THE INDEPENDENT INQUIRY
INTO THE CARE AND TREATMENT OF
A PATIENT KNOWN AS X

COMMISSIONERS:
SOUTH WEST PENINSULA STRATEGIC HEALTH AUTHORITY
2003

INQUIRY PANEL MEMBERSHIP

Jane M Mackay	**Independent Healthcare Consultant (Chair)**
Robert Higgo	**Consultant Psychiatrist Merseycare NHS Trust**
Penny Ross	**Senior Nurse (community forensic services) West London Mental Health NHS Trust**

CONTENTS

Page

PREFACE

We were commissioned to undertake this inquiry by the South West Peninsula Health Authority and invited to examine the care and treatment of a patient, to be known as patient X, by the then Cornwall Healthcare NHS Trust, now known as the Cornwall Partnership NHS Trust. This was required by the guidance laid down for when a homicide has been committed by a person in receipt of mental health services. The guidance HSG(94)27 states *'in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved'*. The guidance was further reinforced in the document *Building Bridges* (Department of Health 1995) and, as yet, has not been amended.

The National Confidential Inquiry into Suicides and Homicides – Safer Services published in 1999, recommended that alternatives to the existing system of external inquiries should be considered. To date there have been something in the region of 120 mental health inquiries, but with little published evaluation. However, anecdotally, there is an impression of variable standards in rigour, methodology, aptness of recommendations and their subsequent implementation, and not least, the timescale and financial cost.

In 2000 the Department of Health published *An organisation with a memory*, the report of an expert group on learning from adverse events in the NHS. The implementation of the recommendations, *Building a safer NHS for patients,* included the creation of the National Patient Safety Agency to improve patient safety by reducing risk of harm through error by establishing a system of adverse event reporting, and to promote learning across the NHS. This new national approach will be supported by a training programme in 'root cause analysis', best described as finding out what happened, why it happened and providing a strategy to prevent it happening again.

To view the quality of mental health services through one particular incident may not be particularly objective and can be seen as a negative response. But on the positive side, an external inquiry can demonstrate and promote good practice by being open

and honest in addressing any shortfall in service provision to users and carers. Therefore such an inquiry should establish the facts, provide an independent perspective on the events, extract areas for development to improve services, and thus endeavour to prevent a similar event happening. The introduction of a Clinical Governance framework of setting standards, sharing information and developing partnerships should encourage a culture of openness, in which quality of care and service to patients can flourish, and move away from the 'blame culture'. The main outcomes must be to increase public confidence and to promote professional competence.

We are aware that we conducted our Inquiry with the benefit of hindsight, drawing on documentation from a wide range of agencies. In any organisation, no matter how well it is managed, there will sometimes be serious incidents requiring attention.

Our terms of reference are set out in Appendix 1.

ACKNOWLEDGEMENTS

The members of the Inquiry Team wish to express their sympathy to the family, children and friends of patient X, whose wife's tragic death led to the establishment of this Inquiry. We are particularly grateful to the respective family members who came to talk to us – we are aware just how difficult this will have been for them. We are also indebted to one of the daughters who provided us with her notes and those of her parents, which they wrote during the time Mr X was a patient both in Treliske and Trengweath Hospitals.

Inquiries are not set up to apportion blame but to identify the gaps in service, improve practice and promote good practice. It is inevitable with such an in-depth look into services that staff will feel sensitive and may require a higher level of support. We were grateful to all the people who came and gave their evidence, despite the personal distress this may have caused, and would like to acknowledge the effect that this incident had on everyone involved.

All witnesses were written to prior to their attendance and sent the terms of reference and the Inquiry procedure; see Appendix 2. (A full list of the witnesses can be found at Appendix 3).

There can be no doubt that the impact of such an inquiry on both staff and families cannot be underestimated. Many families just want to know what has happened, whilst staff may have mixed emotions of guilt and denial.

We are sure that if the process is managed well, organisations, their staff and families benefit and may begin to move on. We were therefore indebted for the help and administrative support of Mrs Rae Wallin, who organised the Inquiry and ensured that we had all the documentation we required.

We were also greatly helped by the efficient and prompt manner in which the Fiona Shipley Transcription Service provided us with the transcriptions of all our interviews.

BACKROUND

We were charged to carry out this independent mental health Inquiry in the knowledge that during the course of our work two such other inquiries would be published. This duly happened, and occurred as we were about to take oral evidence from some members of staff who had been involved in the previous inquiries. Whilst we acknowledge that this was difficult for those staff, the timetabling of such an inquiry is dependent on a variety of factors, many of which were beyond our control.

We were also furnished with both reports - into the care and treatment of 'H' and 'S' - which we have taken into consideration in completing our Inquiry, especially the recommendations from these previous inquiries, which can be found at Appendix 6. As this Inquiry was held shortly after the two previous ones, there has been little time for any of the relevant recommendations to be actioned, save those already been made in the Trust's internal inquiry into the care of Mr X, a copy of which, with its recommendations and action plan, we were also given.

We were made aware that some staff had felt '*bruised*' by their earlier experiences of the inquiry process. We can only hope that the style and content of this report helps to improve services by highlighting those areas needing development.

We were mindful that during the course of this Inquiry the team became privy to some intimate details of Mr and Mrs X's relationship. We have only strayed into this area of their life together when it was necessary to chronologue the facts and staff had difficulty in trying to obtain an accurate medical history. However, we do know from research that moving house and retirement can be stressful for any couple, and in that regard perhaps Mr and Mrs X were no different, with the added stresses of moving away from their friends and previous way of life.

As already stated, we were privileged to have access to detailed notes made by Mr X's eldest daughter and his wife in which their concerns about mental health services were documented. We shall endeavour to ensure that we address their concerns and seek to explain the reality of service provision in west Cornwall in the circumstances surrounding the death of X's wife on 17 February 2002.

SUMMARY OF EVENTS

Mr X was a retired university lecturer who moved to Cornwall on his retirement, where he and his family had spent many happy holidays. He and his wife moved house several times and eventually settling in the Helston area, west Cornwall.

In October 2001 Mr X developed some physical health problems leading to hospital admission for investigations of gastric bleeding, caused by inflammation to the lower end of the oesophagus. He apparently feared that he might have a malignant illness, which was eventually ruled out. Following a serious disagreement, in which they discussed previous marital disharmony, he made a serious suicide attempt and was admitted to Treliske Hospital, Truro, with multiple cuts to his wrists, neck and abdomen, requiring emergency surgery. During his stay in this hospital he tried to jump out of the window. Following his recovery from his injuries and an assessment by the liaison psychiatry team, on 7 November 2001 he was transferred to Trengweath Hospital, the mental health inpatient unit at Redruth, to the care of Dr Jeremy Scott, Consultant Psychiatrist.

This admission was for about 13 days, following which he was looked after in the community by his wife and supported by a Community Psychiatric Nurse (CPN) and his General Practitioner (GP).

Unable to settle at home and becoming more unwell, he was readmitted on 1 December for a further 10 days and then discharged. Sometime during the early hours of 21 December he attempted to strangle his wife and was readmitted to Trengweath Hospital.

During this third admission Dr Scott referred Mr X to a Consultant Psychiatrist for older people, requesting a second opinion as he gave the impression of developing early onset of an organic dementia, possibly of a vascular or Alzheimer's in origin. However Dr Steven Naylor, Consultant Psychiatrist for older people, was of the view that Mr X's clinical presentation was not due to pre-senile dementia but more likely to be as a result of his anxiety.

He was discharged on 12 February 2002, again with support from Ms Helena Harper (CPN). She visited him at home on 15 February 2002. Although he was quiet, it was apparent that he became more anxious the longer the meeting went on.

On 17 February 2002 Mr X made a 999 telephone call to the police. He was described as speaking "calmly and in normal conversation level". He said, "*I have murdered my wife*" and asked that a police officer be sent to their address. Mrs X had suffered 14 stab wounds to the chest and abdomen. Some of the wounds were inflicted after death.

A police surgeon and a psychiatrist assessed Mr X and concluded he was fit to be detained, and so he was remanded in custody. On 25 March 2002, under Section 48 MHA 1983, he was transferred to the Butler Clinic, where he is still a patient.

Mr X pleaded guilty to manslaughter and on 2 August 2002 was sentenced to be detained on a hospital order under section 37 Mental Health Act 1983. It was not seen to be necessary to make an order under section 41 Mental Health Act 1983 restricting his discharge from hospital.

CHAPTER 1

FAMILY HISTORY

Mr X, born 19 September 1938, was the oldest of four children. He has a sister, six years younger, who described him as a "*lovely brother and man*", and two brothers. One brother died in his 40's following a road traffic accident. The inquest returned an open verdict, possibly because he suffered from schizophrenia. His youngest brother, who was 17 years his junior, lives in Australia.

On leaving school at 19 years Mr X went to university and obtained a first class honours degree in mathematics. He taught mathematics for a couple of years and later became a lecturer in statistics, by which time he had completed an MSc and a PhD. He moved from a college in Rugby to another position at Coventry Polytechnic, later a university, and finally retired as a principle lecturer aged 59.

Mr X was married in 1962 and has three daughters who, at the time of writing, are 39years, 37 years and 35 respectively. Two daughters are married, each with one child, and all speak of a happy childhood with fond memories of holidays spent in Cornwall.

On his retirement in 1998, Mr and Mrs X made the decision to move house to Cornwall and purchased a house in Mullion, the first of the five properties they eventually moved to. Mr X enjoyed this house, as it enabled him to play golf, but his wife was not so keen and so they decided to move again, and found a house in Kenneggy. Mrs X, who had been diagnosed with osteoporosis, fractured her wrist, having slipped on the cattle grid at the entrance to this property. She was no longer able to play tennis, something which all the family had played together and was seen as very important to them.

Comment

Mrs X was described as coping well with physical illness but was 'hit hard' by being diagnosed with osteoporosis as it would curtail her tennis playing, which had been so important to her. She tried playing golf with little success but did

enjoy walking, although she was frightened of falling and had to rely on her husband for physical support.

In 1999 Mrs X, who had had previous breast surgery, required further surgery and made the decision to have a mastectomy which, according to her family "*she took in her stride*". As she was not entirely happy with the house in Kenneggy, they moved to Porthleven, first renting a flat and then moving into their own home, where they lived for about a year.

Comment

Mr X has stated to several professionals and us that it was during this time that he felt he became unwell with stomach cramps, leading to him seeking help from his General Practitioner, (GP. When we discussed this with his then GP, Dr Richard Drummond, he described Mr X as " *being too animated, lots of gesturing and handwringing/hand clenching type body language*". This suggested to him that this behaviour was part of Mr X's symptomatology, although "*he was primarily focussed on the physical rather than psychological*".

In October 2000 Mr X went back to his GP still complaining of 'abdominal tightness when anxious', stating that the symptoms were no different from the previous year when he consulted his GP. He confirmed that he had not lost any weight and that he had no symptoms when occupied. The GP's impression was that he was suffering from anxiety and felt he might require antidepressants and cognitive behavioural therapy (CBT) in the future.

CHAPTER 2

MR X'S FIRST ADMISSION TO TRENGWEATH HOSPITAL AND DISCHARGE

1 August 2001

Mr and Mrs X moved again, this time to Cadgwith, and on this occasion they were both happy with the house. However Mr X became unwell with the same kind of stomach cramps he had experienced before.

2 October 2001

Mr X saw Dr Mark Dorrell, his GP, complaining of a high temperature and griping abdominal pain. The next day the GP was called again as Mr X vomited 'coffee grounds' - an indication of internal bleeding. Mr X was referred to Treliske General Hospital at Truro and admitted to the medical admission ward. Investigations showed that he had "*a uniform oesophagitis - which was not typical of a candida infection - most likely due to reflux disease compounded by Asprin. Subsequent oesophageal brushings confirmed inflammatory cells with no evidence of candida or malignant cells".*

8 October 2001

Mr X was discharged from hospital, to be followed up in the outpatient department two months later.

12 October 2001

Mr X saw Dr J Oliver, GP, and said he was now feeling better than when in hospital.

15 October 2001

Mr X saw Dr Dorrell again and requested that he continued to see Dr Dorrell at the Mullion Practice rather than at the branch surgery, which did not have computerised access to medical records. He was concerned that not all the results of the investigations were available at the branch surgery. He was also concerned about prescriptions being dispensed at the surgery, as so often is the case in rural practices, rather than by a community pharmacist.

Comment

Mr X's recollection of this interview is that he and Dr Dorrell argued because Mr X was concerned about the alleged inefficiencies in the practice, and there was no apology forthcoming for what he considered an unsatisfactory service. However Dr Dorrell, who was very frank with us, could only remember having a row with possibly two patients since qualifying, and Mr X was not one of them. Dr Dorrell also told us that he could have insisted that Mr X remained at the branch surgery but chose not to. He gave Mr X the prescription so he could take it to any chemist

2 November 2001

Mrs X's sister and brother in law visited. They were surprised by Mr X's appearance - he looked as if he had lost a lot of weight. He was keen to show them around the garden and chatted about mutual friends. In the evening his demeanour changed and he appeared to 'switch off' as if he was disconnected from his surrounding. Although intending to stay longer they left at about 20.00hours. They were worried about him and surprised that Mrs X, who felt that he would soon be alright, did not appear to be more concerned. Because they were so concerned they telephoned later that evening, and Mrs X told them he was talking normally and was enjoying a comedy programme on the television.

3 November 2001

Mr X was again admitted to Treliske General Hospital having tried to commit suicide by inflicting multiple stab wounds to his neck, abdomen and to both wrists. He required surgical exploration of the abdominal wound, and both wrists necessitated Plaster of Paris splints. He took the car, drove down a country lane and then stabbed himself with a kitchen knife. It so happened it was near to where Dr Drummond, his previous GP, lived and as he was at home he went to see if there was anything he could do. By the time he arrived on the scene both the air and the land ambulance had arrived and the paramedics had taken control. Whilst being transferred to hospital Mr X apparently tried to inflict further wounds.

4 November 2001

Whilst on the ward, Mr X tried to jump out of the window, requiring four people to prevent him from doing so. He also removed his intravenous drip. Dr Flynn, Psychiatric Senior House Officer (SHO), was telephoned and he prescribed Haloperidol 5mgs. He arrived 30 minutes later, at 11.45 hours, to examine Mr X and completed a full assessment. Mr X was very distressed, saying *"I'm in the wrong place….it's too bad….I shouldn't be here"*. Following a discussion with Mrs X, in which she told him that they had frequent arguments, Dr Flynn concluded that Mr X had tentative signs of depression with no clear signs of psychosis.

The treatment plan was as follows:

1. *current treatment of physical condition is undertaken under common law. There is a duty of care to prevent him doing himself any harm…...*
2. *a low dose of regular sedation will aid the treatment of his physical problems suggest Haloperidol 5mgs Lorazepam 1mg Diazemuls 0-10mgs IV and may need anaesthetic backup*
3. *will probably need constant observation*
4. *will need to be aware of physical conditions aggravating distress*
   -hypoxia
   -pain
   -urinary retention
   -dehydration
5. *will inform liaison team tomorrow.*
6. *it would be appropriate to use section 5(2) of the Mental Health Act to prevent him leaving the ward if he attempts to.*

At 14.15 hours Dr Flynn returned to see Mr X who was more settled and a little drowsy. He denied feeling depressed. Dr Flynn recorded "*Affect flat, speech slow and slurred, thought slow muddled and complaining of recent confusion and difficulty in thinking clearly*". Mr X believed he was "*a monster….. a weak man…. A hypocrite" and felt he was ruining the lives of his wife and daughters"*. He also said that if he did not end his life he felt that his wife would have killed him "*sooner or later… in the slowest worst imaginable way possible"*. Dr Flynn thought Mr X had

insight about recent events and was happy to comply with treatment. His impression was that there was "*further clear evidence of a depressive illness with some concrete suggestion of a psychotic element and a depressively delusional appraisal of reality*". His treatment plan was to continue with the previous instructions but to reduce Haloperidol to 3mgs, and withdraw Lorazepam if Mr X became over-sedated, with one further dose if agitated overnight. He could now have oral medication.

5 November 2001

The duty psychiatric nurse saw Mr X and also interviewed Mrs X. She reiterated a history of investigations for oesophageal problems, headaches, accompanied loss of vision and low mood caused by recent disclosure of past marital difficulties.

6 November 2001

Dr Kenneth Wood, liaison Consultant Psychiatrist, saw Mr X and agreed that

i. Mr X should be transferred to Trengweath Hospital when medically fit.

ii. Please check a CT scan and TFT.

iii. Pt at present in agreement; he is detainable should he refuse transfer

iv. Continue 1.1 nursing

Comment

The family recalled that Dr Wood had told them that Mr X was very ill and would require inpatient care for some months, possibly necessitating electro convulsive therapy (ECT). Dr Wood was unable to recall the conversation, but told us that it would have been his practice to have a discussion with relatives. There was nothing in the notes to indicate this view to the mental health team who were going to continue caring for Mr X, but Dr Wood was confident that there would have been telephone contact.

