervision in this regard. Equally, she may also have been helped by more robust processes within the Service which would have provided more structure for her and also her clients.

20.85 It is important that the Care Co-ordinator is trusted by the service user and the service user's own views as to the most appropriate person for this role should be sought. With a service user like Ms A who has proved difficult in the past to engage with services, it is important to maintain stability in their co-ordination. Transfer of care co-ordinators can prove a very anxious time for service users. There was very little information available to the Independent Investigation Team about the rationale behind the choice of Psychiatric Nurse 2 as Miss A's care co-ordinator. This is a matter of concern, particularly because the transfer seems to have been generated by the need for Social Worker 2 to reduce her case load rather than any feature of Ms A's needs (see Paragraphs 22.22 - 22.24).

20.86 It has been mentioned in interview that the transfer was also due in part to the fact that Ms A had not made significant progress with Social Worker 2 and that a change of care co-ordinator might make improvements. It was also suggested that Psychiatric Nurse 2 was being brought in to do some CBT work with Ms A. This is not substantiated in Ms A's notes. Further, Psychiatric Nurse 2 herself did not appear aware of this.

20.87 It is unfortunate that at around the time of the transfer of care co-ordinators, Ms A was experiencing relationship difficulties with the Deceased. She had experienced an unwanted pregnancy and its subsequent termination. Psychiatric Nurse 2 was visibly pregnant at this time. It is unclear what effect or indeed relevance Psychiatric Nurse 2's pregnancy might have had on Ms A's ability to form a relationship with Psychiatric Nurse 2, nor indeed the impact which this had upon her care. Ms A had previously reported that she had undergone a termination of pregnancy, and this is the type of factor which might have been considered relevant in a carefully planned transfer of care co-ordination. No records exist which outline the planning behind the transfer of Ms A's care co-ordination. In the absence of any records outlining the reasons behind the transfer, the Independent Investigation Team has no alternative but to conclude that a planning process did not occur and there was no assessment of whether Psychiatric Nurse 2 would be a good choice of care co-ordinator for Ms A other than as a new member of the team Psychiatric Nurse 2 had capacity to undertake her care.

20.88 Ms A engaged in a pattern of behaviour which could be described as help-seeking with Social Worker 2. This was characterised by her making appointments then phoning to cancel, but in doing so, providing information or clues as to what was going on. Once Psychiatric Nurse 2 assumed responsibility for her care Ms A simply failed to engage without any real notification of why being given. This subtle change may reveal Ms A's unease with the transfer, although this cannot be said with any certainty. It is clear however, that Ms A did not tell Psychiatric Nurse 2 about a potentially significant event in her life at the time.

20.89 It is unclear whether the decision to transfer care co-ordination was agreed with Ms A in advance. This is a matter of concern because there is a significant risk when care co-

ordination is transferred that the relationship which the service user has with the service is destabilised.

20.90 Recommendations to Improve Patient Safety

The interests of the service user should be placed at the centre of the decision to transfer care co-ordination, and not the interests of the relevant service.
Transfer of care co-ordination should be agreed with the service user, and this should also be documented.

20.91 Key Points

Ms A established a good relationship with Social Worker 2. Social Worker 2 was attentive to Ms A's needs and made significant efforts to arrange and rearrange appointments with Ms A. However, the degree to which this transferred to therapeutic benefits is in doubt.
The transfer of care co-ordination was not documented and does not appear to have received careful planning. It is not clear why the transfer took place or whether the key purpose was to benefit Ms A.

21.0 SAFEGUARDING ISSUES

21.1 The Standard Risk Assessment template utilised by HPFT prompts authors to consider '*Risks to children*' and in addition, '*Threatened or actual aggression to carers'*. However safeguarding, whether of adults or children, does not appear to have been given any consideration by those responsible for Ms A's care.

21.2 In the initial risk assessment compiled by Social Worker 1, reference is made to the violence which Ms A inflicted on the Deceased in a domestic setting on 5 October 2007. Following this Social Worker 2 recorded the fact that Ms A repeatedly exhibited violent behaviour toward the Deceased on a regular basis. Despite these reports, there appears to be no exploration of the nature of their relationship in order to assess whether safeguarding issues arose. Crucially, it is not known what the Deceased's response to Ms A's violence was (see also Paragraphs 20.71 and 20.78).

21.3 Little is known about the Deceased from Ms A's records. However, he was a focus for Ms A seeking help from her GP, as Ms A appears to have wanted to maintain the relationship despite its volatility. Post-mortem results showed that the Deceased had consumed a considerable amount of alcohol and had taken drugs in the hours immediately prior to his death. This combination of features raises an issue as to whether safeguarding issues applied to Ms A, the Deceased or indeed both of them.

21.4 Ms A was a young woman who no longer lived with her family and had multiple social problems. She had a number of features which would cause her to be considered 'vulnerable', which included her being thought to suffer from a depressive illness and a potential emerging psychosis.

21.5 Equally, the Deceased was being attacked on a regular basis. Reference during interviews was made to the fact that the couple were not living together or had split up and therefore on either basis safeguarding was not an issue. The Independent Investigation Team cannot accept this explanation. Consequently, the violence in what appears to have been a domestic setting should at the very least have been brought to 'hot spot' for full MDT review or indeed review under the CPA.

21.6 The Independent Investigation Team recognises that the MDT meetings operated by the EIP Service now includes a permanent safeguarding slot. However, in order to be considered in the safeguarding spot, a level of understanding as to what safeguarding is trying to achieve is necessary. This understanding appears to have been absent in Ms A's case. The Clinical Standards introduced to the EIP Service would have made a difference in this respect if the individual care co-ordinator had recognised that an individual was a carer and then recognised their potential vulnerability.

