HASCAS

Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment of Mr Y

by the

Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

Commissioned by
NHS East of England
Strategic Health Authority

JULY 2012

Report prepared by Ian Allured

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1. Investigation Panel Preface

The Independent Investigation into the care and treatment of Mr Y was commissioned by The East of England Strategic Health Authority pursuant to HSG(94)27[1].

This Investigation was asked to examine a set of circumstances associated with the death of a young man in Bedford on 15 November 2008.

Mr Y received care and treatment for his mental health issues from the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. It is the care and treatment that Mr Y received from this organisation that is the subject of this Investigation.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trust Senior Management Team which has granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in a professional and open manner during the course of this Investigation and has engaged fully with the root cause analysis ethos.

This has allowed the Independent Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations. These have been discussed with the South Essex Partnership NHS Trust, which took over the management of the mental health services in Bedfordshire and Luton in 2010, to ensure that the recommendations are relevant to the current situation in the Trust and will help to improve service provision.

1 DoH Guidance HSG(94)27 and Local Authority SSL(94)4

2. Condolences to the Family and Friends of Mr R

The Independent Investigation Panel would like to extend its sincere condolences to the family and friends of Mr R. It is hoped that this Report will not re-awake unhappy memories but will help the family understand the circumstances surrounding the untimely death of their loved family member.

3. Background and Context to the Independent Investigation

The HASCAS Health and Social Care Advisory Service was commissioned by NHS East of England (The Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL(94)27, LASSL(94)4, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced Care Programme Approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the Strategic Health Authority determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to review thoroughly the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Panel is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Independent Investigation Panel to form a view of what should have happened based on hindsight, and the Independent Investigation Panel has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and in the interest of the wider public. This case has been fully investigated by an impartial and Independent Investigation Panel.

3.1 Incident Description and Consequences

Mr Y had a deprived and emotionally barren upbringing in Jamaica until he was nine years old. His father left the family when Mr Y was still a baby and he was largely brought up by his grandmother. When he was nine his grandmother sent him to England to live with his father and his wife and her daughter, aged 14 from another marriage, in Bedford where he has spent the main part of his life. Mr Y found it difficult to settle in England and was frequently ill with physical health problems.

The first mention of Mr Y having mental health problems was in 1980 when he was diagnosed as having schizophrenia. The next mention of him being admitted to hospital was in May 1987. Between then and October 2008 Mr Y had 18 admissions to acute psychiatric admission wards and several stays in psychiatric respite care beds. When in the community he was treated by community mental health teams with outpatient appointments to monitor his mental ill health. All his periods of poor mental health followed the same pattern in that he relapsed quickly, and then once in the ward recovered quickly. It was clear that Mr Y did not comply with his care plans as he frequently did not attend outpatient appointments and often did not take medication and did not go for his depot injections.

In 2001 Mr Y was transferred from the Community Mental Health Team to the Assertive Outreach Team which was established to meet the needs of service users like Mr Y who found it hard to engage with services. Mr Y had a long criminal record with violent offences, drug offences and criminal activities. The full extent of his record was not known to mental health services until his trial for the homicide of Mr R in November 2008. The Assertive Outreach Team did manage to engage Mr Y better than the community health team but he still missed appointments, but they generally had a good idea of where he was and were therefore able to ensure that he usually received his depot injections.

Mr Y had accommodation difficulties and was always on the fringe of criminal activity, which started when he moved to live with his father who was reputed to have dealt in drugs and prostitution, so this life was natural to him. Due to his drug misuse Mr Y was frequently in financial difficulties and he was constantly trying to avoid drug dealers and money-lenders.

The incident happened three days after Mr Y had been discharged from Oakley Court, a psychiatric ward in Luton, on 12 November. Mr Y had been discharged because he had been taking medication, and presented as being very much better. He was an informal patient and there were no grounds upon which to detain him under the Mental Health Act. The following day on 13 November Mr Y was seen as being well at a drop-in centre. He was provided with medication and was due to have another depot injection on 21 November. On the day of the homicide, 15 November, Mr Y went to a bar and had some strong lager, earlier that morning he had bought a knife, as he had been attacked in the street the day before, although this has not been confirmed.

As Mr Y was making his way home he bumped into a young man, Mr R, who was drunk and reacted immediately with violence and stabbed him with the knife. Mr R sustained injuries from which he quickly died as the knife had punctured his heart.

The consequence of this homicide was that a family lost a loved son and Mr R's girlfriend, who was pregnant, has lost her partner and her child has lost its father.

4. Terms of Reference

Aim of the Investigation

To provide an independent report into the care and treatment provided to Mr Y from his first contact with Mental Health Services up to the time of the offence.

This investigation is commissioned in accordance with the Department of Health Guidance and follows the National Patient Safety Agency Good Practice Guidance for Independent Investigations.

Stage 1

Following the review of clinical notes and other documentary evidence:

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

Stage 2

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence;
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself;
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs;
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others;
- Examine the effectiveness of the service user's care plan including the involvement of the service user and any family;

- Review and assess compliance with local policies, national guidance and relevant statutory obligations;

- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence;

- Provide a written report to the Strategic Health Authority that includes measurable and sustainable recommendations.

Method of working

- The Panel will examine all appropriate documentation pertaining to the care of Mr Y and seek evidence from those involved in his care, in order to properly carry out its Investigation;

- The Panel will agree appropriate communication arrangements with family members and give an opportunity to the families to contribute to the Investigation, as the Panel and Strategic Health Authority feels necessary;

- The Panel will consider, at the Investigation Chairman/Panel's discretion, recommendations from similar independent mental health investigation reports so that any significant common factors can be identified;

- The Panel will conduct its work in private.

Output and reporting arrangements

- The Panel will provide a written report including recommendations specific to the care and treatment of Mr Y to NHS East of England, the Trust and the commissioning Primary Care Trust;

- The SHA will make the findings and the recommendations of the Investigation public.

5. The Independent Investigation Panel

Investigation Panel Leader and Chair

Mr Ian Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service

Investigation Panel Members

Dr Androulla Johnstone	Chief Executive Officer HASCAS Health and Social Care Advisory Service, Nurse Panel Member
Dr Simon Britton	Consultant Psychiatrist Panel Member (Retired)

Support to the Panel

Mrs Fiona Shipley	Fiona Shipley Transcription Ltd.

Independent Advice to Panel

Mr Ashley Irons	Solicitor, Capsticks Solicitors

6. Investigation Methodology

Consent

Mr Y refused to give consent to the release of his health and social care records. NHS East of England worked with the Caldicott Guardian to have the records released on the grounds of the Investigation being held in the public interest as the lessons from the homicide needed to be identified and used to improve services. This was granted in January 2011.

Communication with the Family of Mr Y

The NHS East of England and the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (now the South Essex Partnership NHS Trust [SEPT]) were aware that the family did not wish to have contact with the Independent Investigation Team at the inception of the investigation.

Communication with Mr. Y

The Chair of the Independent Investigation Panel wrote to Mr Y via his consultant at the medium secure unit where he is currently detained. He agreed to meet the Chair and the Consultant Psychiatrist from the Panel and this visit was made on 19 July 2011.

Initial Communication with the South Essex Partnership NHS Trust.

The Chief Executive of the South Essex Partnership NHS Trust was informed of the Independent Investigation. It must be noted that the homicide took place when the relevant services were managed by the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. It was only in 2010 that the South Essex Partnership Trust took over the running of that Trust. The SEPT Head of Serious Incidents and Quality was appointed as the liaison person for the Independent Investigation and the clinical records and policies were requested on 17 January 2011. The clinical records were received from the Trust on 17 February 2011.

Interviews were arranged for 23 March and the morning of 24 March, but of the seven staff scheduled to attend only three were available for interview. The other four comprised one member of staff from Oakley Court who had cancelled due to illness, and the three non-medical members of the Assertive Outreach Team who were all on leave. There had been

problems with the post both to and from the Assertive Outreach Team. Similarly, due to postal delivery problems, a letter from Team Manager 1 reached the Independent Investigation Panel Chair several days after the 23 March interviews. The abortive interviews and some additional ones were held on 16 May 2011 with two telephone interviews with two nursing staff from Luton on 18 July 2011 and with Dr 10 from SEPT on 19 December 2011. The staff interviewed are shown in Table 1 below:

Table 1: List of Interviews

Date	**Witness**	**Interviewers**
23/03/2011	Dr 4, Consultant Psychiatrist Dr 8, Associate Medical Specialist Dr 7, Consultant Psychiatrist	Ian Allured Dr Androulla Johnstone Dr Simon Britton
16/05/2011	Social Worker 1 Team Manager 1 Support Worker Dr 9, Consultant Psychiatrist Manager 1 Manager 2	Ian Allured Dr Simon Britton
18/07/2011	Nurses 1 and 2 from Luton*****	Ian Allured Dr Androulla Johnstone
19/07/2011	Mr Y	Ian Allured Dr Simon Britton
19/12/2011	Dr 10, SEPT Management*	Ian Allured Dr Simon Britton
17/02/2012	Manager 3, Performance Manager, East of England SHA *	Ian Allured

*Telephone interviews.

Independent Investigation Panel Meetings:

The Independent Investigation Panel met on 16 March 2011, 23 March 2011, 19 July 2011. In addition a telephone conference was held on the 15 March 2012.

Root Cause Analysis (RCA)

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.**

   This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.

2. **Causal Factor Charting.**

   This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established from which causal factors or critical issues can be identified.

3. **Root Cause Identification.**

   The National Patient Safety Agency (NPSA) advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Fish Bone.

4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Independent Investigation Panel avoids generalisations and seeks to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

7. Salmon Compliant Procedures

The Investigation Panel adopted Salmon compliant procedures during the course of their work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

   (a) of the terms of reference and the procedure adopted by the Investigation; and

   (b) of the areas and matters to be covered with them; and

   (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

   (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

   (e) that they may bring with them a colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

   (f) that it is the witness who will be asked questions and who will be expected to answer; and

   (g) that their evidence will be recorded and a copy sent to them afterwards to sign

   (h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

8. Anonymity

The identities of all clinical witnesses have been made anonymous. All have been identified by their designation and an identifying number as appropriate. Consultant Psychiatrists are referred to as: Consultant 1, Consultant 2, Consultant 3 and so forth and the same for Community Psychiatric Nurses, Community Psychiatric Nurse 1, 2 etc. The patient is referred to as Mr Y and the victim as Mr R.

9. Information and Evidence Gathering

The Independent Investigation Panel was hindered in its work by the lack of an organisational history. SEPT took over the running of the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust in April 2010 and by this time many of the senior managers, including executive directors, who had been in post at the time of the incident in 2008 had left the organisation. This resulted in the loss of an "organisational memory" which made it difficult to understand the early history of the Trust and difficult to find the relevant policies and procedures prior to 2008.

The following documents and policies were examined by the Independent Investigation Panel:

Clinical Records

File 1 Part 1: Outpatient/Community File

File 1 Part 2: Outpatient/Community File

File 2 : Assertive Outreach Team Volume 1

File 3 : Assertive Outreach Team Volume 2

File 4 : Assertive Outreach Team Volume 3

File 5 : Inpatient File

File 6 : Inpatient File (Oakley Court)

General Practitioner Records

Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

Operational Policy for the use of Respite Beds at Progress House (January 2009)

Operational Policy Assertive Outreach Teams September 2001 (Revised May 2006 and December 2008)

Integrated Care Programme Approach and Care Management Policy September 2007 (Review Date September 2008)

Care Programme Approach non Care Programme Approach and Care Management Policy (October 2008)

Policy and Procedure for Reporting Adverse Incidents March 2005 (Review March 2008)

Risk Management Strategy March 2005 (Review Date March 2008)

Policy and Guidance on the Recognition, Prevention and Risk Assessment of Occupational Stress May 2006 (Review Date 2009)

Board Site Visits 2007

The Serious Untoward Incident Report following the Arrest of Mr Y

Specialist Substance Misuse Service for Bedfordshire (excluding Luton) January 2008

10. Profile of the Bedford and Luton Mental Health and Social Care Partnership NHS Trust: Past and Present

The Service in the Bedford and Luton Mental Health and Social Care Partnership NHS Trust

The Independent Investigation Panel found it difficult to obtain information about the services in the Bedford and Luton Mental Health and Social Care Partnership NHS Trust as since 2008 when the incident occurred the running of the mental health services was transferred to the South Essex Partnership NHS Trust in 2010. There was a description of the services provided in the Operational Policy for the Acute Mental Health Service for those of working age which was dated October 2007. These were the services which Mr Y used.

The service comprised:

"Acute in-patient care is provided within three acute mental health units / wards:

- ***Oakley Court, Angel Close, Luton:***
    - 27 admission beds;
    - 2 flexi-beds;
    - 6 intermediate care beds (two of the beds are provided for South Bedfordshire);
    - Section 136 facility.

- ***Townsend Court, Mayer Way, Houghton Regis***
    - 22 admission beds;
    - 3 beds for drug/alcohol detoxification.

- ***Keats Ward, First Floor, Weller Wing, Ampthill Road, Bedford***
    - 18 admission beds
    - 4 Assertive Outreach beds
    - 2 beds for drug / alcohol detoxification
    - 6 intermediate care beds (2nd Floor, Weller Wing)"[2]

In addition there were community based services as described below:

[2] Working Age Mental Health Service: Operational Policy for Acute Mental Health Services (October 2007)

“Each acute care team operates a sectorised service, admitting individuals from distinct geographical locations and managing care through close liaison with specific community mental health teams:

- ***Oakley Court, Angel Close, Luton:***
    - Four Community Mental Health Teams in Luton North East, Luton North West, Luton South East and Luton South West.

- ***Townsend Court, Mayer Way, Houghton Regis:***
    - Four Community Mental Health Teams in Dunstable & Houghton Regis, Leighton Buzzard, Caddington and the surrounding Bedfordshire villages, Ampthill and District and South of County Detoxification Service.

- ***Keats Ward, Weller Wing, Ampthill Road, Bedford:***
    - Five Community Mental Health Teams in Bedford East, Bedford West, Kempston, Biggleswade and District and the North of County Detoxification Service.

The Current Mental Health Services in the South Essex Partnership University NHS Trust (SEPT)

The Mental Health, Learning Disability and Community Health Services are provided mainly in community settings with defined geographical localities. As a result the Trust operates from over 200 locations across Bedfordshire, Essex and Luton. SEPT provides a comprehensive range of services including:

• mental health services for adults and older people;
• Essex wide forensic services;
• low and medium secure services;
• specialist children’s services;
• inpatient adolescent mental health services;
• learning disability services;
• drug and alcohol services;
• other specialist services.

SEPT also provides community health services for those with physical health care needs including

• urgent care;
• long term conditions;
• rehabilitation;
• health improvement;
• quality of life care;
• services for children, young people and families.

The alignment and integration of community health services forms an important part of the Government's plans to deliver 'world class' services for patients, carers and the community. It is an exciting opportunity for SEPT to become more effective in the services it provides and more efficient in the way they are delivered and become a stronger more innovative organisation in the newly competitive NHS market.

SEPT has an annual turnover of approximately £300 million and employs approximately 6,100 people and serves a population of 1.8 million. It works with a wide range of partner organisations to deliver care and support to people in their own homes and from a number of hospital and community based premises. The Trust provides modern community based resource centres and community facilities to provide local services to local people where possible.

In 2009 SEPT was awarded the top score of 'excellent' in both the categories: 'quality of services' & 'use of resources' by the Care Quality Commission (CQC) - the only mental health trust in the country to achieve this high level of quality for three years in a row. In 2010 another landmark was reached by bringing together under a single Board of Directors and Board of Governors the Mental Health and Learning Disability services for the people of Bedfordshire, Essex and Luton. This meant that the service users and carers continued to receive local services but with a reduction in management costs. SEPT was successful in its bid to acquire the Community Health Services in Bedfordshire, South East Essex and West Essex.

11. Chronology

Mr Y was born in Jamaica on 27 March 1957. His parents were not married and separated early in the pregnancy so Mr Y had no contact with his father until he was sent to England in November 1966. He remembered much hardship as a child in Jamaica but was happy and well cared for by his mother and her family. The family all worked on their small plot of land.

In the meantime his father had married an Englishwoman who had a 14 year old daughter. Mr Y was sent to England as life was too hard for his mother in Jamaica. Mr Y thought it would have been better if he had stayed in Jamaica where he was cared for, as in Bedford his step-sister was favoured by her mother and he was largely neglected. He was frightened by his stepmother's drinking habits and felt like a stranger in the house.

Family life was not happy and Mr Y's introduction to school was a painful experience. He arrived in Bedford unprepared for the cold climate, different food and being racially taunted at school. Mr Y also suffered from physical ill health during his first few years in England. He had a succession of illnesses and was treated at Bedford General Hospital for a number of physical conditions.

Whilst a patient at Bedford General Hospital Mr Y was recorded as making the following comments about his life: *'does not want to go home, does not want to go to school, does not like home'* [3]

The Psychiatric Court Report for the North Bedfordshire Magistrates Court written in October 1987 from which the comments above were taken described Mr Y's initial years after leaving school. Mr Y left school aged 16 and had made some academic progress but was still halting with his reading and writing although he appeared to be quite good with figures. He was assessed as being of average intelligence and to be articulate with a fairly good vocabulary. Mr Y spent some periods in Borstal and Hostels whilst 'in care' but no exact dates were available in the records.

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His first job was at a Fortes Service Station in Newport Pagnell where he stayed for a year. He then worked for another year at Texas Instruments followed by another year at the Charles Wells Brewery. This third job had been in 1979/1980 since when he had had no employment.

It was reported in a Summary Report within the clinical records that between **1976 to 1981** Mr Y was involved with the Rastafarians and grew dreadlocks and smoked cannabis freely. He left the religion as he became disillusioned and thought the movement was a fraud and just an excuse for free sex. He then had a period of heavy drinking.

In **1985** Mr Y converted to Islam and was a follower of the Prophet Elijah. He went to the Luton Mosque, had a copy of the Koran and a shaven head but wore a woollen cap to hide it.

Mr Y had a number of girlfriends. He lived with a girl for two years and she was the mother of his first child. Their relationship was stormy and there was an injunction against him visiting her.

At some meetings with Dr 1, the author of the October 1987 Court Report mentioned above, Mr Y had expressed the belief that he was descended from Indians and was related to the Royal Family, Mandarins and Muslims. He described bizarre physical symptoms resulting from an alleged blow to his neck by a policeman in 1980.[4]

The Period from August 1987 to June 1999: Outpatient Appointments and contact with the Community Mental Health Team

Mr Y's first admission to hospital was on 17 May 1987 when he was admitted to the Weller Wing of Bedford General Hospital as a voluntary in-patient following police intervention after him being arrested for bizarre behaviour in the streets. He had been dancing in front of females with an open penknife in his hand. The Police Surgeon who assessed him indicated to Dr 1 in his referral letter that Mr Y was "*rambling on about religious matters and*

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complained that he was persecuted by black police officers. He also claimed to be descended from Mary Queen of Scots"[5].

On admission Mr Y was noticed to be polite but very talkative. A provisional diagnosis of schizophrenia was made and he accepted oral anti-schizophrenia medication. Within a week he had settled and at a ward round on 19 May 1987 he had discussed most perceptively and sensibly the issues of black culture, Rastafarianism, the Moslem faith and discrimination. He had asked if he could be discharged and this was agreed as there were no grounds to detain him under the Mental Health Act (1983).

Dr 1 concluded his Court Report by commenting that Mr Y denied any mental illness and Dr 1 said he was 'a diagnostic dilemma' although he made a provisional diagnosis of schizophrenia whilst admitting it would not stand up to clinical scrutiny. Depot injections every three weeks was the agreed form of treatment which Mr Y reluctantly accepted. He was given 12.5 mg of Modecate. Dr 1 planned to see him in outpatients and hoped he would retain contact for at least six months.[6]

Mr Y said that several people he knew thought he was mad. Dr 1 thought he might have schizophrenia. Dr 2, in 1980, had reached the same conclusion. Mr Y had reported that his paternal uncle in the West Indies had suffered from a severe mental illness. He was discharged on 26 May 1987 with follow-up from the Community Mental Health Team and with outpatient appointments but he did not keep appointments.

On **08 June 1988** Community Psychiatric Nurse (CPN) 2 contacted Consultant 1 to report that that Mr Y had become rather erratic in his attendance for his 3-weekly Modecate 12.5 mg at the Depot Clinic. He refused to have any more medication when CPN 2 visited him, and said that he wanted to be out of the mental health system. He appeared well with normal conversation and mood. Mr Y had agreed to attend an outpatient appointment with Consultant 1 on **22 June 1988**.[7]

Three months later on **12 September 1988** CPN 2 again contacted Consultant 1 to report that following his referral to the Depot Clinic for Modecate 12.5mg injections every 3 weeks Mr

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7 File 2 AOT Vol 1 Pages 254

Y had required constant reminders to attend. At his last visit for the depot injection Mr Y told CPN 2 that he did not want any more injections and refused to attend an outpatient appointment. CPN 2 stated that she would discharge Mr Y from her caseload but would be happy for him to be re-referred if needed.[8]

On **22 September 1988** Mr Y was back with CPN 1 because he had been arrested for assault. He was ordered by the police to go to the Weller Wing for further depot injections and review. Dr 1 wrote to the Depot Clinic explaining that Mr Y had been in contact with him again after having refused his injections for several months. He had been arrested at Greyfriars Police Station in Bedford and was seen by the Probation Service. As he appeared to be mentally ill he did agree to resume Modecate 12.5 mg injections two weekly and this had been started.

On **14 August 1989** Probation Officer 1 wrote to Mr Y saying that he had not kept his appointment with her on 10 August and had also failed to go for his depot that day. He was reminded that it was a condition of his Probation Order that he kept appointments with her. It was also a condition that he accepted depot injections and complied with the treatment provided by the mental health service. His next appointment would be on 24 August and he should go to the Depot Clinic that day and see his Probation Officer on 07 September.[9]

There is little information about Mr Y from **August 1989 to November 1997**. He was clearly still in the Bedford area as there were six admissions to the psychiatric hospital during this period. These admissions were in January 1991, July 1993, November 1993, June 1996 and July 1997. He was again admitted to psychiatric hospital in October 1997 after he been caught brandishing a knife in Bedford Town Centre. The GP records show that Mr Y was being seen in outpatients by Consultant 1 and his Senior House Officers (SHOs), and followed up by the Community Mental Health Team and the Depot Clinic run by them.[10] His compliance was variable and his response once in hospital was rapid as most of his admissions were for periods of one to three weeks. During this period Mr Y was on all occasions admitted as an informal patient.