7 November 2001

Mr X was transferred to Trengweath Hospital and was seen by Dr Alison Birch (SHO). He was feeling much better although admitted to feeling 'resentment'. She wrote in the notes "*hard to live with – row with wife – told her things she didn't need*

to know - wife said she would leave him – he felt that she preferred him dead…….. today he feels much better. Would further admit to sort out 1% resentment he still feels".

The notes commented that Mrs X did most of the talking, and continued with comments from his daughters referring to their father as a "*rock*" as their mother hadn't coped well with his retirement, a diagnosis of osteoporosis and then her need to have a mastectomy. They felt he had been depressed for several months.

The Care Plan was

A) *to remain on line of sight (level 3) to facilitate safety. On 9 November this instruction was changed to checking him every 20 minutes.*
B) *Assist mental health assessment.*
C) *Observe for symptoms of depression by interview and assess level of risk - adjusting observation level accordingly*
D) *Offer support and assist ventilation of his worries*
Risk assessment was Moderate – increasing depression.
Risk of self-harm/ideation

9 November 2001

Mr X was described as feeling low (2/10), finding the ward intimating and noisy, and unable to concentrate on reading the newspaper. The next day he was bright, cheerful and very conversational, allowing staff to help with his personal hygiene. He was quoted as saying he would need a lot of help at home. He continued to improve.

Dr Birch saw Mr X. He told her that during the night he found the level of observation intrusive and hindered his sleep, but appreciated the opportunity to talk to staff. He also found the ward intimidating but was 'getting used' to it. He told her that he felt 'shame' at being so low as he had such a wonderful life and felt that he would not attempt to harm himself again. He did not understand why the previous attempt happened and had he had someone to talk to, he wouldn't have gone through with it. Mr X was undecided about wanting to talk to his wife about his feelings.

His Care Plan was as follows

1. *the level of observation was reduced to every 20 minutes*
2. *give regular night analgesia and lactulose*
3. *review sutures on Monday*
4. *start antidepressants - Citalopram*

13 November 2001

Ms Heidi Thomas, Staff Nurse (S/N) spent considerable time with both Mr and Mrs X, taking the opportunity to discuss the events which led to his admission. They appeared to have resolved whatever difficulties they may have had. Mrs X wanted to be sure that all/any physical reasons for Mr X's change in affect had been explored, and had discussed his medication with their daughter who was a pharmacist. They also told staff that Mr X had been prescribed Losec 40mgs following his admission in October for gastro-intestinal investigations.

Dr Scott's ward round was held later that morning. Mr X stated he was feeling '*good and most of his problems had receded and he felt more cheerful and optimistic*'. He said he no longer had thoughts of self-harm, felt well enough to leave hospital and did not want any further support at home. Mrs X was seen and said she felt her husband was back to normal and she was keen to have Mr X home. The notes stated that Mr X took a passive role whilst his wife did all the talking. Mr X attended the art class, sketched a still life and interacted well with other patients.

Later that evening Dr Scott agreed to Mr X having home leave. All his wounds were redressed and he was given a supply of his medication and details of how to contact the ward if necessary.

14 November 2001

Mr X attended the 'hand' outpatient clinic when a new Plaster of Paris splint was applied to both hands.

15 November 2001

Mr X was seen at home by Mr David Bayne, CPN, and presented as extremely anxious, unclear with the history of recent events and a little vague, though he

maintained that he was well and not suicidal. Mrs X was insistent that this was his normal self.

16 November 2001

Mr X attended the ward to see Dr Birch. He was seen alone and then with his wife. He was enjoying being at home, catching up with friends and eating well. He described his mood as 3/10, looked anxious but felt safe with no thoughts of self-harm. He said he felt he could contact the ward staff if he became low and went on say that if he had had the ward telephone number, he felt the suicide attempt could have been averted. He had stopped the Lorazepam and because of attending the hospital woke early. Mrs X was less anxious than she had been and was extremely happy at her husband's progress. Haloperidol was reduced to 1.5mgs. BD (twice daily) and he was advised to use Lorazepam if he was unable to sleep.

At 21.00 hours that evening Mrs X phoned the ward to say that her husband did not want to be interviewed by either Dr Scott or Dr Birch on his own without her being present. They also requested that only Dr Scott and Dr Birch and the nursing staff were present at the ward round as Mr X was worried by having more people there.

Comment

Dr Scott told us that the only other people present other than Dr Birch and a ward nurse were the pharmacist and possibly a CPN. However on some occasions either or both a social worker and psychologist would attend if needed for a particular patient.

19 November 2001

Mrs X telephoned Mr Bayne to complain that two doses of Mr X's antibiotic medication was missing, reporting that a staff nurse on the ward said that it didn't matter if he missed a couple of doses and that the ward would arrange for the medication to be delivered. She wished to make a complaint about this and accordingly Mr Bernard Kearney, the Inpatient Manager, was informed.

Comment

Mrs X did not tell Mr Bayne about this when he visited four days previously. As soon as he knew about the omission Mr Bayne telephoned the ward to clarify the situation.

20 November 2001

Mr and Mrs X attended Dr Scott's ward round. Mr X still appeared anxious and withdrawn and Mrs X stated that her husband found the ward rounds very stressful. Mrs X agreed to see the CPN. Mr X was given a week's supply of Haloperidol, Citalopram, Lorazepam and Omeperazole, to be used as instructed. Mrs X was pleased that her husband was discharged from the ward. As Mr X was attending the 'hand' clinic that afternoon he was advised to discuss continuing antibiotics with the surgeon.

27 November 2001

Mrs Helena Harper, CPN, visited Mr X at home. (Mr X's care was transferred to Mrs Harper as she had recently joined the community team). Mr X answered any questions put to him but was otherwise quiet, allowing his wife to dominate the conversation. Neither Mr nor Mrs X thought that the drug Citalopram was having any effect but were advised to continue until the following visit, when Mrs Harper would reassess. Mrs X said she was anxious about her husband's poor short-term memory and lack of concentration. When it was explained that these were symptoms of his depression Mr and Mrs X were relieved, as both had feared something more serious was wrong,. Ms Harper gave them all duty desk and out of hours telephone numbers for use if any further help were needed before the agreed next visit in a week's time.

30 November 2001

Mrs Harper telephoned to see how Mr X was but he did not wish to speak with her. Mrs X felt that Mr X was much worse since starting Citalopram as he was experiencing headaches, irritability and insomnia with an upset stomach. As they had an outpatient appointment with Dr Scott to discuss medication, and although Mr X wanted to stop taking it, he was by advised Ms Harper not to stop it completely but to take it every other day until they saw Dr Scott.

CHAPTER 3

MR X'S SECOND ADMISSION TO TRENGWEATH HOSPITAL AND DISCHARGE

1 December 2001

Mrs X telephoned the Community Mental Health Team (CMHT) to question Mr X's medication and spoke to Mr Victor Bridges, Team Leader and duty CPN on that day. Although Mrs X was reluctant he nevertheless visited them at home. Mrs X, though difficult to follow, discussed her discontent with her GP, Dr Scott, Mr Bayne and others in the service. She constantly referred to her notes. Whilst Mrs X was in the kitchen, Mr X affirmed that he felt unable to stay at home as he was feeling suicidal and wished to see a doctor. Mrs X agreed that he should see a doctor and only reluctantly agreed for her husband to be admitted.

Dr Mc Guinness, SHO, assessed Mr X at Trengweath Hospital, over a period of some time during which Mrs X categorically refused to leave the room as Mr X was "frightened of being interviewed alone and bullied". Mrs X queried the medication and said that Citalopram was not working, and that it was being in hospital which made him low. Mr X remained mute throughout. Mrs X physically placed herself between Mr X and Dr McGuinness and refused to leave when he wanted to examine Mr X on his own.

Dr McGuinness decided that Mr X should be admitted as he was suffering from retarded depression, was possibly fearful of his wife and unable to express his feelings. Dr McGuinness discussed Mr X with the duty Consultant, who agreed Mr X should be admitted and, because they had a 'duty of care' to protect Mr X, should he try to leave he should be detained under the Mental Health Act.

Later that evening Mr X became more talkative with staff. Initially Mr X stated he did not want to be in hospital but later realised that he was in the right place as he might have self-harmed again, which would cause distress to his family. At times he presented as confused, not realising where he was, why he was there and concerned about his clothes. He eventually slept.

2 December 2001

Mrs X arrived on the ward at 10.20hours. Mr X was observed as becoming more mute and tense the longer Mrs X stayed with him. Shortly after her arrival Mrs X asked to speak to a staff nurse. She expressed concerns about the way Mr X was admitted the previous day and was adamant that her husband should only be interviewed in her presence because he became very anxious. It was explained that there were occasions when patients needed to be interviewed on their own to build a relationship to establish their needs. Mr X requested to speak to the same staff nurse after his wife left the ward. He was described as clear and concise and said he had asked her to leave because of the 'hysteria'. His 'right' not to have visitors was explained to him and he agreed that he did not want any visitors. He later changed his mind and asked his wife to visit. Mrs X felt guilty at leaving him in hospital and he felt guilty for coming back and for the suicide attempt. He also felt unsafe at home and safe in hospital. He was also worried that his wife was expecting him home in a week, whilst he thought he would not be any better for at least a month. He was interviewed by the duty doctor.

4 December 2001

Mr X attended Dr Scott's ward round. He found conversation very difficult and was feeling isolated; although no longer suicidal he did have thoughts that life was not worth living. He agreed to stay in hospital. He said he had never had depression before but had always been an anxious man. The plan was to continue Citalopram, stop Haloperidol and commence Diazepam 2mgs twice daily.

5 December 2001

Mr X telephoned his daughter stating he had signed a 'witness statement' meaning he had to stay in hospital. It was explained that he had signed a 'Care Plan'.

6 December 2001

Mr X attended the hospital in Truro for an endoscopy. His wife accompanied him but a member of staff did not go with them. When Mr X returned to the ward he felt hungry and thirsty.

7 December 2001

The endoscopy report stated "*completely healed gullet. Suggest to lower dose of losec*". Losec reduced to 20mgs o.d.(once daily). He appeared more relaxed and appropriate in his interactions. He smiled and initiated conversations.

8 December 2001

Mr X's family visited him and he appeared brighter. They visited the following day and took him out for the afternoon, which went well.

10 December 2001

Mr X's wrists were examined by the SHO and, because they were still infected, he was commenced on an antibiotic.

11 December 2001

Mr X attended Dr Scott's ward round initially alone and stated he wished to go home. He admitted to being anxious about medication prior to admission but now denied any feelings of low mood, anxiety or self harm. Mrs X later attended and agreed that her husband would have more to do at home, although he had participated in painting classes on the ward. The agreed plan was

1. *to see the community occupational therapist,*
2. *to continue seeing CPN and*
3. *outpatient appointment. Medication was discussed and Citalopram was to be continued for 6-12 months. Mr X was discharged from the ward.*

13 December 2001

Mrs Harper telephoned the X's and left a message on the answerphone.

18 December 2001

Mrs Harper made a home visit and spoke to Mrs X, who discussed her husband's experience of his recent admission when he felt he was treated badly and 'terrorised'. They both agreed that he was more relaxed now that he was at home although still low in mood. He was worried about his poor short-term memory and expressed the view that he had anorexia, though when challenged he acknowledged that he was

eating healthily. Mr X was worried about Ms Harper's visit and the forthcoming outpatient appointment, requested by Mrs X as a matter of urgency. He said he was frightened if his wife was not present. Despite his anxiety he was looking forward to his daughter's visit over the Christmas holiday. They agreed to telephone the duty desk if either had any worries.

CHAPTER 4

MR X'S THIRD ADMISSION TO TRENGWEATH HOSPITAL AND DISCHARGE

20 December 2001

Mr X was seen in the outpatient clinic and was both agitated and distressed. He was pre-occupied with morbid delusional ideas such as being tortured or burned to death. Mrs X was very insistent that she could look after him at home, knowing that she could keep in touch with ward. Dothiepin 50mgs was prescribed instead of Citalopram, and Diazepam 2mgs to be taken as necessary, up to four times a day. Dr Scott wrote to Dr Dorrell:

> *" …he is again very depressed and anxious but his wife is very insistent that she is able to look after him at home. He is expressing irrational fears and at times he appeared rather confused so we may, in the end, have to readmit him to hospital. However I do hope he may yet be able to settle and recover at home…"*

Comment

Ms Harper told us that Mr X refused to leave the room, or was not able to leave the room. He stood in the corridor motionless and mute. He was given some diazepam or lorazepam and after much coaxing he was transferred to Mrs X's car who then took him home. Ms Harper had not seen him like that before. Mrs X appeared to make matters worse by telephoning family members and friends requesting them to speak to him. He was so confused and did not appear to know what was going on. Dr Scott has informed us that Mr X *" believed he was to be forcibly taken to Trengweath Hospital to be tortured and executed."* Dr Scott had not seen evidence of such psychosis during the previous inpatient stays.

We doubt that Mr X was able to give informed consent to the change in his treatment at this point. The case notes do not record an explanation for his psychosis nor do they record a plan of investigation for the psychosis. He was not prescribed any anti-psychotic medication. We also have reservations about

the extent to which a clinician could successfully make a risk assessment at this point, given how irrational and aroused Mr X was.

Mr X was undoubtedly far worse than at the time of discharge. In our view Mr X should have been admitted to hospital at this stage. It is quite possible that either Mr or Mrs X would have objected to this plan, in which case an assessment under the Mental Health Act (1983) could have been initiated. The nearest relative cannot block admission under Section 2 of the Act, which would have been the appropriate Section to use in the circumstances, allowing as it does for admission for assessment for up to 28 days. Mr X undoubtedly had a mental disorder and there was a potential for serious risk, as evidenced by his very serious suicide attempt. Clinical staff would understandably have reservations about the consequences of such an action on the therapeutic relationship with Mr and Mrs X, but paradoxically such a move might have brought into sharp relief the need to establish clear boundaries with Mrs X.

It has been suggested to the Inquiry panel that the threat of admission might have provoked serious medical problems such as a stroke or heart attack because Mr X had " *serious cardio-vascular disease*." In fact the medical notes explicitly exclude such disease. In addition Dr Scott, in his medical report dated March 2002, refers to Mr X as having no health problems apart from his abdominal complaint and his mental health difficulties.

Clearly Mr X could not have been held against his will at the clinic. If he refused admission he could have been allowed home without the threat of detention, so as not to scare him into any rash action. In these circumstances the risks would justify a lack of frankness to the patient and carer. An Approved Social Worker and the GP could then have performed a Mental Health Act assessment later at the patient's home, following on from Dr Scott's completed recommendation. Assuming they were in agreement with the need for compulsory admission, Mr X could then have been taken to Trengweath.

Had Mr X been admitted at this stage, we cannot say with any certainty what might have transpired with regard to improvements in the accuracy of diagnosis,

a more effective treatment plan, and the ultimate outcomes in this case. As it was, Mr X was sent home, apparently on his wife's insistence, and his medication was altered. Changing his medication was appropriate, but a phased withdrawal of the Citalopram would have been advisable.

21December 2001

The Police and an ambulance crew attended Mr and Mrs X's home at 06.39hours as Mr X had attacked his wife earlier, trying to strangle her. She hid in the toilet as instructed by the police. When they entered the house they found Mr X holding onto the toilet door handle, staring at his hands. Further police assistance arrived at 06.54hours; Mr X was restrained and wrapped in a blanket as he had no clothes on. He appeared passive and in a trance unable to respond to anything. Mrs X was released from the toilet and examined for any injuries. None were visible. Mrs X told the police officers that the previous night she and her husband had had heated discussions, about their previous marital difficulties, which were continued that morning. She stated that she did not believe that her husband would hurt her, and only locked the door when the police instructed her to do so.

Mrs X wanted her husband to go to Trengweath Hospital to have his medication reviewed and so the ambulance crew took him there. During the examination Mr X was worried about being tortured by his wife and daughter. He also worried about being burnt, and that his other daughter wanted to harm him. During the duty SHO's assessment he made contradictory statements about being in Trengweath Hospital, saying –"*not safe here - why should I be risk anywhere. I'm mad – I'm not mad"*. Mr X admitted that he was feeling anxious " *because my wife and daughter are coming to kill me"*. His speech was quiet and repetitive. He scored 16/30 on the mini mental state examination (MMSE) – unable to do tasks which should have been easy for him. During the physical examination Mr X made no verbal responses, and could not be persuaded to leave the clinical room without physical help.

A history was taken from Mrs X. She stated that Mr X was "*terrified he would be put back in hospital again*". She would not leave him and agreed that his depression was increased after his discharge. Mrs X also told the doctor that, in her opinion, when in Trengweath Hospital Mr X had said the Citalopram was working so that he could go

home. She went on to say that he now had delusions, thinking he was "*ESN and that he was a psychopath*" without knowing what it meant. He thought that their youngest daughter was dead and that other family members were going to torture him. The SHO concluded that the diagnosis was, "*?severe anxiety with depression"*. Dr Scott had previously prescribed Prothiaden, which was to be continued, and 10 minute observational checks were started. The following day Mr X took his medication and settled, although he remained very disorientated and confused.