21.7 In the initial risk assessment compiled by Social Worker 1 on 5 October 2007, Social Worker 1 has inserted the words '*none assessed*' in relation to the questions posed about risks to children. Following this Staff Grade 1 recorded, on 17 October 2007, the fact that Ms A spent time with a friend who has children. Later, Social Worker 2 noted that Ms A would like to do a childcare course. No further investigations were made about the nature of the contact which Ms A had with children. The Independent Investigation Team has subsequently been informed that Ms A cared for her friend's children in their mother's absence overnight.

21.8 The Independent Investigation Team raise this as an issue in order to test whether there is now a process within the EIP Service whereby the safeguarding issues attaching to children such as those in Ms A's care could be identified. The answer once more appears to rely on the care co-ordinator's judgment. There is no failsafe procedure other than an effective supervision process and the availability of the MDT meeting.

21.9 The Independent Investigation Team's ongoing concerns about supervision in the EIP Service are more fully set out from Paragraph 19.6 onwards.

21.10 Key Points

Safeguarding was not considered as an issue during the course of Ms A's care.
Safeguarding issues arose in relation to Ms A, the Deceased and potentially children who Ms A was in close contact with but these issues were not explored fully.
Safeguarding has been introduced into the EIP MDT Meeting as a permanent slot, which is a significant improvement in the systems operated by the Service.

22.0 RECORD KEEPING

22.1 Good healthcare records – whether electronic or handwritten – are essential for the continuity of service user care. Good records enable others to reconstruct the essential parts of each service user's contact without reference to memory. They should therefore be comprehensive enough to allow colleagues to carry on where a practitioner left off.

22.2 Key Elements of good healthcare records

22.3 Good healthcare records summarise the key details of every service user's contact and should contain all the pertinent information about a service user's care. In particular, the notes should allow other members of a clinical or multi-disciplinary team to understand the service user's progress, findings on examination, monitoring and follow-up arrangements. It is also important to record judgments or opinions reached at the time of the consultation regarding, for example, diagnosis.

22.4 Good healthcare records allow the essential parts of each service user contact to be reconstructed without reference to memory. They should be comprehensive enough to allow colleagues to maintain continuity of care. Care notes being electronic and multi-disciplinary are a good way to ensure that good record keeping supports a whole team in managing care effectively.

22.5 GMC expectations

22.6 In its publication Good Medical Practice (November 2006, Paragraphs 3f–g), the GMC states that:

> *'In providing care you must… keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment; make records at the same time as the events you are recording or as soon as possible afterwards.'*

22.7 All of the other statutory bodies governing other health and social care professionals have adopted similar guidance regarding record keeping, including the Nursing and Midwifery Council (NMC) and the General Social Care Council (GSCC). The NMC have published 'The Code', clearly and simply setting out the nursing profession's standards of conduct, performance and ethics. Within The Code the NMC state:

> *'You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been'.*

22.8 Any assessment of the quality of a service user's care will involve careful consideration of their records. If there are deficiencies in the records, practitioners are left exposed to criticism and may find it difficult to defend themselves in the event that their judgments or decisions are placed under scrutiny.

22.9 The Independent Investigation Team noted that HPFT use an electronic record keeping system called Care Notes, which is widely used within the NHS. Care Notes provides an integrated electronic health and social care record that covers all aspects of service user's care, including the CPA.

22.10 Quality of Record Keeping within EIP Service

22.11 Overall, the Independent Investigation Team considered the clinical notes to be of a generally poor quality. However, the Independent Investigation Team noted some examples of very good notes.

22.12 The Independent Investigation Team has identified in Section 15.0 the difficulties which it had in following the rationale behind Ms A's diagnosis and her resultant care. These difficulties have been exacerbated by poor record keeping.

22.13 It should be noted that Social Worker 2 appears to have recorded each of her contacts with Ms A promptly after the consultation which is a demonstration of good practice. Social Worker 2 has also been conscientious in relation to correspondence which is sent out concerning Ms A. Correspondence was dispatched promptly, usually within a few days of a consultation, which is commendable.

22.14 However, the Independent Investigation Team has noted some difficulties in relation to Staff Grade 2's record keeping.

22.15 Firstly, entries in the notes relating to Staff Grade 2's clinical contact with Ms A are consistently made by Social Worker 2. Social Worker 2 is a social worker and not a doctor. It is not surprising therefore that key clinical information has been omitted. If this task is to be delegated to a non-clinician, then it is the clinician's responsibility to ensure that all relevant clinical information is contained in the record. Failure to do so could prejudice service users care and cause the clinician to be in breach of GMC guidance.

22.16 Staff Grade 2 has only made two entries in relation to Ms A's care herself. This entry was made on 27 December 2007, one week after she saw Ms A for the first time. The second was made on 4 July 2008, four days after she saw Ms A in crisis on 30 June 2008. Both entries are brief.

22.17 When the GMC undertakes a performance assessment of a doctor's practice, one aspect of his/her work which is looked at is record keeping. A sample of the doctor's notes is assessed. A key question which the assessors would seek to answer is *'if another practitioner were to take over this case, would the record give them systematic and ready access to all the information which they require?'* It would be difficult to answer *'yes'* to this question in relation to Staff Grade 2's notes.

22.18 Secondly, Staff Grade 2 appears to have experienced some administrative difficulties, in that correspondence generated by her consultations often took some time to be sent to Ms A's GP. For example, following Staff Grade 2's first consultation with Ms A on 20 December 2007, a letter was not sent to her GP until 22 January 2008. Staff Grade 2's letters to Ms A's GP are regularly signed by Social Worker 2 on Staff Grade 2's behalf. Delays in forwarding correspondence to GP's can, as happened in Ms A's case, cause difficulties in providing care. For example, if a change in medication has been suggested but this does not take place because the GP is not informed promptly, the service user will not receive the care that the clinician intended. An example of how this caused difficulties in Ms A's care is set out more fully at Paragraph 17.12.

22.19 Thirdly, during the course of her care of Ms A, Staff Grade 2 has prescribed medication outside NICE and BNF Guidelines. It is open to any medical practitioner to do this, subject to the exercise of proper clinical judgment. However, if a medication is prescribed for an unlicensed use, then the service user's consent to this should be recorded in their notes. This did not happen at any stage in Ms A's care.