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9 File 2 AOT Vol 1 Page 242
10 File 2 GP Records Page 159

CPN 3 became his key worker from the Community Mental Health Team **03 November 1997**. Seven weeks later, on **26 December 1997**, Mr Y was arrested in Northampton for aggressive behaviour and criminal damage. The police had concerns about his mental state and the Bedford social worker confirmed that Mr Y had schizophrenia. He was admitted to the Farringdon Wing in Luton over the Christmas period and was discharged to the Community Mental Health Team on **06 January 1998**.[11]

On **02 July 1998** Mr Y was seen by the Community Mental Health Team. He stated that he was feeling suicidal and depressed and thought this was because he was still grieving the death of his father. He thought his mental health would deteriorate further. The SHO agreed to see Mr Y in the Accident and Emergency Department and following assessment agreed that Mr Y could be admitted to the Weller Wing. In the GP file the discharge letter from SHO 2 stated that the admission had been caused because Mr Y thought he could fly and was threatening to jump out of the window. Mr Y also mentioned that he heard his father calling to him saying *"one day you will come with me."* He added that he sometimes got very angry and smashed things up in his flat. The ongoing reaction to his father's death was noted in the Community Mental Health Team file.[12]

On **26 January 1999** Mr Y was seen by SHO 3. He appeared depressed and an addition of Prozac 20 mg once daily to his medication was made.[13] Three months later, on **12 April 1999**, Mr Y demanded an admission as he was low in mood and was unable to cope due to problems with finances. On further questioning it emerged that Mr Y had issues with a friend from whom he had borrowed money. This man was a well known loan shark. Mr Y was not admitted to hospital and there was no respite place available. Mr Y was not seen again until two months later when on **11 June 1999** he reported ongoing housing problems which forced him to walk the streets rather than staying in his flat. A respite care place was arranged for Mr Y at Progress House, but he stayed there for only a few hours.[14]

Nearly 10 months later, on **04 April 2000**, Mr Y was behaving strangely at his flat. He had been removing mats from doors and generally being a nuisance. He then threw a bicycle from a 7th floor flat window. The police were called and they requested a Mental Health Act

11 GP Records Pages 152/153
12 File 2 AOT Vol 1 Page 98 and GP Records Pages 139/140
13 File 2 AOT Vol 1 Page 97
14 File 2 AOT Vol 1 Page 86

Assessment for Mr Y. The following day, **05 April 2000**, Mr Y was taken to the Accident and Emergency Department by police as there had been a fire in his flat due to his friends smoking cannabis. Mr Y was assessed to be displaying symptoms of mental ill health, as he stated that he knew that the Holy Grail was in Bedford Prison. He was admitted to Keats Ward as an informal patient. It was noted that he had been five weeks late for his depot injection. Mr Y had also tried to set fire to his flat.[15]

A detailed risk assessment was undertaken on the ward and this stated that Mr Y had a history of in-patient admissions and the following risks history was described:

"Past Incidents

- *Theft;*
- *Threatening members of the public with bottles (1991);*
- *Flashing a knife in town (1992);*
- *Violence to police when unwell and verbally abusive and physically hostile to workers;*
- *Exposed himself in a public place.*

Mr Y has been detained under Section 3 and 37 in the past a well as making use of voluntary care.

Trigger Factors

- *Non-compliance with services;*
- *Drinking excessive alcohol;*
- *smoking excessive cannabis.*

Professional Observations

Mr Y withdraws from services which causes him to relapse. He frequently leaves Bedford to go to London to visit friends without informing any staff so contact is minimal at these times. Factor which increase risk are:

- *Mr Y believes he can fly when he is unwell;*
- *He becomes angry and destroys the possessions in his flat;*
- *Fighting and causing trouble in public;*

15 File 3 AOT Vol 2 Page 70 and File 2 AOT Vol 1 Page 114 plus GP Notes Page 119

- *Verbally and physically aggressive towards workers.*

Relapse Indicators

- *Paranoid ideas;*
- *Mood swings;*
- *Auditory hallucinations;*
- *Suicidal ideas (*The consultant and CPN put on the risk assessment form that they did not agree that Mr Y posed a suicide risk as he had not displayed this in the past*);*
- *Reduced appetite and disturbed sleep;*
- *Excessive use of alcohol and cannabis;*
- *Non-compliance with services.*

Summary of Risk Assessment

If Mr Y does not engage with services he is likely to relapse which leads him to be a danger to himself and the public".[16]

Mr Y was allowed leave but did not return to the ward and was therefore discharged in his absence on **08 May 2000** as he was reported to have gone to stay with friends in London.

A Care Plan was made on **07 June 2000** and Mr Y was on Level 2 of the Care Programme Approach.

"The plan was to:

- *monitor mental health;*
- *monitor medication;*
- *administer depot every two weeks;*
- *give ongoing support to client enabling him to live in the community".*[17]

Mr Y was seen by Dr 3 as arranged and by CPN 3 fortnightly for depot injections and the monitoring of his mental health and to look for any signs of side effects from medication and to generally support him.

16 File 2 AOT Vol 1 Pages 120/122
17 File 2 AOT Vol 1 Pages 124/126

On **22 August 2000** Mr Y visited the Accident and Emergency Department. Mr Y explained that he had been in London for two weeks and had missed his medication and was experiencing hallucinations and hearing voices telling him to jump off a bridge. When the doctor outlined the possible responses to Mr Y's situation but did not mention admission, Mr Y became angry and shouted that he could not return to his flat and he felt he needed admission to the Weller Wing. He then stormed out of the Accident and Emergency Department.

The next day he was admitted to Oakley Court as he was complaining of feeling unwell, hearing voices and he claimed to have stopped taking his medication two weeks prior to admission. (Oakley Court sometimes has to be used if the Weller Wing is full). The SHO to Dr 4 reported in his discharge to GP 1 that Mr Y had behaved well on the ward and had interacted well with the other patients. He had been cooperative with staff and compliant with his medication. He had complained that he felt sad and lonely and felt that he needed somebody to talk to.[18]

Mr Y was transferred to the Weller Wing in Bedford on **31 August 2000**. He was granted leave and when he did not return to the ward CPN 3 visited his home on **08 September 2000** but he was not there. Mr Y had been discharged whilst on leave but his depot was due. The dose was 100mg Modecate every 2 weeks. His ex-partner did not know where Mr Y was and CPN 3 registered him as missing with the police on **04 October 2000**.[19]

The next mention of Mr Y was on **25 November 2000** when he was discharged from a respite bed at his own request. He had had the locks changed on his flat the previous day. CPN 3 had supported Mr Y's application for a home exchange as he was being harassed by someone in Bedford. There was mention in the notes that this was a drug dealer who kept his paperwork at Mr Y's house and had a key. Mr Y was reluctant to report the matter to the police for fear of being beaten up. His application for an exchange of accommodation to either London or Luton failed.[20]

18 File 2 AOT Vol 1 Pages 58/60
19 GP Records Pages 106/109
20 File 2 AOT Vol 1 Page 54

On 26 January 2001 Dr 5 wrote to CPN 3 saying that Mr Y had not attended an outpatient clinic since his discharge from Keats Ward in **August 2000**.[21]

On 26 April 2001 CPN 3 referred Mr Y to the Bedfordshire Community Outreach Team stating that he was often difficult to engage and failed to have his depot regularly thereby causing his mental health to relapse. He added that he thought the contact would be long-term. The immediate problem highlighted was that *"Mr Y is currently being harassed for money although he is reluctant to report this to the police as it could lead to him being beaten up. He wants to move from Bedford and identified Luton as a place of choice to live, however it is difficult to complete exchange application forms due to his erratic lifestyle. Other areas of concern highlighted on the referral form were drug and solvent abuse, alcohol and violent behaviour".*[22]

July 2001 to 15 November 2009: Bedford Assertive Outreach Team

The Bedford Assertive Outreach Team accepted the referral from CPN 3 and on **19 July 2001** Social Worker 1 wrote to Mr Y introducing himself and asking him to visit him in the office in Barkers Lane, Bedford on **27 July 2001** when CPN 3 would also be present. Mr Y attended.[23]

On 20 August 2001 Mr Y had been attacked by a money lender to whom he owed money after he had collected his benefits from the Department of Social Security. He was forced to go back to his flat. At the flat the loan shark threatened Mr Y and his girlfriend and forced him to hand over £300 in cash.[24]

On 08 October 2001 Mr Y had split up with his girlfriend in a nearby town. He was very upset by this and had visited Social Worker 1 at his office. He mentioned that he would prefer a smaller flat and that he needed to have respite care to avoid the harassment over the money. Progress House was full and there was therefore no bed available. Two weeks later Mr Y was introduced to Support Worker 1 who was going to work with him and help with some of the practical tasks he needed to do regarding his change of accommodation. The situation with

21 File 2 AOT Vol 1 Page 52
22 File 2 AOT Vol 1 Page 45/49
23 File 2 AOT Vol 1 Page 38
24 File 2 AOT Vol 1 Page 30

the money lender was ongoing and there were times when Mr Y was fearful of sleeping in his own flat as the money lender had stored some furniture there.[25]

As Mr Y was likely to be alone over the Christmas period, because his girlfriend had friends staying with her, Social Worker 1 arranged a respite stay in Steppingstones in Dunstable. He described Mr Y to Steppingstones as *"being in low mood but not to be experiencing any psychotic symptoms and he had no concerns regarding risk to self or others. He had been compliant with his medication and had also been reasonably consistent in keeping appointments with his care team"*. Two days earlier Mr Y had phoned the Assertive Outreach Team requesting a respite place due to the money lender harassing him. He had Mr Y's Disability Living Allowance book. Mr Y was scared to sleep at his own house. **On 21 December 2001** a two week stay at Steppingstones was arranged to cover the Christmas and New Year period.[26]

While Mr Y was at Steppingstones a Care Plan was devised for him on **02 January 2002.** This stated that the role of the Assertive Outreach Team was to:

- monitor Mr Y's mental state and support him in the community;
- minimise his potential risk of self harm and self neglect;
- provide regular outpatient care;
- review his care and medication – Modecate 100mg every two weeks.

One additional ongoing concern was that Mr Y did not like living in his flat in Bedford because a money lender had been taking all his Benefits money. The police were aware of the situation and had been investigating it. Mr Y therefore had moved out of Bedford for considerable periods due to his stress. This meant he lacked regular depot injections as he moved around a great deal.

Mr Y spent much of 2002 living with his girlfriend in a nearby town. He had been charged with possession of drugs with the intention to supply. **On 07 February 2002** Mr Y was informed by his landlord, Bedfordshire Pilgrims Housing Association, that he owed £249 in rent.[27]

25 File 3 AOT Vol 2 Page 59
26 File 2 AOT Vol 1 Pages 6/12
27 File 3 AOT Vol 2 Page 49

A year later on **10 February 2003** the Assertive Outreach Team was informed by his girlfriend that Mr Y had been given a nine month custodial sentence suspended for two years, on both the drug possession offences. He had also been placed on a Supervision Order with a requirement to continue working with the Assertive Outreach Team and to undertake a drug rehabilitation programme.[28]

On **01 July 2003** Mr Y's girlfriend telephoned the Assertive Outreach Team and informed Social Worker 1 that Mr Y had stolen £1000 from her and she was certain he was again using Class A drugs.[29]

Mr Y was admitted to the Weller Unit on **11 March 2004** after complaining of suicidal thoughts and hearing voices. He settled well on the ward after taking medication (Risperidone Consta). A Brief Risk Profile identified that Mr Y was at low risk of severe neglect or accidental self harm and exploitation. At the Ward Round on Weller Wing on **16 March 2004** Mr Y told Dr 5 that he wanted to jump into the river. This appeared to be when he was using cannabis and lots of *"other stuff"* but he no longer had suicidal ideas or thoughts of killing.[30]

On 30 March 2004 Mr Y was discharged from the Weller Wing. He had complained of suicidal thoughts and hearing voices for a few days after admission, but he had responded well to Risperidone and Fluoxetine 20mg once daily. The latter was maintained after discharge together with Injection Risperidone Consta 25mg intra muscularly every two weeks. Mr Y had leave but admitted that he had abused cannabis and cocaine during this time. The dangers of these drugs to his mental health were explained to him and he agreed that he would not use drugs in the community. Mr Y was placed on the enhanced Care Programme Approach and was to be followed up by the Assertive Outreach Team.[31]

On the next day, **31 March 2004,** Mr Y was apprehended by the police for a breach of his Probation Order. He had been searched and an eight inch long kitchen knife was found in his bag. He was charged with being in possession of an offensive weapon. Mr Y had tried to get

28 File 3 AOT Vol 2 Page 30
29 File 3 AOT Vol 2 Page 24
30 GP Records Page 52
31 File 5 Inpatient Page 40/41

himself admitted to hospital or detained in the cells as he thought these were better options than being in his flat.[32]

On **06 May 2004** Mr Y had an assessment with Healthlink, the Substance Misuse Service in Bedford. He was scheduled to have weekly contact with the service, but he failed to attend most of his appointments. Mr Y changed his accommodation on **13 August 2004** when he eventually moved out of the flat in Eastville Road and took up residence in Station Road.

Consultant 6 removed Mr Y from his patient list as he had failed to attend three outpatient appointments in succession.[33] Six weeks later, on **29 October 2004,** Mr Y was referred to the Emergency Duty Team by the police who had arrested him for having a knife in a public place. He had claimed he had just returned from a prison sentence in Cuba, and the Community Psychiatric Nurse had commented that "*he had never seen [Mr Y] looking so bad*".[i] Mr Y was admitted to the Weller Wing from police custody because he was exhibiting bizarre thoughts and deluded claims. The next day, **30 October 2004**, an assessment was undertaken which stated that Mr Y had tested positive for marijuana (THC) and negative for Cocaine, Amphetamine, Methamphetamine and Opiates. A Brief Risk Profile stated that he was deemed to be a:

- *"Low risk – verbally aggressive, violence or harm to others, severe neglect or accidental self harm (does not eat properly when unwell), exploitation.*
- *Significant risk – offending especially carrying an offensive weapon"* [34]

Mr Y remained on the ward until **08 December 2004** when he was discharged. During the admission, on **10 November 2004,** Mr Y was involved in a fight with another patient on the ward as he was abusive to him. It took several staff to separate them. Mr Y was transferred to Bronte Ward where he was caught with cannabis. He was noted to have talked a lot about bizarre religious beliefs.

On **15 November 2004,** Mr Y handed in an axe and a knife to staff. He was in an elated state and was very noisy chanting what appeared to be nonsense, but he did not present as a management problem on the ward. On **01 December 2004** Mr Y was given weekend leave,

32 File 3 AOT Vol 2 Page 9
33 File 5 Inpatient File Page 33
34 GP Records Page 44 and File 5 Inpatient File Pages 26/28

but he was returned to the ward by the Police as he had displayed a knife in the community, which was the reason for his original arrest and admission to hospital.[35]

Mr Y was discharged on **08 December 2004.** He had been admitted on **29 October 2004,** making this one if his longer admissions, having being brought to hospital by police for showing a knife in public. He was severely deluded. He had a Risperidone Consta injection which stabilised his mental state but he asked to go back on Modecate which was agreed. He had a swollen right leg which was investigated. His dimer level was high but his Doppler scan of legs was normal and he was treated with antibiotics for this. Mr Y blamed the depot injections for the problem. The Ward Team considered that his relapses were due to his abuse of cannabis and he was to be followed up in the outpatient clinic.[36]

On **16 December 2004,** Dr 6, a locum consultant, prepared a psychiatric court report about Mr Y as he was due to appear before magistrates in Bedford charged with the possession of a knife in a public place. The Report stated that Mr Y had a diagnosis of paranoid schizophrenia and multiple substance misuse. It was clear that he had been suffering an acute relapse at the time of the offence and had required urgent medical treatment. This pattern of acute symptomatology had lasted for the first two weeks of his admission.

Dr 6 stated that *"it appears probable that Mr Y's mental illness is affected by his lifestyle choices; illicit drug use but what is less clear is whether the onset of schizophrenia was precipitated by, or the subsequent course worsened by, the use of psychoactive substances. There does appear to be a temporal link between the acute psychotic relapses and illicit drug use or refusal of medications*".[37]

Risk Issues

"I am told that Mr Y is a very amiable individual when he is well although he had been friendly with some very unsavoury characters in the past. The risks attendant to his condition are magnified when he becomes unwell and relate mainly to his propensity for self-neglect, offering violence to third parties and the habitual carrying of knives……The combination of a personal habit of knife carrying, a subculture of casual violence and weapon carrying, an

35 File 5 Inpatient File Page 168/171
36 File 5 Inpatient File Page 12
37 File 5 Inpatient File Page 15

underlying mental illness characterized by paranoia and impaired judgement as well as frequent intoxication with alcohol and cannabis is, in my opinion, a potent recipe for disaster[38]

Recommendations

The four recommendations made were that:

- Mr Y should be encouraged to continue to engage with mental health services for long-term treatment, with medication and environmental manipulation being crucial towards improving his mental health and wellbeing;
- Mr Y should be judicially compelled to engage in a formal drug rehabilitation programme in addition to his usual treatment;
- The habitual carrying of knives and proclivity to brandish them must not be excused as an involuntary manifestation of altered mental health state;

"The opportunity ought to be seized now to defuse this potent mix of risk factors as I feel we could be moving towards a serious untoward event." [39]

Mr Y was sentenced to two years imprisonment on **04 February 2005** but was released on **05 August 2005.** After registering for housing he went to a nearby town to stay with his girlfriend.[40]

On **13 October 2005** Mr Y stated that he was only using cannabis and alcohol. His girlfriend thought that he was using more than he had done previously as he had spent a lot of time on his own in his bedroom.[41]

A Care Programme Approach meeting was held on **25 January 2006.** A Care Plan was developed. It was recorded that Mr Y needed to complete a new housing application to the Bedfordshire Pilgrim's Housing Association (BPHA) having recently failed to get a tenancy. He had requested a reduction in his depot and it had been agreed that it be reduced from 100mg Modecate every three weeks to every four weeks.[42]

38 File 5 Inpatient File Page 16
39 File 5 Inpatient File Page 16
40 File 4 AOT Vol 3 Pages 89/90
41 File 4 AOT Vol 3 Page 88
42 File 4 AOT Vol 3 Page 152/167

Social Worker 1 was to visit Mr Y monthly to monitor his mental state and CPN 4 was to visit monthly to give him his depot medication. The risk assessment from **13 October 2005** was deemed to be still current and valid.

A list of his risk incidents was recorded:

- **30 July 1991 –** picked up by police for exposing himself in public and throwing a park bench into the river;
- **16 November 1993 -** police took Mr Y to Keats Ward as he was throwing things out of the window of his flat and making a noise at night. He threatened an estate agent with a knife and also some neighbours;
- **03 October 1997 –** admitted to Weller Wing (S136) for brandishing a knife in Bedford Town Centre;
- **26 December 1997 –** arrested by police in Northampton for a minor offence of criminal damage (charges dropped) and he was admitted to the Farringdon Wing at Luton and transferred to the Weller Wing at Bedford Hospital;
- **02 July 1998 –** admitted to Weller Wing as he thought he could fly and threatened to jump out of the window;
- **18 August 1998 –** charged with theft;
- **04 April 2000 –** Admitted under S136 for throwing a bicycle and a burning mattress from a 7th floor flat;
- **06 April 2000 –** Admitted to Keats Ward on Section 2 of the Mental Health Act – he had delusions that he was related to the Duke of Edinburgh and Nelson Mandela;
- **03 February 2003 –** convicted of possession of cannabis with intent to supply;
- **15 November 2004 –** Mr Y handed nursing staff an axe and a knife, believed to be his own possessions;
- **09 November 2004** – he was involved in a fight with another patient on the ward;
- **29 October 2004 –** arrested for possession of offensive weapon (knife);
- **30 October 2004 –** MHA assessment and Mr Y agreed to informal admission;
- **04 February 2005 –** sentenced to nine months for possession of an offensive weapon plus three months of a suspended sentence activated.

Mr Y was seen as a risk of committing an offence and a medium (significant) risk of violence or harm to others, risk of suicide and of being exploited.