At this time Dr Maggie Hand, Medical Director, was conducting a survey of patients who were re-admitted as an emergency within 90 days or less having previously discharged. This was in response to a National Performance Indicator to evaluate performance. The Trust had a high emergency re-admission rate and the survey was seen as a way of identifying which service developments were required to decrease the number of re-admissions. The completed form was returned to the Clinical Audit office and no copy was kept in the patient's notes because of individual confidentiality and the need for anonymity. The form was divided into five sections as follows:

1. *what care did you receive at home since your last admission?*
2. *how helpful did you find your last admission?*
3. *why do you think you needed to come into hospital on this occasion?*
4. *what other services or care, if it had been available, would have been preferable to hospital admission or might have prevented admission?*
5. *is there anything else you think it would be useful for us to know about?*

Mr and Mrs X completed such a form and they kept two copies as part of their own note keeping. One copy had Mr X's comments only and the other had his original comments with annotated notes we presume by Mrs X. In the completed section on care at home, the CPN, outpatients, out of hours service and GP contact had been ticked.

On the form Mr X described the previous admission (following the attempted suicide), as " *my absolute nightmare*" and annotated against it was

"*the manner of (name)'s last admission so terrified him he was unable to speak to me at all. The next morning, he became more and more depressed, losing weight and started compulsive teeth grinding. Unknown to me he persuaded the nursing staff he was getting better and told Dr Scott the drugs had started working. (name) was suffering from the delusion that I was trying to kill him. He then tried to strangle me"*

Mr X described his reason for admission on this occasion as

" I wanted to speak to a doctor about my medication as my wife had done the previous week. I did feel very depressed but not in any imminent danger. I would have been happy to see a doctor next week".

He went on to write against question 4

" a doctor to consult to speak to over the phone to discuss medication and change it if necessary. Too long between consultations"

and against question 5

"*on my notes I had asked to be seen with my wife present. I was having difficulty with social interactions. The on-call doctor terrified me and ordered my wife to leave the room. I was worried about what I would say to the doctor and we had been told she could stay with me previously. When I was asked if I would be seen alone, and I was too frightened to speak, Richard said that if I said nothing, that would mean yes. After my wife had left I felt coerced into agreeing to a witness statement with David and Heidi. I felt it was against my will. I was then under the impression that I would be there for life. Later David told me I would be in Trengweath Hospital for a very long time and at the very least months"*

Comment

As this was a confidential questionnaire this information was never shared with the staff in this format.

23 December 2001

The SHO spoke to Mrs X and her daughter, telling them that Mr X was settling although he had been observed in his bed area trembling, feeling unsafe and at risk of being attacked by his wife. These symptoms were explained as part of the depression and anxiety rather than as the result of any physical problem. The SHO thought it would be useful to have an EEG and to bring forward the CT scan.

24 December 2001

Mr X was seen by Dr Birch and appeared unable to talk and only able to follow simple commands. She ordered blood tests and for his fluids and food intake to be increased. He didn't know that it was Christmas Eve and that the following day was Christmas Day. However he did recognise a staff nurse who had not been on duty for 10 days.

25 December 2001.

Mr X was visited by his family and ate the sandwiches they had brought in for him as he was still reluctant to eat the hospital food. He brightened up as the evening wore on, ate his supper and enjoyed watching television.

26 December 2001

Mr X was found wandering around the sleeping area, saying he had lost his clothes. He was in fact looking in the wrong space.

1January 2002

Mr X was still having periods of confusion but these had become less in the last few days.

2 January 2002

Mr X kept an appointment at Treliske Hospital accompanied by his wife. When Mr X returned to the ward he was agitated, finding it hard to concentrate, and was confused about his washing and clothes. Because of his confusion the staff found it necessary to help him have a bath that evening.

3 January 2002

Mr X attended Dr Scott's ward round. He expressed no feeling of paranoia although still felt 'panicky'. He gave a good account of what he had done the day before and his memory seemed good. His wife said he was suffering from the same stomach cramps that he had experienced before, in the two years since she had had breast illness.

Later that night he was seen by Dr Birch, as he collapsed whilst retching in the toilet. His pulse was 100 and regular, blood pressure 150/60 and there were no neurological deficits. He was very distressed saying " *I haven't been telling the truth. I'll never get out of this*", expressing guilt about the past and secrets he had never told anyone. She concluded that he had a gastro-intestinal infection and nausea following anxiety. Haloperidol 5mgs was given and he was encouraged to rest in bed.

Comment

The family were of the belief that Dr Birch thought these symptoms were the same stomach cramps he was experiencing due to his anxiety, but this was clearly not the case from her records.

4 January 2002

Mrs X telephoned to express her concerns about her husband's presentation. She felt that he presented as "quite well" at the ward round but to her he was confused at times and "obsessed" about his clothing, believing he didn't have any. He had cried before the ward round, and she felt he was not getting better. Mrs X queried whether the medication was making him confused and asked that she should be present at the ward rounds, so that she could provide her perceptions of her husband's well being and presentation. The ward was notified that the EEG was arranged for the 16/1/01.

5 January 2002

The duty SHO was called as Mr X apparently collapsed in his chair shortly after his wife had left. He had not been feeling well for a couple of days with abdominal aches. He said he was a coward, had not been totally honest with his family as he had wanted to die because his wife might leave him. She had threatened to do so before. His speech was slow, rational and coherent. His mood was depressed and anxious

with suicidal thoughts. The diagnosis was severe depression with anxiety. The doctor spoke to Mrs X who told him that she thought the Diazepam and Lorazepam made him worse and confused.

6 January 2001

Mr X remained unwell and more anxious and confused, and was advised to rest on his bed away from his wife. He slept, and on waking felt better, but when he returned to the day area and his wife he became confused and anxious again. Later that evening he was reluctant to take his medication, saying that his wife had told him not to take it as it made him worse.

8 January 2002.

Dr Birch saw Mr X. He was no longer vomiting but had some diarrhoea. He knew which day it was but didn't manage to count beyond 51 before becoming anxious. Mrs X was interviewed and she again said she thought the diazepam was making him confused. She talked at great length about Mr X's childhood. She was unable to give an exact history and spoke in a long monologue presenting as distressed and anxious.

The Care Plan was reviewed as follows

1. *continue the medication*
2. *refer …..for opinion re. Cognition*
3. *no leave at current time.*
4. *The CT scan was normal*

9 January 2002

Dr Birch saw Mr X alone. He had had his breakfast and had had no further abdominal pain or vomiting. He made good eye contact with good speech, if a little slow. At times he found it difficult to answer questions, and was anxious about saying the right things when asked how he was feeling. He feared being incarcerated and split up from his family. He didn't feel his memory and cognition was improving and on occasions he complained he couldn't remember what day it was, or what the correct route was when his wife was driving.

10 January 2002

Mr X went out with his wife in the afternoon. Dr Scott referred Mr X to Dr Steven Naylor, Consultant Psychiatrist for older people, requesting a second opinion. He outlined Mr X's medical history to date, including the attempted suicide, which seemed to be linked to " *a depressive illness and marital problems*". He went on to say

> "*……fortunately no sinister pathology was found and his symptoms were attributed to some benign inflammation in the lower oesophagus. He seemed much relieved when he learned of the results of his investigations and he went home in good heart and with apparently much improved marital harmony although the psychodynamics of family relationships seem extremely complicated. Both Mr and Mrs X are very anxious and their interactions are difficult to understand and probably much influenced by a wide range of fears some of which seem to be illogical or unfounded.…… For a short time Mr X did quite well at home with a CPN and antidepressant medication (Citalopram). However before Christmas he re-presented at the outpatient clinic in a very disturbed state in which he appeared to be deluded and to have lost his grasp on reality. He behaved in an agitated state, pacing up and down and fluctuating from being almost mute to shouting loudly…. He calmed down with some Diazepam but later at home attacked his wife and had to re-admitted to Trengweath. He had since then shown varying degrees of disorientation and cognitive impairment. Initially he was grossly disorientated and on Christmas Eve he did not have any awareness of the date or the season. Quite rapidly he regained much of his orientation and the subsequent fluctuations have been less marked. At his best he is fully orientated and his short-term memory is reasonably good though still impaired. However he appears to function well below the sort of level that would be expected in view of his background as a university lecturer in mathematics.…… He also shows emotionally lability and incongruity and his mental state is generally unstable. The whole picture is strongly suggestive of an underlying organic disorder possibly of vascular aetiology leading to a presentation of early dementia with relatively lucid intervals. His*

depressed mood and his severe anxiety clearly played some part in his impaired functional capacity but I am not so sure that we can attribute the symptomatology purely to a depressive pseudo- dementia".

11 January 2002

Dr Birch saw Mr X. He was still anxious at times and still experiencing poor memory, misremembering a previous conversation the day before with Dr Birch. He scored 26/30 on the MMSE. He enjoyed going out for lunch with his wife and they both requested to have home leave over the next weekend. He was sleeping well and so diazepam was reduced to 1mgs.

14 January 2002

Mr X telephoned his daughter and was heard crying, presenting as anxious, indecisive and confused. In discussion with Mr David Taylor, (S/N), he stated he did not want to be separated from his family. Mr Taylor told him that as an informal patient he could go home the following day. He stated he was physically unwell and needed to be in hospital.

15 January 2002

Mr X attended the ward round. Dr Scott spent considerable time with Mr and Mrs X. Mrs X felt that her husband should have a sigmoidoscopy and or a colonoscopy as she was concerned that he might have bowel cancer with brain metastases. She also thought he had a testicular lump.

Comment

Mrs X had already been given the results of the CT scan by Dr Birch, which revealed no abnormality.

Mr X was seen later on the ward when he expressed concerns that he might be sectioned and therefore never leave the ward. He was reassured that this was not the case.

16 January 2002

Mr X had an EEG at Treliske Hospital.

17 January 2002

Mr Robin Gordon, occupational therapist, saw Mr X. He was also seen and examined by Dr Winters, SHO, prior to referral to Dr Levine, Consultant Physician, because of Mrs X's concerns about the possibility of her husband having a testicular lump. Mr X was very anxious that he might be physically ill. The EEG results showed nothing of any significance. Later in the day he went out with his wife.

18 January 2002

Dr Steven Naylor interviewed Mr X to provide a second opinion of his confusion and poor memoryDr Steven Naylor interviewed him. Dr Naylor concluded that his symptoms were consistent with severe anxiety disorder/panic disorder, exacerbated by antidepressant introduction, with episodes of dissociative cognitive impairment. He wrote the following treatment plan

1. *that his current antidepressant (Dothiepin) be reduced and withdrawn, and later if needed Imipramine (a different antidepressant) could gradually be introduced.*
2. *Use Lorazepam or Clorazepam for trial period to control panic as clinical test of extant anxiety is causing symptoms.*
3. *Dothiepin reduced to 50 mgs.*

20 January 2002

Mr X still very anxious, quite inarticulate and concerned that he had not made sufficient progress since admission. He needed much persuasion to take his medication.

22 January 2002

Mr X attended Dr Scott's ward round and presented as anxious and distressed at times. He had spent time out of the hospital with his wife. Mr X's antidepressant medication was reduced. The EEG showed signs suggestive of early stages of dementia. His wife told Dr Scott that prior to his admission her husband had taken St John's Wort, which made him worse. On this occasion, Mrs X presented as 'very dramatically distressed'

23 January 2002

Dr Scott wrote to Dr Naylor:

> *"…… I would certainly agree there is a large functional overlay arising from his severe anxiety. His wife describes his pre-morbid personality as confident, self assured and gregarious and it would appear that there was probably an absence of dissociative phenomena until very recently. I wonder, there fore, if there is a co-existing organic component contribution to the psychopathology even though the recent improvement in his orientation and short term memory is sufficient to enable him to perform well during testing. Our suspicions are supported to some extent by the EEG report which indicates diffuse changes consistent with possible mild dementia…."*

24 January 2002

Mr X spent time painting in the activity room and according to Mr Gordon was more relaxed.

25 January 2002

Dr Birch telephoned Dr Levine's secretary to ascertain when Mr X's appointment would be. Dr Levine was on holiday and would see the referral on his return. Mr X was very confused and unable to string together a sentence which made any sense.

28 January 2002

Mrs X anticipated seeing Dr Naylor, but had not shared this information with the staff and, as Dr Naylor was not due on the ward that day, she was unsuccessful.

29 January 2002.

Mr X did not attend Dr Scott's ward round and so Mrs X was seen. She told Dr Scott that Mr X was improving in his cognition since the Dothiepin had been stopped but that he was still anxious. Mr X had a strong belief that the police would arrest him when he went home. She inquired about the appointment with Dr Levine.

30 January 2002

Mr Bernard Kearney, Team Leader, had a long conversation with Mrs X about all her concerns since Mr X had been admitted. During the conversation it seemed that her concerns appeared to have been resolved. Mr X remained anxious.

31 January 2002

Mr X spent time in the activity room revisiting his computer skills with the occupational therapist.

1 February 2002

Mr X commenced two days leave from the ward.

3 February 2002

Mr X returned from leave and both he and his wife reported that it had gone well. Mr X had cleaned the car and cooked meals.

5 February 2002

Mr X attended Dr Scott's ward round and he requested to have more home leave as well as extra doses of Lorazepam. Mrs X was pleased with his progress, though asked whether it was possible that Mr X had encephalitis.

8 February 2002

Mr X returned from leave to be interviewed by Dr Birch, who had a long discussion with him about his admissions. He was given six days medication and told to return in four days time for the ward round.

12 February 2002

Mr X returned from leave to attend the ward round. He was fully orientated and reasonably cheerful. He was sleeping well and had a good appetite. He was active at home, gardening and visiting friends. He was discharged from the ward to be followed up by the CPN. His medication was prescribed as Lorazepam 0.5mgs twice daily and could be omitted on the days that he felt relaxed. Mr X agreed to see a therapist for massage and relaxation classes.

Dr Scott referred Mr X, as a private patient, to Dr McClean, Consultant Neurologist, for a further opinion of his physical health as Mr and Mrs X had requested an appointment. He informed Dr McClean about the EEG and CT head scan. He went on to say

> "*the EEG results lent some weight to the possibility of an organic dementia but subsequent clinical progress has been encouraging and Mr X now shows good recall for recent events and he is once again fully orientated. I wondered if perhaps the EEG abnormalities might have been due to some reversible inflammatory process and I had in mind repeating the EEG in about six months to see if any significant differences had occurred in that period. Mr X and his wife would be most interested to hear from you on your thoughts on his EEG and I am sure they will be most appreciative if an opportunity to talk to you about this matter on a private patient basis could be offered*".

13 February 2002

Dr Sarah Ashley, SHO to Dr David Levine, saw Mr X, as Dr Levine had seen him previously and diagnosed 'irritable bowel syndrome'. She recommended a CT scan and paracetamol tablets for the pain. There was no plan to see Mr X in the clinic again. Dr Birch completed the discharge prescription form, which was faxed to the GP. Mr X's medication was

1. *Lorazepam 0.5mgs twice daily to be reviewed in 2-3 weeks*
2. *Omeprazole 20mgs daily*
3. *Asprin 75mgs daily*

Dr Birch also noted that he had had a poor/adverse response to Citalopram/Dothiepin. He was given an outpatient appointment for three weeks and was to be visited by Ms Harper CPN.

15 February 2002

Mrs Harper, CPN visited Mr X at home. He was quiet during the meeting and Mrs X did most of the talking, mainly complaining about his treatment and in particular, not receiving the EEG results and not knowing why Dr Naylor was asked to give a second opinion. Mrs X had stopped Mr X's medication two nights previously and so was advised to recommence as prescribed, 0.5mgs Lorazepam in the morning and again in

the evening. Mr X was referred to an anxiety management group when there was a vacancy.

17 February 2002

The Police received a 999 call from Mr X at 08.47 hours. He stated that he had murdered his wife. She had multiple stabs wounds. When the police arrived, the front door had been smashed with a mallet, which was in the kitchen. Mr X was arrested on suspicion of murder and taken to the police station. Mr Rob Waring acted as the Appropriate Adult, and later that evening Dr F Lehmann-Waldau, Consultant Psychiatrist, conducted a mental health examination. As a result Mr X was considered unfit for interview but fit to be detained with 24 hour one to one observations.

CHAPTER 5

MR X'S PRESENTATION AND POTENTIAL RISK TO HIMSELF AND OTHERS.

In order to provide effective and safe care and treatment for Mr X and his mental health problems, an accurate formulation of those problems was required at each stage of his care. Such a formulation would also underpin the assessment and management of any identified risks. In addition the requirements of the Care Programme Approach (CPA) also needed to be followed.

By formulation we mean the summary with which a mental health worker makes sense of an individual patient within the general context of psychiatric understanding and diagnostic frameworks. A formulation should seek to describe and explain a patient's presenting symptoms, so that one can understand why the patient presented at that particular time, with those particular symptoms, and with the symptoms being manifest in that particular way.

In considering these issues it is important to bear in mind the evidence available to the treating team at any given time, and also to consider any confounding factors that might have made their task more difficult or complex. One particular confounding factor was the difficulty in communication between the clinical staff on the one hand and Mr and Mrs X and their family on the other hand. This particular issue will be discussed further in Chapter 6.