22.20 During the course of the interviews conducted with the management team of the EIP Service, problems with administrative support were acknowledged. However, the Independent Investigation Team noted that all other individuals involved in Ms A's care did not seem to experience the same delays in issuing correspondence as Staff Grade 2.

22.21 Missing Information

22.22 It is not possible to determine from the records whether all service user contacts have been recorded in Ms A's records. It appears that at least one consultation has been omitted. The Independent Investigation Team believes that care co-ordination was transferred to Psychiatric Nurse 2 on 12 August 2008, because an entry was made on the system titled 'CPA care change new co-ordinator Psychiatric Nurse 2'. This was created by Social Worker 2. However, there are no notes about the transfer or how it was to be achieved.

22.23 The care co-ordinator's handover process is not documented at any point in Ms A's notes. Therefore the reasons for the transfer are not recorded in Ms A's notes, the actual process of handover is not documented and the reasons behind the choice of care co-ordinator are not documented in care notes or in supervision, which is disappointing. Equally, Ms A's inclusion in this process is unclear. Clarification of these points was not achieved at interview, with the interviewees displaying a lack of consensus as to the reason for Social Worker 2's replacement by Psychiatric Nurse 2 as Ms A's care co-ordinator and the role which Psychiatric Nurse 2 was to play in delivery of Ms A's care going forward.

22.24 Transfer of care between care co-ordinators is a difficult step for some service users. It is therefore very disappointing that so little information exists about how the transfer between

Social Worker 2 and Psychiatric Nurse 2 took place. This represents a significant gap in the record of Ms A's care.

22.25 Supervision Records

22.26 Deficiencies in the recording and storage of supervision records are dealt with more fully in Paragraphs 19.6 – 19.16 and 22.28 – 22.30. The Independent Investigation Team recognises that steps have been taken to address these problems with the introduction of the Clinical Standards.

22.27 However, one issue arose during the course of the Internal Investigation which highlights the difficulties which can arise from an informal system, such as that maintained by the EIP Service in 2007. The Independent Investigation Team has included this example, not in an attempt to ascribe blame in an area which has reportedly been strengthened but instead to stress the importance of regular and ongoing audit, to ensure that the Clinical Standards introduced by the Service are being adhered to.

22.28 The example relates to supervision records maintained by Psychiatric Nurse 1 who was responsible for the supervision of Psychiatric Nurse 2. In Psychiatric Nurse 1's signed statement given to the Internal Investigation dated 20 December 2008, Psychiatric Nurse 1 confirmed that she was no longer in possession of Psychiatric Nurse 2's supervision notes because she had lost the memory stick upon which they were kept. When this matter was brought to the attention of the Internal Investigation Team, no action appears to have been taken to investigate the potential loss of data. The loss of the memory stick failed to attract any comment in the Internal Investigation Report which is a matter of some concern.

22.29 However, Psychiatric Nurse 1 confirmed at her subsequent interview with the Independent Investigation Team that in fact the notes were not maintained on a memory stick but had become lost when Psychiatric Nurse 1 received a new computer. Psychiatric Nurse 1 had previously saved her supervision records to the desktop of her old computer. The data loss occurred at this time, although the mechanism of how the notes failed to be transferred is unclear. What is clear, however, is that there was no failsafe or back-up procedure to preserve data.

22.30 The reason that this issue remains relevant is that in interview, Psychiatric Nurse 1 stated that the manner in which supervision records are maintained is not currently the subject of audit. Given the historical variations which have occurred in the EIP Service and the ramifications of a data loss such as that suffered by Psychiatric Nurse 1, the Independent Investigation Team believes that there would be considerable merit in such an audit in order to check that all supervision records are now maintained in the same manner and are backed-up in order that they are easily accessible as part of the continuity of service user care. In addition, the NMC Code states that nurses must ensure that all records are kept securely.

22.31 Amendments to Records made post-incident

22.32 During the course of the Internal Investigation, it became clear that Social Worker 1, who was a social worker with Cheshunt CMHT, had not confirmed an entry on the Care Notes system which allowed subsequent members of the EIP Service to amend a Needs Assessment prepared by Social Worker 1 together with a Standard Risk Assessment also prepared by Social Worker 1.

22.33 The Internal Investigation recommended further training for staff to prevent a recurrence of this type of incident happening. In addition, Trust staff involved in this incident received training on the importance of not altering records retrospectively for whatever reason. The duty not to amend notes retrospectively features in a number of codes of professional practice.

22.34 The Independent Investigation Team would concur with this advice. However, the Independent Investigation Team notes that had a copy of Ms A's notes been made at the point at which HPFT received notification of this incident, Social Worker 1 would not have been able to amend the records. Amendments of this nature can have serious implications for the individuals who make the amendments professionally. The NMC Code states that *'you must not tamper with records in any way'*. Equally, HPFT's position in legal proceedings could be seriously jeopardised should it come to light that amendments have been made to notes following an incident such as that involving Ms A.

22.35 The Independent Investigation Team would recommend that HPFT's Adverse Incident Policy should be strengthened to take this into account in order to ensure that a 'master' set of notes is created at the point at which HPFT becomes aware of an incident such as that involving Ms A.

22.36 Not Assessed / None Assessed

22.37 Throughout the course of what is a good initial record of Ms A's presentation, Social Worker 1 has used the phrase 'none assessed' on a frequent basis. This phrase raised concerns in the minds of the Independent Investigation Team because it is unclear what it means. It was not clear from the phrase whether Social Worker 1 went through a process to conclude that there was nothing of note. Or alternatively, no process was undertaken and the matter needed to be investigated by another practitioner. What is missing is the recording of the process which Social Worker 1 went through in order to discount any potentially relevant clinical features. When asked about this in interview, Social Worker 1 confirmed that the usage of 'none assessed' meant that she had undertaken a process but nothing had emerged. These workings could contain relevant information for the clinicians who assumed responsibility for Ms A's subsequent care and it would have been better that this was set out.