The signs of relapse were listed as being:

- *"Non-compliance with care plan and medication;*
- *Being unkempt in appearance;*
- *Excessive use of alcohol and illicit substances;*
- *Stress caused by exploitation and harassment of others;*
- *Noticeable change of mood, becoming verbally aggressive and threatening to others;*
- *Expressing suicidal ideation i.e. joining his late father."*

Plan of Action if Risk present was to arrange:

- *GP or psychiatric visit;*
- *Respite care;*
- *Mental Health Act Assessment.*

It was noted that Mr Y was most responsive to Social Worker 1, his Care Coordinator and CPN 4 from the Assertive Outreach Team.[43]

Mr Y took possession of his new home in Richbell Court from BPHA on **04 January 2007.** He was concerned as his new accommodation was in a high-rise block of flats and he did not like heights.[44]

On **21 February 2007** a Detailed Historical and Continuing Risk Assessment was completed. Mr Y's girlfriend in a nearby town told the Assertive Outreach Team that Mr Y's other lady friend had been round to collect money as had some other people to whom he owed money. She said she had had enough and had decided to finish their relationship.[45]

On **26 February 2007** the caretaker at Richbell Court telephoned the Assertive Outreach Team to inform them that Mr Y had been seen taking people who were under the influence of alcohol into his flat.[46]

43 File 4 AOT Vol 3 Page 264/274
44 File 4 AOT Vol 3 Page 84
45 File 4 AOT Vol 3 Page 83
46 File 4 AOT Vol 3 Page 82

Five days later Mr Y reported at his Care Programme Approach Meeting that he loved his new flat. This was despite his comments a few weeks before on **04 January 2007.**

On 22 March 2007 Mr Y was not available at his home for the depot injection. This was given to him at his home nearly two weeks later on **05 April 2007.** The next depot injection was given to Mr Y at his girlfriend's house as he had not been at his home when it was due on **04 May 2007.** Mr Y had been staying with his girlfriend and the depot was given the following day **(05 May 2007).** It was noted that Mr Y had frequently left the room which was taken to be an indication that he did not want CPN 4 to stay long.[47]

The August depot injection was given to Mr Y at his girlfriend's flat on **01 August 2007.** Mr Y said that he wanted to leave Richbell Court as he did not like heights and his flat was on the 7th floor. It can be noted that his views altered about the flat as did his fear of heights. Four weeks later on **29 August 2007** the depot injection was again given to Mr Y at his girlfriend's home. She reported to CPN 4 who was giving the depot that she was unhappy with her relationship with Mr Y and that he was going to return to Bedford for a few days later that week.[48]

On 25 September 2007 Mr Y was again staying with his girlfriend and CPN 4 gave him the depot there. His girlfriend told the CPN that she had been having health problems and that when she had asked Mr Y for help he had refused and had moved out of her flat for a few days. The following month on **23 October 2007** CPN 4 again gave Mr Y his depot at his girlfriend's home. Mr Y said he found his girlfriend's children hard to manage and cope with although he had been with her for 12 years. CPN 4 suggested that he stayed in his flat in Bedford for periods in order to have a break. Mr Y explained that his ex-partner, with whom he had twin daughters, had agreed for him to have access to them so he wanted to apply for a two bedroom flat so that they could stay with him.[49]

On **22 November 2007** Mr Y had called into the drop-in service and had his depot there, but had said he was busy and did not stay long. There was no entry for December and on **18 January 2008** he was not at his home when CPN 4 visited. He was seen at his home four

47 File 4 AOT Vol 3 Page 81
48 File 4 AOT Vol 3 Page 80
49 File 4 AOT Vol 3 Page 80

days later, **22 January 2008,** by CPN 4 and Social Worker 1. He was assessed as being mentally stable and his depot was given. His girlfriend was staying with him there and it was noticed that he appeared to be *"grinding his teeth a lot".*[50]

On **01 February 2008** the Assertive Outreach Team received a message from the Crisis Team that Mr Y was at the police station asking to be admitted to hospital. When seen he reported that he felt low in mood, lonely and suicidal and lacked motivation. Mr Y was escorted to the Accident and Emergency Department where he told the doctor that he wanted to "*stay on the ward for a few weeks to get his head together and to nip the problem in the bud before he turned to drink and did something he would regret"*.(e.g. walking in road or starting fights). He added that he felt extremely isolated.[51]

Mr Y reported that he had hallucinations, hearing voices of his family telling him to take care but there were no command hallucinations. It was agreed that he could go to the Phoenix Unit. He had given poor attention to his personal hygiene on the ward and did not want to be discharged. When he was discharged, having been allowed to stay an extra day, he went to register with a GP as had been discussed earlier in his four day stay.[52]

On **05 February 2008** CPN 4 had noticed Mr Y walking in the street and he had invited her to his flat for a chat. He appeared low in spirits and said that he missed his girlfriend and that he was concerned about her health and her whereabouts. CPN 4 reassured him that his girlfriend was with her children and that if she wished to live with him again they would not interfere.

Mr Y was reported to be struggling with his mental state prior to the depot being due when it was given on **19 February 2008.** A Care Programme Approach Review was held on **28 February 2008.** At this meeting it was noted that Mr Y had remained mentally stable throughout the previous year but had required a short time on the Phoenix Unit at the start of February. His main worry was his need to move home as he felt unsafe and it was not possible for his two teenage daughters to stay at his flat overnight. It was agreed that:

- the Assertive Outreach Team would help him request a housing transfer;

50 File 4 AOT Vol 3 Page 79
51 File 4 AOT Vol 3 Page 78/79
52 File 4 AOT Vol 3 Page 77

- a blood sugar test be arranged to check for diabetes, and a dental check also be arranged.

Mr Y stated that he no longer used class A drugs and he did not currently carry a knife for protection.[53]

The next month when the depot was due Mr Y was not at home on **18 March 2008,** but CPN 4 visited daily and eventually found him in on **23 March 2008** in the afternoon. He was having his dinner and appeared well and took his depot injection. Mr Y attended the Drop-in on **27 March 2008.** He asked for £20 per night for putting another service user up. CPN 4 suggested it would be better to get the money from the service user when he was paid the following week which they both agreed to.[54]

On **24 April 2008** CPN 4 saw Mr Y at the Drop-in where he appeared well but did not wish to have his depot there. This was given to him at home during the afternoon. He said he felt drowsy and was going to go to bed.

On **11 June 2008** Mr Y was seen by CPN 4 by chance in Midland Road. He told the CPN that he was worried about his girlfriend who was refusing to leave his flat and he said she was drunk all the time. By **19 June 2008** she had returned to her home and Mr Y wanted to help her but her son would not let him go there. Mr Y was due in court a few days later charged with possession of cannabis. He said he would like someone to support him. Mr Y said that he would welcome more one to one support from the Assertive Outreach Team as he felt more isolated since he broke up with his girlfriend. Mr Y was reflecting on how his life might have been had he not become unwell after a "*serious kick in*." [55]

CPN 4 attended the magistrates Court with Mr Y on **23 June** but after two hours his case had still not been heard so she had to leave. Mr Y was not at home on **26 June** and **01 July 2008** for his depot injection. This was administered on **03 July 2008**.[56]

53 File 4 AOT Vol 3 Page 62
54 File 4 AOT Vol 3 Page 61
55 File 4 AOT Vol 3 Page 60
56 File 4 AOT Vol 3 Page 59

The following month Mr Y was not at home on **22 and 23 August 2008,** but was seen at home the following day. He appeared to be hypomanic and was restless, excitable and used religious references. He refused his depot until the Thursday of that week. CPN 4 thought that he had probably been using recreational drugs.

On **20 October 2008** Mr Y took a student nurse to a group he had started engaging with. He had been to two, Ashanti and Nyabungi Groups and commented that he preferred them to the Drop-in. Four days later, **24 October 2008**, the Student Nurse visited Mr Y at his flat but he was not in so no depot was given. Later that day the caretaker at Richbell Court reported that Mr Y had been throwing things out of his window. He had also been playing loud music all night. On the next day Mr Y agreed to an informal hospital admission.[57]

The next morning, **25 October,** Mr Y was seen by CPN 4 at his flat and his depot medication administered. He seemed settled and said that a girl in his flat had thrown a stereo out of the window. He denied that he had thrown things from the window. Mr Y appeared mentally settled and CPN 4 advised him that the consequences of the previous night could have been serious.[58]

On **28 October 2008** Mr Y was admitted to Oakley Court in Luton as an informal patient as there were no available beds in Bedford on the Waller Wing. He was delusional and thought he was God; at times his conversation was incoherent. He said the police were harassing him and that he wished to return to Birmingham. He said that he had thrown things out of his bedroom window but that they had belonged to a "*a kerb crawler and her pimp"* who had moved into his flat. Mr Y was considered to have given informed consent to admission as he had appeared to have had both insight and capacity. He was admitted to Oakley Court with a police escort although he remained calm and cooperative throughout.[59]

The Period at Oakley Court (28 October to 12 November 2008)

On admission to Oakley Court at 18.00 on **28 October 2008** Mr Y was shown round the ward and the plan for him was that he should have his medication reviewed and his blood tests would be done the following day. He was placed on General Observations and the staff nurse

57 File 4 AOT Vol 3 Page 57
58 File 4 AOT Vol 3 Page 56/57
59 File 4 AOT Vol 3 Page 54/56

noted that his old clinical notes needed to be obtained, as did Dr 11, the Senior House Officer. The Treatment Plan on admission was to him to have PRN as needed, namely Haloperidol and Lorazepam.

The CPA4.1 Form (First Contact/Crisis Assessment of Risk) was completed and the risks identified on a 1-4 scale with 4 being immediate risk were:

- violence or harm to others: 1
- risk to self: 2
- risk of substance misuse: 3
- risk of arson: 1
- risk of non-compliance with treatment: 2

Mr Y was placed on Level 2 Observation, being observed every 10/15 minutes.

On **29 October 2008** Mr Y had breakfast and lunch and was observed to be calm but he did walk around the corridors on the ward. A urinary test showed positive for cannabis. It was noted that someone from the AOT would be invited to the ward round on 03 November. Mr Y was seen in a corridor talking to himself. He displayed clear signs of thought disorder. He appeared elated in mood and reported that he had not slept well. Later that day he was given Lorazepam (1mg) to help calm him down and by lunchtime Mr Y appeared calm as he walked round the corridors. A further dose of Lorazepam was provided at 22.30 that evening.[60]

A Care Plan (CPA 5 Form) was completed with the goal being to help Mr Y manage his anger and refrain from violence. This would be achieved by his named nurse administering PRN medication (Lorazepam) as and when required to prevent him becoming violent, agitated and restless. Staff were asked to monitor, record and report on his mood and behaviour on every shift. They were to engage him and encourage him to join in on the ward and Occupational Therapy activities. The named nurse was to have a 1:1 session with Mr Y every other day to explore his stressors and risk. Mr Y refused to sign the form.

60 File 6 Inpatient File Oakley Court Pages 10, 38, 40 and 50

Mr Y was give further doses of Lorazepam (1mg) at least three times a day, at the discretion of the nursing staff, until **06 November 2008**. From **30 October** to **7 November 2008** Mr Y was agitated, elated, pacing round the ward talking and giggling to himself and generally appeared unwell.

On **03 November 2008** Mr Y attended an art psychotherapy session but refused to explore personal issues. The ward round was held and Social Worker 1 from the Bedford Assertive Outreach Team was present. He provided some information about Mr Y and confirmed that Mr Y could be aggressive at times. There was a discrepancy in the account of the ward meeting decisions in that the medical entry states that Mr Y would have his Modecate increased to 100mg every two weeks and the plan was to await transfer to the Weller Wing at Bedford General Hospital.[61] The nursing entry stated that the frequency of depot injections was changed but that there would be a discharge meeting the following week and Social Worker 1 would attend.

Mr Y stated that he was stressed as people were using his flat. He admitted that he threw their things out of the window. He agreed that he would stay on the ward for a further 10 days. Later the same day Mr Y became involved in a fight with another service user and the Senior House Officer (SHO) had had to be called to the ward. When questioned by the SHO Mr Y accused the other service user of starting the fight.

On **04 November 2008** Mr Y continued to be elated and was singing and making strange noises, but his mood was reported to fluctuate from irritable to being 'slightly pleasant'. He attended a communication group on the ward and joined in appropriately. Afterwards he was agitated and confrontational and was given Haloperidol 5mg and Lorazepam 1 mg. He was given the same dosage four times on **05 November 2008.**

At the ward review Mr Y stated that he would like to go back to his flat as the people there when he was admitted were no longer there. It was explained to him that the ideal discharge would be through Bedford (taken to mean via the Weller Wing). If he stayed well Mr Y would be considered for discharge on Monday (**10 November**). He apologized for the fight with the other service user. The notes state that the plan was for:

61 File 6 Inpatient File Oakley Court Pages 28/29

- Mr Y to have a bandage applied to his swollen ankle and cream to his foot which he had complained of in the meeting;
- him to receive a haloperidol tablet 5mg on demand;
- discharge to be considered on 10 November.

He was not given any Lorazepam on **06 November 2008** but it was given on **07 November 2008**.[62] During these two days Mr Y remained elated but his behavior was described as manageable. He continued to appear restless at times but remained calm, pacing the corridors and singing and talking to himself. He willingly accepted his Modecate. The next depot would be due in a fortnight on **21 November 2008**. Mr Y joined a discussion group and was observed to have been relaxed and talked about his family, some of which was sensible whilst other parts did not make sense.

On **08 November 2008** Mr Y appeared elated early in the morning at 06.00 and was given was given Zoplicone (7.5mg). Mr Y was observed throughout the day interacting appropriately with other service users and appeared calm.

The next day, **09 November 2008**, Mr Y appeared calm and settled on the ward and received no further PRN medication during his stay. Mr Y appeared to welcome the company of the other service users. He saw the Trust Grade Doctor as he had complained of diarrhea since the morning.

On **10 November 2008** at the Oakley Court ward round meeting it was agreed that Mr Y would continue with the same medication as agreed on admission and to still await transfer to Bedford. It was arranged for Social Worker 1 to attend the ward round two days later (**12 November**).

Throughout **11 November 2008** Mr Y appeared to be calm and settled and had interacted well with the other service users and played pool. He also helped another service user tidy up their room, and remarked that he liked helping other people. At some point in the night of **11/12 November** (the entry was not timed) Mr Y was heard to say "*leave me alone don't kill*

62 File 6 Inpatient File Oakley Court Pages 50/58

me". When approached by staff he said he had been singing and did not mention any concerns. It was noted that he had slept fairly well.

12 November to 16 November 2008

During the morning of **12 November 2008** Mr Y was described as being settled in mood and appropriate in manner with no loud outbursts. He interacted well with others and presented no management problems.

A Care Programme Approach Care Plan was completed by Social Worker 1 at 11.30 on **12 November 2008**. The CPA 5 (Care Plan) Form stated that the areas of need were for Mr Y to:

- move to more appropriate accommodation; (Mr Y wanted to move to a quieter area in a ground floor flat where his daughters could stay overnight);
- refrain from using street drugs and excessive alcohol;
- maintain positive mental, physical and emotional health.

The Plan would be overseen by the Assertive Outreach Team and the summary of agreed interventions and support were listed as being to:

- regularly liaise with other professionals and agencies involved in Mr Y's care to ensure he received appropriate support;
- continually assess Mr Y's mental health and care needs;
- organise regular CPA reviews;
- organise regular outpatient appointments and to review medication;
- administer depot medication and monitor effects;
- Primary Care to meet his mental and physical health needs.

Mr Y was prescribed Modecate 100mgs every two weeks and Haloperidol 5mgs by day. The form was signed by Social Worker 1 and Dr 4 but Mr Y did not sign it.

At the ward round on the afternoon of **12 November 2008** Mr Y stated that he was "*much more relaxed and staying on the ward has benefitted me*". He said that at times he felt frustrated but only for a short time and added that his "*flat is fine now*" and that he wanted *"to help people in need. Sometimes I put myself in danger by helping someone in need*." He

appeared to be happy at the prospect of going back to his flat, did not display suspicion about anyone and was willing to be followed up by the Assertive Outreach Team. Social Worker 1 agreed to the discharge and took Mr Y home in his car.[63] He described Mr Y as being calm with some slight religious delusions. Social Worker 1 did not consider Mr Y to be mentally unwell. When he had arrived at his home Mr Y said he would visit the Drop-in the following day.

Prior to leaving Oakley Court Mr Y was provided with enough medication for three days, which was a continuation of the medication he had had on the ward. He was to be followed up by the Bedford Assertive Outreach Team.

CPN 4 telephoned Bedford Pilgrims Housing Association to check on the status of Mr Y's application to change property and discovered that the senior lettings officer would be involved in the decision.

On **13 November 2008** Mr Y had his medication at the drop-in and appeared settled, calm and sociable. He was not seen the following day but on **15 November 2008** Team Leader 1 was informed by another member of staff that someone had been stabbed in Alexander Road and that Mr Y had been seen near the area. Team Leader 1 contacted the Police Control Centre at Greyfriars and mentioned that Mr Y had been seen near the scene of the murder. She was told that the police were not interested in Mr Y in connection with this stabbing. The Emergency Duty Team was also advised of the situation by Team Leader 1. The staff there stated that they were not contacted by the police about the murder at that time.[64]

Support Time Recovery Worker 1 was due to visit Mr Y the following morning but due to the murder CPN 4 decided she would accompany her. Mr Y was in a good mood and appeared mentally settled. He talked about someone being stabbed along Alexander Road while he was at the Studio Club. His medication was given to him and CPN 4 reminded him that his depot was due the following **Friday, 21 November 2008.**[65]

63 File 6 Inpatient File Oakley Court Page 32/33
64 File 4 AOT Vol 3 Page 52/53
65 File 4 AOT Vol 3 Page 57

Postscript to the Chronology

On **19 November 2008** Mr Y was arrested in connection with the murder of Mr R. Social Worker 1 attended his interview with the police as the Appropriate Adult. The Assertive Outreach Team remained in contact with Mr Y following his arrest. He was released on bail to Progress House where the staff remained in regular contact. In fact the team had more contact with Mr Y during this period than at any other time he had been in the community. This was because Mr Y was answering Police Bail and the staff at Progress House needed support. Mr Y's mental state was frequently monitored and no symptoms of psychosis were discernible.[66]

This contact continued until **20 January 2009** when Mr Y was arrested and formally charged with the murder of Mr R and was remanded in Bedford Prison.[67]

66 File 4 AOT Vol 3 Page 51
67 File 4 AOT Vol 3 Page 6

12. Identification of Critical Issues

Root Cause Analysis (RCA) Second Stage

Timeline

The Independent Investigation Panel formulated a Timeline in tabular format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other.

This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns identified by the Independent Investigation Panel.

Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Panel initially identified eight critical issues and junctures that rose directly from the care and treatment that Mr. Y received from the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. These critical issues and junctures are set out below:

1. Documentation and Record Keeping.

2. Diagnosis and Medication.

3. Care Programme Approach and Risk Assessment and Risk Management.

4. Use of the Mental Health Act (1983).

5. Management of the Clinical Care – Inpatient and Community Services.

6. Referral from Community Mental Health Team to Assertive Outreach Team and the Role of Community Psychiatric Nurse and Care Coordinator.

7. Carer's Assessment.

8. Clinical Governance Processes.

13. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

This Section of the Report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity, each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the Report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below:

Key Causal Factor

The term is used in this Report to describe an issue or critical juncture that the Independent Investigation Panel have concluded had a direct causal bearing upon the events of 15 November 2008. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives, and any subsequent homicide perpetrated by them.

Contributory Factor

This term denotes a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the breakdown in Mr Y's mental health and/or the failure to manage it effectively.

Service Issue

The term is used to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this Report, whilst having no direct bearing on the events of 15 November 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

13.1: Documentation and Record Keeping

Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off.' 68

Pullen and Loudon writing for the Royal College of Psychiatry state that:

"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised." 69

Professional and Interagency Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion." 70

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one

68. http://www.medicalprotection.org/uk/factsheets/records
69. Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286
70. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121

agency alone[71]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[72] The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

Local Context

The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust Acute Mental Health Service Operational Policy (2007) stated:

"To ensure that the service-user receives the most appropriate and effective treatment and care, information about their treatment and care will need to be shared between members of the acute care team and the CMHT / CRHT, and with other agencies, including Social Services. Completed and current CPA documents should be faxed or e-mailed between the acute care team and the CMHT / CRHT – as a minimum, this should include forms CPA1 (service-user profile), CPA3 (assessment), CPA4 (risk assessment), CPA5 (care-plan) and, where one has been agreed, a copy of the service-user's advance directive / statement.

The admitting nurse will ensure completion of the following as part of the admission process:

- *commencement of the specialist mental health assessment, which should, as a minimum, include:*
    - *the reason for admission and a brief description of presenting problems;*
    - *known personal history of mental illness;*
    - *known physical health conditions and prescribed medications;*
    - *known individual cultural / spiritual beliefs and preferences / needs;*
    - *family & living circumstances;*
    - *immediate needs and risks – to include completion of the brief risk assessment."*[73]

The policy also notes that written clinical records will be audited at six monthly intervals.[74]

71. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999) P144.
72. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
73 The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (2007*) Acute Mental health Service Operational Policy* p.10
74 Ibid p.20

The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust Policy "Guidelines for Clinical Records Standards" (November 2003 with a Review date for November 2009) states that "*records are central to all aspects of the service's work and therefore they must meet the need and be of a high ethical standard. They must be accurate and up-to-date, which means recording must be a high priority activity and all staff need to be aware of their personal responsibility and accountability. Records must be completed within relevant timescales in accordance with standards and procedures, and each entry should be dated and signed by the person making/receiving contact as per Trust policy on Clinical and Practice records."*

The 'Guidelines' also state that "*staff are required to meet their professional guidelines with regard to the quality of written notes and also those required by the Trust …. In addition, clinicians and other clinical staff need to be aware of guidelines given by their own professional body. In addition records should:*

- *be written, wherever possible, with the involvement of the patient, client or carer*
- *be written in terms that the patient or client can understand*
- *be consecutive*
- *identify problems that have arisen and the action taken to rectify them*
- *an evaluation of the problems [assessment of need] shared with the client as appropriate, including consideration of carer needs and carer assessments being offered where appropriate*
- *a statement concerning eligibility/legal status of justification for intervention*
- *risk analysis when indicated*
- *a clear statement of objectives and resources required; i.e. a case/care plan*
- *options that are offered, include direct payment*
- *positive care plans with reasons for, and evidence upon which, decisions are made*
- *setting out of objectives and anticipated outcomes*
- *an account of the service that has been provided or is required with costings as appropriate*
- *copies of relevant contracts/orders etc.*
- *the decisions, reviews, records of communications and other similar recordings and documents which the Department needs to carry out its responsibilities*
- *evidence of involvement with other statutory agencies/service providers, as relevant*

- *evidence that the user of the service is aware of and has given consent to personal information being shared with other parties, [subject to statutory requirements etc.]*

Records must show evidence of service user involvement and receipt of key documents – including service user signed assessments, care plans, information offered and complaints procedures." [75]

Findings of the Internal Investigation

The Internal Investigation commented that:

"*The clinical notes for inpatient care and medical notes make little reference to the service user's mental state. However, during the course of admission there is evidence that he appeared to improve and was involving himself in the therapeutic programme on the ward.*

It was also identified during the course of reviewing the inpatient notes that the record keeping in relation to the initial and ongoing medical assessments was barely satisfactory."[76]

Findings of the Independent Investigation

Record Keeping

Primary Care

The Independent Investigation Panel considered 1,461 pages of clinical records. These included letters sent to Mr Y's GP and to other agencies. These letters provided a clear summary of Mr Y's condition and always provided details of his current medication. The 191 pages of the Primary Care Records included letters from the various consultant psychiatrists providing details of each outpatient appointment Mr Y attended. Mr. Y's GP was routinely informed when he had failed to attend an appointment or had not received his depot injections.

The Independent Investigation Panel concluded that the level of contact and communication with Primary Care was good, and also when the GP requested help for Mr Y the Assertive Outreach Team responded quickly and appropriately. This had also been the case with the Community Mental Health Team which had provided the treatment and care to Mr Y prior to 2002. Each outpatient appointment was reported to the GP as were Mr Y's many failed

75 The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (November 2003) Guidelines for Clinical Records Standards.

76 The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (2009*) Serious Untoward Investigation Report.* P. 28

appointments. The community psychiatric nurses also informed the GP whenever Mr Y had missed his depot injection.