CPA was introduced in 1991 to provide a framework for effective mental health care. It applies to all those people who are under the care of the secondary mental health service (health and social care), regardless of setting. The CPA describes the approach that should be taken by specialist mental health services for all service users aged 16 and over. The four main elements are as follows:

1. Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services

2. The formulation of a Care Plan which identifies the health and social care required from a variety of providers
3. The appointment of a Keyworker to keep in close contact with the service user and to monitor and coordinate care
4. The regular review and where necessary modification of agreed Care Plans.

The assessment and management of risk is an integral part of Care Planning. These items are therefore discussed together. This point is amplified by two recent publications. In the Department of Health document *Modernising the CPA* (1999) it is stated that risk assessment and risk management is at the heart of effective mental health practice, and needs to be central to any training developed around the CPA. The *National Service Framework for Mental Health* (Dept of Health 1999) states that local health and social care communities should focus on ensuring that staff are competent to assess the risk of violence or self-harm, to manage individuals who may become violent, and to know how to assess and manage risk and ensure safety.

A Care Plan is a plan of care. It is not simply a form for completion or otherwise. A plan of care exists even when a patient or carer does not wish to accept all or part of the plan. Clinical staff frequently excuse their failure to document a Care Plan by stating that all involved knew what the plan was. This however rests on perfect recall and a shared memory of discussions. By recording the plan the actual agreed content is clear to all. Those involved can refer to it, and equally importantly it can provide a useful guide to staff who do not know the patient but who might be required to provide an assessment out of hours or during colleagues' absence.

Similar comments apply to risk assessment and its documentation. Forms can act as a useful prompt to ensure that staff cover all relevant aspects. By referring to earlier forms for a given patient one can ensure that previous concerns are not forgotten. This is particularly important given the dynamic nature of risk.

As is clear from the chronology, Mr X had symptoms, which might have suggested a depressive illness, in his prodromal period prior to his first hospitalisation for his abdominal problems. However, the symptoms suggestive of depression were obscured by the fact that his abdominal complaints were so prominent, and he and his

wife were particularly concerned about them. Their help-seeking was with particular reference to those symptoms. As they had changed GP surgeries during the course of their various house moves, there was no single GP in a position to easily note any changes in Mr X's behaviour. Although Mr X told Dr Dorrell that he had been a little depressed by his house moves, the conversation was very much taken up by his concerns about his general physical health, and his dissatisfaction with the alleged failings of the practice organisation.

Following on from Mr X's admission to Treliske Hospital after his attempted suicide, a detailed psychiatric assessment concluded that he had a severe depressive illness possibly with psychotic features. A high risk of suicide was noted, and appropriate plans were made for his further care and treatment. The significant history of recent and more remote marital difficulties was properly included in an understanding of the genesis of his illness. Unfortunately, however, the detailed notes of this assessment were not sent on to Trengweath Hospital, although we do understand that a telephone conversation took place between the relevant trainee psychiatrists.

Dr Birch made a detailed and thorough assessment of Mr X on his admission to Trengweath Hospital. Further evidence emerged of the important causative factors, including the difficulty with various house moves, Mr X's continuing abdominal complaints, and the relationship difficulties between him and his wife. A mental state examination was not recorded in the case notes at this time, but the case notes do record consideration of the relevant risk factors. No evidence of psychosis was noted. Over the following days evidence of significant improvement was observed on several occasions by staff. Within a week his wife stated that he was back to his normal self and she was keen to have him back home.

After a further week Mr X was discharged. He told us that, in retrospect, he probably did feel significantly better at this stage. During this second week of his inpatient stay Mrs X was very positive about her husband's progress. Members of the clinical team told us that they did consider Mr X to have improved but still considered him to be quite ill. But it was their view that he could be safely discharged home with continuing arrangements for care and treatment. The family informed the Inquiry

Team that they had some reservations about his degree of improvement, but the clinical team did not know of these reservations.

By the time of his first discharge from inpatient care it would appear to have been reasonable for the treating team to conclude that Mr X had made some steps towards recovery. He did not require continuing inpatient care. Other than the fact that he had a depressive illness and had previously tried to harm himself, there were no particular indicators of further risk of significant self-harm. The couple were at last happy with their house. There were no further recordings in the case notes to indicate the presence of psychosis. The improvement appeared, quite reasonably, to have arisen in part out of a rapprochement between the couple. The treatment plan formulated appears to have been satisfactory, and there were no reasons to question the original diagnosis.

The family have stated to the Inquiry team that Mrs X was unaware that her husband had been discharged, but thought rather that he had been sent on a further week's leave. This is difficult to understand. The staff concerned had no doubt that Mr X had been discharged, and no arrangements were recorded for his return to the ward. Mr X had been given medication to take with him. Rather, it was the case that arrangements had been made for him to be seen at home by a CPN, which was what happened.

Comment

In our view there was sufficient evidence to warrant discharging Mr X from inpatient care at this stage. We accept that staff did consider the issue of risk arising from discharge. However a risk assessment should have been explicitly completed in collaboration with Mr and Mrs X. In addition he should, in the light of his recent serious attempted suicide, have been discharged on the enhanced level of the CPA with a copy of the plan to Mr X and his carer ie Mrs X.

Mr X was next admitted to the ward on 1December 2001. When assessed by the CPN on that day, and by the duty Doctor later, there was clear evidence of deterioration in his mental state. In addition, it was reasonable at that time for staff to conclude that

there were continuing marital difficulties between Mr and Mrs X, given some of his statements to them. Mr X himself did not appear to be adverse to admission to hospital although his subsequent comments have been very different. However, there were the first indications that he appeared confused at times, and he seemed to be inappropriately concerned about his clothes. This might reasonably have led to suspicions that he might be psychotic. The already difficult relationship between staff and Mrs X deteriorated further over the next few days, as will be discussed in the following chapter.

By 10 December 2001 there was some evidence of improvement. No further evidence of possible psychosis or confusion had been noted, and by 8 December Mr X was denying the presence of any suicidal thoughts. He appeared more relaxed and brighter in mood. He was therefore discharged on 11December 2001. The case notes did not record whether Mrs X was satisfied with this decision but, according to one daughter's account, both Mr and Mrs X wished him to be home.

Comment

Mr X did not appear to have made quite so convincing a recovery from this episode as from the previous episode of inpatient care. However, apart from a brief period of apparent confusion, there was no evidence to suggest that a change of diagnosis was called for, nor was there any evidence to suggest that the fundamental treatment plan was inappropriate. Arrangements for his care and treatment out of hospital appear to have been adequate, and there were no obvious indications of imminent risk, either to himself or others, arising from the discharge, bearing in mind of course that a severe depressive illness always carries risks. The same comments that we have made with respect to care planning and risk assessment after his first discharge apply equally here.

During the period between his discharge on 11th of December and his outpatient appointment with Dr Scott on 20th of December Mr X's family became aware that he had significantly deteriorated. One daughter has described him as expressing abnormal thoughts, but this was not conveyed to the CPN who visited on 18 December 2001. Mr X was described as still low in mood, but both he and his wife considered him to be more relaxed when he was back at home. Mrs X spent most of

the interview time expressing her concerns about his previous treatment on the inpatient unit. No changes were made to his treatment prior to the outpatient appointment with Dr Scott, which was due to take place two days later.

On the 20 December however when seen in the outpatient clinic, Mr X was clearly significantly worse. He was described as agitated, distressed, and preoccupied with morbid delusional ideas. Dr Scott described him as expressing irrational fears and being confused at times. This clearly represented a significant deterioration. The changes in Mr X's presentation should have called into question the accuracy of the diagnosis, and as a consequence of that one could not be entirely confident about the appropriateness of any treatment plan, and the accuracy of any risk assessment. The fact that Mrs X was eager to look after him at home should not by now have reassured the clinical staff.

Following admission on 21 December, after the serious assault on Mrs X, Mr X was noted to express paranoid ideas, which appeared to be delusional in nature. He was also noted to be significantly confused, with clear indications of cognitive impairment on a mini mental state examination. This could have suggested a depressive pseudo-dementia or alternatively organic brain disease.

Medical and nursing staff informed us that they did attempt to discuss with Mr and Mrs X the attempted strangulation. Unfortunately these conversations were not recorded in the case notes. We were told that Mr X became distressed when asked about the matter and Mrs X tended to minimise the episode. They both referred to an argument as being the triggering event for the assault. The case notes did record in some detail his mental state and the concerns regarding his possible organic brain disease and general physical health. In the face of these immediately pressing concerns, the issue of risk appears to have been neglected when reviewing the case note recordings.

The diagnosis however came into question at this stage, and alternative diagnoses were considered. Mr X's presentation in the week following his admission continued to give concern. He appeared very anxious at times, had irrational fears, and seemed confused. His daughter described him as dramatically better on Christmas Day but

this dramatic improvement was not sustained during the next few days, although there were some signs of modest improvement by the beginning of January. The clinical team continued to consider the diagnosis, favouring an organic disorder.

Arrangements were made for appropriate investigations. Mr X was already on the waiting list for a CT scan, but a request for an MRI scan could have been made at this point, given that there was a suspicion that he might be suffering from small vessel disease. The clinical team has told us that Mr X's irrational thoughts were not persistent or sustained. The fluctuations in his condition and the absence of fixed delusions appear to have dissuaded the clinical team from considering that his presentation represented a worsening in his depressive illness with increasing symptoms of psychosis. Certainly, the degree of fluctuation during this period was unusual, and features of his presentation were highly suggestive of an organic disorder. Perhaps the attempted strangulation was ascribed to an organic confusional state, but this was not clearly formulated in the case notes. It was appropriate for the clinical team to continue with his medication at this point in time, and to await further clarification on his progress and the results of special investigations.

The standard textbook on organic psychiatry, by W.A. Lishman (*Organic Psychiatry*, 2nd Edition, Blackwell Scientific Publications: London, 1987), describes the clinical picture of depressive pseudo-dementia as follows:

> "*the patient becomes slow to grasp essentials, thinking is laboured, and behaviour becomes generally slipshod and inefficient. Events fail to register, either through lack of ability to attend and concentrate, or on account of the patient's inner preoccupations. In consequence he may show faulty orientation, impairment of recent memory, and a markedly defective knowledge of current events. The impression of dementia is sometimes strengthened by the patient's decrepit appearance due to self-neglect and loss of weight, or when the elderly depressive becomes tremulous and assumes a shuffling gait. Some patients tend to emphasise the physical components of the disorder in their complaints and fail to report the change of mood; or when depression and agitation are detected these may be regarded as secondary to the supposed dementing process.*"

Although detailed clinical assessment and special investigations might aid in diagnosis, it is not always possible to distinguish between a pseudo dementia and a true dementia. Sometimes the diagnosis can only be made in retrospect. Continuing treatment for depression and using time as a diagnostic tool were appropriate and might have led to a resolution of the concerns.

On 18 January Mr and Mrs X saw Dr Naylor for a second opinion. Dr Naylor was told that Mr X was going out with his wife by this stage, and enjoying his days out, although he continued to be anxious at times and he was "phobic" with regard to ward rounds. There were no signs of cognitive impairment during this examination and Dr Naylor concluded that Mr X was suffering from severe anxiety disorder/panic disorder and that his condition had been exacerbated by antidepressant medication. He further mentioned the presence of dissociative cognitive impairment. He recommended a reduction in the current antidepressants and the cautious introduction of a different antidepressant at a later stage. Mrs X was happy with this diagnosis and was convinced that he had recommended the cessation of all antidepressants. She was therefore very unhappy when Dr Scott followed Dr Naylor's suggestions, and did wish to continue with a different antidepressant. Mrs X told her daughter that Dr Naylor had inquired closely into the question of strangulation. This was however not recorded in the case notes, and therefore no explanation for the attempted strangulation was explicitly provided to the clinical team as a result of this second opinion. In his evidence to us, Dr Naylor attributed the suicide attempt directly to the marital conflicts and states of hyper arousal, with the same explanation for the attempted strangulation. The second opinion did not advance the question of risk assessment and management.

Comment

It is a psychiatric truism that people who present with anxiety for the first time in later life usually have an underlying depressive disorder. With the benefit of hindsight we can state that there was abundant evidence for a depressive disorder with an organic psychiatric condition as a reasonable alternative diagnosis.

In his interview with us Dr Naylor described how he had considered the various alternative diagnoses. He also referred to the continuing sense of marital conflicts between the couple. Dr Naylor spent three hours with the couple. He took a thorough history and performed a detailed mental state examination, including an attempt to elicit evidence of psychosis. He described Mrs X to us as a confident and articulate person who was attentive to his line of questioning, fully cooperative and eager to seek the full benefit of his opinion. She in her turn seems to have had confidence in him. He had no reason to doubt that he would receive a complete and accurate account from her of Mr X's presentation and subsequent progress. It seems clear that she was able to voice all her concerns to him.

Comment

Whilst we now know that severe anxiety was not the correct diagnosis, Mrs X, who knew her husband, was pleased with the diagnosis and thought it was correct. There is no evidence to suggest that this assessment was anything other than thorough and careful. We conclude therefore that the correct diagnosis was difficult to determine at the time.

Following Dr Naylor's assessment Mr X appears to have steadily improved. Mrs X told her daughter on 11February that he was "*doing really well*" and, when their daughter spoke to Mr X on the telephone, she thought that he seemed "*okay*". He knew what was going on and his voice was back to normal. Earlier in the month Mrs X had remarked on the fact that his map reading had improved and he was starting to make plans for himself. She reported to her daughter that Mr X was still anxious at times. She described him as able to enjoy things, and she could reason him out of his anxious thoughts.

Mr X had periods away from the ward during this time and no adverse reports were presented to the clinical team. At the point of discharge on 12 February, therefore, Mr X appeared to have made significant progress. His wife appears to have been happy to have him home, and appropriate plans were made for further treatment and monitoring. It was 3 1/2 months since he had harmed himself. Nothing had been said or done during this time to indicate that he constituted a significant risk to himself. Whether he could be judged to constitute a significant risk to others is more

problematic. Staff assured us that they did consider the matter but it is not appropriately recorded in the case notes. There were various explanations for the attempted strangulation ie that it had arisen in a state of hyper arousal or panic, or alternatively that it was a reflection of the troubled marital relationship. It does not appear to have been considered to arise directly out of a depressive illness and, more particularly, it was not linked to the presence of any psychosis that we now know was still present but not volunteered or elicited by careful inquiry.

Much of the case note recording covered the sort of things that Mr and Mrs X had been doing, general comments regarding his sense of well being and observations on his mood state. There is no evidence of a careful inquiry into the presence or absence of psychosis, although we were told it did take place. It is however quite possible that at this stage Mr X would not have disclosed such delusional thinking. We know that his family and his wife, who knew him very well, did not notice the presence of delusions during this period.

Comment

In her evidence to the inquiry Helena Harper (CPN) told us that no Care Plan had been formulated nor had any risk assessment been completed at the ward round when Mr X was discharged from the Trengweath Hospital. When she discovered this error on the following day she completed a standard CPA. Given that Mr X's last admission had been precipitated by the attempted strangulation of his wife, it was clearly vital that a risk management plan should have been devised with the involvement of Mr and Mrs X as soon as it was possible to do so. The plan should then have been discussed and reviewed with all concerned prior to discharge. In addition Mr X should have been on the enhanced level of the CPA, as we have previously noted. As we discuss further in Chapter 6, we believe that contact should have been made with the couple's children so that their views and opinions could have been used in the risk assessment and Care Planning.

Ms Helena Harper (CPN) visited Mr X at home on the 15th February. Two of X's daughters had spoken to him on the telephone on the 14th of February, and both had been concerned about his mental state. Mrs X told them that he was anxious,

struggling to do simple puzzles, and full of irrational fears. This was not the picture presented to Ms Harper during her visit. She was told that Mr X had been anxious when in contact with friends, and that he was anxious because of her visit. Mr X had been anxious during the previous contacts, and there was nothing different about information presented on this occasion to warrant a significant change in the treatment plan. Much of the available time was given over to discussing Mrs X's concerns about various aspects of the care and treatment to date. Whilst Mr X appeared anxious, this was no more so than he had done on other occasions during his episode of illness. No evidence of psychosis was volunteered or elicited, and hence no risk of violence to Mrs X came to light.

Comment

There were major difficulties in assessing and managing Mr X's presentation to mental health services. He appears to have presented with different symptoms and complaints, to different members of the clinical team, at different times. There was little consistency in the clinical picture, and in the early stages particularly, rapid apparent progress. Especially in his first contacts with services, the picture was complicated by his physical health symptoms, some of which persisted throughout his periods of inpatient care. There were two inter-current physical health problems. In addition, during his third admission, there were symptoms strongly suggestive of an organic confusional state.

These difficulties were compounded by the health seeking behaviour of Mr and Mrs X, and the apparent tensions in their relationship. Difficulties in communication between the clinical team and Mr and Mrs X are discussed further in Chapter 6.

The clinical team relied too much on Mrs X and not enough on their careful and sceptical scrutiny of the situation. Their assessment of Mr X's risk was poorly documented and as such was not shared and discussed with Mr and Mrs X.

CHAPTER 6

COMMUNICATION BETWEEN THE CLINICAL TEAM, MRS X AND THE X FAMILY

Difficulties in communication between clinical staff on the one hand, and Mr & Mrs X and their family on the other, were crucial in this case. Arbitrating between such different accounts is always difficult, as one is faced with different perceptions and evaluations of the same transactions. In this particular case the accounts that we were given have obviously been filtered by the passage of time and understandable reactions to the tragic outcome. Our wish to explore these matters is motivated by our desire to attempt to understand them and to draw lessons from them.