22.38 Use of Highlighter Pen by CMHT

22.39 During the course of the interviews, it became clear that it was a common practice for members of the CMHT to highlight key areas in their letters to GPs using marker pens. The rationale given for this was that GPs had provided feedback which confirmed that they found this helpful.

22.40 This is not good practice. It creates difficulties when photocopying documents. Further, it is not the responsibility of CHMT to decide upon what is relevant for GPs to read; that is an exercise of judgment for the individual GP. The Independent Investigation Team takes the view that all of the communication should be considered as being relevant; otherwise the question would arise as to the purpose of the information being included in the correspondence.

22.41 Recommendations to Improve Patient Care

Practitioners should be reminded of the professional requirement to maintain accurate and contemporaneous records.

The Independent Investigation Team recommends that the Clinical Governance Lead for HPFT is given a copy of this report in order to assess the training needs of staff in the EIP Service with regard to note keeping standards.

Cheshunt CMHT should desist from the practice of highlighting paragraphs of their letters to GPs with marker pen.

22.42 Key Points

Record keeping was at times poor:

1. Clinical records maintained by medical staff did not outline a complete record of the discussions which were had with Ms A, the assessments which were made and an explanation of the care plan and choices of medication to facilitate service user's care by members of the MDT.
2. Transfer of care co-ordinator from Social Worker 2 to Psychiatric Nurse 2 is not recorded.
3. Ms A's notes were not preserved at the outset of the investigation into her care by HPFT. This meant that staff were able to make amendments to the records.
4. Clinicians have relied on other members of the MDT to enter notes concerning clinical detail into the service user's records. This is not good practice.
5. Delays in sending correspondence could have impacted upon the quality of service user's care.
6. Cheshunt CMHT has adopted the practice of highlighting paragraphs of their letters for General Practitioners.

23.0 INVESTIGATIONS OF MS A'S CARE CONDUCTED BY HPFT

23.1 Framework

23.2 In 2005, the National Reporting and Learning Service (the 'NRLS') issued guidance on communicating effectively with service users when things go wrong. Following changes to the NHS since the launch, the NRLS has reviewed the guidance and developed a new 'Being Open' framework on 19 November 2009.

23.3 The framework is a best practice guide for all healthcare staff, including boards and clinicians. It explains the principles behind 'Being Open' and outlines how to communicate with service users, their families and carers following harm.

23.4 Open and honest communication with service users is at the heart of healthcare. Research has shown that being open when things go wrong can help service users and staff to cope better with the after effects of a service user safety incident.

23.5 Background to the investigation of Mental Health Homicides

23.6 In June 2005, the Department of Health issued guidance on the investigation of serious service user safety incidents in mental health settings. The guidance was issued in an attempt to help ensure a consistent approach to investigations across the NHS and to raise standards.

23.7 In March 2008, the National Patient Safety Agency (the 'NPSA') produced further guidance describing ways in which the process of investigation could be improved with a view to identifying and communicating themes for national learning.

23.8 In its document entitled 'Independent investigation of serious patient safety incidents in mental health services good practice guidance' (the 'NPSA Guidance') the NPSA sets out a framework of best practice which aims to facilitate identifying and communicating the root causes of incidents to all concerned in an open and honest fashion. The framework was designed to guide staff through the process in a consistent manner across the NHS.

23.9 Trust Policies and Procedures

23.10 HPFT issued a document entitled 'Learning From Adverse Events: Policy Document And Reporting & Managing Adverse Events Procedure And Investigation of Incidents, Complaints & Claims' (the 'Adverse Events Policy') (see Appendix **H**) in May 2007. The policy was approved by the Risk Management and Patient Safety Group. It is stated to have been reviewed in May 2008.

23.11 However, the NPSA Guidance which was published in February 2008 is not included in this document. This is despite the following statement which can be found at page 15 of the Adverse Events Policy:

'1.7 POLICY REVIEW
This policy and the linked procedures will be reviewed bi-annually, or in response to changes in legislation, NHS Directives, or any other relevant event. Feedback will be actively sought from staff and other stakeholders as to this policy's usefulness and applicability.'

23.12 Trust response to Ms A's arrest

23.13 The Deceased died in hospital at 06.28 on Saturday 20 September 2008. At 18.25, the Forensic Medical Examiner working with Hoddesdon Police contacted the CATT Team regarding Ms A's arrest on suspicion of murder. An entry in Ms A's records states:

'He was querying the mental health of Ms A and requested recent information to this end. He also queried whether CATT would be able to assess her present mental state to ascertain the presence or not of any psychotic illness, however, advised that Ms A is currently under the care of the Early Intervention in Psychosis Team and has been seen by themselves as recently as 10/09/08, no evidence of anxiety, low mood or psychotic symptoms present at that time, and that further discussion with themselves would be appropriate, however, they are not available at weekends.'

23.14 The Forensic Medical Examiner requested that information be faxed to Hoddesdon police station regarding Ms A's current mental state, diagnosis and treatment. A number of telephone calls were then made by the CATT team before finally getting in touch at 19.00 with the first level on-call manager for mental health on duty that night. A copy of Ms A's most recent review was then faxed to the police.

23.15 There is no information in the note of the contact with the Forensic Medical Examiner of how Ms A was at that time, nor were there any details of the offence recorded. Information received as part of the Independent Investigation suggests that Ms A was hysterical and suicidal upon arrest. She had been drinking and taking drugs during the hours leading up to the Deceased's death. She had to be physically restrained in the Police Station.

23.16 On Sunday, 21 September 2008 at 19.55, the Mental Health Helpline Team was contacted by Ms A's aunt who was concerned about her niece's medication while in custody. It appears that Ms A's family had tried to contact EIP over the weekend but were advised that the Service was staffed between 9am and 5pm, Monday to Friday. She received reassurance that CATT was aware of the situation.