Acute Care

The standard of the inpatient records was less detailed and the progress of Mr Y's illness following admission was neither described nor charted with any great detail. It is noted that Mr Y usually responded well to medication once he was admitted to hospital, but the details of interventions is sparse. It was noted that the record keeping about Mr Y's initial mental state on admission was usually detailed. However subsequent medical assessments were reported in less detail and did not provide a clear picture of his overall progress, other than that he was progressing and appeared more stable.

The records of Mr Y's mental state on admission to hospital are all very full and provide a good account of his condition at the time. On most of the admissions there is a brief history taken from Mr Y and occasionally it is evident that the admitting clinician has looked back over some of the case records to provide a context for the current ill health problems and consequent admission.

Once admitted the medical assessment of Mr Y's mental health state is spasmodic and not detailed. The nursing records are generally full and provide a narrative of his use of time on the ward, but do not provide any insight into how he is progressing, other than, for example, that "*he is improving and has been granted leave".*

The nursing plans have rather general objectives, the exception being during the admission in August 2000 where there were very full notes using the Nursing Assessment Profile.[77]

In Mr Y's final admission to hospital before the homicide, the notes are very short and provide little detail of how he spent his time. It appears that he was being held at Oakley Court because he was a danger to others in the community, but active treatment, other than medication, and detailed recording of his mental state was lacking. The records for this stay are fairly minimal. Had Mr Y been offered more active therapeutic treatment it is not known whether he would have accepted it given his history of non-compliance. The ward staff

77 Based on Collista Roy's Adaptation Model.

provide a record of where he was on the ward and document the main incidents which occurred such as him having a fight with another patient, but there is little clinical information and no evidence of detailed mental state examinations nor any attempt to test whether the diagnosis of paranoid schizophrenia was still appropriate for this psychotic episode. There was no recording of what the care plan was for Mr Y on the ward, and it concentrated on his being discharged home via the Weller Wing at Bedford Hospital, and then as his condition improved, for him to be discharged home within a week should no bed in Bedford become available.

It was noted by the Independent Investigation Panel that the records for Mr Y were not available on Oakley Court as they stayed in Bedford. This was not in line with the Trust Policy which stated clearly that the notes should be with the patient. The staff did have contact with Social Worker 1 who knew Mr Y well but do not appear to have utilised this opportunity to find out more about Mr Y which confirms that they very much saw their role as a 'holding one' until he could return to Bedford. There was no evidence of any liaison between Dr 4 and Dr 7 regarding what the latter had in mind as ongoing treatment for Mr Y.

Assertive Out Reach Team Records

Non-Medical Records

The records kept by the Assertive Outreach Team detail the contacts staff had with Mr Y and also provide descriptions of the steps taken to discover where he was when he failed to attend the outpatients clinic for his appointments with the psychiatrist, or his not attending for his depot. Regular Care Programme Meetings were held as required. Throughout the period he was known to the Assertive Outreach Team Mr Y had virtually the same care plan. The key elements of his care plan were:

- to monitor his mental health;
- to administer his depot injections and review his reaction;
- to provide support to enable Mr Y to remain living in the community.

There was occasionally an additional objective which was to assist Mr Y to find appropriate accommodation. The Risk Assessment and Risk Management Forms will be discussed fully in the Section covering the Care Programme Approach.

To a very large extent the care plans were similar to those drawn up by the Community Mental Health Team when his main support was from regular outpatient appointments with the consultant psychiatrist or a Senior House Officer (SHO) and a community psychiatric nurse was administering depot injections. The difference was that the Assertive Outreach Team had greater resources and was therefore better able to 'keep track' of where Mr Y was in order to be able to keep to the Care Plan.

The records are full and provide a good description of all the actions taken by the team.

Medical Records

There are no case summaries. The team psychiatrists did not regularly review all the patients. In fact Dr 7 did not see Mr Y nor review his case and examine all the case record until his last admission to hospital in October 2008. Dr 8 did provide some reviews for the Assertive Outreach Team but did not ever see the need to review Mr Y's diagnosis. Generally the medical records when Mr Y was in the community under the Assertive Outreach Team are lacking in detail.

Some clinical staff in their interview with the Independent Investigation Panel explained that the psychiatrists in the Assertive Outreach Team did not have a system whereby all the service users receiving a service from the team were given a regular medical review. The majority of Mr Y's care and treatment from the Assertive Outreach Team was provided by his Care Coordinator (Social Worker 1) and a Community Psychiatric Nurse. The original diagnosis of paranoid schizophrenia was never challenged despite the knowledge that Mr Y deteriorated rapidly once he stopped his medication by non-attendance at the arranged time for his depot. It was also known that once in hospital following a psychotic episode he very quickly responded to medication which could have indicated that he had a dual diagnosis or that his psychosis was drug induced.

The Independent Investigation Panel was concerned at the lack of summaries within the clinical records and the fact that there was no evidence that the medical staff in the Assertive Outreach Team had gone through all Mr Y's notes to examine his past history. There was nowhere in the notes where a full history was properly set out. Mr Y, apart from his inpatient admissions did not see the medical members of the team following Dr 7's appointment in April 2006.

The nature of Mr Y's clinical condition is examined in greater detail in the next Section of the Report.

Conclusion

Mr. Y's clinical records were poor and the documentation and the records were not easy to follow. There is no record of Mr Y being medically reviewed regularly or his diagnosis of schizophrenia being reviewed. Throughout his time with the Assertive Outreach Team the contacts with Mr Y by the Care Coordinator and the Community Psychiatric Nurse are recorded as are the Care Programme Approach meetings. There were few full risk assessments and care plans recorded in Mr. Y's notes and those that are recorded appeared to remain static with little added to them over time.

The Independent Investigation Panel considered that the record keeping by the mental health services was often poor, especially in the inpatient services and by the clinicians within the Assertive Outreach Team. The medical reviews for Mr Y did not occur and this was contrary to Trust Policy.

13.2: Diagnosis and Medication

An often critical element in the assessment of need and the planning of care within the general framework of the Care Programme Approach is the diagnostic process.

Context:

There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and efficient treatment then there has to be a clear formulation of his/her difficulties, which informs a plan determining how the individual might be helped to achieve identified goals.

In medicine, diagnosis is the process of identifying an illness or disease by its signs and symptoms. Within psychiatry diagnosis is usually reached after considering information from

a number of sources: a thorough history from the service user, corroborating information from carers, family, GP, and interested others, Mental State Examination and observation.

In the United Kingdom the World Health Organisation's "*International Statistical Classification of Diseases and Related Health Problems*", commonly known by the abbreviation ICD, is employed to classify mental health diagnoses and for the collection of epidemiological data. Currently ICD 10 (10th revision - published in 1992) is used in British psychiatry. This provides the criteria for diagnosis and a common language for use in mental health services and research.

Diagnosis is useful in that it provides clinicians, service users and their carers with a common framework to conceptualise the service user's experiences and difficulties. Diagnostic labels also provide a convenient way to systematise information and guidance on mental health problems, their prognosis and treatment.

Findings of the Independent Investigation

The first record of mental health problems experienced by Mr Y appears in the Bedford General Hospital medical notes (Psychiatric Department dated 17 May 1987). It is a fairly full and clearly written assessment describing Mr Y as a single, 27 year old Jamaican man who had been admitted from a police station. He had been released five days previously from Staffordshire Prison having completed a nine months sentence for indecent assault and wounding. He admitted to three previous periods in prison for GBH, ABH, breaking into gas meters and taking and driving away cars. He stated that he had been married for three years. On mental state examination he was not considered overtly psychotic but was admitted informally for assessment.

A further inpatient assessment 24 hours later noted that he had shown bizarre and dangerous behaviour waving knives at people in the street. The notes record a history suggestive of a psychotic state.

Over the next five years a number of diagnoses were considered including substance misuse, hypo-mania, bipolar disorder and chronic paranoid schizophrenia. The consultant psychiatrist Dr 1, who was originally involved in Mr Y's care, is recorded as recognising Mr Y as

someone suffering from paranoid schizophrenia. He was treated largely with Modecate depot intramuscular anti psychotic medication.

Records continue to record a diagnosis of schizophrenia to the present day and there is frequent mention of cannabis misuse with occasional reference to other illicit drugs such as cocaine. Periods of significant intake of alcohol are also recorded including immediately prior to the stabbing of Mr R.

Clear mention is made, especially in an early fairly comprehensive assessment, of a significantly traumatic and unstable childhood. This included being removed from a turbulent home in Jamaica and the transfer to the care of his father in the United Kingdom. Here Mr Y joined a dysfunctional family in which his father was to leave the family home and his stepmother was reported as being ambivalent towards Mr Y. He showed early signs of educational and behavioural difficulties which were initially, and possibly mistakenly, put down to low intelligence.

A clear and comprehensive assessment is provided by a locum consultant, Dr 6, on 16 December 2004. This report provides a working diagnosis of paranoid schizophrenia complicated by continued and regular alcohol and cannabis misuse, the latter significant enough to warrant a diagnosis of mental and behavioural changes due to multiple substance misuse (ICD F10) It was also mentioned in this report that there appeared to be a temporal link between acute psychotic relapses and illicit drug misuse and the refusal to take medications.

From 2001 until 2008 Mr Y was supported by the Bedford Assertive Outreach Team with support for inpatient treatment from both Bedford and Luton inpatient units. Mr Y's primary diagnosis remained paranoid schizophrenia with concurrent substance misuse. He was partially compliant with medication but had multiple short admissions to inpatient units when he appeared disturbed and psychotic. These admissions were frequently precipitated by anti social behaviour such as throwing items out of his window without due care. There was a parallel and disconnected history within the criminal justice system where Mr Y was arrested for incidents of possessing and wielding knives in public places. He received two significant prison sentences one in 1987 for indecent assault and wounding and later, in 2003, a further prison sentence for possession of an offensive weapon.

At this later trial the prosecution, to assist the judge in sentencing, read out in court the circumstances of this offence and mentioned 53 other offences including offences connected with threatening behaviour and the carrying and use of knives. This detailed evidence was not known at the time or subsequently to the Bedford Assertive Outreach Team or mental health services in the area, although it had come before the courts.

In April 2006 Dr 7 came to work for the Bedford Assertive Outreach Team under whose care Mr Y had been placed. Mr Y received care under the Care Programme Approach. His care included visits from a care coordinator, outpatient assessment and intramuscular injections of Modecate, a depot anti psychotic medication. He was not seen as a major problem to the team who were aware of his propensities to carry knives but who was not perceived as presenting a threat to team members. He was generally compliant with medication occasionally missing his depot injections.

During admission to Weller Ward Mr Y occasionally presented as disturbed and a threat to other patients but was compliant with inpatient medication and nursing care. His psychotic symptoms settled rapidly and he was considered fit for discharge from many admissions within two to four weeks of admission. The Assertive Outreach Team and inpatient staff were aware of his difficulties and his dependency on his girlfriends, one of whom offered him intermittent stays at her house which he shared with her daughters.

Interviews with the Assertive Outreach Team members and the consultant psychiatrist suggested that Mr Y had never been the subject of an in-depth review or a MAPPA meeting.

A review of medical records identified that the following diagnoses had been considered at some time during Mr Y's care by the Bedford and Luton Mental Health and Social Care Partnership NHS Trust:

- Chronic Paranoid schizophrenia;
- Psychotic state;
- Affective disorder;
- Substance misuse ;
- Educational and intellectual difficulties;

Review of the diagnoses and treatment of Mr Y.

It is not the role of an Independent Investigation to adjudicate on the "true" diagnosis of a service user, rather its role is 'to scrutinize and comment on the diagnosis practices and formulations which informed the interventions of the service user's care plans so that, where appropriate, lessons can be learned and services improved.

In Mr Y's case the Independent Investigation Panel had the advantage of reviewing all available medical notes, court reports and material not available to the Assertive Outreach Team at the time.

As has been noted above, a number of diagnostic labels were applied to Mr Y during the time he was cared for by the Trust. If this was a manifestation of reflective practice, a regular reviewing of Mr Y's diagnosis as new information came to light, this was good practice. It is good practice in psychiatry to identify differential diagnoses and to review the service user's diagnosis and, consequent, interventions on a regular basis.

Chronic Paranoid Schizophrenia

ICD 10 defines paranoid schizophrenia as follows:

"Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous." (Code F20.0)

The diagnosis of Chronic Paranoid Schizophrenia was applied throughout the time Mr Y was under that care of the Bedford and Luton Mental Health and Social Care Partnership NHS Trust, from 1991 until 2008. Mr Y manifested psychotic persecutory and grandiose delusions. He appears to have responded reasonably well to Modecate intramuscular depot injections.

However it is important to note that: Mr Y displayed a rapid and apparently complete resolution of his delusions when he was admitted to hospital, an environment that was drug free, stable and where he received his medication in a consistent manner; and he does not appeared to have developed 'negative' symptoms such as lethargy, lack of motivation, postural abnormalities or cognitive difficulties. Mr Y was described, when well, as friendly,

insightful and an active participant in his relationships with his two main girlfriends. These are not characteristics suggestive of someone manifesting the deteriorating course of a schizophrenic illness.

The homicide occurred three days after Mr Y had been discharged from Oakley Court on 12 November 2008. He was not observed to be displaying any symptoms of psychosis in the days following his discharge, before the homicide, nor immediately after it. When Team Manager 1 heard that Mr Y had admitted that he had committed the offence she was of the firm view that the offence had not been committed in response to any psychotic influence. The staff caring for Mr Y had not considered him as presenting a significant threat to others, based on their recent and lengthy contact with him.

One of his consultant psychiatrists, Dr 7 reported at interview with the Independent Investigation Panel that he had not questioned the diagnosis of paranoid schizophrenia and had trusted the label given to Mr Y by previous clinicians. Dr 7 had not offered Mr Y a medication-free period during any of his admissions to try and substantiate this diagnosis.

The records for Mr Y's last admission to Oakley Court are fairly minimal. The ward staff provided a record of where he was on the ward and documented the main incidents which occurred such as his having a fight with another patient, but there is little information and no evidence of detailed mental state examinations nor any attempt to test whether the diagnosis of paranoid schizophrenia was still appropriate for this psychotic episode.

Mental and behavioural disorders due to psychoactive substance use (F10-F19)

An alternative diagnosis was drug induced psychosis (ICD 10 F 19.5). This is described as follows:

"A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present."

Consideration that Mr Y's psychotic episodes were drug induced is an important element in the differential diagnosis of Mr Y's condition. If his psychotic episodes were the result of his misuse of drug and alcohol then tackling Mr Y's drug problems would have to be a key element in his treatment and risk management. The medical records and the interviews conducted with staff demonstrated only two mentions of referral to the local drug and alcohol team (Healthlink): one as part of a Court Order to attend a Drug Rehabilitation Programme in February 2003 and the other an appointment with Healthlink in May 2004. There is no record as to whether he attended appointments with the substance mis-use services on either occasion, but the lack of further records strongly suggests that he did not engage with the service.

The usual method of differentiation of these two diagnoses is through an observed period of abstinence from both illicit and prescribed medication. If the condition is drug induced the psychosis resolves, if it is a schizophrenic illness, it tends to worsen.

The teams that treated Mr Y were not aware of any trial period of enforced abstinence from illicit drugs prior to the homicide in November 2008.

Dual Diagnosis

While the treating team appeared clear that they were caring for a man who had schizophrenia and substance and alcohol misuse problems there is no mention in the clinical records of the need for a dual diagnosis approach towards treatment to be adopted. This approach requires both the primary serious mental illness and the substance misuse problem to be tackled with equal vigour, but with separate approaches.

Interviews with staff demonstrated that little training had taken place within medical or nursing groups on the Government's prescription for a dual diagnosis approach.[78] This guidance advises that staff should be trained to identify the simultaneous concurrence of serious mental illness and substance misuse disorders and be organised into teams which have appropriate training to enable them to prescribe and deliver an intervention to increase compliance and efficacy of treatments for both serious mental illness and substance misuses.

[78] DOH Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice Guide 2002.

Mental Health Trusts are required to design services where teams have in-house skills to motivate and treat Dual Diagnosis patients, and to have specialist services available that are enthusiastic in their support and acceptance of these complex problems on their case-load. The Bedford Assertive Outreach Team understood Mr Y's drug and alcohol problems, but focused their efforts on offering community support for his anti psychotic treatment and only referred him to Healthlink on one occasion (May 2004).

Substance Misuse.

There is little doubt from the interviews conducted by the Independent Investigation Panel, and from the clinical records examined, that Mr Y habitually indulged in drugs and alcohol throughout his late adolescent and adult life. He was a self proclaimed Rastafarian for a period and has admitted to prolonged use of Cannabis and the stronger form, Ganja. He has admitted to the use and enjoyment of crack cocaine and LSD but does not appear to have been dependent on or addicted to these particular drugs.

Mr Y also admits to the use of alcohol and reported drinking several hours before the incident when he consumed two cans of strong lager (9-10%), equivalent to 15 units of alcohol.

It seems probable that Mr Y's misuse of alcohol and cannabis from a young age had a deleterious effect on his behaviour and his thinking. There is no evidence that Mr Y had any significant contact with the drug and alcohol treatment agencies, nor do his drug and alcohol problems appear to have driven the treatment plan developed by his treating teams.

Affective Disorder

Bipolar affective disorder is described in ICD 10 as follows:

"A disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar." (Code F31.0)

Although mentioned early in Mr Y's medical record there is no recent record that he manifested any evidence of an affective disorder. Any over-active or disinhibited behaviour

would appear to be better explained in the context of either delusional disorder or the influence of illicit drugs or alcohol.

Personality Disorder

ICD 10 describes Dissocial Personality Disorder **(**F60.2) as follows:

"Personality disorder characterised by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to blame others, or to offer plausible rationalisations for the behaviour bringing the patient into conflict with society".

There seems to be little reference in interviews or medical records of the contribution Mr Y's personality made to his thinking and behaviour. The teams who cared for him noted his ability to join in warm relationships with clinical staff. He was capable of a certain amount of banter and relaxed conversation which seems to have served to reassure the clinical team against risk of violence to others.

On leaving hospital just before the incident Mr Y recalled being assaulted by a man or a group of men and then deciding to buy a knife. He had done this on previous occasions and indeed over the previous 20 years had received two significant prison terms for the carrying and use of knives. On this occasion he admitted to feeling aggrieved and to deliberately purchasing the knife. It was a day later when meeting what appears to have been a relatively non-threatening man, Mr Y decided to use his knife. From the evidence available the precursors to this episode seem likely to have been generated by the complex tensions within his personality rather than any impulse formed from a delusional belief.

Mr Y has a very long history of criminal behaviour which has been recorded within the criminal justice system, but unfortunately this record was not all available to the mental health team. This pattern of criminal behavior would suggest that Mr Y has enduring impulsive and asocial behaviours which manifest when under stress or perceived threat. He does not appear remorseful or to have any inkling to worry about his victims and if he did, it has not influenced his subsequent criminal behaviour. These behaviours bear the hallmark of personal characteristics acquired at an early stage in his life when he was not subjected to

loving or protective role models and had to defend himself emotionally and physically without parental figures. His early life was made more insecure by a move to a strange country and a dysfunctional family.

Educational and intellectual difficulties

It is reported in the medical notes that Mr Y, on arrival in the United Kingdom at the age of nine, had significant difficulties at school. He was assessed for learning difficulties and subsequently diagnosed with dyslexia. He is recorded as struggling at school and having significant behavioural problems. It is not clear how he reached boarding school but appears to have been placed there by the Local Education Authority. Mr Y appears to have returned to the family home around the age of 14. By his own account this was a highly inappropriate setting. His step mother had moved out and his father was involved in a number of criminal activities. Several women stayed at the house and by Mr Y's account he learnt a number of criminal behaviours and experienced age inappropriate relationships with household members.[79] It is however noted that Mr Y went on to obtain several jobs, one with an instrument making company and held this for about nine months.

On interviewing Mr Y and reviewing the medical records there is little evidence to support a diagnosis of learning difficulties. However Mr Y gives an account of his childhood which suggested extreme emotional deprivation and the exposure to damaging, hostile emotional forces.

Medication

Mr Y has, according to his medical records, a fairly simple psycho/pharmacological history. He is recorded as having been treated with commonly used oral antipsychotics such as Haloperidol when being assessed for acute psychotic symptoms, and most commonly in the community he was offered Modecate intramuscular depot medication. This type of medication is one of the more commonly used anti psychotics and Mr Y has been on it for many years.

79 Mr Y interview transcript.

Conclusion

During the time Mr Y was cared for by the Bedford and Luton Mental Health and Social Care Partnership NHS Trust a number of possible diagnoses were considered but for most the time he was under the care of the Trust he was diagnosed as suffering from paranoid schizophrenia. This diagnosis does not appear to have been reviewed after 2001.

However it has been noted that his symptomatology remitted rapidly on admission to hospital. His admissions tended to last no longer than four weeks (with the average length of stay over 17 admissions being 16 days); and despite a 25 year history of mental health problems he does not display any negative symptomatology. It was also noted that Mr Y had habitually misused drugs and alcohol from an early age and it is likely that this misuse influenced his mental state and behavior.

Given the complex picture presented by Mr Y it would have been good practice to have recorded differential diagnoses and regularly to review Mr Y's diagnosis as new information became available. This sound diagnostic practice should have been used, explicitly, to inform the understanding of Mr Y's behavior and the appropriateness of the interventions put in place. Such reflective practice is not evident in Mr Y's clinical records.

13.3: The Care Programme Approach, Risk Assessment and Risk Management

Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve care for people with mental illness by ensuring that they received a comprehensive assessment of their needs, an agreed care plan to meet those needs and that an individual was identified to ensure that the care plan was delivered in a co-ordinated fashion.[80] Since its introduction it has been reviewed twice by the Department of Health: in 1999 [81] to incorporate lessons learned about its use since its introduction and again in 2008 with a re-statement of the Care Programme Approach.[82]

80 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services: DoH 2008

81 Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach : DoH 1999

82 Refocusing the Care Programme Approach : DoH 2008

'*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services.*'[83] This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of needs, risks and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure appropriate support for mentally ill people. It is applicable to all people accepted by specialist mental health services and its primary functions are to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a key worker whose job is:
  - to keep in close contact with the patient;
  - to monitor that the agreed programme of care remains relevant; and
  - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

83 Building Bridges: arrangements for interagency working for the care and protection of severely mentally ill people: DoH 1995

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Local Context

As explained in the Introduction it was difficult to find the policies within the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust as the Trust Board was replaced in 2010 and there is very little 'organisational history' from that time. Many staff have left and the senior management has been reorganised and reshaped under the South Essex Partnership NHS Trust.