By their very nature independent inquiries into homicides are obliged to scrutinise the conduct of clinical staff. They are not intended to criticise the patients, their families and their carers, and we have attempted to follow that tradition. We recognise that in our attempt to be even handed we risk being condemned by all parties.

Many people in society hold strong beliefs about mental health problems and mental health services. Many people are embarrassed or ashamed to see a psychiatrist, and resent being told that they have a mental health problem. Patients and their carers often prefer to be told that there is some underlying, treatable, ordinary medical problem that accounts for the changes in their sense of well being and behaviour. Such beliefs and attitudes are part and parcel of the work of staff in mental health services, and they need skills in dealing with them.

Mental health services are consistently under-funded by the government of the day. This situation has pertained for decades. Recent research by the Sainsbury Centre for Mental Health (*Briefing Paper 22*, The Sainsbury Centre for Mental Health) has indicated that much of the projected increase in mental health service spending in recent years has not reached mental health services, and has been diverted to acute hospitals. The government disputes this finding and claims that the Sainsbury Centre has miscalculated the figures. Acute inpatient wards throughout the country are

known to be busy, with bed occupancies of above 100%, high rates of staff shortages, excessive reliance on agency nursing staff, poor quality unattractive buildings, limited therapeutic work and recreational opportunity, and many other such deficiencies. We make these observations not by way of excuse, but to put the conditions in Trengweath Hospital ward into a social context, and to convey how understandable and common the reaction of Mr & Mrs X and their family was to the conditions that they found. Furthermore, according to Mr X, he and his wife did not like doctors, and expected standards of dress that are not always shared by society at large.

It is clear that Mrs X shared many of the common apprehensions about a diagnosis of mental health problems in her husband. Family members have told us that she would have preferred a definite physical cause for Mr X's state. He himself told us that when he was experiencing his various abdominal symptoms prior to his suicide attempt he did tell his wife that he thought his problems were due to stress, but she was quite clear in thinking his underlying problem was something such as ulcers. Mr X recalled the couple arguing about this. Mrs X's own notes included extensive information about various forms of cancer, some of which was obtained for her by relatives. In her many conversations with medical staff she raised the possibility of various medical problems that she wanted to be investigated and, if need be, excluded. At times she cast her net quite widely, seemingly more so than most relatives do. Against this, it has to be noted that at times she did recognise that he was indeed depressed. Her own notes recorded this fact, and she told a relative that Mr X had been like this before, although their daughters did not know that. Given that Mrs X seems sometimes to have recognised and accepted the presence of depression, we wonder whether staff might not have made more progress in persuading her of the accuracy of their views.

In addition to thinking that Mr X's problems had an underlying physical cause, Mrs X was also inclined to attribute all negative aspects of his progress to the medication that he was receiving. For example, on 30 November she attributed headaches, irritability and insomnia to the Citalopram. He had in fact experienced such symptoms long before the introduction of anti-depressants. Mr X himself has told us that he had little in the way of side effects from anti-depressants, although he admits to some difficulty

in remembering the latter part of his hospital stay. Mrs X's views on medication formed an important part of her attitude to both his treatment and to his doctors.

Mrs X's ideas about her husband's problems and psychotropic medication are not uncommon. They were however strongly held. They are particularly important because she wished to be present whenever her husband was interviewed, and there are many occasions in the case notes when it is clear when she insisted on speaking for him. It is clear that she cared deeply for him, and wanted the best for him. However, what she had to say was filtered by her own beliefs and wishes. She did not want him to take anti-depressants, often preferred to have him at home, and ultimately seems not to have believed he had depression. Her approach to the attempted strangulation is also relevant. After the initial shock she seems to have minimised the seriousness of the assault. It was reasonable for staff to have reservations about the reliability of the information that she presented. Indeed they might have been more sceptical in interpreting what she had to say, especially with regard to the assault.

Mrs X was strongly of the view that clinical staff would listen to what her husband had to say, would uncritically accept it, and act accordingly. She told a relative that she was caught in a dilemma ie Mr X was not reliable, which is correct for significant periods at least, and staff would, in her view, not believe her. The case notes do not substantiate this latter view. She seems always to have been given the opportunity to express her opinions, and was always involved in the discharge process. Staff expressed the view that it was difficult to see Mr X on his own. She would attend the ward from perhaps 10 o'clock in the morning and stay until the day shift of staff had already gone home.

Comment

Far from the team being too inclined to be influenced by seeing Mr X on his own, they were too reliant on Mrs X.

The clinical team was aware of the fact that a dispute between the couple had precipitated Mr X's attempted suicide. Although the couple were positive toward each other for the vast majority of the time that Mr X was on the ward, there were occasions when Mr X made sharply critical remarks about his wife. He also stated

that he felt safer on the ward rather than at home, On more than one occasion Mrs X commented on their marital rows. The clinical team appeared to have been strongly influenced by these considerations. They perceived the marital relationship as far more problematic and volatile than family members believe it to have been, and saw it as an important factor both in terms of causation of his illness and in the evaluation of risk.

In our attempts to record and understand Mrs X's experience of Trengweath Hospital ward and the clinical team, we have had to rely on the notes that she made, which were often not in chronological order, and on what her daughters recalled of her conversations with them. Whilst this information has been very useful for the enquiry team, it would appear to be the case that Mrs X did not always convey the full depth of her concerns to the clinical team. This was possibly because she wished to emphasise positive developments, or was perhaps motivated by her beliefs and wishes as previously outlined in this chapter.

The couple's daughters appeared to have had a good understanding of their father's mental health problems, and were aware of the times that he deteriorated, and much of the nature of his symptoms. Their own contact with the clinical team was, however, limited by geographical considerations. The clinical team did not attempt to contact them when they were not in Cornwall, and for their part the daughters relied on their mother to give a detailed and accurate account of their father's progress and continuing problems. If we compare what Mrs X conveyed to her daughters at various times and what she was noted to say to clinical staff, they could not always have known the true picture. We comment further on this issue later in this chapter.

Family members feel that there should have been more support in the community whenever Mr X was discharged. Mrs X however did not want that, requested shorter visits from the CPN, and tried to resist a visit on 1 December 2001. At times of discharge Mr X did have CPN follow up, booked outpatient appointments, and information on how to contact services if required.

In our culture happily married couples with open relationships tend to share full details of their medical history and problems with each other. For Mrs X, no doubt, it

was acceptable and unremarkable that she should insist on seeing her husband's surgical notes, and that all details of his treatment and investigations should be passed on to her, even at those times when he was having difficulty in comprehending them himself. However, NHS staff are regularly informed that they must respect patients confidentiality, and they can be strongly admonished if they fail to do so. Families and carers often experience such reticence as evasiveness and unhelpfulness, but this is usually not the case. Difficulties in this regard were a source of frustration for Mrs X. She was particularly annoyed by the clinical team's reluctance to share with her and her husband the results of his EEG, which suggested that he might have a diffuse organic process consistent with dementia. The clinical team judged that giving such information at the relevant time would have caused a great deal of distress for the couple, and may have delayed his progress.

Comment

Whilst it is accepted practice for staff to take such an approach we would suggest that it was an error of judgement, especially as Mrs X was well known to be particularly tenacious, and the information was bound to come out. It would have been better to deliver it as soon as it was available.

Family members have, understandably, stressed that the clinical team should have told Mrs X that a depressive illness could account for her husband's symptoms, especially including the abdominal ones, and also his problems with concentration and memory. Furthermore they think she would have been helped to know that it is sometimes necessary to try several different anti-depressants before any of them work, and that it can take quite some time for the symptoms to start to resolve. Medical and nursing staff were of the opinion that they did cover this ground but that fact was not well documented in the case notes.

Dr Birch in particular told us that she had several long talks with Mrs X. Such talks would typically start with Mrs X quite anxious and aroused. The conversation would often end with some resolution of concerns and an improvement in the relationship. However when next Dr Birch saw Mrs X it was as if everything was back to square one. In such circumstances it might have been advisable to provide Mrs X with more written material about her husband's condition and the treatment. This seems to us

particularly relevant in the light of her misattributing symptoms to medication, and clearly misunderstanding or misreporting Dr Naylor's opinion. Mrs X did have a considerable amount of written material regarding depressive illness and its possible causes, but as far as we can tell much of this came from the family.

A further example of misunderstanding was Mrs X's belief that her husband had been sent on further leave when he had in fact been discharged. Interestingly Mr X told us that he understood that he had been discharged. A copy of the Care Plan would have made this clear.

Some members of the clinical team were of the opinion that Mrs X interfered with her husband's medication, and possibly encouraged him not to take it. Mr X is quite emphatic that his wife always encouraged him to take his medication, and they would tend to take their medication at the same time. In her notes Mrs X records that on 24 January she told X not to take his anti-depressants. This was presumably due to her misunderstanding of Dr Naylor's treatment plan. We do know that Mrs X omitted some of his medication after his last discharge from hospital. She implied to one daughter at this time that he had stopped all of his treatment, but told the CPN that he had missed some doses. Whatever happened in the last week, it does seem to be the case that the staff perception about her interference earlier in his care was largely incorrect.

We have already mentioned Mr & Mrs X's dissatisfaction regarding information about the EEG. Their confidence in the clinical team and in its communication was not assisted by the mistakes in prescriptions, which are mentioned in the chronology. Whilst none of these mistakes where significantly unsafe, they nevertheless were unsatisfactory.

A further source of misunderstanding and some dissatisfaction was the second opinion provided by Dr Naylor. Mrs X pressed for a second opinion, which in the circumstances was entirely appropriate. The status of second opinions can be ambiguous. Is the opinion to be delivered directly to the patient and his family, or is it to be passed to the original consultant for his or her consideration and further action? If the referring consultant disagrees with the second opinion is he or she

obliged to follow it or merely to consider it? Difficulties here were compounded by Mrs X's misunderstanding of Dr Naylor's recommendations with regard to anti-depressant medication.

The clinical team assured us that, in the light of Mrs X lengthy visits to the ward and her reluctance to allow staff to interview her husband directly without her presence, they did discuss and consider how best to manage their interactions with her. Again, this is not clearly documented in the case notes. We asked them whether they had considered restricting her visits to the agreed visiting hours, and whether, if she was explicitly allowed to say all that she wished to, she would then have allowed them to talk to her husband without answering for him. It was pointed out to us that Mr X became most anxious if there were conflicts between the clinical team and his wife, and they therefore did their utmost not to thwart her or do anything that she would find unacceptable.

The clinical team was of the view that laying down clear and appropriate boundaries with her would have exacerbated the situation rather than resolved it. Mr & Mrs X had three well-informed and concerned daughters, and it is our opinion that the clinical team should have given more consideration to contacting them in an effort to understand their father, to understand Mrs X, and possibly even to mediate in the difficulties. They did after all have first hand knowledge of their parents' characters, the marital relationship, and most importantly a great deal of information about their father's mental state, because of their frequent telephone conversations with him.

CHAPTER 7

MANAGEMENT OF THE INCIDENT AND SUBSEQUENT ACTION

Once the news of Mrs X's death was notified to the Trust, Ms Julie Hostick (formally Prouse), locality clinical manager, completed an 'Immediate Notification of Serious Untoward Incident' form on 17 February 2002. The members of staff mentioned as being involved were Dr Jeremy Scott, Ms Helena Harper, CPN, and Mr Bruce Arnott, acting deputy Team Leader and inpatient keyworker. On the same day Ms Prouse liaised with Dr Scott, and Mr Mark Steer, Deputy Director of Nursing, was informed. Mr Kearney attended the ward to meet with all the staff. On 18 February 2002 Ms Prouse arranged to debrief the staff who were not on duty the day before and to collect statements from all staff. We were given statements from Dr Scott dated 19 February, Dr Birch dated 19 February, Ms Richards dated 17 February, and Mr Arnott The immediate findings were in relation to CPA, risk assessment and discharge arrangements. A 'Learning from Experience/Critical Incident Review' meeting was planned for 4 March 2002 at 16.00 hours.

Mr Michael Donnelly, general manager (mental health service) was charged with managing the internal investigation. He had recently joined the Trust, and had experience of a previous external inquiry following a homicide. He prepared a briefing paper, requesting that Ms Prouse and the staff be recognised for the professional way they dealt with the incident, and in particular the detailed report prepared by Ms Prouse, dated March 2002, for the Chief Executive and the Medical Director. He also discussed the arrangements for staff support, and identified the review team in line with guidance from the Regional Office. We would agree that the initial report prepared by Ms Prouse was indeed professional, identifying deficiencies in the system, which undoubtedly helped formulate the recommendations of the subsequent multi-professional review. Nowhere in this briefing paper was there mention of contact having been made, or indeed planned, with the family members.

The Inquiry Team was unable to interview Mr Donnelly as he retired from the Trust shortly before our Inquiry was commenced, and chose not to attend when invited. He

did, however, prepare a written statement. In it he told us that he had drawn up the terms of reference for the internal inquiry along with Mr Steer on behalf of the Chief Executive, as well as identifying Ms Anthea Hancock, Locality Clinical Manager for north and east Cornwall, to lead the review. He also told us that he was unaware of any support given or offered to the family.

Internal Inquiry

In accordance with the terms of reference for this Inquiry, we were asked to comment on the previous internal review completed by the Trust. (The terms of reference can be found at Appendix 5).

Ms Hancock was charged with setting up and managing the review. The remaining team members were Dr Peter Irwin, a recently retired Consultant Psychiatrist, Mr Clive Denny, Senior Nurse, and Ms Sandra Miles, the Health Authority representative. The timescale for completion of the final report was six weeks, which was interpreted as the beginning of April 2002 by Ms Hancock. However, in evidence she told us that there was difficulty in arranging suitable dates for all four people to meet, especially the two who did not work for the Trust. In the end there were only two meetings, in May 2002.

When it was put to Ms Hancock that perhaps she could have requested senior help in bringing forward the dates, she said there were always people to get help from: *"In all honesty and to be fair to everyone, I was over confident and I must take responsibility for that"*. Ms Hancock also drafted the report and then circulated it to her colleagues for comments/ feedback, which amounted to very little, if anything.

In assessing the quality of this report we were aware that the internal inquiry team had access to less information than we did, and that the report was prepared against a tight time schedule. As a consequence, corners were cut and we find the process of conducting the inquiry unsatisfactory, not least of all because no member of staff who was responsible for any aspect of Mr X's care was interviewed. Of course Ms Hancock had the benefit of Ms Prouse's initial findings report, and was able to incorporate it into her report before sending it to the Chief Executive. The internal review was presented to and accepted in the confidential section by the Trust Board,

with a resultant action plan to be managed by Mr Donnelly, General Manager. However, it was only in February 2003, during a meeting between Dr Hand and Dr Scott when the action plan was discussed, that Dr Scott informed her that he was surprised that the internal inquiry team did not interview him as part of their process. It was only then that senior staff realised that none of the staff who had cared for Mr X were interviewed.

As a result, in June 2003 Dr M Hand, Mr M Steer, now Director of Nursing, and Mr John Sumnall, a senior manager in the Trust, undertook a rolling programme of interviewing all staff members involved in the care of Mr X. Mr Steer reported the outcome of this round of interviews and progress of the pursuant action plan to the Trust Board in October 2003. In this paper, he highlighted the need for clinical supervision, which we discuss in Chapter 9.

Whilst no one person or organisation wants to be faced with having to investigate serious incidents, even in the best managed services there are times when things go wrong. The outcomes of any investigation need to be firm, with a clear expectation of who should do what, by when it should be completed, include checks to ensure that it has been done, and finally an evaluation of its effectiveness needs to be in place. This can only occur with appropriate training to provide competence and instil an appropriate level of confidence.

Comment

Knowing that there had been a recent internal inquiry, when all staff involved were interviewed, the Inquiry Team was surprised that Ms Hancock did not seek guidance from her colleague. We were pleased to hear about the 'Learning from Experience' forum following a serious incident, facilitated by a senior manager in another locality. The outcomes are collated and then disseminated through a regular bulletin. In addition, the National Patient's Safety Agency has appointed a lead person to work with Trusts in a specific geographical area to educate staff in 'root cause analysis'. Indeed Mr Steer had already attended the training.

The Report of the Independent Inquiry into the care and Treatment of H (Weereratne et al September 2003) made the following recommendation about the internal review in that Inquiry:

> ***The Trust (Cornwall Partnership Trust) policy on investigating Serious Untoward Incidents should be reviewed to ensure its consistency with the guidance issued by the National Patient Safety Agency. Particular attention should be paid to a) root cause analysis, b) in all cases terms of reference should be followed and c) any change of these terms should be formally recorded.***

We would endorse this recommendation

Support for Families

Safer Services National Confidential Inquiry into homicides and suicides by people with Mental Illness (issued by the Department of Health in 1999) shows that extreme crimes of violence such as murder or manslaughter were more likely to be committed by a family member than by a stranger. Carers need help to deal with the crisis they find themselves in, and to be reassured about the future action to be taken.