23.17 At 09.45 on Monday 22 September 2008, Social Worker 3 received a telephone call from Ms A's aunt outlining details of the offence. In Ms A's aunt's view, Ms A was suicidal and she had not had her medication. At this time Staff Grade 2 was advised of the incident as was Consultant 1 and a Service Administrator. EIP Manager could not be informed due to his absence on sick leave. The notes indicate that it was Social Worker 3's view that Service Manager 1 should be advised of the situation. This was to be discussed with Consultant 1.

23.18 Later on that day at 15.36, Psychiatric Nurse 2 has made an entry in Ms A's notes which states:

> *'Awaiting advice from Service Manager 1 (sector manager) re appropriate actions to take in terms of reporting incident according to HPFT policy guidelines.'*

23.19 Psychiatric Nurse 2 contacted Ms A's mother on 23 September 2008 to offer the team's condolences and provide an opportunity for Ms A's mother to talk.

23.20 The EIP Service subsequently maintained contact with Ms A's family and indeed Social Worker 2 visited Ms A in prison on 10 March 2009. At this time Ms A's mother was offered a carer's assessment.

23.21 Trust Reporting of Incident

23.22 The Adverse Events Policy states that members of the Senior Management Team in each Directorate are primarily responsible for ensuring that all incidents/accidents are reported and incident investigations are undertaken (Paragraph 1.5.3 Page 12 of the Adverse Events Policy). Following an adverse incident it is the responsibility of the respective consultant and senior professional staff to ensure continuity of service user care (Paragraph 1.5.6 Page 13 of the Adverse Events Policy). The Risk Management Department (principally through the Incidents and Claims Manager) is responsible for gathering information to report and facilitate the learning arising out of the event (Paragraph 1.5.6, Page 13 of the Adverse Events Policy).

23.23 HPFT procedure for dealing with an incident is set out at Paragraph 2.4.2, Page 19 of the Adverse Events Policy. It states:

> '*REPORTING AN INCIDENT/ACCIDENT/NEAR MISS WITHIN THE TRUST*
> *2.4.2 Out of Hours (including weekends and bank holidays)*
>
> *'…If a level 3 or 4 incident occurs out of hours, and needs senior involvement for whatever reason, the senior manager should report to the Executive Director on call via the Albany Lodge switchboard. If necessary they will take responsibility for the management of the incident.'*
>
> *'……There are also specific requirements for Out of Hours reporting to the Health & Safety Executive for relevant incidents (see Paragraph 2.8.4) and to the Strategic Health Authority for Serious Incidents (see Paragraph 2.8.1).'*

23.24 Clearly, the CATT team was able to eventually contact the on-call manager for mental health on duty that night. However there were difficulties in the process, which included the practicalities of being able to obtain the correct contact details and the non-contactibility of on-call staff. A significant delay did not occur in information being provided to the police.

23.25 However, once the on-call manager had been contacted, little appeared to happen until the morning of 22 September 2008 in terms of practical management of the incident.

23.26 The Adverse Events Policy gives a detailed outline for staff as to how to report an *'Incident/Accident/Near Miss within the Trust*' (see Paragraph 2.4 of the Adverse Events Policy), including reference to the Incident Form which has to be completed. No express guidance or procedure is given for an event which occurs outside HPFT, or indeed one which occurs outside office hours. It may be that the term '*within the Trust*' includes incidents which occur geographically distant to HPFT but involving its service users. Equally, whilst the reporting requirements for staff inside office hours are clear, the process is not as clear for incidents occurring outside office hours. Consequently, there may be merit in HPFT clarifying this section of the Adverse Incidents Policy in order to enhance its current control scheme.

23.27 Initial Management Review

23.28 The Adverse Events Policy states that, following the reporting of an adverse incident, the following procedure should apply:

> *'2.5.1 7 Day Report*
>
> *For level 2 incidents and above, a 7 Day Report must be prepared within a maximum of 7 working days. This should be sent to the Senior Manager responsible for the area concerned, and the Incidents and Claims Manager.*
>
> *The 7 day report contains a detailed synopsis of the incident using the basic principles of Root Cause Analysis, also giving a summary and brief history of the person involved and details of the actions taken at the time of the incident, along with recommendations provided by the Senior Manager.*
>
> *This report is necessary in order to assist the team and the Senior Manager to:*
> - *Fully understand the seriousness and the level of the incident.*
> - *Assist a Scrutiny Panel to decide what type of further investigation, if any is needed (See 2.5.3) for further information regarding the Scrutiny Panel).*
> - *Provide an update to the Chief Executive and other Directors as necessary*
> - *Provide the SHA with a 1 week follow up report (if this is a serious incident reported to the SHA when it occurred — see Paragraph 2.8.1)*
>
> *Appendix K: 7 Day Report Template.'*

23.29 In contrast the NPSA Guidance states:

> *'When any serious incident occurs, an initial internal service management review should take place within 72 hours. The aim of the review is to take any immediate clinical or managerial action necessary to ensure safety, such as ligature point removal, or make any necessary urgent changes to policies or procedures.*
>
> *Action may also be required in relation to staff, other individuals or organisations. Potential evidence, such as clinical notes or medical equipment, should be secured in preparation for more detailed investigation. Early contact with carers and families is important.*

To ensure a systematic approach to the initial service management review, the steps outlined below are suggested…..
Obtain all relevant physical, scientific and documentary evidence, and make sure it is secure and preserved.
Identify witnesses, including staff, and other service users, to ensure they receive support.'

23.30 Arrangements were made by HPFT to provide post incident support to members of staff who were involved in Ms A's care.

23.31 72 Hour Report

23.32 A 72 Hour Report was completed in respect of this incident on 24 September 2008 by Service Manager 1.

23.33 The Report inaccurately states that the incident was reported to HPFT on 22 September 2008. This was the date that the matter came to the attention of EIP Service. It also states incorrectly that HPFT was notified of the incident by Ms A's family. During the course of the interviews, the author of this report referred to the fact that she had only recently assumed a management position in relation to the EIP Service and had not received any training in preparing this type of report. The author of the report has stated that she has 25 years of management experience which does require her to be proficient in report writing. However, due to the nature of her previous responsibilities she would not have had to complete a 72 hour report previously. She stated that the quality of HPFT's policy was good in her opinion and provided her with the information which she needed.