There were two CPA Policies dating from the time Mr Y was receiving care and treatment from the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. These were the CPA Policies from 2007 and 2008 which were the two final years that Mr Y was in contact with the Trust:

- Integrated Care Programme Approach and Care Management Policy September 2007 (Review Date September 2008).

- Care Programme Approach non Care Programme Approach and Care Management Policy (October 2008).

The September 2007 CPA Policy stated that the "*Care Programme Approach (CPA) is a model of assessing, planning, implementing/delivering care and then evaluating the effectiveness of that care or intervention. It promotes effective liaison and communication between agencies, thereby managing assessed risk and meeting the individual needs of people with mental health problems so they are better able to function in society.*

This policy applies to people receiving care from the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. The policy applies to all those aged 16 and over who are: currently accepted for treatment by the Trust: or where the initial referral and assessment process requires more than one appointment to complete.

It is the cornerstone of the Government's Mental Health Policy. It is designed to improve the co-ordination of care for all people of working age accepted by mental health services. CPA is also applicable to people within learning disability who also have mental health problems and who require support from the Trust's Specialist Assessment and Treatment Service for people with a learning disability. Finally, it also applies to older people with complex mental health needs. (DOH, 1999, pp3)."[84]

The Policy also states that "*CPA is a system of care which spans all areas of service provision. It is not intended as an additional layer of bureaucracy that overlays or stifles clinical practice. It is the building block of integrated care and has the service user at its centre."*[85]

The Assertive Outreach Team is not mentioned specifically in the September 2007 CPA Policy which refers to the Working Age Mental Health Services and mentions Community Mental Health Teams, the Crisis Resolution and Home Treatment Team and the Drug and Alcohol Services. It is assumed that that the Assertive Outreach Team was taken to be one of the community teams. The October 2008 Care Programme Approach non Care Programme Approach and Care Management Policy is similar but also concentrates more on the integration of the Care Programme Approach and its Social Care equivalent the Care Management Processes.

The Policy states that:
"*Whilst integrating CPA and Care Management into a single process it is worth considering the similar concepts upon which the two processes have been developed. The integration of CPA and Care Management ensures that the above processes are fused together into a single integrated process. Health and Social Care elements of a service user's care plan will become intrinsically linked into a single package of care aimed at meeting all of a service users needs. CPA and Care Management effectively become one and the same process*." There is a useful Table in the policy which highlights the key elements of the CPA and those of the Care Management Process, this is replicated below.

84 Integrated Care Programme Approach and Care Management Policy September 2007: Page 2
85 Integrated Care Programme Approach and Care Management Policy September 2007: Page 7

Table 2: The Integration of CPA and Care Management Processes

Key Elements of CPA	**Key Stages for the Care Management Process**
Systematic arrangements for assessing the health and social care needs of people accepted into mental health services	Referral, initial screening and information giving
The formulation of a CPA Care Plan which identifies the health and social care required from a variety of providers	Assessment of needs and risks
The appointment of a Care Coordinator to keep in close contact with the service user to monitor and coordinate care	Care and Risk Management Planning
Regular review and where necessary, documentation of agreed changes to the care plan	Care Management (implementing the care plan and commissioning services)
	Monitoring the Care Plan
	Review and recording unmet needs

This Policy does categorically state that "*all service users under the care of the AOT will be supported within the CPA process*" and that "*a member of the AOT should be nominated as the care coordinator*".[86]

Appendix 2 of the 2007 and 2008 CPA Policy describes a 'Pathway' in relation to acute ward admission and discharge and it is clear that on admission the following tasks need to be undertaken. The service user should be greeted by a Hospitality Nurse, be placed on Enhanced CPA if not already on this, and then the following documentation needs to be completed:

- User Profile (CPA 1);
- Medical Assessment/Physical Assessment;
- Completion of Physical Observation;
- Specialist Assessment (CPA 3 Part 1);
- Brief Risk Assessment 1 (CPA 3);
- Core 72 Hour Treatment/Care Plan;

86 Care Programme Approach non Care Programme Approach and Care Management Policy (October 2008). Page 7.

- Core Nutritional Monitoring Care Plan (including BMI measurement);
- Special Observations Care Plan;
- Agreement on Sharing Information;
- Check completion of relevant Mental Health Act documents, if relevant and explain rights.

There is also a Discharge Process with three requirements:

- HONOS Assessment 2 (CPA 4h Form);
- Completion of CPA Care Plan (CPA 5) if on enhanced CPA;
- Completion of Discharge Check List.

In Mr Y's case the Admission Forms were completed but not all the Discharge Procedure was properly followed and completed.

The CPA Forms used by the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust.

The CPA forms used in the clinical records of Mr Y were as follows:

Table 3: CPA Forms Used in the Clinical Records

Number of Form	**Purpose of Form**
Form 1*	Admission to Hospital
Form 2	Preparation for discharge
Form 3	Risk Assessment and Risk Management and Supervision Register
Form 4	Preparation for Discharge
Form 7	Plan for care in the Community
CPA 1**	User profile
CPA 2	Agreement on Sharing Information
CPA 3	Specialist Mental Health Assessment
CPA	Completion of HONOS
CPA 4 Part 1 CPA 4 Part I a) and b)	Brief Risk Assessment 1 (completed Days 1, 3 and between Days 4-7 for inpatients Full Risk Assessment
CPA 5	Individualised Care Plan
CPA 6	Care Plan Evaluation (*****Up to 2007 ******From 2007)

The Care Programme Approach and Mr Y

It is clear from the clinical records that the Assertive Outreach Team did use the CPA and that Mr Y was subject to it. His care coordinator was the social worker and an Approved Social Worker (ASW) and an Approved Mental Health Professional (AMHP) in the Assertive Outreach Team who remained in this role from the referral in 2001 until the homicide in November 2008 and Mr Y's arrest in January 2009.

The Use of the CPA Forms

The Table below shows the use of the various CPA forms by the dates they were signed. Not all the forms were used on each occasion so the forms identified from the case records are listed in date order.

Table 4: Record of CPA Forms Used

	Forms completed
06/01/1997	Form 3
17/07/1997	Forms 3 and 7
03/10/1997	Forms 2 and 4
30/12/1997	Forms 1 and 3
06/01/1998	Form 3
16/01/1998	Form 7
20/07/1998	Form 7
09/05/2000	Form 3
07/06/2000	Form 7
12/09/2000	Form 3
10/07/2001	Form 7
02/01/2002	CPA 5
13/02/2002	CPA 5
17/01/2003	CPA 4
14/10/2003	CPA 4
11/03/2004	CPA 6
24/03/2004	CPA 1, 2 and 6
26/04/2004	CPA 5
30/10/2004	CPA I,2,3,4,4a,and 5
12/08/2005	CPA 5
13/10/2005	CPA 4
25/01/2006	CPA 5
01/02/2007	CPA 4
28/02/2007	CPA 5
02/02/2008	CPA 1 and 4
28/02/2008	CPA 2, 4a and 6
05/09/2008	Assessment for new CPA
29/10/2008	CPA 4 and 5
12/11/2008	CPA 5 and 6
14/11/2008	CPA 4

Whilst the list above shows that many forms were used, the actual comprehensive use of the full CPA forms was poor as only some forms were used and rarely the apparently needed full set. This could have been because the Assertive Outreach Team needed to use the forms which were most appropriate for Mr Y in the context of their service. Whilst Mr Y was on enhanced CPA his identified needs were consistent and were met largely by the care

coordinator (Social Worker 1) and CPNs 3 and 4. It is clear that the CPA requirement for regular medical assessment was not met, except when Mr Y was admitted to hospital.

In examining how well the CPA was used by the Assertive Outreach Team and the Inpatient Service it is appropriate to use the four key elements of the CPA as headings to determine compliance with the overall Policy.

Systematic Assessment

From the evidence available in the clinical records Mr Y did receive a systematic assessment when he was admitted to hospital, but it did not include a fresh examination of the nature of his mental ill health. His previous diagnosis of paranoid schizophrenia was accepted and not challenged. From April 2006 Mr Y did not see the psychiatrist within the Assertive Outreach Team and his care was not reviewed medically when he was in the community. When he was admitted to hospital Mr Y did see a consultant psychiatrist but his treatment and care plan tended to stay the same.

The other area which was not fully explored was Mr Y's risk history, as not all the offences committed by Mr Y were known to the Assertive Outreach Team.

The Independent Investigation Panel considered that the lack of any reflective practice when reviewing the service users in the Assertive Outreach Team missed the opportunity to identify other ways in which he might have been treated.

Only twice, in February 2003 and on 26 May 2004, was Mr Y referred to the Substance Misuse Service, Healthlink. Following his assessment by this service the plan was that Mr Y should attend a six-week programme to address:

- The pros and cons of using drugs;
- The impact of drugs on mental state;
- Information and education about drugs; and
- Developing short term goals and how to achieve them.

There is no record in the files to confirm if Mr Y attended any of these later sessions. It was not included in any subsequent care plans for Mr Y who remained unwilling to address his drug and alcohol issues.

The Formulation of a Care Plan;

The Care Plans for Mr Y were all very similar throughout his time with the mental health services in Bedfordshire and there is no evidence in Mr Y's clinical record of regular reassessment of Mr Y's needs and the risk associated with him, as good practice would recommend. At the same time it must be acknowledged that the pattern of Mr Y's life style remained relatively consistent and in this context it is perhaps not too surprising that the content of his Care Plans manifested some degree of consistency.

There were four main areas which were to be addressed:

- Monitoring his mental health state;
- Administering depot and observing its effect;
- Supporting Mr Y to remain living in the community and attending outpatient appointments when he was with the Community Mental Health Team up until 2001;
- Helping Mr Y with his housing issues and his financial matters whenever these were worrying him.

Although the plans did not vary they were reasonably effective for Mr Y as he did retain more contact with the AOT than he did with the CMHT. This was because the Assertive Outreach Team sought him out and provided support when he was stressed by allowing him to have respite periods in Progress House. Whilst with the CMHT in 1999 he had three very short admissions to Progress House from 11 June to 12 June, from 05 August to 07 August and for a few hours on 21 September. These interventions were appropriate, but were reactive and did not then become proactive by being included in his care plan.

When Mr Y felt threatened by circumstances in his life he was more compliant with services and actively sought help. When he was less stressed by his environment or having to repay debts he often did not attend meetings and outpatient appointments and frequently missed his depot injections. Despite this, contact with him was maintained to a degree and Mr Y did value the support he received when in need. He also had no qualms in missing appointments, as he knew the service was there and they would support him in an emergency.

The allocation of a Key Worker/Care Coordinator;

Throughout his time with the CMHT and the AOT Mr Y had a Care Coordinator and, if this member of staff was not a nurse, he also had a Community Psychiatric Nurse to provide him with his depot injections. In addition he also had a Support Worker to help him with practical issues related to his flat and his wish to change his seventh floor accommodation.

Social Worker 1 was the Care Coordinator for Mr Y throughout his time with the Assertive Outreach Team. He helped Mr Y with his practical problems over debt and accommodation and generally provided positive support to him. This arrangement served Mr Y well as the staff would be proactive in seeking him when his depot was due and often knew where he might be spending his time.

Holding Regular Reviews

There were regular CPA Reviews but Mr Y did not always attend, and a feature of the CPA records is the length of time between the date of the CPA meeting and Mr Y having signed the relevant forms.

The main concern of the Independent Investigation Panel was the lack of medical review during Mr Y being with the AOT. Dr 7 did not conduct regular six monthly reviews of the AOT caseload and Dr 8 was not proactive, waiting to be asked for an opinion about any particular service user. There was also no built-in arrangement for a reflective multidisciplinary session where the progress of specific service users could be fully discussed with alternative treatment or care plan options put forward. As a result there were only two referrals to Healthlink for Mr Y, even though it was known that he had a substance misuse problem, and that he tended to relapse quite quickly when he missed his depot medication, and recovered quite quickly once he was admitted to hospital following a relapse and being on regular medication.

Conclusion

The criticism which can be made is that the Assertive Outreach Team was forced to adopt a reactive role with Mr Y due to his difficulty in consistently engaging with the service. The four needs listed in most of his needs assessments and within his Care Plans were to help Mr Y by monitoring his mental health state, administering depot and observing its effect,

supporting Mr Y to remain living in the community (and attending outpatient appointments when he was with the Community Mental Health Team up until 2001 and until April 2006 when he was with the Assertive Outreach Team) and finally helping Mr Y with his housing issues and his financial matters whenever these were worrying him.

The approach adopted throughout his contact with mental health services in Bedfordshire was largely concerned with containing Mr Y and not about providing treatment and tackling the cause of his illness, which was in part his inability to abstain from alcohol and illicit drugs. It was noticeable that the care plan seldom mentioned the need for Mr Y to have treatment for his alcohol and substance misuse problems although his addressing this was sometimes identified as an aim.

The lack of regular medical reviews and the ability to have reflective practice sessions inhibited the AOT looking at alternative strategies to meet Mr Y's needs. His use of illicit substances and alcohol was well known but was rarely addressed.

Risk Assessment

Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Mental Health Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery. It is essential that risk assessment and risk management are supported by a positive organisational strategy and philosophy as well as through the efforts of the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that '*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed.* [87].

As long as a decision is based on the best evidence, information and clinical judgement available at the time, it will be the best decision that can be made at that time. Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and/or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Local Context

Findings of the Internal Investigation

"An analysis of the documentation suggests that the text within the various risk descriptor sections of the tool do not appear to have changed over the previous assessments. There was

87 Best Practice in Managing Risk (DoH June 2007)

no documented evidence that the alleged conviction for possession of cannabis in June 2008 was considered as part of the revised risk assessment. Whilst of course it is conceivable that from a risk perspective the situation was largely unchanged, it may have been appropriate to have demonstrated a fresh analysis of risk rather than the relying on the previous assessments…..

The service user's care plan was recorded on Trust documentation CPA5. There is evidence in February 2008 of a care plan review taking place in line with Trust policy. There is further evidence that he was asked to sign his care plan in line with good practice. On the 12 November on discharge from the ward, staff identified as being involved in providing care follow up was the Care co-ordinator, the Associate Specialist, the Community Psychiatric Nurse and the General Practitioner….

Throughout the course of our discussions with inpatient staff they advised us that as previously stated that they were unfamiliar with the service user. They informed us that they had little information on his previous history when he was admitted." [88]

Findings

The teams do not appear to have had the benefit of a full re-assessment of the historical and forensic details and appear to be proceeding on the assumption that Mr Y suffers from a simple recurrent paranoid psychosis. Neither team meeting discussion nor individual staff appear to have been informed by the extreme events of Mr Y's childhood and teenage years, nor his gradual progression towards crime involving knives and wounding.

Senior Team Staff who were interviewed by the Independent Investigation Panel were shocked to hear that by the time of his penultimate attendance in court for a knife related crime in 2003 Mr Y had been found guilty of 53 previous criminal offences including two previous serious knife crimes for which he received prison sentences.

Mr. Y's risk history was variable and sometimes incomplete. The staff in the Assertive Outreach Team were compromised as they were not aware of a significant earlier offence when Mr Y had used a knife to attack two schoolgirls, cutting one on the neck. This

88 The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (2009*) Serious Untoward Investigation Report.* P. 27

knowledge would have increased the assessed likelihood of risk associated with him often carrying knives. The risks identified in a selection of CPA Brief Risk Profile Forms in 2004, 2007 and 2008 were quite similar but with subtle differences as shown in Table 5 below.

It should be noted that if Mr Y was relapsing then his risk of violence or harm to others would be higher at 3 or 4, namely a high risk, or a high and imminent risk. These were the occasions where he had been arrested for having a knife in public and threatening to use it. There were also incidents where Mr Y was indiscriminately throwing large objects from a seventh floor window including a bicycle, a burning mattress, and smaller objects aimed at parked cars.

Table 5: A Sample of Brief Risk Assessments/Profiles

Date	Violence/ Harm to Others	Risk of Suicide	Deliberate Self Harm	Neglect/ Accidental Injury	Risk to Children	Abusing Others*	Exploitation	Offending
11/03/2004	**1**	**0**	**0**	**1**	**0**	**n/a**	**1**	**2**
24/03/2004	**1**	**2**	**1**	**2**	**0**	**n/a**	**2**	**2**
30/10/2004	**1**	**0**	**0**	**1**	**0**	**n/a**	**1**	**2**
01/02/2007	**1**	**2**	**1**	**2**	**0**	**1**	**2**	**2**
26/02/2008	**2**	**2**	**1**	**2**	**0**	**1**	**2**	**2**
15/11/2008	**2**	**2**	**1**	**2**	**0**	**2**	**2**	**2**

The scoring guide for the tool identifies that:

0 = no / very low risk. 1 = low risk. 2 = medium (significant risk). 3 = high risk.

4 = high and imminent risk.

As previously mentioned in the Section on Diagnosis and Medication and highlighted in the narrative chronology, Mr Y had been assessed in December 2004 by Locum Consultant Psychiatrist 1 as a very serious risk as:

"it appears probable that Mr Y's mental illness is affected by his lifestyle choices; illicit drug use but it is less clear whether the onset of schizophrenia was precipitated by, or the subsequent course worsened by, the use of psychoactive substances. There does appear to be a temporal link between the acute psychotic relapses and illicit drug use or refusal of medications."

Risk Issues

"I am told that Mr Y is a very amiable individual when he is well although he had been friendly with some very unsavoury characters in the past. The risks attendant to his condition are magnified when he becomes unwell and relate mainly to his propensity for self-neglect, offering violence to third parties and the habitual carrying of knives……The combination of a personal habit of knife carrying, a subculture of casual violence and weapon carrying, an underlying mental illness characterized by paranoia and impaired judgement as well as frequent intoxication with alcohol and cannabis is, in my opinion, a potent recipe for disaster".

Dr 6 concluded with the following four recommendations for the Court to consider when sentencing Mr Y.:

"Recommendations

[The four recommendations made were that:]

- *Mr Y should be encouraged to continue to engage with mental health services for long term treatment, with medications and environmental manipulation being crucial towards improving his mental health and wellbeing;*
- *Mr Y should be judicially compelled to engage in a formal drug rehabilitation programme in addition to his usual treatment;*
- *The habitual carrying of knives and the proclivity to brandish them must not be excused as an involuntary manifestation of altered mental health state;*
- *"The opportunity ought to be seized now to defuse this potent mix of risk factors as I feel we could be moving towards a serious untoward event."* [89]

Conclusion

These words were, as it turned out, prophetic, but there was no clarity as to when, where, how or to whom such violence would be unleashed. There was a need for Mr Y to remain in touch with mental health services and to continue to take his medication. His substance misuse problems should be addressed, but he never took this seriously and did not appear to think there was a connection between his drug and alcohol consumption and his mental ill health.

89 File 5 Inpatient File Pages 15/16

The staff interviewed from the Assertive Outreach Team were surprised when they were told of this 2004 Court Report and its assessment of the risks Mr Y presented. They, in common with the majority of staff who had known Mr Y, saw him as having mellowed with age and considered that he was a 'bit of a character' for whom they had some affection.

As will become evident in the Section about the Assertive Outreach Team, the care coordinator and the community psychiatric nurse took their role seriously and did all they could to keep track of where Mr Y was in order to monitor his mental state and to give him his depot regularly. Given Mr Y's mobility during the time he was with the AOT the staff coped well in maintaining the contact they did achieve, as he regularly moved around within Bedfordshire and the surrounding counties, but also visited towns and cities further afield such as London, Birmingham and Northampton.

The real issue in the risk assessments made by the Assertive Outreach Team was that the main offence where Mr Y had tried to stab a young girl and her friend on their way to school had never been known by the local Bedford services and did not figure in any of the lists of convictions cited in the risk assessment analysis.

There was also a problem in that almost all of the information about Mr Y was collected from Mr Y and there was very little external independent validation. Mr Y was not always a reliable informant and historian when asked about events in his life. The team did not question his accounts of events, and did not appear to recognise just how many times Mr Y did use violence. There was also little knowledge of his whole history, including early childhood, apart from the summary provided by Dr 1 in October 1987.[90]

Risk Management

The basis of most of Mr Y's care plans, which did not vary much over time, was his need to have regular mental state examinations and to regularly have his depot injections. The risk forms tended to be rolled forward without adding anything new and the resultant care plans similarly were very like those in place for several years.

90 File 2 AOT Vol 1 Pages 235/237

There was a lack of a clear and concise chronological history of Mr Y which highlighted the main features of his history and the risks he had demonstrated in the past. The AOT appeared to be unable to see the potential violence Mr Y presented as they did not know all the forensic history, but also because they did not probe sufficiently to get behind some of his stock answers. They saw a quiet, usually genial service user who they thought they knew well.

13.4: The Use of the Mental Health Act

Context

The Mental Health Act 1983 is an Act of the Parliament of the United Kingdom but applies only to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people suffering from a mental disorder can be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

Section 117

Section 117 of the Mental Health Act 1983 (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include, amongst others, meeting psychological needs, helping with crisis planning, the provision of accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

Findings

Mr Y was appropriately supported by Section 117 when he was in the community and the Assertive Outreach Team helped him to move to different accommodation on two occasions, as well as providing occasional respite stays at Progress House. He was helped with an open invitation to attend the Drop-In Centre on Thursday lunchtime and was always able to visit the Assertive Outreach Offices.

Informal Patient Status

Context

The Mental Health Act 2007, as did the Mental Health Act 1983, distinguishes between informal admission to a psychiatric hospital and compulsory admission, where Sections of the Act are used to compel service users to be admitted to hospital for their own safety and/or the safety and protection of others, so that they can be assessed, or assessed and treated, for their mental health problems.