In 1995 the Home Office published a folder entitled '*Information for Families of Homicide Victims*'. This folder includes the useful leaflet, *The Work of the Coroner, Going to Court, Coping when someone has been killed*, as well as leaflets about the criminal justice system and information about organisations that can help. This publication does not appear to have been widely distributed; however it contains the type of information which could sensibly be distributed to families at, for example, the time of dealing with the death certificate. It is worth commenting in this context on the role which the voluntary sector can play in the provision of support to the families of homicide victims, eg Victim Support.

From previous experience, the Inquiry panel expected that the family would have received helpful support from a police officer assigned to them for the duration of the criminal proceedings, and in fact this was the case. Some staff were of the opinion that contact had been made by someone, but were unable to identify who this might have been. Neither could any of the family members recall any contact.

Comment

In giving evidence to the Inquiry, a member of staff told us that it was normal to write to any family members, offering condolences and to make them aware of services that were available to them. However, there was no copy of any such letter and so we had to assume that no letter was sent.

Efforts should also be made to keep families involved in this type of serious incident informed about the inquiry process. In this case no information was given to the family, from either the Trust or the Health Authority, until steps were taken to set up this Inquiry and the Inquiry manager made contact with them.

In Mr Steer's October Board paper he stated

> *"Although in this particular case the family did not wish to have support following the incident, the importance of this being available was recognised"*.

Although the family in this case were not contacted, the Inquiry panel was pleased to read this, as we do also consider that early contact with, and offers of support to, a victim's family in the aftermath of an incident such as this is very important, and should be documented. There have been about 120/130 inquiries following a homicide by someone in receipt of mental health services. In most instances, the perpetrator knows the victim, and in fact is quite often a close family member, but even this fact does not usually trigger any offer of support to the families at the time of the tragedy. In this case the family members were left to deal with press intrusion and Court proceedings, as well as their individual grief. Whilst recognising that the health services may not have all the details of families concerned in these matters, we consider that more effort should be made to contact families and to keep theminformed of the Inquiry process. There should also be the offer of appropriate counselling and support services if required by families, whilst recognising their grief and respecting that they may not wish to engage with the same clinical team. Fortunately, these incidents do not happen very often, but staff need to have the confidence in dealing with bereaved families; therefore consideration should be given to the implementation of a training programme to promote the sensitive treatment of victims, their families and the families of perpetrators.

It is our recommendation that

The Trust should appoint a senior person to make and maintain contact with the family until the independent inquiry has been appointed. This individual should be responsible, amongst other things, for:

a) **keeping the family informed and up to date in relation to all investigations and proceedings consequent upon the event, including internal investigations, court hearings, and the possibility of an external independent inquiry; and**

b) **(b) arranging access for the family to appropriate care, support and counselling services.**

It is our recommendation that

All contacts with the victim's family, including telephone contacts, are recorded in the Serious Untoward Incident report prepared for the Trust Board and the Health Authority. If no such contacts have taken place at the time of the report, then senior management will be alerted to the need to ensure that appropriate offers of support are then made. Details of contacts and offers of support made subsequent to the preparation of the Serious Untoward Incident report should be forwarded to the Trust representative responsible for the preparation of the Serious Untoward Incident report.

It is our recommendation that

- **The voluntary sector be involved in, or at least consulted in relation to, the content of the training programme being prepared, together with any associated printed material available for families/carers.**
- **The Trust identifies an appropriate strategy for providing families affected such by incidents with support, and for putting them in touch with relevant organisations.**

These are not just issues for organisations in Cornwall.. We suggest, therefore, that the Trust Chief Executive use the experience of the three inquiries to discuss with his colleagues the future arrangements for such inquiries, taking account of the negative media impact such inquiries have on the general public in relation to the delivery of safe mental health services.

CHAPTER 8

MENTAL HEALTH INPATIENT UNIT

A week or so before the Inquiry team met the inpatient services were relocated from Trengweath Hospital to a new purpose-built unit named Longreach House on the Camborne/Redruth Community Hospital site. We visited Trengweath Hospital, but as it was full of old furniture we could only imagine what it might have been like when Mr X was an inpatient. The building, prior to being an inpatient unit, had originally been built as an office block and was in use for about 17 years. It was considered to be ahead of its time as acute admissions became locality based and away from the large psychiatric institution. Everyone we asked described the ward as 'very busy', and some described it as 'chaotic'. It was situated on two floors with the day area, consulting rooms and dining area on the ground floor, and sleeping accommodation, including a four-bedded dormitory and three single rooms, on the first floor. In all there were 26 beds and six Consultants admitting patients. Bed occupancy could be anything up to 120%.

The Mental Act Commissioners in their regular visiting reported on the poor fabric of the building at Trengweath. From information we received, it seems that plans to relocate from Trengweath Hospital were in progress from 1994, finally coming to fruition when the builders commenced their work in May 2002. The building was completed in June 2003 and patients moved in August 2003. The Commissioners returned in September 2003 and were pleased to report that the move from the older units was achieved smoothly. Although it must also be said they recorded that all six detained patients were actually on leave away from the unit.

Longreach House has brought together both Trengweath Hospital and Gwaynten units, previously two geographically separated units, and now a total of 67 beds provide care for people living in parts of west and central Cornwall. The ground floor houses a 25 bedded unit for elderly people, and for the purpose of this report we are only concerned with the 42 beds for acutely mentally ill adults. The 42 bedded Bay Ward, was divided into three bays, 16, 14 and 12 beds respectively. All the bedrooms have ensuite facilities and, to provide privacy and respect, patients have the facility to

lock their bedroom. In contrast to Trengweath Hospital, Longreach House has a pleasant garden, which was well used when we visited and relieved some of the congestion. This was seen as a potential problem in the forthcoming winter as patients would not want to venture out but would prefer to spend their time in the central part of the unit.

On the ground floor a suite of rooms, the Haven Therapy Unit was available for daytime activities such as cooking, a fitness suite, a craft room and therapy rooms. This kind of facility was not available at Trengweath, although Mr X did attend painting sessions. When he was asked if he wished to participate, he was of the view that he was not well enough and, because his wife was present most of the time, it was not possible. It was difficult to provide activities at Trengweath as there was a shortage of occupational therapists. Nurses, when time allowed, carried out group work, especially relaxation and preparation for discharge. Community based workers also attended, but it was difficult to engage with some patients.

The move to 'de-institutionalise' mental health care has had a significant effect on the inpatient population. Patients who are no longer acutely ill are rarely kept in hospital but cared for at home, which has led to shorter admission stays and patients being more acutely ill. Patients also present with more complex needs, which in turn requires a high level of clinical skill to meet the challenge. We have already mentioned the bed occupancy rate at Trengweath Hospital, and when we visited Longreach House we were told that all the beds were occupied and at least another 20 patients were on home leave.

Service Commissioners and managers have struggled to provide alternative care to acute inpatient beds, and indeed Dr Scott raised this with us. He said he would have preferred to admit Mr X to a quieter and less busy environment than Trengweath Hospital, but that the only other facility (Lower Cardrew House) was for about six or seven patients with their own private accommodation. It was described as 'long-term rehabilitation' and patients were usually there for quite a long time; there was staff stability but also a long waiting list. Mr X was either at home or in hospital, twhere he was in a very over-stimulating, busy unit in which nursing staff were often dealing with quite disturbed patients.

There were a number of disadvantages for Mr X due to the very nature of the unit, the turnover of staff due to sickness, and staff shortages. Sometimes there were some very acute, disturbed patients on the ward, resulting in some violent episodes and leading to an uncomfortable environment for a man who was confused and unable to comprehend what was happening to him. Most of the staff told us that staffing was always a problem at Trengweath Hospital and this does not seem to have improved since the move. One of the identified problems was seen as the long day shift pattern and working three days in a row, which no doubt left some nurses feeling tired. Some nurses went 'sick' rather than face another long day and the demands of the acute ward. We heard that since the move up to four nurses had left. Bank and agency nursing staff could be used, but it took time to help them familiarise themselves with the ward and the patients

The Inquiry Team was pleased to learn that service users were involved in the planning of the new unit and that an Independent Visitor Scheme was introduced during the last year.

Comment

The Inquiry Team was told that monthly meetings are held at Longreach to discuss operational problems as they are identified, which seems appropriate.

It is our recommendation that Clinical Improvement groups are convened to discuss

a) the effect on the quality of patient care of the current shift pattern, sickness and staff shortages

b) changes in the delivery of and management of acute care to ensure effective service user involvement

CHAPTER 9

NURSING PRACTICE

The NMC code of professional conduct (April 2002) states that *'as a registered nurse or midwife you must maintain your professional knowledge and competence'*. The purpose of the code is to inform the professions and the public of the standard of professional conduct expected by a practitioner, and therefore justify the trust and confidence the public can expect. Under this heading we shall consider clinical supervision, record keeping and continuing professional development. They are integral to good practice and instrumental in providing a quality service in which practitioners are both competent and confident.

Clinical supervision

The notion of clinical supervision, in addition to managerial supervision, was introduced into the nursing profession since the early 1990's and enshrined in the UKCC Code of Conduct 1992 - '*Nurses, midwives and health visitors must act in a manner as to promote and safeguard the interests and wellbeing of the patients and clients, maintain and improve professional knowledge and competence'*.

A working definition of clinical supervision can simply be described as 'an exchange between practising professionals to enable the development of professional skills' (Butterworth, 1992). Another is 'the interactive process between providers of health care, which enables the development of professional knowledge and skills' (Butterfield and Faugier 1993). Either way, clinical supervision provides an opportunity to look at all aspects of care given in individual cases, which takes account of personal professional development and changing needs in service delivery. Clinical supervision is perceived by nurses to be a 'sounding board', which gives practitioners the opportunity to clarify thinking, question established practice and seek new approaches to care.

We believe that the development of a clinical supervision is essential to develop professional competence, improve in the quality of service delivery, and to benefit the organisation by providing a skilled and supported workforce.

We were told that nursing staff at Trengweath Hospital had no formal clinical supervision but that sometimes they initiated peer group supervision through their own monthly meetings. In fact Mr M Steer told us that, during the recent interviews forming part of the follow up review conducted by him and Dr M Hand, they were told that clinical supervision was not happening, despite the development of a county-wide policy about a year ago with their primary healthcare colleagues across the county. In fact we were given a copy of '*A Supervised Led Approach to the Supervision of Clinical Practice*' dated March 2002, and ratified February 2003. There is an expectation that the practitioner will complete a pro forma, in which the named clinical supervisor, frequency of supervision and the issues discussed will be recorded.

When we asked one of the more senior nurses about clinical supervision, he told us

> *"The arrangements now are the same as they were at Trengweath Hospital, if somebody wants clinical supervision they can request it. It was never something that was pushed purely because of the time. Some people did get it. We are supposed to be implementing it but I don't know if we have anybody on the ward who has done a course in how to run clinical supervision".*

The staff member did not think that many nurses were aware of the policy and went on to say

> *"You do get people who will get their clinical supervision come what may, they're really keen on it. Other people just see it as something they have to go through and they don't really want to discuss their professional lives with anybody. It's something that needs to come in; it's finding the time to do it. Given the choice of finding a bed for three patients who have been admitted with no beds and giving somebody clinical supervision, meeting the necessities of daily life on an acute ward win every time".*

There is no doubt that to introduce a full programme of clinical supervision, particularly in the inpatient setting, dedicated time must be set aside and staff trained in the principles of delivering and receiving supervision, if it is to be perceived as

more than a 'cosy chat'. Undoubtedly it will have staffing and time implications and managers will need to build this extra commitment into their staffing establishment.

The Report of the Independent Inquiry into the Care and Treatment of H **(**Weereratne et al September 2003) made the following recommendation about clinical supervision

> ***The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.***
>
> ***The clinical supervision arrangements described above must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.***

In addition to these very helpful recommendations we would further endorse them but have added another one.

It is our recommendation that the '*A Supervised Led Approach to the Supervision of Clinical Practice*' policy is formally implemented, with a separate training programme for supervisors and supervisees. The Trust Board should discuss the resources implications and agree a suitable budget to introduce meaningful supervision

Primary Nursing

In recent years there has been a move away from task allocation in nursing towards new approaches in individualised patient care recognising the benefits for patients in developing a one to one with a practitioner. The concept was formally adopted in the Patient's Charter1992:

> *"The Charter Standard is that you should have a named, qualified nurse, midwife or health visitor who will be responsible for your nursing and midwifery care".*

This concept is sometimes referred to as primary nursing, in as much that the primary nurse is the named nurse, with an associate nurse who takes on the role in the absence of the named nurse. The principles of named nursing should enable practitioners to:

- Have the freedom to exercise accountability and autonomy within the bounds of professional knowledge
- Have confidence and interpersonal skills to develop appropriate relationships with patients and the other members of the multi-disciplinary team
- Manage a caseload determined by ability and experience and the needs of patients
- Deliver direct patient care enabling a therapeutic relationship but also being able to manage, co-ordinate and delegate when necessary

But probably as importantly

- Be able to work in partnership with other nurses, acting on their behalf and not saying "you are not my patient"

In Mr X's case there were entries purported to be by the named nurse, but that person was not necessarily the nurse who attended the ward round or who completed the Care Plan. The family were not always sure who the named nurse was, or indeed if there was one. They were aware that there were many agency staff, but agreed that it might have been because of Christmas and staff taking holidays. They did tell us that trying to pass on symptoms and asking for progress was difficult, as there never seemed to be anyone on duty for more than two days running, and even then the nurses may not have seen the patient since the previous week.

This was quite possible as the current 12 hour shift pattern means that nurses complete their hours of work over a shorter period of time, resulting in patients and their families rarely seeing the same nurses. Patients were allocated to staff on a daily basis, but usually within a team of nurses working with a named consultant. However, even this system broke down fairly frequently because of absences due to annual leave, days off and illness.

We understand that following the move to Longreach House the situation had not altered. Two previous inpatient units have amalgamated so there are more consultants and therefore patients. Frequently there was not a full complement of staff on each shift and now, instead of nurses working with one consultant's patients, there were more consultants with the consequent increase in patients. Inevitably care was

delivered on an ad hoc basis, which clearly had implications for patients who were on regular observation, as well as continuity of care and communications with family members. We were told that the 'named nurse' concept was in name only, and certainly from the evidence we were given that was the impression we gained.

In other mental health nursing services the primary nurse completes a 'dedicated' record sheet that will inform other qualified staff when the primary nurse is unavailable.

It is our recommendation that Primary Nursing is fully established and appropriate documentation used.

Record keeping

The UKCC, now The Nursing and Midwifery Council, document '*Guidelines for Records and Record-keeping'* (1988 updated 2002) sets out the profession's expectations of how nurses should document their interaction with clients and patients. The guidelines state that record keeping is an integral part of nursing practice and as such is a tool that helps the care process. Good record keeping protects the welfare of patients by providing:

i) accurate, current, comprehensive and concise information including a chronology of events, reasons for decisions and any other problems

ii) evidence of care;

iii) a baseline against which improvement or deterioration may be judged.

Managers should expect records to be factual, consistent and to accurately reflect the intervention carried out by the individual writing the notes. In present day services there is an understanding that Care Plans are written with the involvement of the patient. Therefore records should be constructive and provide clear evidence of planned care and its delivery, whilst including any decisions made and a note of all professionals involved in the process. Any member of the multi-disciplinary team who has contact with clients has a responsibility to document that contact in the notes.

In the case notes we identified errors in the record keeping, even referring to Mr X by another name, and whilst we did not think that these errors detracted from the delivery of his care, they did demonstrate that the responsibility of the qualified nurse is to audit the entries prior to countersigning them.

The Report of the Independent Inquiry into the Care and Treatment of H **(**Weereratne et al September 2003) made the following recommendation about record keeping*:*

> ***The Trust (CPT) must audit the quality of clinical record keeping within six months. This must include the relevance of clinical entries to the patient's care and the comprehensiveness of that record, and compliance with Trust policy and procedures.***
>
> ***The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that practitioner's skills levels are appropriate to their caseload.***

Nursing handover

The handover from day to night and vice versa, at both Trengweath Hospital and now Longreach House, is 07.00 until 07.15 for the handover from the night staff to the day staff, and then from 7.15 until 7.30 or 7.45, from day to night staff. Occasionally it goes on until 08.00 if the day has been particularly eventful. The morning handover was described as 'very rudimentary' and possibly only one daytime staff member was present. In addition, a member of staff – a link nurse - who was on duty the previous day, gave a more comprehensive hand over to the staff who were not on duty the previous day. However, quite frequently there were no members of staff who were on duty the day before and so the only form of communication was that written in individual patient records and a note in a book kept in the office. This note may only refer to the patient record, or be expanded if there had been an incident on the ward the day before.

We were also informed that it was quite difficult for the 'named' nurse to attend the Consultant's ward round. Frequently the named nurse was not on duty and this task was also allocated to another nurse.

Communication and the sharing of information is the essence of good professional practice, is vital to ensure continuity of care and should never be underestimated, particularly as nurses and their associates, in the main, provide a large part of patient care.

It is our recommendation that the process for nursing handover be reviewed to provide a more systematic approach to individualised patient care which will ensure that the nursing staff are able to fulfil their role within the multi-disciplinary team.