23.34 A comparison of the content of the untoward incident form maintained by HPFT and the pro-forma for the 72 hour report reveals little difference in the information required for completion. However, the untoward incident form prescribed by HPFT does contain the following boxes, completion of which may have caused the Internal Investigation Team to consider whether their investigation was comprehensive:

'What factors are considered to have led to the incident occurring:'
'What immediate action was taken to manage the incident? (Please consider post incident support for those involved).'

23.35 7 Day Report

23.36 HPFT also compiled a 7 day report concerning the incident. This report is also dated 24 September 2008.

23.37 The 72 hour report and 7 day report are in fact drafted in identical terms save that blacking out present in the 72 hour report is missing in the 7 day report. The Independent Investigation Team was advised that the 72 hour report is completed within 72 hours in order to allow the Trust to have comprehensive information about the incident quickly. The untoward incident form is part of the system used by HPFT to ensure all incidents are logged.

23.38 The Independent Investigation Team has the following concerns relating to HPFT action taken around the 7 day report.

23.39 Firstly, the clinical notes were not secured in the format in which they were in on 20 September 2008. As became clear during the course of the Internal Investigation, Social Worker 1 was able to add information to the notes. This has introduced confusion into subsequent investigations which would not have occurred if the NPSA Guidance had been followed and a copy of the notes had been preserved.

23.40 The conclusions set out in the report are largely unsubstantiated. For example, the 7 day report states that:

> *'CPA: There was clear evidence of the CPA process being used effectively with this individual. All actions agreed in the CPA process were clearly identified and followed.'*

23.41 For the reasons set out at Paragraph 20.23 of this report, the Independent Investigation Team cannot agree with the conclusion that the records are well documented with clear and concise information being provided.

23.42 In relation to the Risk Assessments carried out, the 7 day report states '*The Risks were clearly identifiable with appropriate actions in place.*' For the reasons set out at Paragraphs 20.64 - 20.79 of this Report, the Independent Investigation Team would disagree with this conclusion, which again is unsupported by information, either oral or written.

23.43 However, the Independent Investigation Team would agree with the following statement:

> *'Medication Overview*
> *There were changes in medication over the period of time she was treated by the Early Intervention for Psychosis Team, some of which had a clear rationale for use and others not identified. There may be a need to investigated this further.'*

23.44 The Independent Investigation Team could find no evidence that this recommendation was in fact followed through, which in light of the Independent Investigation Team's comments at Paragraphs 17.58 - 17.644 is unfortunate.

23.45 The 72 hour and 7 day reports also made reference to suggested changes to the on-call reporting system which the Independent Investigation Team notes have been implemented. This is an example of a positive piece of learning arising out of an adverse incident.

23.46 The 7 day management review report provided a satisfactory immediate review of the circumstances surrounding the incident.

23.47 Incident Reporting - Internal Audit

23.48 The Independent Investigation Team understands that following comments made in previous Independent Investigation Reports, HPFT very responsibly undertook a detailed internal audit

of its incident reporting procedures. The review was undertaken by an external risk management company. A final report was produced on 29 October 2009. In relation to the Adverse Incidents Policy, the company were able to confirm that the Policy is regularly reviewed and that it was deemed adequate for the purpose of managing incidents within HPFT.

23.49 Internal Investigation

23.50 An Internal Investigation was established into an incident involving Ms A. The Internal Investigation Team compiled a report which is dated 23 January 2009.

23.51 Clear terms of reference were drawn up, which included the review of care and treatment of Ms A. The Internal Investigation had broad terms of reference which were compliant with HSG (94) 27. The investigation was undertaken using root cause analysis techniques in order to facilitate a systemic understanding of the incident.

23.52 However, as legal proceedings were ongoing, the Internal Investigation Panel were limited as to the scope of its review as neither Ms A nor the Deceased's family were included in the review process. In addition, Ms A's mother was also not approached as part of the investigation due to the ongoing legal proceedings. At no stage in the investigations carried out by HPFT were the Deceased's family contacted.

23.53 The Internal Report made 9 recommendations relating to the care and treatment of the service user. During the course of the Independent Investigation, the Independent Investigation Team was pleased to note that key individuals connected with Ms A's care were aware of the recommendations which had arisen from the Internal Report and could explain how change had been implemented in compliance with an action plan produced by the Internal Investigation Team. This demonstrates a willingness to learn from the incident involving Ms A.

23.54 However, the Independent Investigation Team was unable to concur with a number of the fundamental findings made by the Internal Investigation Team, in particular the Internal Investigation Team's conclusions on the following points:

1. The Internal Investigation Team concluded that Ms A had received good quality care by the Service. The Independent Investigation Team would disagree with this conclusion for the reasons set out at length earlier in this Report. However, the Independent Investigation Team would acknowledge that Ms A received prompt assessment by Cheshunt CMHT and the EIP Service. The Independent Investigation Team is also aware that the EIP Service retained Ms A as a service user during a period of diagnostic uncertainty.

2. Ms A received clinically appropriate treatment and management. The Independent Investigation Team would disagree with this conclusion for the reasons set out in Section 16.
3. Ms A's care complied with all relevant Trust policies and procedures. The Independent Investigation Team would disagree with this conclusion for the reasons set out in Sections 19, 20 and earlier in this Section 23.

23.55 Given the clear discrepancy which has arisen between the Internal Investigation Team's conclusions and those of the Independent Investigation Team, it becomes necessary to look at why this divergence of views might have arisen in order to determine whether there is scope for learning.

23.56 The Independent Investigation Team undertook its investigation following the conclusion of the criminal proceedings involving Ms A. Consequently, they had the benefit of access to a number of witness statements and reports, which the Internal Investigation did not.