An informal patient is not subject to any restrictions on leaving the ward, although the staff would expect the patient to co-operate with them and to adhere to the ward rules and procedures. The nursing and medical staff have a duty of care to informal patients, as they do to all inpatients, and will therefore need to assess how they can best help the informal patient. Staff also have a duty to know where all inpatients on the ward are at any time for health and safety reasons, as well as to be able to observe and assess all the inpatients' mental health and to help them as and when indicated.

An informal patient is not subject to statutory powers and cannot be held on the ward against their wishes. There are however, some important related issues. Where ward exit doors are locked there may be a number of reasons for this, such as

- to keep undesirable visitors out;
- to prevent very ill patients who present a danger to themselves or others from leaving the ward.

The door should not be locked to prevent an informal patient from leaving. An informal patient has a right to request staff to open the door to allow him/her to leave. Should an informal patient wish to leave the ward this may be on a short term basis (a few hours during the day), long term (including a stay away from the ward overnight) or permanently (discharge).

Should an informal patient wish to leave the ward area staff will need to assess if it is safe for that patient to leave the ward, and if they consider the risk to the informal patient or another person is too high they can use Section 5 of the Mental Health Act. The staff will assess both

the possible harm that may occur to the informal patient, or to others, and the overall welfare of the informal patient. Section 5(2) or 5(4) of the Mental Health Act could then be used to enable the patient to be held against his will for 72 hours if detained by an approved clinician or for six hours by a nurse, until a medical assessment can be arranged should the risk persist. Mr. Y had 18 admissions to hospital from May 1987 to October 2008 and these are shown in Table 6 below:

Table 6: Admissions to Hospital: May 1987 to October 2008

Admission & Discharge	**Reasons for Admission**
17/05/1987 – 26/05/1987 (9days)	Informal admission following bizarre behaviour including him dancing in front of females holding an open penknife.
01/01/1991 – 07/02/1991 (38 days)	Unrecorded.
04/07/1993 – 13/07/1993 (10 days)	Informal admission after having physically abused a lady in Bedford Town Centre and for being threatening with a knife. He was deluded.
16/11/1993 – 23/11/1993 (8 days)	Informal admission after being aggressive to police and disturbing neighbours and threatening them with a knife and frightening their children. Religious beliefs and being a messenger towards evil. Also threatened estate agent with a bottle.
27/06/1996 – 04/07/1996 (9 days)	Mr Y was upset as his father had died and sought informal admission as a precaution due to unsettled behaviour.
02/07/1997 – 04/07/1997	Picked up by police in Cambridge wandering the streets and being deluded and claiming to have been to Mars. Admitted to Fulbourn Hospital.

04/07/1997 – 15/07/1997 (combined 14 days)	Mr Y transferred to Weller Wing, Bedford from Fulbourn Hospital.
03/10/1997 – 14/10/1997 (12 days)	S136 and admitted to Weller Wing for brandishing a knife in Bedford Town Centre.
26/12/1997 – 30/12/1997 (combined 12 days)	Arrested in Northampton. Was admitted to Farringdon Wing at Luton due to his bizarre behaviour and was later transferred to Bedford on 30/12/1997.
30/12/1997 – 06/01/1998	Admitted to hospital over Christmas and transferred to Weller Wing.
02/07/1998 – 14/07/1998 (12 days)	Admitted to Weller Wing for thinking he could fly and threatening to jump out of window.
04/12/1998 – 16/12/1998 (12 days)	No details available.
06/04/2000 – 08/05/2000 (31 days)	Admitted under S2 MHA as being aggressive and was taking cannabis. Set fire to mattress in flat and threw it out of window and also a bicycle. Had refused his depot injection. He was discharged in absence as he had gone to London whilst on leave.
23/08/2000 – 15/09/2000 (23 days)	Admitted to Oakley Court, Luton then transferred to Weller Wing on 31/08/2000. Informal as he felt unwell and was having hallucinations.
11/03/2004 – 30/03/2004 (19 days)	Admitted after complaining of suicidal thoughts and hearing voices. Settled well on ward after taking medication (Risperidone Consta).
30/10/2004 – 08/12/2004 (40 days)	Admitted from police custody for having and showing a knife in public and displaying bizarre thoughts and deluded claims.
01/02/2008 – 05/02/2008 (4 days)	Informal admission as Mr Y was experiencing auditory hallucinations from family members and was increasingly unhappy with his accommodation.
28/10/2008 – 12/11/2008 (16 days)	Arrested for throwing things from his 7th floor window onto cars below. He displayed flight of ideas and threatened to kill the psychiatrist and the Royal Family.

As is evident from the Chronology, Mr Y relapsed fairly quickly when he stopped accepting his depot. He had a fairly clear relapse signature which in 2000 was described as his exhibiting these symptoms and behaviours:

- paranoid ideas;
- mood swings;
- auditory hallucinations;
- suicidal ideas (CPN and Consultant Psychiatrist objected to this as they had never seen this behaviour);
- reduced appetite and disturbed sleep;
- excessive use of alcohol and cannabis;
- non-compliance with services.

In 2004 Mr Y's relapse signature was almost the same:

- non compliance with services, care plan and medication;
- psychotic symptoms – paranoia and auditory hallucinations;
- noticeable change of mood, becoming verbally aggressive and threatening towards others;
- increase in alcohol and illicit substances affecting his stability of mood;
- expressing suicidal ideation i.e. joining his late father;
- unkempt in appearance;
- lack of finances, associated with substance misuse.

Mr Y tended to become violent quite quickly and as the list of admissions to hospital shows his behaviour was similar. He was admitted six times for strange and aggressive behaviour with a knife involved in the incident. There were five occasions when he was admitted following aggression and deluded behaviour such as throwing things out of his flat window. On four occasions Mr Y sought admission himself because he:

- was upset as his father had died and needed to be quiet somewhere;
- he felt unwell and was having hallucinations;
- had suicidal thoughts and was hearing voices;
- was experiencing auditory hallucinations from family members and was also unhappy about his accommodation being on the seventh floor of some flats.

Once in hospital he generally complied with taking his medication and took part in some ward activities. At discharge Mr Y agreed to be followed up in the community by having outpatient appointments with the consultant psychiatrist and having regular depot injections prior to 2001. After this date he was referred to the Assertive Outreach Team and accepted visits from a Care Coordinator and also regular visits from a Community Psychiatric Nurse for the depot injections as well as being supported by a Care Support Worker.

Mr Y responded well to the Assertive Outreach Team as it was better able to actively follow him up in the community than the Community Mental Health Team had managed to. The prime reason for Mr Y to have been referred to the Assertive Outreach team was his failure to attend many of his outpatient appointments and to not attend for depot injections. The compliance to his treatment plan, whilst not always good, was much improved when he was under the Assertive Outreach Team.

The members of the Assertive Outreach Team were genuinely fond of Mr Y as the psychiatrists who had worked with him in the Community Mental Health Team had been. The good rapport he had with staff together with the appropriate use of the Mental Health Act enabled Mr Y to spend most of his time in the community, as generally his periods of admission to hospital were relatively short. Table 6, Admissions to Hospital, shows that his average length of stay in hospital was 16 days and the range was from four days to 40 days.

Mr Y was usually admitted to the Weller Wing at Bedford General Hospital but on two occasions he was admitted to Oakley Court in Luton and on one occasion to the Farringdon Unit in Luton. The first time was in 1997 on Boxing Day when he had been arrested in Northampton for criminal damage and he was admitted to the Farringdon Unit in Luton and transferred to the Weller Wing on 30 December 1997. The second occasion was in August 2000 when he was admitted to Oakley Court on 23 August and transferred to the Weller Wing a week later on 30 August.

The third time Mr Y was admitted to Oakley Court was on 28 October 2008 for his last admission prior to the homicide. There was no room at the Weller Wing and Mr Y was assessed under the Mental Health Act 2007 and diagnosed as having had a relapse of his paranoid schizophrenia. He had been agitated and violent and had been throwing things from the window of his flat on the seventh floor onto cars below. He displayed a flight of ideas and

delusions and had threatened to kill the psychiatrist and the Royal Family. Once assessed Mr Y became calmer and agreed that he needed to have some time in hospital and was admitted to Oakley Court as an informal patient. He had, on several admissions, asked the psychiatrist if he could be admitted as he was depressed and stressed, and tried to use admission to avoid facing trouble in the local community due to drug debts and owing money to money lenders.

Conclusion

The legal status of Mr Y was that he was not subject to the Mental Health Act and was therefore free to leave the hospital. If he had asked to leave in the first two days of his admission to Oakley Court it is highly likely that this request would have been refused as he was still showing psychotic symptoms and he would have been detained under the Mental Health Act (1983). In the event Mr Y did not wish to leave the ward as he had nowhere to go in Luton.

Mr Y was adept at 'working the system'; when his life became too complicated he knew that the Community Mental Health Team, up to 2001, would always help him. The position with the Assertive Outreach Team after 2001 was similar, and he again was admitted to hospital or for respite at Progress House if he felt stressed and needed a break.

Mr Y's final admission was to Oakley Court as an informal patient. However, because the staff at Oakley Court did not know Mr Y, and did not have access to his clinical notes, the period he spent there appeared to be one of waiting for a bed in Bedford so he could return to the Weller Wing where he was known. There was little evidence of active assessment or treatment during this period. Whether Mr Y was admitted to hospital as a formal or as a voluntary patient should not have influenced the duty of care owed to him and the actions that should properly have flowed from this. A recent judgement on a case in The Pennine NHS Trust has highlighted the issue by ruling that the duty of care to people admitted as informal patients is as high as that for detained patients.[91]

91 Rabone & another (Appellants) v Pennine Care NHS Trust (Respondent) [2012] UKSC 2 On Appeal from (2010) EWCA Civ 811

The Mental Health Acts, 1983 and 2007, were used appropriately for Mr Y. He was admitted to hospital as a voluntary patient as he agreed that he needed to be in hospital. He was only sectioned under the Mental Health Act on one occasion on 06 April 2004.

After Care under Section 117 was provided and the AOT worked to help him gain appropriate accommodation. Applications were sent to several local Housing Associations and at the time of the offence it appeared that appropriate accommodation might be forthcoming, but his bail conditions stated that he had to reside at Progress House, so a change in accommodation had to be put on hold. Once he was charged with murder and detained in prison the accommodation issue had to be abandoned.

13.5: Management of the Clinical Care – Inpatient and Community Services

Context

If a service is to function effectively, each of its component parts must have a clear remit as to its responsibilities, the functions it is to undertake, the services it is to provide, and the client group it is to serve. These parameters need to be set by the organisation in clear and relevant polices.

The Department of Health published *New Ways of Working* in 2007.[92] This required a change to established team working practice. A successful implementation of *New Ways of Working* required clear multi-disciplinary team management and clinical leadership. These roles were no longer identified with particular disciplines. The purpose of introducing this new policy was to promote patient-centred care and to ensure that the available resources were employed most efficiently and effectively for the benefit of service users. In this sense *New Ways of Working* supported the central role given to the care co-ordinators.

Findings

Multidisciplinary Team Working

From 1987 Mr Y was treated by outpatient appointments with a consultant psychiatrist and meetings with a community psychiatric nurse to give him depot injections. Mr Y did not

92 DoH (2007) Mental Health: *New Ways of Working for Everyone*

comply well with either intervention and there were many failed appointments. Little else was offered to him. When an inpatient his stays in hospital were generally of short duration. He joined in some ward activities but did not really engage with any therapeutic work and there was little attempt by professionals to refer him to the substance misuse service, Healthlink.

The Internal Investigation highlighted that between July 2000 and December 2004 Mr Y was offered 20 outpatient appointments and had attended only two of these. Of the other eighteen appointments, one was re-arranged due to the doctor being on annual leave, and one was re-scheduled as Mr Y stated he was unable to attend.

With the Assertive Outreach Team the approach was similar except that the care coordinator and community psychiatric nurse visited him and were able to be more flexible in their approach and dogged in their determination to find him.

Mr Y did not often see the consultant psychiatrist or the associate specialist within the Assertive Outreach Team and his care was largely delivered by the care coordinator and the community psychiatric nurse. The Team did have access to a psychologist. When the weekly Drop-In at the West Indian Club was established the team psychologist attended and informally spoke to the service users there. Mr Y spoke to the psychologist but when he was asked if he would like to have more formal sessions he declined and said he did not really want to talk about his experiences and would not engage in therapy.[93]

There is no evidence in the clinical records or care plans that consideration was given to providing Mr Y with therapeutic interventions, such as Cognitive Behavioural Therapy, as recommended by NICE, how these might be most effectively delivered and what benefit they might have for Mr Y's mental state and well being. It has to be acknowledged that given his usual response to therapy, it is unlikely that Mr Y would have made good use of it. Similarly was little serious consideration given to helping Mr Y tackle his substance misuse issues.

Dr 7 stated that in his experience the Assertive Outreach Team prior to the homicide did not have formal medical reviews of service users. The Associate Specialist provided day-to-day

93 Transcript 2

advice as required. The team appeared not to function with a comprehensive bio-psycho-social model. It tended to place greater emphasis on using a more social model.

When Mr Y was an inpatient there was not a multidisciplinary team on the ward. On the Weller Wing there was a consultant psychiatrist, nurses, and an occupational therapist but no wider multidisciplinary team. The same lack of a full multidisciplinary team was evident at Oakley Court where there were only medical and nursing members of the team plus the care coordinator from the community services. Mr Y did not have any other interventions from a wider group.

Conclusion

There was no full multidisciplinary team available to support Mr Y, although from his history of only partial engagement with services when it suited him, it is very unlikely that he would have accepted additional help. He did not wish to have formal sessions with the AOT Team Psychologist when this was offered and he did not engage with Healthlink for assistance with his substance misuse issues.

A wider range of disciplines and potential interventions may have been useful in the inpatient facilities as Mr Y did join in some groups both on the Weller Wing in Bedford and also to a lesser extent during his two admissions to Oakley Court in Luton.

Professional Communication

Communication

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion." [94]

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours cannot be met by one agency alone[95]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively.[96] In 1996 the Department of Health set out the

94 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) Pg.121

95 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). P.144.

96 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required, in its guidance *Building Bridges* (1996).

Within Mental Health Services the Care Programme Approach (CPA) plays a central role in ensuring that service users receive a co-ordinated service, with all those having in-put into the individual's care, sharing an understanding of his/her problems and working to a common set of goals. Communication is key to the CPA and to effective and efficient multidisciplinary and inter-agency team working in general. While good communication is not a guarantor of good clinical care, without good communication between those caring for an individual it is difficult, if not impossible, to achieve efficient and effective clinical care.

Local Context

Findings of the Internal Investigation

"Communication is the principle way of managing risk and providing safe and effective services. During the course of the review [Internal Investigation] we were struck by some examples of good communications and others where this could be strengthened. We have already made recommendations about communication links between community and inpatient services and we would urge the Trust to monitor these communication handovers."[97]

Findings of the Independent Investigation

During Mr Y's admission at Oakley Court from 28 October to 12 November 2008 the Luton staff had no information about his previous admissions to hospital. They did have his admission documentation and the results of the Mental Health Act Assessment. The clinical notes from the Weller Wing should have been sent to Oakley Court with Mr Y when he was admitted there, but this did not happen. The local policy on the notes going with the patient was thus breached.

Dr 4 did comment that because of the geographical area it was difficult to fully assess patients from Bedford, particularly in relation to deciding to give them leave to discover how they function before they are discharged. Communication with relatives tended to be infrequent or they did not visit. Dr 4 explained that it was very difficult to get collateral

97 The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (2009*) Serious Untoward Investigation Report.* P. 27

history when patients come from outside the Luton area. It was difficult for the care coordinators to attend regular meetings as travelling and attending the meeting could take almost half a day.[98]

In the situation with Mr Y it was fortunate that he was known to the Assertive Outreach Team which enabled the Care Coordinator to visit and to take him home on discharge. Some information was gleaned from Social Worker 1 when he attended the ward round on 03 November 2008 and was able to inform the staff about some of the background history. The plan for Mr Y after this ward round was for him to await transfer to the Weller Wing.

From the clinical notes it appeared that that the plan for Mr Y was that he would be discharged from Oakley Ward to the Weller Wing and then be discharged home. The notes for 03 November 2008, the day of the ward round state that there would be a "*discharge meeting next Wednesday [12 November] and that Care Coordinator 1 had been invited*." On 10 November 2008 the note on the clinical file stated that Mr Y was "awaiting transfer to Bedford" and if there was no bed available on the Weller Wing he would be discharged home on 12 November from the ward round that day.

As there was no bed in Bedford Mr Y was discharged with Social Worker 1 in attendance and in agreement with the decision for him to be discharged back to his flat. There was no formal Care Programme Approach Discharge Meeting. The Assertive Outreach Team Consultant Psychiatrist was not aware that Mr Y had been discharged home until after the homicide. This clearly breached the Trust Discharge Policy.

Forensic Opinion

Context: Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA are the statutory arrangement for managing sexual and violent offenders. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated way. Agencies at all times retain their full statutory responsibilities and obligations. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and later strengthened by the Criminal Justice and Courts Services Act 2003.

98 Transcript 1

The Criminal Justice and Courts Services Act 2003 did not change the criteria for inclusion in the MAPPA, but extended the scope by imposing a duty on public bodies outside the Criminal Justice System, including NHS Trusts, to cooperate with the responsible authority for MAPPA.

In practical terms this duty imposes the following obligations:

- a general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management;
- a duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPA criteria;
- the need to develop protocols between agencies for exchanging information and other forms of cooperation.

Every MAPPA is required to consider whether disclosure should take place to protect the public, especially children.

The 2007 guidance identified three categories of individuals who were eligible to be referred for MAPPA management: Category 1 – registered sexual offenders, Category 2 – violent and other sexual offenders and Category 3 offenders.

"*2.16 Category 3 Offenders: Other Dangerous Offenders - Sections 325(2) (b) Criminal Justice Act (2003)*

This Category is comprised of offenders, not in either Category 1 or 2 but who are considered by the [Responsible Authority] RA to pose a risk of serious harm to the public which require active inter-agency management. The inclusion of offenders in this Category is determined by the RA. Unlike Categories 1 and 2, identification is not determined by the sentence or other disposal of the court.

To register a Category 3 offender, the RA must:

Establish that the person has committed an offence with indicates that he/she is capable of causing serious harm to the public. This is not limited to those convicted by the courts, rather it includes adults who have been formally cautioned and juveniles who have been

reprimanded or warned. This is because all of those processes require an admission of guilt in relation to an offence.

Reasonably consider that the offender may cause serious harm to the public and that a multi-agency approach at level 2 or 3 is necessary to manage the risks.

The offence may have been committed in any geographical location, which means offenders convicted of a similar offence abroad fall within the MAPPA remit.

Establishing that a previous offence demonstrates a capability to cause serious harm can be complex. In some cases it will relate to the circumstances surrounding the offence, rather than the seriousness of the offence. For example, shoplifting of a camera may suggest a risk of serious harm if there are concerns about the offender taking indecent photographs of children.
The responsibility for identifying Category 3 offenders lies with the agency that initially deals with them. It is for the RA to determine if they meet the criteria set out above." 99

The levels of "risk of serious harm" used by the Offender Assessment System (OASys) are:
Low: current evidence does not indicate likelihood of causing serious harm;

Medium: there are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstance, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol abuse;

High: there are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious;

Very High: there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious.100

There are three levels of MAPPA management. They are based upon the level of multi-agency cooperation required with higher risk cases tending to be managed at the higher levels. Offenders are moved up and down levels as appropriate.

99 National Offender Management Public Protection Unit (2007) MAPPA Guidance: Version 2 p.25
100 MAPPA Guidance 2007 Section 5 Page 39

Level 1 – Ordinary agency management is for offenders who can be managed by one or two agencies (e.g. police and/or probation). It will involve sharing information about the offender with other agencies if necessary and appropriate;

Level 2 – Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at Level 2, there will be regular MAPPA meetings about the offender.

Level 3 – The same arrangements as Level 2 but cases qualifying for Level 3 tend to be more demanding on resources and require the involvement of senior people from the agencies, who can authorise the use of extra resources, for example surveillance on an offender, or emergency accommodation.

All offenders supervised by the Probation Service must comply with the conditions of their order or license. Any failure to do so results in action being taken. For those on license this could mean a return to prison and, in emergency situations, this can happen within two hours. A failure to comply does not necessarily mean that an offence has been committed. It could be a missed appointment or any behaviour which gives cause for concern.[101]

Findings

Mr Y was not referred to the forensic service in Bedford. The Independent Investigation Panel was informed that there was a small community forensic service but that Mr Y would not have been seen as an urgent referral as he appeared to be complying reasonably well with the Assertive Outreach Team.

Conclusions

Given his forensic history and his known history of aggressive and violent behaviour it would have been useful for the Assertive Outreach Team to have had a forensic assessment. The Assertive Outreach Team was not in possession of a full risk history which possibly caused then to underestimate the risk Mr Y posed when he was relapsing.

101 http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_074106

They saw Mr Y as having mellowed over the years and had observed that his arrest history and risk record had slowed down significantly since being with the Assertive Outreach Team. At the time of the homicide he was then a man in his fifties, and they thought that he had got slower and older and had matured. Mr Y had presented to the staff as an adult and more intact, in some respects, than many of the younger clients who were more prone to protest and demand instant responses. Although Mr Y had not had particularly pleasant life experiences he did not complain about his situation all the time as younger clients with the Assertive Outreach Team were reported to have done.

Given his forensic history the Independent Investigation Panel felt that Mr Y would have been an appropriate person to have been discussed by the Multi-Agency Public Protection Arrangements (MAPPA) process. He may have been beneath the criteria for inclusion, but he was certainly someone who when he was ill was known to several different agencies, including health services, housing, probation and the police.

Mr Y had not been referred to MAPPA and Team Manager 1 stated that at the time it could have been appropriate for Mr Y to have been referred. The system in place for 'complex cases' was that 'Volatile Service User Returns' had to be sent fortnightly to the Risk Team. The criterion was that the service user had a significant risk history. The then Medical Director examined the returns and decided, as the link to MAPPA, which cases were referred. This process was later validated by a manager within the Trust.

Conclusion on Mr Y's overall management and clinical care

The choice of treatment and care for Mr Y was rather one-dimensional in the sense that throughout his involvement with the mental health services from the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust he saw just a psychiatrist and a nurse up until 2001, and then saw a community psychiatric nurse and a social worker plus outpatients appointments up to 2006, when he saw a community psychiatric nurse, a social worker and a care support worker after this, except when he was an inpatient.