Continuing professional development

Nursing practice takes place in a context of continuing policy changes and ongoing service developments. Such changes and developments may occur as the result of research, and lead to improvements in patient care and treatment, social pressures and evolving professional roles. Indeed nurses have a responsibility through their code of conduct to maintain professional knowledge and competence (*Code of Professional Conduct*, chapter 6, NMC 2002). Nurses have to renew their registration every three years, during which time they should have spent five days of learning activity and maintained a personal professional profile of this learning. There is an expectation that employers will allow this to happen as a major plank of their clinical governance process. We asked all the nurses we interviewed about training opportunities and, although there were many, in reality it was difficult for ward based staff to attend because of replacement issues. One of the areas for continuing professional development for nurses working in acute psychiatric care is risk assessment and management, but we found out that ward based nurses rarely attended training. This matter was also identified through the interviews conducted by Mr Steer, and was highlighted by the nurses that we saw as a negative aspect of remaining in the inpatient setting. Training needs are usually identified through the annual appraisal,

when training plans are reviewed. We were not convinced that staff had training plans and, when asked to attend for appraisal rarely did.

On the whole nursing staff only managed to attend those training events required through legalisation, such as health and safety. We were pleased, therefore, to hear that some individual nurses took it upon themselves to spend time imparting their specialist knowledge of an area of practice to their colleagues. However this is not sufficient if nurses are to fulfil their legal requirement to stay on the register.

The Report of the Independent Inquiry into the Care and Treatment of H **(**Weereratne et al September 2003) made the following recommendation about training:

> ***The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that practitioner's skills levels are appropriate to their caseload.***

We were given a copy of '*Making a Difference in Cornwall's Community Health Services Cornwall Healthcare*', the Trust's Strategy for Nursing 2000-2005. This document covers aspects of all community nursing as it was written before the separation of mental health and learning disability services into a specialist Trust. Mr Steer told us that a 'Nurse Forum' had been set up for all nurses to attend and discuss issues that were of concern to them. It was mainly the specialist nurses who attended on a bi-monthly basis. However, when we asked nurses about the Nurse Forum, they were unaware of it and we question whether busy inpatient nurses had the time or the energy to attend. We were given a copy of the Trust '*Core Brief*', published in December 2003, in which the information about the 'Nurse Forum' was buried in some 20+ pages. We believe a more positive approach should be taken in communicating nursing information if the Trust wishes to show that it takes nursing seriously.

Staff, as has been said many times and by many people, are an organisation's most valuable asset and as such need to be nurtured and refreshed. If staff are to perform to their best potential, there needs to be a systematic approach to assess their performance and identify individual potential and training needs. One way of achieving this is through a scheme based upon mutually agreed targets and objectives,

which form the basis upon which a nurse's performance can be fairly appraised. The intended outcome is to establish training and development needs, which will lead to improved motivation and staff feeling that they are making a valid contribution to the Trust's achievement.

It is our recommendation that all staff have access to annual appraisal when training plans can be discussed and individual nurse's performance measured against agreed objectives.

It was clear to us that, although some nurses liked the long day shift pattern, many did not, and it was not conducive to continuing patient care. We gained the impression that Trengweath Hospital was extremely busy. A bed occupancy of well over 100%, and many patients on home leave, led to 'hot-bedding'. The shortage of nurses, either because of sickness, days off or just taking regular breaks, must have meant that the staff were 'stretched' just to fulfil the regular commitments of attending wards rounds, administering medication and dealing with transfers, admissions and discharges**.** Whilst we do not believe that the standard of nursing practice contributed to the incident, we do believe that for these reasons the family members may well have perceived the nurses to be not as *'professional'* as they wished.

We were pleased to hear that the Trust had already appointed one Nurse Consultant whose responsibilities included looking at ways in which nursing practice could be improved. However, whilst we considered this to be a step in the right direction, we feel that in addition to improving practice there was need to provide more nursing leadership. We understood that such an appointment had already been established in the east of the county and we were informed that the Trust Board supported the need to *"have sufficient senior nurses to lead nursing and lead the governance of nursing".*

It is our recommendation that the Trust reviews nursing models, shift patterns and the skill mix within the nursing establishment on the acute admission ward at Longreach House.

It is our recommendation that the nursing strategy should be brought up to date in light of the particular needs of mental health nursing and takes account of changes in Nursing Practice. in reviewing policies and procedures,

It is our recommendation that the Director of Nursing considers the appointment of a clinical nurse specialist or nurse consultant post based at Longreach House to take forward the recommendations in this report and provide clinical leadership.

Chapter 10

FURTHER DISCUSSION OF ISSUES HIGHLIGHTED IN THE PREVIOUS REPORTS

It would seem unusual if we had not looked at the previous reports in some detail. Much has already been discussed in previous chapters but in this one we not only endorse the recommendations from those reports but have added some which we feel complement them and help the Trust in delivering quality mental health services.

Policies and procedures

The Report of the Independent Inquiry into the Care and Treatment of H (Weereratne et al September 2003) made the following recommendations about policies and procedures in that Inquiry:

> ***"The Trust (CPT) should ensure that all clinical and operational policies are consistent with National Guidance and are implemented promptly. All policies should be introduced with a detailed implementation plan which identifies resource implications, training requirements and changes from previous practice.***
>
> ***The Trust (CPT) should commission an independent review of the changes to clinical policies and practice described by senior managers to the panel in the course of this inquiry. In particular the review should measure the effectiveness of these changes at the patient interface."***

When we interviewed Mr Tony Gardner, Chief Executive, he told us that they were in process of commissioning an external review of all their policies and procedures. The previous external inquiries noted that some policies were out of date and in some instances not dated. They were also critical that staff had interpreted policies differently. We were given policies of various dates from 1997 to the 2003. We also understand that the Trust have, supported by the Health Authority, requested that the Commission for Health Improvement (CHI) carry out a clinical governance review. This process should demonstrate how robust their services are, and instil staff and

public confidence. We were a little concerned that this process will be the fourth external review in a short time and hope that there is a reasonable 'run in time' for staff to be properly prepared. However, we have since learnt that to date the Trust has not been informed when this might happen.

Comment

Whilst we acknowledge that policies and procedures provide the framework within which practitioners work, it is necessary to ensure that staff fully comprehend the implications of not following or using policies. For example, although changes had been made to the CPA policy many staff were unable to remember when they had last attended training and updating sessions; rather, they learnt from each other during staff meetings. There has to be a consistent approach, which can only be developed through a detailed implementation and feedback programme with ongoing training, followed by regular clinical audit.

It is our recommendation that following the external review of policies and procedures, the implementation of such recommendations that are made is accompanied with an in-service training programme, and audited within one year of the implementation.

Care Programme Approach

The Care Programme Approach was introduced in mental health services as long ago as 1991, and provided a framework for the delivery of effective mental healthcare. We are now eight years on and yet there are still issues in the way the process is perceived, implemented and understood by both staff, patients and carers alike. CPA is applicable to people who are in contact with secondary mental health and social care services irrespective of the setting.

The four main elements of the Care Programme Approach are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;

- The formation of a Care Plan which identifies the health and social care required from a variety of providers.

- The appointment of a Key Worker to keep in close contact with the service user and to monitor and co-ordinate care.

- Regular review and where necessary, agreed changes to the Care Plan.

In February 2003 the Cornwall Partnership Trust introduced a new CPA policy. During our Inquiry we identified some issues pertaining to the policy and its implementation. We heard from various nurses working at Trengweath Hospital during the time Mr X was an inpatient there. Many members of staff told us that the CPA process was poorly implemented, and nearly all stated they had received no formal training with regard to this procedure. At best a couple of hours was spent on the ward looking at the new paperwork.

Whilst we would not to overstate the role of staff in accomplishing an effective CPA framework, there is a need to remember the contribution made by carers and families. Their needs of carers should be an integral part of the CPA process. As our inquiry proceeded it became evident to us that Mrs X had many concerns and anxieties regarding her husband's illness and periods of hospitalisation. Although these were recognised by certain staff and appropriate support offered, it is probable that these concerns were never allayed. The use of written information can be helpful to clients and carers in such situations. Service User leaflets describing the CPA process can be given to clients and family members soon after admission. The Royal College of Psychiatrists has published a checklist – 'Questions to ask your psychiatrist' – which is designed to help clients and their families obtain information concerning their illness and treatment.

The previous Inquiries held to examine the care and treatment of two other patient also highlighted deficiencies in the way CPA was managed in the Trust. *The Report of the Independent Inquiries into the Care and Treatment of S and H* (Weereratne et al September 2003) made the following recommendations about the Care Programme Approach in that Inquiry;

"The Trust (CPT) should within six months

a. review the drafting and implementation of its CPA policy and

b. ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of <u>all</u> patients under the care of the CMHT."

In addition to this it is our recommendation that the Trust implements a multi-disciplinary training programme all staff who are involved in the CPA process and ensures that CPA is included in the induction programmes for newly appointed clinical staff.

Carers play an important role in helping to look after patients, particularly those with severe mental illness. Their contribution has been recognised nationally (*Caring about Carers a National Strategy for Carers,* 1999), and in the National Service Framework (NSF) for mental health one of the standards is specifically about carers and their needs.

It is our recommendation that

The Trust should ensure that

- **All carers are positively involved in the CPA process, and should discuss their needs and how they relate to the task of caring for the patient.**
- **A care worker is appointed who can assess the carer's needs for ongoing support and respite care, if and when necessary, and to enable carers to become positively engaged in the CPA process**
- **In line with the NSF for mental health, standard 6, carers should have their own Care Plan, which includes names of key professionals and how to contact them.**

Furthermore, to facilitate good communications, we recommend that a handbook describing the CPA process and all available services should be written and distributed to all new clients families/carers of people in touch with mental health services.

CHAPTER 11

KEY INQUIRY FINDINGS AND SUMMARY OF RECOMMENDATIONS

The Inquiry Team was asked to examine all the circumstances surrounding the care and treatment received by Mr X whilst he was a patient of the west Cornwall mental health services. We have concluded that Mrs X's death was not as consequence of any deficit in the care received by her husband. From all the evidence we have heard and received, we feel that it is not appropriate to lay blame for what occurred upon individual professionals, as we feel that most professionals who came into contact with Mr X provided him with the care that he, and perhaps more importantly what his wife would allow.

Nevertheless there were some shortcomings and we hope that we have identified areas of practice where lessons can be learnt. The earlier reports have highlighted some of the issues we now raise here, but as these areas are of such importance to the effective delivery of mental health services we see nothing amiss in reiterating them.

Key Issues

1. We have noted various shortcomings in the clinical management of Mr X.
    a) It would have been helpful had the notes of the very detailed assessment at Treliske Hospital been passed to the Trengweath Hospital.
    b) We considered that there should have been more detailed and systematic collation of symptoms of mood disturbance, psychosis, and the relevant associated features.
    c) We are of the opinion that Mr X's leave from the Trengweath Hospital was often poorly planned and inconsistently monitored.

2. We have noted shortcomings with respect to the documentation and formulation of risk assessment and management.

3. We have noted shortcomings with respect to the implementation of the Care Programme Approach.

a) We consider that further thought should have been given for a carer's assessment of Mrs X. We think that the clinical team should have been more sceptical about the information that she provided, and less reliant on her for their assessments.

b) We have noted the potential value of contact being made with the couple's daughters to gain further information about Mr X's mental state, and his relationship with his wife. We accept that restricting Mrs X's visits to visiting times might have upset her, but such an action might have facilitated the assessment and treatment of Mr X.

c) Finally, we think that consideration should have been given to more extensive use of written material for Mrs X. This could have included leaflets about Mr X's condition, the documentation of information previously given to her, and copies of Care Plans.

4. We have discussed at length the difficulties in communication between the clinical team on the one hand and Mr and Mrs X and their family on the other hand. We recognise that there are no easy solutions to such difficulties. Clinical staff will be aware of the views that some members of society have with respect to mental illness, its nature, and its treatment. Such views have to be managed as best as one can.

5. We heard that the inpatient unit at Trengweath Hospital was busy, noisy and not always suitable for patients like Mr X. The new build at Longreach has only been open a few months but some of the same problems were already emerging, such as a lack of space for patients to spend their time when in activities. In the Summer months the garden provided a welcome refuge from the busy ward but it was not clear how this vital resource could be utilised in the winter. There is much more space, with the different wings and separate lounges, but still patients congregated around the central area causing congestion, and staff will need to learn new ways of working with patients away from the nurses' station.

6. An event of this nature does not happen often and, although there had been two previous serious incidents, support mechanisms for both staff and families were less than robust. The family were quite sure that they had received no support

from any member of staff. We were told that it was usual practice to contact the family in writing, but as no copy of such a letter was found it was assumed that nothing was sent. Staff who were involved in the incident were not interviewed in the internal review but, when this omission came to light, a series of interviews took place shortly before we commenced our work. We know that lessons have been learnt from this process and senior staff in the Trust now make contact with staff to provide such support as they may require.

7. Care co-ordination, management of CPA and involvement of carers were inadequate. CPA documentation was poor and the early part of Mr X's care was difficult to follow in the notes. Very little if any attention was paid to the possible needs of Mrs X. No effort was taken to obtain more family evidence in assimilating Mr X's Care Plan.

8. Aspects of nursing practice gave us some concerns and required review of elements of practice and care.
   a) We felt that a review of nursing practice was necessary if care was to be delivered in a more systematic way, taking account of individualised patient care and a model of primary nursing.
   b) We identified deficiencies in the continuity of care, caused by low staff numbers on each shift and sickness/absences. The consequent use of bank and agency staff lead to gaps between the same staff being on duty.
   c) Whilst it is not our responsibility to criticise shift patterns, there can be no doubt that to be on duty for 12 hours, dealing with highly charged patients and all the usual responsibilities of dealing with lack of beds, ward rounds and delivering care, must have an effect on staff morale.
   d) In essence the ward nurses needed more time, not just to provide care, but to receive professional refreshment. Education and training, along with clinical supervision, should help them in personal development.

Recommendations

For ease of reading we have grouped our recommendations under the following headings

1) Family support
2) Service management
3) Training and development

Family Support

1. It is our recommendation that the Trust should appoint a senior person to make and maintain contact with the family until the independent inquiry has been appointed. This individual should be responsible, amongst other things, to:
   a) keep the family informed and up to date in relation to all investigations and proceedings consequent upon the event, including internal investigations, court hearings, and the possibility of an external independent inquiry; and
   b) arrange access for the family to appropriate care, support and counselling services.

2. It is our recommendation that all contacts with the victim's family, including telephone contacts, are recorded in the Serious Untoward Incident report prepared for the Trust Board and the Health Authority. If no such contacts have taken place at the time of the report, then senior management will be alerted to the need to ensure that appropriate offers of support are then made. Details of contacts and offers of support made subsequent to the preparation of the Serious Untoward Incident report should be forwarded to the Trust representative responsible for the preparation of the Serious Untoward Incident report.

3. It is our recommendation that the Trust identify an appropriate strategy for providing families affected such incidents with support and for putting them in touch with relevant organisations.

4. It is our recommendation that the Trust should ensure that all carers are positively involved in the CPA process, and should discuss their needs and how they relate to the task of caring for the patient.

a) A care worker should be appointed to assess the carer's needs for ongoing support and respite care, if and when necessary, and to enable carers to become positively engaged in the CPA process in line with the NSF for mental health, standard 6.
b) Carers should have their own Care Plan, including names of key professionals and how to contact them.
c) A handbook describing the CPA process and all available services should be written and distributed to all new clients' families/carers of people in touch with mental health services.

Service Management

5. It is our recommendation that Clinical Improvement groups are convened to discuss
   a) the effect on the quality of patient care of the current shift pattern, sickness and staff shortages
   b) changes in the delivery and management of acute care to ensure effective service user involvement.

6. It is our recommendation that the Director of Nursing considers the appointment of a clinical nurse specialist or nurse consultant post based at Longreach to take forward the recommendations in this report which relate to Longreach, and to provide clinical leadership.

7. It is our recommendation that Primary Nursing is fully established, and appropriate documentation used.

8. 8.It is our recommendation that the process for nursing handover be reviewed to provide a more systematic approach to individualised patient care, which will ensure that the nursing staff are able to fulfil their role within the multi-disciplinary team.

9. 9.It is our recommendation that the Trust reviews nursing models, shift patterns and the skill mix within the nursing establishment on the acute admission ward at Longreach.

Training and development

10. It is our recommendation that the voluntary sector be involved in, or at least consulted in relation to, the content of the training programme being prepared, together with any associated printed material available for families/carers.

11. It is our recommendation that the '*A Supervised Led Approach to the Supervision of Clinical Practice*' policy is formally implemented with a separate training programme for supervisors and supervisees. The Trust Board should discuss the resource implications and agree a suitable budget to introduce meaningful supervision.

12. It is our recommendation that all staff have access to annual appraisal, when training plans can be discussed and individual nurse's performance measured against agreed objectives.

13. It is our recommendation that the nursing strategy should be brought up –to date in light of the particular needs of mental health nursing and their policies and procedures, and taking account of changes in Nursing Practice**.**

14. It is our recommendation that, following the external review of policies and procedures, the implementation of such recommendations that are made is accompanied with an in-service training programme, and audited within one year of the implementation.