23.57 The interview process conducted by the Internal Investigation Team was not conducted in accordance with best practice, in that line managers such as Consultant 1 who had an involvement in the case in their own capacity attended junior members of staff's interviews. This could have been off-putting for the more junior members of staff.

23.58 Whilst the Internal Investigation Team had access to Ms A's records, the clinical information contained in the records does not appear to have formed the basis for discussion.

23.59 The Internal Investigation Team does not appear to have documented an audit trail of its findings. For example, its conclusion that a good quality of care was provided by the EIP Service is not supported by evidence gathered in the Internal Investigation.

23.60 The Internal Investigation Team included the Practice Governance Lead for Community Services, This is not best practice as it does not maximise the potential for the investigation to be considered independent of those with responsibility for the management of the EIP Service. It is the Independent Investigation's view that greater care could have been taken in the choice of the members of the Internal Investigation Team.

23.61 The Internal Investigation Report did not identify care or service delivery issues or contributory factors. For example, it was reported to HPFT that Ms A had been taking drugs and had been drinking at the time of the offence. The potential impact which this information might have had upon the quality of care which was delivered to Ms A does not appear to have been considered. This would suggest a lack of systematic and robust methodologies being employed within HPFT's Internal Investigation process.

23.62 Key Points

HPFT produced 3 reports into Ms A's care. The investigations which produced these did not fully adopt the guidance given by NPSA in relation to the investigation of mental health homicides.

Conclusions in the Internal Investigation Report were not always supported by a secure audit trail.

The Internal Investigation Report did not build on the learning from the 7 day report, which suggested an assessment of the medication which Ms A was prescribed. This could have opened up a significant learning opportunity, which did not occur.

The interview process adopted by the Internal Investigation Team would not sustain external scrutiny.

Key witnesses were not included in the Internal Investigation.

24.0 PREDICTABLE OR PREVENTABLE?

24.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the Deceased's death was preventable or predictable.

24.2 Many Independent Investigations, like that conducted in this instance, have identified missed opportunities about the perpetrator's care or a failure to appreciate the extent of the perpetrator's difficulties or to provide good quality care. In these cases, there may be evidence of failure in carrying out individual policy requirements or evidence that the care delivered may not have exhibited features of best practice. However, this does not mean that the homicide could have been either predicted or prevented.

24.3 The Independent Investigation Team has applied the following tests to assess whether the Deceased's death could have been predicted or prevented.

- The homicide is predictable if there was evidence from Ms A's words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.

- The homicide could have been prevented if there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done better.

24.4 Predictable

24.5 The Independent Investigation Team's view is that it was predictable that Ms A could behave violently and had done so historically. This was known to the EIP Service. Her aggressive behaviour has been documented as part of this investigation.

24.6 In the initial risk assessment undertaken by Social Worker 1, it was noted that:

> *'Ms A describes wanting to attack someone if she believes them to upset her or if she was in a fight with a person, "Ms A wishes them dead".'*

24.7 Significantly, Ms A did not use the word "kill", nor does she identify a specific individual. However, it is also true that the self reports of aggression which Ms A made to the EIP demonstrated a pattern of violent behaviour which was not fully investigated.

24.8 Ms A demonstrated a pattern of violence which was closely linked to impulsivity. This is demonstrated by the fact that she used a variety of weapons, e.g. teeth, fists, a bottle in a night club. There was no element of planning in her attacks. She appears to have used

weapons which were to hand, rather than a conscious choice to use a weapon which would cause a specific level of injury. Therefore, the Independent Investigation Team does not believe that it was predicable that Ms A would use a level of violence which would result in the death of an individual.

24.9 It is a matter of great concern to the Independent Investigation Team that reports of violence, particularly towards the Deceased, were not investigated more fully by the EIP Service. The root cause of the violence was not established, although there were a number of clues in the information which was provided to the EIP Service. This attitude to the violence was not investigated and responded to. These clues were either not followed-up or were simply not recognised as being of diagnostic importance.

24.10 There was a failure to recognise the impact of alcohol use on Ms A's mood. Alcohol was signposted at a very early stage by Ms A's General Practitioner and also by Ms A herself. Ms A made it clear that she was more violent when she had been drinking alcohol. However, there is no evidence of any meaningful attempt to assess and evaluate the impact of alcohol on Ms A's presentation throughout the period when she was receiving care from the EIP.

24.11 Further, at an early stage Staff Grade 1 raised the possibility of Ms A having a personality disorder. With the benefit of hindsight, all of the experts involved in Ms A's criminal trial accepted that the most likely diagnosis for her presentation was that of personality disorder. Individuals with personality disorder exhibit persistent characteristics of maladaptive behaviours which cause impairment to themselves or others. Individuals who have a personality disorder potentially pose a greater risk to others than those experiencing depressive symptoms. There is no evidence of any awareness of risk to Ms A and to others which she might have posed in the context of personality disorder. Equally, in failing to recognise the possibility of personality disorder at an early stage, Ms A was denied access to psychological interventions which could have been beneficial to her, such as DBT or CBT. These interventions might also have had an impact upon the risk which she presented to herself and others.

24.12 However, notwithstanding the failures to properly assess Ms A and the potential risks which she posed, the Independent Investigation Team does not believe the level and degree of violence which Ms A exhibited towards the Deceased on the day of his death was predictable.

24.13 Preventable

24.14 None of the failures identified in this report should have happened. The cumulative effect of these failings meant that Ms A was not effectively treated for personality disorder and alcohol abuse and was sub-optimally treated for depression. At her trial the judge accepted that Ms A's behaviour on 20 September 2008 was fuelled by alcohol and drugs.

24.15 As Ms A's needs were unmet in relation to alcohol, there is potentially a link between the effectiveness of her care and treatment and her conduct, which resulted in the death of the Deceased. The evidence in her records suggests that her aggressive behaviour was affected by alcohol. However, in order for treatment for alcohol abuse to be successful, Ms A would have had to have engaged in that treatment and avoided alcohol. Equally, in relation to the therapies indicated for personality disorder, there is also an element of buy in. Consequently, the Independent Investigation Team does not consider that the Deceased's death was preventable.