The Independent Investigation Panel accepts that Mr Y was difficult to engage and that he did not have much insight into his problems, but it did question whether a more comprehensive approach to providing support to him may have been worthwhile. The involvement of a forensic service could have proved useful given his history of offending. It

would have been fruitful to have referred him to the MAPPA so that he could have been better supervised with a multi-agency view being gathered and a better opportunity to keep abreast of his activities and whereabouts. It would also have provided his antecedent criminal record which would have included the early, and forgotten, attack on the two young girls. It is worth noting here that at his Court Case for the manslaughter of Mr R on 27 November 2009, the Crown stated that Mr Y had criminal antecedents, namely "26 convictions, 53 offences, [of which] 10 were against the person, 12 against property, five public order offences, six offences relating to the police, eight drug offences and three offensive weapon-related offences. Many of these were not known to the Mental Health Services in Bedfordshire and Luton.

It could be that Mr Y would not fulfill the criteria for being reviewed by MAPPA, but in many areas the MAPPA process has accepted that there are people who, whilst being 'sub-MAPPA', do cause agencies considerable concern and so a separate meeting is arranged where these people can be fully discussed and a joint approach can be developed to help meet their needs. This could have been useful to the Assertive Outreach Team in dealing with Mr Y's difficulties from 2004 to 2008.

The use of Oakley Court was inevitable when the beds in Bedford were all in use. However that fact that Mr Y was seen to be awaiting transfer back to Bedford led to little proactive work being offered to him. This was not best practice. The relevant clinical notes should have been sent to Oakley Court so that the inpatient team knew the situation with Mr Y and his previous history, and did not have to rely on the verbal details provided by Social Worker 1. Little appeared to have been done to locate and access the notes. There was no evidence of Dr 4 having discussed with Dr 7 (the Bedford Consultant Psychiatrist) what treatment plan he would want for Mr Y prior to his discharge. Dr 7 had arranged this hospital admission and this would have been good practice.

The Independent Investigation Panel considered that the lack of a full multidisciplinary team at both the Weller Wing and at Oakley Court was poor practice given the needs of Mr Y and the other clients of the Assertive Outreach Team and the Community Mental Health Teams. A range of professional views is an important part of building up an accurate picture of the needs of patients and also in developing appropriate and achievable care plans for them. NICE guidance is explicit that for individuals with a diagnosis of schizophrenia

psychological interventions, such as Cognitive Behavioural Therapy (CBT) should be available, and that one should not wait until discharge for such treatment to commence.

The discharge from Oakley Court was poorly handled although the Care Coordinator was present, there was no formal Care Programme Approach Meeting or Discharge Meeting and not all members of the Assertive Outreach Team who were involved with Mr Y were aware of his discharge. There was no record of a full mental health state examination prior to Mr Y being discharged back to his flat in Bedford.

The decision appeared to have been based on how Mr Y had responded to his medication and the observations of the nursing staff on his improving behaviour and better inter-relationships with staff and other service users and the lack of incidents requiring attention on the ward in the last five days prior to discharge.

The difficulties identified by Dr 4 about the management of patients from Bedford at Oakley Court appeared to the Independent Investigation Panel to be a service issue as the best interests of patients and their friends and families was clearly not being considered. Some rapid way of moving patients back to their home area should have been identified.

13.6: The Assertive Outreach Team/Role of the Care Coordinator and the Community Psychiatric Nurse

Context

The Assertive Outreach Team

The Department of Health Policy Implementation Guidance[102] stated that Assertive Outreach Teams would provide a service for adults aged between 18 and approximately 65. It continued to specify the types of mental illness the teams were designed to assist:

> "*A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability*
>
> 1. *A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than six months inpatient care in the past two years)*

102 The Mental Health Policy Implementation Guide, DoH 2001 Pages 26-42

2. *Difficulty in maintaining lasting and consenting contact with services*
3. *Multiple, complex needs including a number of the following:*

- *History of violence or persisting offending;*
- *Significant risk of persistent self harm or neglect;*
- *Poor response to previous treatment;*
- *Dual diagnosis of substance misuse and mental illness;*
- *Detained under the Mental Health Act (1983) on at least one occasion in the past two years;*
- *Unstable accommodation or homelessness."* [103]

The Guidance went on to state that "using an assertive outreach approach can:

- *Improve engagement;*
- *Reduce hospital admissions;*
- *Reduce length of stay when hospitalisation is required;*
- *Increase stability in the lives of service users and their carers/family;*
- *Improve social functioning;*
- *Be cost effective."*

The Assertive Outreach Service was reported to be able to:

- *"Develop meaningful engagement with service users, provide evidence-based interventions and promote recovery;*
- *Increase stability within the service users' lives, facilitate personal growth and provide opportunities for personal fulfillment;*
- *Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs;*
- *Support the service user and his/her family/carers for sustained periods;*
- *Promote effective interagency working;*
- *Ensure effective risk assessment and management."* [104]

103 The Mental Health Policy Implementation Guide, DoH 2001 Page 26
104 The Mental Health Policy Implementation Guide, DoH 2001 Pages 27

Other highlighted qualities of the Assertive Outreach Approach included the need for regular review in the form of brief daily review meetings to ensure those with the greatest risk and/or needs were identified. Weekly review meetings with the consultant psychiatrist were seen as important so that action would be agreed and any changes in treatment with discussion involving the whole team. Progress and outcomes were to be regularly monitored with a care plan formally reviewed at least six monthly.

The composition of an Assertive Outreach Team was also specified but with some allowance for local circumstances. A team was designed to cover a population of approximately 250,000 and its make up was to reflect the local demography. A team would be expected to have a clientele of 90 service users and the team should comprise the following staff:

Table 7: Recommended Staffing and Actual Staffing in the Assertive Outreach Team

Staff Members	**Numbers (DoH) specified**	**Bedford AOT**
Community Psychiatric Nurses*	There needed to be	3
Approved Social Workers*	8 Care Coordinators	3
Occupational Therapist*	from the	1
Team Leader*	five staff groups	1
Psychologist*	Listed and marked *	1
Consultant Psychiatrist	0.5	0.3
Non Career Grade Psychiatrist	0.5	0.5
Support Workers	To reflect local needs	3

*Able to act as care coordinator

The Policy Implementation Guide proposed that the care coordinators should not have responsibility for more than 12 service users.

Local Context

The Local Operational Policy for the Assertive Outreach Team

As can be seen from the section below taken from the local Bedfordshire Assertive Outreach Operational Policy, the Assertive Outreach Team providing a service to Mr Y had an Operational Policy which closely reflected the National Policy Implementation Guidance.

"*The Bedfordshire Assertive Outreach Service was developed in partnership with the Bedfordshire and Luton Community NHS Trust, Bedfordshire Social and Community Care, Luton Social Services and the Bedfordshire Health Authority in 2001. The service was extended to the South Bedfordshire area in December 2008.*

The Operational Policy for the Assertive Outreach Team very largely conforms to the definition provided in the National Service Framework Policy Implementation Guidance. The Operational Policy states that the purpose of the Assertive Outreach Team is to:
"provide a service to meet the needs of people with a severe and enduring mental illness and who historically have not engaged with mental health interventions for a variety of reasons. The AOT's aim to safely and effectively manage risk to service users, the public and providers of services and aim to deliver their service in a 'culturally sensitive' and flexible manner"

The objectives of the Assertive Outreach Team were to:

- *develop meaningful engagement with service users, provide evidence based interventions and promote recovery;*
- *increase stability within the service users' lives, facilitate personal growth and provide opportunities for personal fulfillment;*
- *provide a service that is sensitive and responsive to service user's cultural, religious and gender needs;*
- *support the service user and his/her family/ carers for sustained periods;*
- *promote effective interagency working particularly with drug and alcohol services, police, probation, prison, housing and child protection services;*
- *ensure effective risk assessment and management;*
- *promote improved access to services which promote physical, sexual and dental health;*
- *promote social inclusion and recovery;*

- *facilitate money management and reduce the impact of poverty;*

- *reduce homelessness and advocate allocation of appropriate housing.*[105]

Transfer of Cases Policy

The Policy for the Transfer of Cases was included in the Care Programme Approach Policies dated 2007 and 2008 and was unchanged between the two versions of the policy. No earlier Policies are available within the Bedfordshire and Luton Mental Health and Social Care NHS Partnership Trust so it is not known what policy should have been followed when the CMHT contacted the Assertive Outreach Team and requested a transfer.

The Care Programme Approach Policies for 2007 and 2008 stated that the transfer process should be as shown below:

"*Before a service user requiring an Enhanced CPA care plan moves out of the geographical area where they are being cared for, liaison must take place between the relevant organisations. The original NHS Trust and Social Services Department have responsibility for passing all relevant information to the receiving NHS Trust and Social Services Department. This may involve a joint review with the appropriate team members from the sending and receiving NHS Trust and Social Services Department. In the case of spontaneous unplanned moves, every effort must be made to maintain contact with the individual and to transfer care to the receiving authorities. This should involved the appropriate team members from the original MDT contacting appropriate team members in the team that is most likely to receive the service user in a new area – simply sending written information to a "Department" is not sufficient.*

The same principle applies for the transfer of service users requiring enhanced CPA care plans between teams within the specialist Adult Mental Health Services. However, it is good practice that the service user is transferred to another team only after a 3-month period of relative stability. This may be subject to change depending on the needs of the service user. This should be explicit in the operational policies of each service and their transition protocols.

When discharging a service user from an inpatient setting CPA 11 should be completed and a copy held in the records.[105]

The Referral from the CMHT to the Assertive Outreach Team

The referral from Community Psychiatric Nurse 3 was initiated by letter on 10 July 2001.

The letter stated: *"I have worked with [Mr Y] for nearly three years. He is usually friendly but tends to leave long gaps between his depot injections, which should be every two weeks. He often visits friends or relatives at various other locations, London and Birmingham for example. On his return he is often in a psychotic state, dishevelled and unkempt. It is thought that he abuses drugs and alcohol on many occasions but he denies this.....*

He has had numerous admissions to Weller Wing and respite stays at Progress House. His main diagnosis is schizophrenia with a secondary diagnosis of substance abuse. For further information please see assessments, reports and correspondence within his file"[106]

Findings

Given his history over several years Mr Y appeared to be exactly the type of service user the Assertive Outreach Team had been set up to work with. Throughout the previous 22 years he had missed outpatient appointments and failed to comply with his medication even though he knew this could lead to his psychosis returning. He never really accepted that continuing to drink alcohol and take illicit drugs, usually cannabis and crack cocaine, was detrimental to his mental health.

The description of an Assertive Outreach Team and the people such a team was designed to cater for appeared to meet the profile of Mr Y very well. The Independent Investigation Panel concluded that the Bedford Assertive Outreach Team worked well with Mr Y, but found him reluctant to accept any specific therapies or other structured interventions. He fitted the criteria for an assertive approach in terms of his criminal record and his history of violence, as well as his use of illicit drugs and alcohol. His accommodation was not secure although he was fortunate to have a girlfriend in the local area with accommodation where he spent

105 Integrated Care Programme Approach and Care Management Policy (2007) Pages 17/18
106 File 2 AOT Vol 1 Page 45/49

considerable periods of time when things were difficult for him in Bedford. These difficulties arose due to his substance misuse and his poor relationships with money lenders and the people his father had had dealings with in relation to illicit drugs.

The Care Plan dated 10 July 2001 stated that the objectives of the Care Plan were:

- to monitor psychological, physical and social circumstances in the community;
- the administration of depot medication and observation of the effects of same;
- to support and advise client in the community;
- to review on a regular basis.

On 19 July 2001 Social Worker 1 wrote to Mr Y seeking a meeting with him on 27 July when Community Psychiatric Nurse 3 would also be present to agree how the Assertive Outreach Team could best help him.

This was a reasonable transfer as the main worker from the CMHT and the proposed Care Coordinator from the Assertive Outreach Team were planning to meet with Mr Y to discuss the way forward with his care. It was clear that the Assertive Outreach Team had more resources in terms of staff and protected caseloads to provide a more rigorous and assertive approach to Mr Y's care and treatment.

Throughout the Clinical Records there is evidence that the Assertive Outreach Team provided a 'safety net' for Mr Y, as whenever he had social problems Social Worker 1 and the Support Worker 1 would find him appropriate help and support. They found him a change of housing on two occasions and provided practical support at the Drop-In on Thursdays. The Community Psychiatric Nurse helped Social Worker 1 to assess the mental state of Mr Y and gave him his depot injections.

The main therapeutic intervention for Mr Y from the Assertive Outreach Team was the provision of depot injections. Mr Y had an extremely poor track record for attending outpatient appointments and for going for depot injections at the appointed time and day; the Assertive Outreach Team workers are to be congratulated for maintaining a working relationship with him.

Table 8 below shows the date for depot injections, and when and where they were given, from December 2006 to the day of the homicide on 15 November 2008.

Table 8 List of Depot Injections (December 2006 to November 2008)

Date	**Venue**	**Notes**
22/12/2006	Girlfriend's flat	Depot given
04/01/2007	At Mr Y's new accommodation at Richbell Court	Depot given
22/01/2007	Girlfriend's flat	Depot given
22/02/2007	At Prebend Day Centre	Depot given
22/03/2007	Mr Y did not turn up at his home for the depot.	Not given until 05/04/2007 at Richbell Court
04/05/2007	Girlfriend's flat having gone to Mr Y's flat to find he was not there.	Depot given
05/06/2007	Girlfriend's flat	Depot given
03/07/2007	Girlfriend's flat	Depot given
01/08/2007	Girlfriend's flat	Depot given
29/08/2007	Girlfriend's flat	Depot given
25/09/2007	Girlfriend's flat	Depot given
23/10/2007	Girlfriend's flat	Depot given
20/11/2007	Depot due – Mr Y not at home nor at Girlfriend's flat. Mr Y was at drop-in two days later where depot given.	Depot given on 22/11/2007.
18/01/2008	Depot due – Mr Y not at home. Was seen on 22/01/2008 at home.	Depot given on 22/01/2008.
19/02/2008	At his flat	Depot given.
18/03/2008	Mr Y not at his flat but at Girlfriend's flat.	Depot given.
24/04/2008	Mr Y was at drop in but wanted his depot at home.	Depot given.
22/05/2008	Mr Y not at home. He was seen on 27/05/2008 but refused to have depot until Thursday.	*Assume it was given a few days later but no record in files*
26/06/2008	Depot due no answer at flat.	Depot given 03/07/2008
29/08/2008	Mr Y's flat	Depot given
26/09/2008	Mr Y's flat	Depot given

24/10/2008	Depot due. Mr Y not at flat.	Acuphase 100mg given 29/10/2008. Depot given on 07/11/2008.
21/11/2008	Depot due	Not clear when given. Probably whilst at Progress House.

The Table above shows that in the 22 months from 22 December 2006 to 07 November 2008 Mr Y should have received 24 depot injections. He actually received 22 having missed those due in March and December 2007. This was a significant increase to his previous compliance since 2001, and a totally different set of figures when he was being treated by the Community Mental Health Team.

Conclusion

The Independent Investigation Panel considered that the Assertive Outreach Team did the best they could in ensuring that Mr Y had his regular depot injections and reviewing his mental health. This was largely achieved by frequenting the places where he was likely to be: his flat in Bedford, with his girlfriend in a nearby town or at the weekly Drop-In service. In this way the Care Coordinator, the Community Psychiatric Nurse and the Care Support Worker managed to keep in touch with Mr Y, although he was at times able to avoid them by going to London or elsewhere.

Despite Mr Y's reluctance to fully engage with services the AOT managed to know where he was most of the time and certainly during the period from January 2007 until the homicide in November 2008.

Mr Y did not want to be involved in therapeutic interventions and only partially engaged with the services offered by the AOT. As discussed at length above in the Section on Diagnosis, the Independent Investigation Panel thought that Mr Y's primary diagnosis might be substance abuse given the nature of his psychosis developing quickly and responding quickly to medication once Mr Y was an inpatient. Greater use might have been made of the Healthlink Substance Misuse Service as it is clear that Mr Y actively used alcohol and illicit drugs throughout his time in contact with the mental health services. He openly acknowledged this when interviewed in the medium secure unit by two members of the Independent Investigation Panel.

Mr Y also relied heavily on the Assertive Outreach Team when he was 'stressed'. He would present at the Police Station or the Accident and Emergency Department and say that he felt his psychosis was returning. Such action usually led him to be offered an inpatient placement which, on all but one occasion, resulted in Mr Y being admitted as a voluntary patient. On these occasions Mr Y was admitted to an acute ward, usually Keats Ward on the Weller Wing at Bedford Hospital.

Mr Y also relied heavily on his girlfriend in a nearby town and the Assertive Outreach Team usually knew where to find him if he missed his depot injection. The next section looks at whether the Assertive Outreach Team should have offered his girlfriend more support in the form of a Carer's Assessment in her own right to identify her needs.

The Independent Investigation Panel considered that the Assertive Outreach Team worked well with Mr Y but that there was a lack of medical review and reflective practice to try to identify if there were other interventions which would be appropriate for Mr Y. One of the tasks of an Assertive Outreach Team was to "*promote effective interagency working particularly with drug and alcohol services, police, probation, prison, housing and child protection services."*

Mr Y was known to regularly use illicit drugs and alcohol but he was seldom engaged in conversation about the need for him to make contact with Healthlink, the local Bedford Substance Misuse Service. He was known to have a dual diagnosis but the drug and alcohol issues were seldom addressed, even though some staff did think he could have had a drug induced psychosis.

13.7: Involvement of Carers

National Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at*

meeting their wishes'. In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that '*People with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care*'. Also that it will '*deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed*'.

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also legislated for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensures that services take into account information from a carer assessment when making decisions about the cared for persons' type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they cared for.

The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health stated that all individuals who provide regular and substantial care for a person on CPA should:

1) *"Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.*

2) *Have their own written care plan which is given to them and implemented in discussion with them".*

Local Policy

The Local Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust Care Programme Approach Policy dated 2006 had a short section about the Carers Assessment. It stated:

"*The service user's needs assessment should also prompt staff to carry out a Carers Assessment in line with the Carers Equal Opportunities Act (2004) and the Carers Recognition & Services Act 1995. Carers are defined as individuals who provide regular and substantial care for a person on CPA. Carers should:*

- *have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;*
- *have their own written care plan which is given to them and implemented in discussion with them. This is defined at the end of the revised carer's assessment form CPA8 (Standard 6, NSF for Mental Health 1999.)*

All carers (as defined below are entitled to an assessment of their needs, and the Care Coordinator must consider a carer's outside interests, work, study, or leisure activities/interests. (The Carers Equal Opportunities Act 2004)

A Person under the age of 18 who provides support in the context of the above paragraph is defined as a Young Carer. Where a Young Carer is identified referral to Child and Family Services should be made.

A person aged 18 or over who provides support in the context of the above paragraph is defined as an Adult Carer.

Involvement of an Advocacy Service and/or Translation/ Interpreter Service should be accessed where required to ensure effective agreement and/or communication between the service user and/or carer and the Multidisciplinary Team."[107]

Findings

Mr Y relied on his girlfriend and he spent considerable amounts of time with her. He moved between Bedford and a nearby town depending on how threatened or uncomfortable life was

107 Integrated Care Programme Approach and Care Management Policy Pages 11/12

in his own flat in Bedford. Table 5, showing the record of Mr Y having his depot injections, demonstrates that he spent the majority of his time in a nearby town with his girlfriend from December 2006 until March 2008.

As has been seen the mental health staff from the Assertive Outreach Team made great efforts to keep in touch with Mr Y in order to ensure that he took his medication and so that they could assess his mental health. There is no evidence from the clinical records that the girlfriend was offered a carer's assessment, and she may not have considered herself a carer. It appears evident that Mr Y treated her as such and saw her home as a convenient bolt-hole should his less desirable acquaintances and former associates in Bedford be chasing him for money.

His life was certainly more comfortable than it would have been had he not had this relatively longstanding relationship. In this context she would have been eligible for an assessment in her own right, and this may have provided her with additional support. It was also noted that the only source of information about Mr Y was himself, and he may not necessarily have been the most reliable historian about his past or current situation. In assessing his girlfriend she could have acted as a further source of information about Mr Y and been able to confirm or deny some of his history.

Conclusion

The Assertive Outreach Team did not follow the Trust's policy in relation to the CPA Section about the need to invite carers to have an assessment of their own needs, and any assistance which would help them provide care to the service user. It is unclear whether Mr Y would have seen his girlfriend as a carer, and also whether she thought of herself as a carer, but nevertheless this should have been discussed with her.

13.8: Clinical Governance Processes

13.8.1 SEPT describes its current governance structures as follows:

SEPT's key aim for the Trust's serious incident reporting and learning process is to reduce the risk of recurrence, both in the service in which the original incident occurred and elsewhere in the Trust and, as appropriate, in partner organisations. This process has been formalised via the establishment of the Trust's Serious Incident Review Group.

The timely and appropriate dissemination of learning from a serious incident is core to achieving this aim and to ensure that lessons are firmly embedded in practice. As additional assurance around embedding learning, SEPT ensures that there is a clear link between the learning from serious incidents and serious case reviews carried out under the multi-agency safeguarding policies and procedures.

Reporting and Monitoring Governance:

The Trust's Clinical Governance Committee reports to the Integrated Governance Committee, which is a formal sub-committee of the SEPT's Board of Directors.

Action plans capturing recommendations made as a result of serious incident internal investigations are put in place as soon as final reports are submitted. The Trust's Head of Serious Incidents and Quality shares these plans with Commissioners through central reporting mechanisms.

Action plans are monitored robustly through local operational governance arrangements until all recommendations are completed satisfactorily. The Head of Serious Incidents and Quality has a clear and measurable monitoring role in this process. Portfolios of evidence are required from service leads to demonstrate that the relevant learning has led to change.

Disseminating Learning:

Learning is disseminated by the Learning Lessons Review Group to staff and key leads. The minutes of the Learning Lessons Group are shared with the Trust's Clinical Governance Committee.

The Learning Lessons Review Group has representation from all the services Trust-wide. It reviews and disseminates learning in aggregate from incidents, serious incidents, near misses, complaints, audits, external investigations and claims.