15. It is our recommendation that the Trust implements a multi-disciplinary training programme for all staff who are involved in the CPA process and ensures that CPA is included in the induction programmes for newly appointed clinical staff.

As we have said before, our Inquiry followed very soon after two previous homicide inquiries and so there has been little time for the Trust to implement those inquiry recommendations. Therefore our final recommendation is that:

16. This Inquiry team is invited back

a) to review the implementation of the recommendations of this inquiry and those of the two previous inquiries which relate to the Trust

b) to assess the progress made through the Trust's ongoing action plan.

APPENDIX 1

TERMS OF REFERENCE

The remit of the Inquiry is as follows, having been discussed and agreed with the Chief Executive of the South West Peninsula Strategic Health Authority.

1. With reference to the homicide that occurred on 17th February 2002, to examine the circumstances of the treatment and care of X by the mental health services, in particular:
   a) the quality and scope of health care, social care and risk assessment
   b) the appropriateness of his treatment, care and supervision in respect of any of the following that are relevant:
      i. his assessed health care and social care needs;
      ii. his assessed risk of potential harm to himself or others;
      iii. any previous psychiatric history, including drug and alcohol abuse;
      iv. number and nature of any previous court convictions.

   c) statutory obligations; national guidance (including the Care Programme Approach, SG(90)23/LASSL(90)11); Discharge Guidance HSG (94)27; Mental Health Act 1983 and code of practice as well as any local operational policies for the provision and support of mental health services.

   d) the extent to which X's prescribed treatment and Care Plans were
      i. Documented;
      ii. Agreed with him;
      iii. Communicated with and between relevant agencies and his family;
      iv. Delivered;
      v. Complied with by X and assisted by his carer

2. To examine the appropriateness of the training and development of those involved in the care of X.
3. To examine the adequacy of the collaboration and communication between Health, Social Services and any other agencies which were, or might appropriately have been, involved in the care of X
4. To review the structure of the internal inquiries into the care of X.
5. To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require.
6. To prepare a report and make recommendations as appropriate to the South West Peninsula Health Authority

APPENDIX 2

PROCEDURE ADOPTED BY THE INQUIRY

A) Witnesses received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement as the basis of their evidence to the Inquiry, and informed them of the terms of reference and the procedure adopted by the Inquiry. It also covered the areas and matters that were to be discussed with them, and they were assured that they could raise any matter which they felt might be relevant to the Inquiry.

B) Witnesses were invited to bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation, or anyone else they wished to accompany them, with the exception of another Inquiry witness. It was explained to the witnesses that although there was an expectation that the questioning would be directed towards themselves, there might be occasions when the person accompanying him/her could be asked to clarify a particular point.

C) Witnesses were not asked to affirm their evidence, but the seriousness of the proceedings was pointed out to them, and we were assured that all the witnesses we saw would answer our questions in their own truthful manner.

D) Evidence was recorded and a written transcription sent to witnesses afterwards for them to sign.

E) Any points of potential criticism were put to witnesses of fact, either verbally when they first give evidence, or in writing at a later time, and they were given a full opportunity to respond.

F) All sittings of the Inquiry were held in private. The draft report was made available to the Strategic Health Authority and the Trust, for any comments as to points of fact.

G) The findings of the Inquiry and any recommendations are usually made public.

H) The evidence which was submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the Inquiry's report.

I) Findings of fact were made on the basis of the evidence received by the Inquiry.

J) Comments which appear within the narrative of the report, and any recommendations, were based on those findings of fact.

APPENDIX 3

WITNESSES

Ms C E Bailey, Staff Nurse, Cornwall Partnership Trust

Ms S Benjamin, Policy Manager, Mental Health, South West Peninsula Strategic Health Authority

Dr A Birch, Senior House Officer, Cornwall Partnership Trust

Mr V Bridges, Community Mental Health Team Leader, Cornwall Partnership Trust

Mr X subject of the inquiry

Mr X's eldest daughter

Mr X's middle daughter

Mr X's youngest daughter and her husband

Mr X's sister

Mr X's sister in law and her husband

Mr X's brother in law

Ms E Collins, Healthcare Assistant, Cornwall Partnership Trust

Dr Dorrell, General Practitioner

Dr Drummond, General Practitioner

Mr T Gardner, Chief Executive, Cornwall Partnership Trust

Mrs A Hancock, Clinical Manager, Cornwall Partnership Trust

Ms H Harper, Community Psychiatric Nurse, Cornwall Partnership Trust

Ms J Hostick, Clinical Manager, Cornwall Partnership Trust

Mr B Kearney, Team Leader, Trengweath Hospital

Ms R Marsden, Staff Nurse, Trengweath Hospital

Dr Marshall, Consultant Psychiatrist, Butler Clinic

Dr S Naylor, Consultant Psychiatrist, Cornwall Partnership Trust

Mr R Potts, Staff Nurse, Trengweath Hospital

Mr C Renton, Deputy Team Leader, Trengweath Hospital

Mr M Riddell, Mental Health Implementation Manager, Cornwall Partnership Trust

Dr J P D Scott, Consultant Psychiatrist, Cornwall Partnership Trust

Mr M Steer, Director of Nursing, Cornwall Partnership Trust

Mr D M Taylor, Staff Nurse, Trengweath Hospital

Mr R Warin, Project Co-ordinator (Mental Health), Cornwall County Council

Ms L Watt, Mental Health Lead, Cornwall Primary care Trusts

Dr K Wood, Consultant Liaison Psychiatrist, Cornwall Partnership Trust

In addition the following people provided us with written statements but did not attend in person

Dr C M Asplin, Consultant Physician, Royal Cornwall Hospitals NHS Trust

Mr D Bayne, Community Psychiatric Nurse, Cornwall Partnership Trust

Dr W Donovan, Consultant Psychiatrist, Butler Clinic

Mr M Donnelly, General manager, Mental Health, Cornwall Partnership Trust

Dr N Eastwood, Consultant Psychiatrist, Cornwall Partnership Trust

Mr R Gordon, Occupational Therapist, Royal Cornwall Hospitals NHS Trust

Dr M Hand, Medical Director, Cornwall Partnership Trust

Dr A Lillywhite, Consultant Forensic Psychiatrist, The Priory Hospital

Ms R Patterson Richards, Staff Nurse, Trengweath Hospital

Mr M W Regan, Consultant Orthopaedic Surgeon, Royal Cornwall Hospitals NHS Trust

APPENDIX 4

DOCUMENTS RECEIVED AND REVIEWED

Documents relating to X

GP case notes

Inpatient records, Treliske Hospital

Inpatient case notes ,Trengweath Hospital

CMHT records, west Cornwall

HMP medical records

Department of Health

The Care Programme Approach HSG (90)23/LASSL(90)11 (1990)

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27 (1994)

Building Bridges a guide to arrangements for inter agency working for the care and protection of severely mentally ill people (1995)

A National Service Framework for Mental Health (1999)

Code of Practice Mental Health Act 1983 HMSO (1994 and 1999)

Effective Care Co-ordination in Mental Health Services A Policy Booklet (1999)

Still Building Bridges The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management (1999)

Modernising the Care Programme Approach (1999)

An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS (2000)

Building a Safer NHS for Patients – Implementing an Organisation with a Memory (2001)

Safety First Five-Year Report of the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness (2001)

The Journey to Recovery – The Government's vision for mental health care (2002)

Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision (2002)

Cornwall Partnership NHS Trust

Action Plan following X Internal Inquiry

Adult Mental Health Discharge Planning Policy (2003)

Annual Report 2003

Care Co-ordination Policy (2003)

Clinical Risk Assessment and Risk Management Policy in Mental Health (2001)

Complaints Policy an d Procedure (2001, 2003)

Cornwall Joint Agencies Training Initiative (Mental Health) (2003/2004)

Education, Training and Practice Development for the NHS Health Community in Cornwall & the Isles of Scilly September 2003 – August 2004

Guidelines for Ordering, Prescribing and Administrating Drugs (1997)

Health and Safety at Work Act Improvement Notice (2001)

Making a difference in Cornwall's Community Health Services – a strategy for nursing 2000-2005 (2000)

Management and Board Structure (2002)

Modernising Mental Health Services Developing and Improving Acute in-patient Care (2002)Serious Untoward Incident Policy (2000)

Sharing Good Practice day Programme September (2003)

Staff Sickness Returns Trengweath Hospital November 2001- February 2002

Staff Rotas Trengweath Hospital November 2001- February 2002

Staff Appraisal Pack (2003)

Strategy for Education Training and Development (1996)

A supervised Led Approach to the Supervision of Clinical Practice (2003)

Supervision Register System Policy and Procedure (2002)

Commissioning Documents

2002/03 Service Agreement

Community Mental Health Team final Draft (1995)

In patient Mental Health Services (2000)

Local Implementation Team Minutes 2001-2003

South West Peninsula Strategic Health Authority

Special Board meeting minutes September 2003

Report of the Independent Inquiry into the Care and Treatment of H (2003)

Report of the Independent Inquiry into the Care and Treatment of S (2003)

Audit Commission

Review of Adult Mental Health Services – report and recommendations (2002)

Cornwall and Devon Constabulary

Report and Summary of Evidence

Witness statements

Cornwall Social Services

Inspection of Social services June 2001

Mental Health Act Commission

Reports of visits to Trengweath Hospital May 2001, 2002 2003

Nursing and Midwifery Council

Code of Professional Conduct (2002)

Employers and PREP –information for employers on registered nurses and midwives about post-registration education and practice (2002)

Guidelines for records and record keeping (2002)

Position Statement on clinical supervision for nursing and health visiting (1996)

The PREP handbook (2001)

Supporting nurses, midwives and health visitors through lifelong learning (2001)

Standing Nursing and Midwifery Advisory Committee

Mental Health Nursing : 'Addressing Acute Concerns' (1999)

APPENDIX 5

TERMS OF REFERENCE AND RECOMMENDATIONS OF INTERNAL INQUIRY

Review of the care of Mr (name)

1. Introduction

   The regional office has published directions on how mental health incidents and near misses should be reported, and gives guidance on the action to be taken in the event of a person receiving care and treatment from the specialist mental health services being involved in manslaughter or homicide. This requires the undertaking of an audit of events, and to propose recommendations for immediate actions to be taken, prior to any formal external review that may be commissioned.

2. Terms of Reference

   a) To produce a chronological sequence of events leading up to an incident.

   b) To produce a narrative, using the written records and interviews with staff, to support the chronology of events.

   c) To make recommendations on immediate actions to be taken and learning to be disseminated

   It is not the role of the review team to seek to establish blame, apportion responsibility or to consider disciplinary matters. Should the review team identify matters that would lead in such direction, they should report their concerns directly to the Chief Executive, who will ensure that these matters are addressed separately from the review process.

3. Review Team

   The review team will be made up of a Consultant Psychiatrist, a senior nurse, a senior manager and a representative from the Health Authority. The team to report directly to the Chief Executive. It is proposed that the review panel will be;

Dr Peter Urwin	Consultant Psychiatrist
Clive Denny	Senior Nurse
Anthea Hancock	Senior Manager

Sandra Miles Health Authority

4. Timescale

Draft report to be produced within four weeks, with the final report for consideration by the Trust Board within six weeks

Recommendations

i) Past relevant history should be investigated, formally and comprehensively summarized by medical staff to form an active part of the clinical record.

ii) All immediate family members should be actively involved in information gathering and their contributions recorded and identified for appropriate use in risk assessment and Care Planning.

iii) Factual details of significant current life events should be recorded on file and reflected as potential triggers for reviews of care need, ie completion of patient protection plans.

iv) Agreement to give leave from hospital should make clear statements concerning expectations or factors which might lead to the ending of leave or its refusal, which are specific to the individual, eg medication compliance.

v) All inpatients should be discharged on enhanced tier Care Plan and remain on it for a period of three months following suicide attempt. The implementation of care co-ordination in terms of this should be the subject of review to ensure compliance with good practice standards.

vi) Greater emphasis on the risk of homicide should be included in risk assessment training.

vii) Staff should be supported in managing prolonged visiting and greater training in what Mental health Act Code of practice 1983 recommends in respect of this.

viii) The care co-ordination and care pathway document is cumbersome, impracticable and requires review.

ix) Efforts should be made to obtain relevant history/impressions from primary care when this is not made available at the time of admission.

x) Where warning signs/risk factors are identified it is essential that a risk management plan is established with the involvement of the client, carer and all relevant inpatient and community staff. The plan should reflect the factors highlighted and concerns raised and should detail clearly on the action plan what may be applicable/translated for both inpatient and community settings. Risk assessments must be reviewed regularly, especially at transition times prior to leave/discharge.

xi) Carer's Needs assessment should be completed.

xii) Therapeutic activities, including anxiety management and psychological therapies, eg CBT, should be intrinsic to treatment regimes in disorders such as C.O.s

APPENDIX 6

RECOMMENDATIONS FROM INDEPENDENT INQUIRIES INTO THE CARE AND TREATMENT OF H AND S

H inquiry

1. The Trust (CPT) should within six months:
    a) review the drafting and implementation of its CPA policy and
    b) ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator, and the regular, comprehensive and systematic review of all patients under the care of the CMHT.

    Additionally all policies must be dated and the date of implementation be clear.

2. The Trust (CPT) should ensure that all clinical and operational policies are consistent with National Guidance and are implemented promptly. All policies should be introduced with a detailed implementation plan that identifies resource implications, training requirements and changes from previous practice.

3. The Trust (CPT) must audit the quality of clinical record keeping within six months. This must include the relevance of clinical entries to the patient's care and the comprehensiveness of that record, and compliance with Trust policy and procedures.

4. The Trust (CPT) should commission an independent review of the changes to clinical policies and practice described by senior managers to the panel in the course of this inquiry. In particular the review should measure the effectiveness of these changes at the patient interface.

5. The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.

6. The clinical supervision arrangements described above must include checks on the degree of autonomy being exercised by individual practitioners, and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

7. The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that practitioner's skills levels are appropriate to their caseload.

8. All agencies must ensure that all documentation likely to be of relevance to an internal or external inquiry is secured as a matter of priority following a serious adverse event.

9. The Trust (CPT) and Social Services must act to resolve the co-location difficulties in the West Cornwall CMHT. Appropriate professional/clinical supervision, that is acceptable to the body of practitioners, must be provided for all staff. We recommend that external expert advice be sought on this issue and that the recommendations of the Social Services Inspectorate be taken into account.

10. The Trust (CPT) and Social Services must, as a matter of urgency, review the effectiveness of their joint working at all levels of both agencies.

11. The Trust (CPT) policy on Investigating Serious Untoward Incidents should be reviewed to ensure its consistency with the guidance issued by the National Patient Safety Agency. Particular attention should be paid to
    a) root cause analysis,
    b) in all cases terms of reference should be followed and
    c) any change to these terms should be formally recorded.

12. The Trust (CPT) should review the way in which discharge summaries are written, to ensure compliance with the findings of this inquiry as set out above and mental health policy and best practice. In particular, discharge summaries should record the detailed decision as to why discharge is considered appropriate at the time, and the specific arrangements for follow up of the patient, including the names, designations and contact details of those responsible for ensuring follow up plans are maintained.

13. The Devon and Cornwall Constabulary review the guidance and training for custody sergeants on methods of obtaining mental health assessments for persons already in custody.

14. The Strategic Health Authority, Cornwall Social Services and the Devon and Cornwall Constabulary should jointly agree and provide section 12 MHA training for police surgeons and general practitioners, with a view to increasing the availability of section 12 MHA approved doctors in the locality. In the interim, there should be clear joint agency guidelines on the requirements for gathering available and relevant information about an individual prior to mental health assessments, consistent with the MHA Code of Practice.

15. Cornwall Social Services must reinforce to all Approved Social Workers that, in accordance with paragraph 2.11 of the MHA Code of Practice, the overall responsibility for co-ordinating the process of a mental health assessment for a potential admission to hospital under the MHA rests with them.

16. The Trust (CPT), Cornwall Social Services, Devon and Cornwall Constabulary must provide multi-agency, cross-discipline training and guidance on the processes involved in conducting a mental health assessment, to include general practitioners and police surgeons.

17. The Trust (CPT), Cornwall Social Services, Devon and Cornwall Constabulary must ensure that a joint agreed S136 assessment is recorded in writing, and that it includes brief details of information available and unavailable, and details of arrangements made for the person. A copy of the assessment should be provided for the records of a person where they are known to mental health services, or otherwise be available to those making subsequent assessments of the person.

18. The Trust (CPT) and Cornwall Social Services to ensure, through suitable training, audit, monitoring and management, that practitioners are consistently making accurate and relevant records designed to demonstrate good practice.

S inquiry

1. The Trust (CPT) and general practices in Cornwall should review the effectiveness of communications between GPs and CMHTs.

2. The Trust (CPT) should within six months:
    a) review the drafting and implementation of its CPA policy and
    b) ensure regular and effective audit of its use, to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of all patients under the care of the CMHT.

3. The clinical supervision arrangements must include checks on the degree of autonomy being exercised by individual practitioners, and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

4. The Trust (CPT) should within six months put in place new arrangements to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that practitioner's skills levels are appropriate to their caseload.