25.0 SUMMARY OF RECOMMENDATIONS TO IMPROVE PATIENT SAFETY

25.1 The Independent Investigation Team have included recommendations to patient safety within relevant chapters. However, for ease of reference, this is a complete summary.

25.2 Diagnostic Processes (Paragraph 15.49)

Patient safety was compromised in this case by a failure to adopt a structured approach towards diagnosis. This could have been mitigated by a robust supervision process or equally by discussion in a MDT meeting.

The EIP Service has strengthened its supervision and MDT processes since this incident and has produced clinical and practice standards for Early Intervention in Psychosis. However, the Independent Investigation Team is of the view that these systems should be the subject of regular audit to ensure that the improvements which have been made have been implemented and that they are effective.

25.3 Recording of the Medication Dispensed to Ms A (Paragraph 17.6)

EIP may wish to consider reviewing their policies and procedures regarding the recording of medication and/or prescriptions in order to ensure that a full record of the medication dispensed is maintained.

The EIP Service should scan or otherwise record copies of prescriptions issued to service users in the service user's records.

25.4 Recording of the Medication Dispensed to Ms A (Paragraph 17.70)

The EIP Service should take steps to ensure that, when a clinician wishes to prescribe a drug which is unlicensed for the condition for which it is prescribed, the service user's express consent is obtained concerning the increased risk of side effects.

The EIP Service should review and strengthen its procedures relating to the monitoring of medication side effects.

The EIP Service may wish to review its procedures relating to the monitoring of antidepressants in young people both in relation to ensuring that a review is undertaken following a request from a doctor and also in relation to how that review is undertaken, in what circumstances and by whom.

The EIP Service may wish to review its procedures relating to the consent process attached to the prescription of medications which are prescribed outside the guidance produced by NICE and recommendations made in the BNF.

25.5 Psychotherapeutic Interventions (Paragraph 18.23)

The Clinical Standards should be revised to include a process for referral of service users for psychological review and assessment.

25.6 Clinical Governance Structures (Paragraph 19.43)

The Clinical Standards introduced by the EIP Service constitute a positive step forward in terms of improving its own control structure and processes. The EIP Service should consider the introduction of *'Practice Guidance Notes'*, setting out what is required by each element of the Standards to ensure consistency of implementation of the Standards across the service.

There are different models of clinical supervision that reflect the differing professional training and expectations, work contexts and needs of team members. The Standards are silent as to how supervision is to be carried out in practical terms to ensure that a consistent standard is applied across the MDT. The Independent Investigation Team understands from interviewing team members that there has been a great deal of discussion within the team but no consensus reached due to differences in professional attitudes towards supervisory practice. This failure to reach a consensus and adopt a consistent stance is a significant threat to the clinical governance framework operated by the EIP Service.

The Standards do not incorporate any 'failsafe' procedures. The Standards assume that they will be implemented by team members. The Standards are not designed to mitigate the effect of a team member failing to comply with the Standard in order to protect the object of supervision which is stated to be the 'quality of recovery outcomes for EIP clients'. Significantly, if a social worker failed to bring a case to supervision for 3 months, for example because of work load pressure, there is nothing to catch that omission and ensure that that client's case is brought into the supervision process.

The Independent Team were concerned about responses which it received concerning how compliance with the Standards is achieved. For example, questions were asked about checking that care co-ordinators were entering supervisory records into Care Notes. No audit has been undertaken of this and so it is not clear whether compliance with the Standards is being achieved. Given the importance of the Standards to the clinical governance structure of the EIP, it is a matter of concern that an audit cycle has not been implemented to assess the level of compliance with its objectives.

The Standards were due to be reviewed in June 2011. To date this review has not taken place. This is disappointing, given that an opportunity has been missed to evaluate what has gone well with the introduction of the Standards and what has not gone as well with a view to making improvements in the provision of care.

The Standards are silent as to the responsibilities of supervisor and supervisee. For example, it is not clear whose responsibility it is to ensure that supervision takes place on a 3-monthly basis. There is some clarity upon the practicalities of supervision in the HPFT Statement on Supervision, but there may be merit in this aspect of the Standards being reviewed in order to ensure clarity for staff in EIP.
The Standards do not address the issue of client confidentiality in the supervision process.

25.7 Clinical Governance Structures (Paragraph 19.55)

The Independent Investigation Team is of the view that an audit should be undertaken to review the effectiveness of the introduction of the Standards and specifically to ensure that cases are now being referred to MDT Meetings, in accordance with the terms of the Standards.

25.8 Clinical Governance Structures (Paragraph 19.76)

The EIP Service should consider and produce guidance for staff as to the use of the 'hot spot' facility in order to maximise its benefit.

25.9 Care Programme Approach (Paragraphs 20.59 & 20.80)

The Independent Investigation Team believes that care planning could be improved by a slot being made available at the weekly MDT Meeting to allow for discussion of more complex care planning and ongoing planning issues.
The documentation surrounding care planning should be reviewed to make it easier for care co-ordinators to structure care into its key elements.
The quality of care planning should feature in the clinical audit cycle of the EIP Service.

25.10 Care Programme Approach (Paragraph 20.90)

The interests of the service user should be placed at the centre of the decision to transfer care co-ordination, and not the interests of the relevant service.
Transfer of care co-ordination should be agreed with the service user, and this should also be documented.

25.11 Record Keeping (Paragraph 22.41)

Practitioners should be reminded of the professional requirement to maintain accurate and contemporaneous records.
The Independent Investigation Team recommends that the Clinical Governance Lead for HPFT is given a copy of this report in order to assess the training needs of staff in the EIP Service with regard to note keeping standards.

Cheshunt CMHT should desist from the practice of highlighting paragraphs of their letters to GPs with marker pen.