Serious Incident learning summaries are produced and widely shared through a robust formalised process which requires confirmation by managers that the learning has been received and discussed by their team. Any change to practice made by other teams is captured through this process.

Learning summaries from mental health serious incidents are also shared with community health services colleagues, so that lessons are learned across the whole organisation.

The Learning Lessons Review Group considers whether learning can influence on-going work streams. Recent examples of this include the review of the clinical risk training programme to include lessons learned from serious incidents, input into the outpatient redesign project and input into the development of the Trust's annual clinical audit programme.

New Ways of Working

Context

In October 2007 *New Ways of Working for Everyone* was published. This document set out the national implementation guide for policy change that had been in development over a period of four years previously. The Department of Health stated that *New Ways of Working "promotes a model where distributed responsibility is shared amongst team members and will no longer be delegated by a single professional such as the consultant".*

The Department of Health also stated that *"this cultural shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs. More experienced staff will then support other staff to take on less complex or more routine work. All qualified staff will be able to extend the boundaries of what they do (i.e. non medical prescription) and there will be more chances for new roles*

such as support time and recovery workers (STR), primary care mental health workers and assistant practitioners to take their places within teams".[108]

Findings

During interviews with staff from the Assertive Outreach Team and with the new managers from the South Essex Partnership NHS Trust it became clear that the medical staff, at the time of these events, within the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust felt marginalised from the mental health multidisciplinary teams. This was partly due to the non-medical members of the team working closely together and operating as though the medical staff were there primarily to prescribe medication and to undertake assessment under the Mental Health Acts 1983/2007. The psychiatrists themselves did not help matters by adopting a largely reactive role rather than being proactive, and challenging, constructively, the care plans and mode of treatment for the service users through regularly reviewing their care.

New Ways of Working was introduced in the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust without inclusive and comprehensive discussion of what it would entail and its possible effects. As a result the psychiatrists felt isolated from their teams and adopted the role in which they were viewed by the staff of the Assertive Outreach Team, as prescribers and Mental Health Act assessors.

The Independent Investigation Panel was surprised by the sense of relative 'powerlessness' displayed by the medical staff from the Assertive Outreach Team, and their having little opportunity to meet as a group of psychiatrists across the Trust. Far from leading the Team they appeared to have waited to be asked to become involved.

In 2010 The Royal College of Psychiatrists produced a document entitled 'Responsibility and Accountability – Moving on from New Ways of Working to a creative, capable workforce' This is clearly after the period that the Assertive Outreach Team was working with Mr Y, but it does highlight the disruption the initial implementation of 'New Ways of Working' caused in many mental health services. The document states that:

108 DoH (2007) Mental Health: *New Ways of Working for Everyone*

"New ways of Working (NWW) is about the development and maintenance of multi-disciplinary creative, capable teams working with efficient processes to deliver person-centred care, and it has brought questions relating to responsibility and accountability to the fore, for a variety of reasons:

- *The degree of multi-disciplinary working required to develop and implement NWW has revealed that professions often understand little about one another's roles and responsibilities, in particular their regulation.*
- *Practitioners, managers, service users and carers have had to understand the responsibilities of colleagues undertaking new roles in mental health care, and how those roles mesh with the others in the team and across the system.*
- *The possibilities for extending roles beyond the scope of traditional practice have resulted in more areas of overlapping skills.*
- *The emphasis on effective team-working and distribution of responsibility has necessitated a re-evaluation of notions of responsibility relating to particular roles or professions.*
- *Responsibilities may never have been clear, and new staff or new interfaces with other teams have made this apparent.*
- *Greater service user and carer involvement in service design and improvement initiatives may lead to greater challenges to long-held assumptions."*[109]

Whilst this was written just over a year after the homicide in November 2008 it does provide a good analysis of some of the difficulties the members of the Assertive Outreach Team described during their interviews with the Independent Investigation Panel. This was confirmed by Manager 3 from the East of England Strategic Health Authority who reported that the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust Management Team appeared to struggle to reform the governance arrangements and the clinical difficulties apparent in the implementation of News Ways of Working were further evidence of this.

Initially the Chief Executive of South Essex Partnership NHS Trust was asked to help the managers of the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust to improve the management structure, and to improve the quality of the mental health

109 Responsibility and Accountability: Moving on for New Ways of Working to a creative, capable workforce. Best practice guideline. DoH February 2010.

services. Service users were unhappy about the service they received as inpatients, and ultimately the management of the Trust was changed and a tender process established for another Trust to take over the management of the services in Bedfordshire and Luton. The South Essex Partnership NHS Trust was successful and the staff from the Assertive Outreach Team commented that the management was much improved and that support and help was more available than in the past.

Findings

In April 2006 Dr 7 was appointed to be the consultant psychiatrist in the Assertive Outreach Team and to provide two sessions a week. He was also the consultant psychiatrist providing six sessions a week to the Crisis Resolution and Home Treatment Team. At that time Responsible Medical Officer (RMO) responsibility was with individual community mental health team consultants, and there was an Associate Specialist who was "*running*" the Assertive Outreach Team. Once Dr 7 was appointed to the Assertive Outreach Team he became the RMO for all its patients and had support from the Associate Specialist, Dr 8, who had been there for some time.

It was clear that the medical staff, at this time, within the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust did not routinely see all the caseload of the Assertive Outreach Team for medical reviews, and there were some service users who were not seen. Dr 7 only knew of Mr Y because he was called to undertake a Mental Health Assessment when Mr Y was throwing things out of the window of his flat in October 2008. Dr 7 was considering placing Mr Y on a Section 3 of the Mental Health Act as he was clearly psychotic, but following the assessment Mr Y agreed that he needed to be in hospital and was thus admitted as an informal patient.

Within the Assertive Outreach Team Dr 7 felt uncomfortable as 'the new member of the team'. He had been unable to implement some practice changes in the way the team worked which were based on his previous experience as the Consultant of an Assertive Outreach Team in Birmingham. The team was well established and several members had worked with the team since its creation in 2001. As a result they tended to 'override' Dr 7's suggestions and continue with the way they had always worked. As he put it the balance between the medical contribution and the professional input was not right at that time, being opposed to the medical opinion.

There was a weekly Multi-Disciplinary Team Meeting to which members of the team would bring issues connected with service users they were concerned about, but the consultant did not discuss any people he might have had views about. The care-coordinators controlled the agenda and highlighted those situations where service users had stopped taking their medication or had other potentially risk raising issues which they wished to discuss with the consultant.

In discussion it was also pointed out that when a new service user was referred to the Assertive Outreach Team the medical staff were not involved. When, following an assessment and a new referral was accepted, the team manager made the decision that they were suitable for the service. The Associate Specialist, Dr 8, would see a new service user and go through all the details of their mental health history. The consultant considered that his contribution was to provide an assessment and to give advice if a service user was suffering a relapse or if other staff were concerned and needed a medical opinion.

Dr 8 confirmed the role of the medical members of the Assertive Outreach Team. He commented that when Mr Y had been discharged from Oakley Court on 12 November 2008 Social Worker 1, his care coordinator, had taken him back home to Bedford. Dr 8 explained that usually the care coordinator or the CPN would see service users when they were discharged from hospital, and that he would review the situation if they requested it, but otherwise he would see them after roughly two weeks.

On this particular discharge Mr Y had been at Oakley Court, and the plan prior to the day of discharge had been for him to be discharged back to the Weller Wing and for the team that knew him to decide on the discharge to his home. It was known that there were no spare beds in Bedford and that Mr Y would be going back to his home, and therefore the view of Dr 8 who knew him quite well, and Dr 7 who had admitted him to Oakley Court two weeks earlier, would have been helpful. As it was Social Worker 1 knew him very well and considered him to be well with no evidence of psychosis other than talking about religion a little on the journey back to Bedford.

Had Mr Y not been apprehended by the police on 28 October 2008 Dr 7 would never have seen him. There was no system whereby all the service users known to the Assertive

Outreach Team were reviewed, and Dr 7 admitted that he did not know the detailed histories of all the team's caseload. There were opportunities for 'reflective practice' with service users about who there were concerns, but no formal review system, and Mr Y had not been raised in this context.

Conclusion

As is evident from the situation described above the various roles and responsibilities were in need of review, and New Ways of Working perhaps 'muddied the waters' in the Trust due to the lack of attention given to the governance arrangements. The Trust Board was struggling to improve the services it provided.

Due to the difficulties the medical staff had in understanding their roles under the New Ways of Working agenda the Assertive Outreach Team did not use its resources to best effect and service users did not receive the level of medical oversight they should have had.

14. Findings and Conclusions

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

Root Cause/Causal Factor

The term is used in this Report to describe an issue or critical juncture that the Independent Investigation Panel has concluded had a direct causal bearing upon the death that occurred on 15 November 2008. In the realm of mental health service provision, it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide (manslaughter) perpetrated by them.

The Independent Investigation Panel did not find a root cause for the murder of Mr R on 15 November 2008.

Contributory Factor

The term is used in this Report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the breakdown in Mr Y's mental health and/or the failure to manage it effectively.

The Independent Investigation Panel found seven contributory factors.

Service Issue

The term is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 15 December 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

The Independent Investigation Panel found one service issue.

Root Cause Analysis

The key question in any investigation into a homicide committed by a mental health service user is 'why did they kill the victim?' In Mr Y's case this is a particularly difficult question to answer as the person he killed was, as far is known, a stranger with whom Mr Y had not had previous contact.

Mr Y was known to have a mental illness which had consistently been diagnosed as suffering from schizophrenia. It was known that alcohol and illicit drugs could lead to a relapse in his mental health. In December 2004 Dr 6 had written in a Court Report about Mr Y that *"It appears probable that [Mr Y's] mental illness is affected by his lifestyle choices; illicit drug use but what is less clear is whether the onset of schizophrenia was precipitated by or the subsequent course worsened by the use of psychoactive substances. There does appear to be a temporal link between the acute psychotic relapses and illicit drug use or refusal of medications.*

Recommendations

- *Mr Y to be encouraged to continue to engage with mental health services – long term treatment with medications and environmental manipulation would be crucial towards improving his mental health and wellbeing;*
- *Mr Y to be judicially compelled to engage in a formal drug rehabilitation programme in addition to his usual treatment;*
- *Take the current opportunity to defuse this potent mix of risk factors as I feel we could be moving towards a serious untoward event."*[110]

Although the volatile temperament of Mr Y could be predicted if he relapsed, there was no certainty when this would happen. The outcome of a violent attack could be considered likely, but there was no way of knowing when or where it would occur, or if anyone would be hurt.

At the Luton Crown Court on 27 November 2009 Mr Y pleaded guilty to manslaughter on the grounds of diminished responsibility which was accepted by the Crown. In his sentencing His Honour Judge Foster stated:

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"Let me make it absolutely clear that but for his mental illness, the Defendant would, if convicted of murder, have received a sentence of life imprisonment with a minimum term in the region of fifteen years. Even on a manslaughter conviction, from all that I have heard and read about this Defendant, there is overwhelming evidence in support of a finding of dangerousness in accordance with the Criminal Justice Act 2003 which would have given rise to an indeterminate sentence for public protection…..Four forensic psychiatrists have provided reports, all of which recommend a Hospital Order pursuant to Section 37 of the Mental Health Act 1983. I am quite satisfied that the statutory criteria for such an order are made out. I therefore make such an Order. The condition from which the Defendant suffers is paranoid schizophrenia…."

"I am entirely satisfied that such an order is necessary and appropriate, having regard to the nature of the offence, the antecedents of the Defendant, and the risk of his committing further offences if set at large, and that such an Order is necessary for the protection of the public from serious harm."[111]

The eight contributory factors identified by the Independent Investigation Panel will now be examined to determine the nature of their separate and joint effect on the manslaughter of Mr R.

Examination of the Eight Contributory Factors

The Independent Investigation Panel considered the eight factors using the Fishbone Root Cause Analysis Tool which groups factors under nine headings which are:

a) Team and Social Factors;

b) Communication Factors;

c) Task Factors;

d) Education and Training Factors;

e) Patient Factors;

f) Organisational and Strategic Factors;

g) Working Conditions Factors;

h) Equipment and Resources Factors;

111 Court Transcript of Proceedings at Luton Crown Court on 19 November 2009

i) Individual Factors (which stand alone and are not embraced by the other items).

1. Documentation and Record Keeping

The Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust staff did not all manage to follow the Trust's Policy "Guidelines for Clinical Records Standards" (November 2003). The written communication between the Community Mental Health Team which provided care and treatment to Mr Y was good and provided the GP with an up to date knowledge of Mr Y. This was also the case with the Assertive Outreach Team as the Community Psychiatric Nurse regularly communicated with the GP to inform the Practice of whether Mr Y was having his depot injections or if he had 'gone missing' as he was sometimes prone to do.

The other clinical records were poor and their filing sometimes hard to follow. Throughout Mr Y's time with the Assertive Outreach Team from 2001 the contacts by the Care Coordinator, Social Worker 1 and his Community Psychiatric Nurses were recorded, as were the Care Programme Approach Meetings, but not all the necessary paperwork was completed, for example, using all the appropriate CPA forms, less than full accounts of some interventions with service users, and a lack of new risk assessments.

There was no recorded evidence of discussions about whether the care plan for Mr Y should change, and it remained essentially the same throughout his contact with services. There were few fully completed risk assessments contained within Mr Y's clinical records. New material tended to be added to the existing information and without any recorded reflection, further discussion or an overall evaluation of how this new information affected the understanding of the risk Mr. Y posed.

The Assertive Outreach Team, and the Community Mental Health Team before 2001, were disadvantaged as they did not know about the full risk history of Mr Y as the attack on two schoolgirls resulting in the cutting of one of them was not within the clinical records, but was known within the legal system.

The same was true of the inpatient records which had the full assessments of the Mental Health Act assessment prior to Mr Y being admitted, but there was little evidence of further mental state examination, other than the nursing descriptions of how Mr Y spent each day.

Whilst the recording and documentation was poor the Independent Investigation Panel did not conclude that this directly contributed to the death of Mr R, but that it did mean that not as full a history and overall picture of Mr Y was available to the clinicians working with him. It also led to there being no evidence of reflection and active care planning in accordance with best practice. This was particularly the case during his last admission to Oakley Court from 29 October to 12 November 2008, which was really 'holding' him until he could be discharged. This was undertaken without having the benefit of his clinical records which remained in Bedford.

The poor quality of the documentation and the lack of his original clinical notes from Bedford meant that the treating team at Oakley Court did not have as full a picture of Mr Y as they should have had. Social Worker 1 provided some information when he went to the ward round on **03 November 2008** but this did not provide a detailed account of Mr Y and the nature of his mental ill health nor his complete risk history.

It was noted in Mr Y's care plan on arrival at Oakley Court that his clinical records from Bedford should be sought and be available on the ward. This did not occur.

Conclusion

Using the Fishbone, the documentation issues and the failure to obtain Mr Y's clinical notes were regarded as communication and organisational factors. They contributed to the Oakley Court staff not having as full a picture of Mr Y as they should have had at the time of his discharge back to Bedford.

2. Diagnosis and Medication

The Independent Investigation Panel considered that the medical treatment of Mr Y was not as robust as it could have been. Once Mr Y had been diagnosed as having schizophrenia with a continued substance misuse this was not seriously questioned by clinicians. There were two detailed and systematic assessments of Mr Y's history and mental state, one in 1987 by Dr 1, and again in 2004 by Dr 6 for a court report. Otherwise there was little evidence of clinicians examining his full record and his early childhood history to try to gain a greater understanding of why he was as he was.

Dr 7 and Dr 8 did not complete a full reading of Mr Y's history, and like the previous medical staff did not challenge the original diagnosis. Up to April 2006 Mr Y did attend outpatients, although he missed many appointments, but was seen by clinical staff. After 2006 Dr 7 became the consultant for the Assertive Outreach Team and he saw people he was asked to see by the Team and did not organise reviews for all the service users known to the Team.

The possible effect of illegal substances on Mr Y's behaviour was never fully examined. It was evident that Mr Y suffered fairly quick relapses but also recovered fairly rapidly once he was taking his medication regularly. There was very little contact between Healthlink and the Assertive Outreach Team and no well established dual diagnosis service available.

More could have been done to better understand Mr Y and to know more about his psychiatric condition. Dr 4, the consultant at Oakley Court, commented that because Mr Y was from Bedford he would not have queried the diagnosis but have treated him for his aggression and psychosis on admission and then have discharged him to the Weller Wing for discharge by the staff who knew him well. This did not occur because Mr Y became well and as there was still no bed available in Bedford he was discharged to his home. Dr 4 was on leave the day Mr Y was discharged but he agreed with the decision because he knew he was well from his behaviour on the ward compared to his presentation on admission.

A Care Programme Approach Review was undertaken by Social Worker 1, the care Coordinator for Mr Y, and the necessary CPA forms were completed. It is unclear whether a formal mental state examination was conducted prior to Mr Y leaving Oakley Court. It appears that the decision was based on how improved Mr Y had been on the ward since **07 November 2008.** Mr Y attended two ward meetings on **10 November** and **12 November**, the day of his discharge, in the afternoon. The SHO agreed the discharge and Dr 4 said he backed him based on what he knew of Mr Y since he had been on Oakley Court.

It would have been normal practice for Mr Y to have awaited a transfer to the Weller Wing in Bedford and for the team which knew him well to have made the decision about his return home. Social Worker 1 agreed with the decision to discharge Mr Y and considered him to have been well. The actual discharge is not fully recorded and Dr 7 did not know Mr Y had been discharged home until after the manslaughter.

Conclusion

The Oakley Court Team had observed Mr Y throughout his admission and had charted his behaviour each day. By **07 November 2008** Mr Y did appear to have improved in mood. His discharge was accelerated and there is no formal mental state examination report in the clinical records. The Independent Investigation Panel concluded that the lack of medical review in the community after April 2006 to have been bad practice. It was a Team Factor as the psychiatrist (Dr 7) did not act proactively and provide clinical leadership to the Assertive Outreach Team.

Dr 7 felt excluded by the rest of the Team and Dr 8 only reviewed new service users and others he was asked to see when Dr 7 was not available. The multidisciplinary team was not using its meetings to review service users adequately nor to seek any alternative ways of working through reflective practice.

The Independent Investigation Panel concluded that this was a contributory factor as it led to Mr Y continuing to have the same treatment and care plan. Had he been thoroughly medically re-assessed alternative or additional ways of helping him may have been identified. Mr Y was referred to the substance misuse service but he had not engaged with this service and no alternative strategy for addressing Mr Y's illicit drug and alcohol misuse, which was known to have an impact upon his mental health, was put in place.

3. Care Programme Approach, Risk Assessment and Risk Management.

As mentioned in the Section above on Documentation, there were gaps in the recording of information and the compilation of clinical records. The Care Programme Approach forms were completed but seldom a full set and sometimes only one or two forms as illustrated in Table 4 on Page 77.

The approach adopted by the Mental Health Services was somewhat reactive rather than proactive. The Care Plan was essentially the same throughout Mr Y's time with the Bedford Services. It comprised ensuring: that Mr Y had his mental health monitored, received his depot injections, had the effect observed, was supported to be able to remain in the community and to assist with any housing or financial issues as and when they arose.

Risk assessment and risk management was undertaken, but with some early serious violent episodes missing as they were only known to the Criminal Justice System. During interviews staff were openly 'shocked' when these offences were mentioned, as they were with the prognosis provided by Dr 6. He had predicted that as Mr Y displayed a "*potent mix of risk factors [he felt] we could be moving towards a serious untoward incident*."[112]

The attention to risk assessment, risk management and care planning could have been more rigorous, but even given Dr 6's prediction there was no way of knowing when an incident would occur and what would be the trigger.

The discharge arrangements from Oakley Court were not conducted in line with the Admission and Discharge Policy of the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. In the 2008 Care Programme Approach Policy there is a pathway for acute ward admission and discharge. This was not fully followed.

Conclusion

The Independent Investigation Panel considered that these issues of not fully complying with the CPA, risk assessment and risk management were team factors. They also represented an organisation and strategic factor as the Governance Arrangements did not identify the poor compliance and lack of new risk assessments and risk management plans. The lack of regular assessment and reassessment with additional risk assessments being undertaken led to not all the information available being readily accessible to the mental health service.

4. Use of the Mental Health Act (1983 and 2007)

Mr Y had a good relationship with the Community Mental Health Team and the Assertive Outreach Team which was positive. The team also had a good relationship with Mr Y and sought to meet his needs and to enable him to remain in the community. They were aware that there were occasions when Mr Y relapsed due to not taking his medication and/or due to using illicit drugs and alcohol.

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If Mr Y was concerned, he would seek help from the team and was either admitted for respite care at Steppingstones or Progress House if he was not assessed as requiring admission to hospital.

Prior to his admission to Oakley Court on **28 October 2008** Mr Y had been throwing things out of his seventh floor flat which caused damage to cars parked below. He was detained under Section 136 of the mental Health Act (1983) and a Mental Health Act Assessment was carried out. It was decided that Mr Y needed to be admitted to hospital and he agreed and was admitted as an informal patient.

Conclusion

The Independent Investigation Panel concluded that there was appropriate consideration of and use of the Mental Health Act by those caring for Mr Y.

5. Management of the Clinical Care – Inpatient and Community Services.

The management of the clinical care was relatively poor in that neither the Weller Wing in Bedford nor Oakley Court in Luton had access to the range of resources which would allow them to provide the range of interventions best practice guidance recommends.

The position with the Bedford Assertive Outreach Team was that after April 2006 when Dr 7 became the Consultant Psychiatrist, there were no regular medical reviews of all the service users receiving a service from the team. This was because once the Assertive Outreach Team had its own consultant, albeit for only two/three sessions a week, the community mental health team consultants no longer retained responsibility for outpatient appointments for service users other than for those being treated by those teams. Dr 8, the Associate Medical Specialist saw the service users he was asked to see by the Team, but did not regularly review them every six months or annually.

There was also no time for reflective practice sessions where the team would discuss specific service users and consider how they might be differently managed or offered potentially better care plans. The staff asked Dr 7 to review the service users about whom they had concerns, but Mr Y was not one of these.

The lack of assertiveness and lead-taking by the medical staff was discussed with the clinical staff by the Independent Investigation Panel, and it appeared that they felt marginalised by the New Ways of Working which significantly altered the roles of clinicians and staff within multidisciplinary teams. The medical staff were unsure of their role, and therefore waited to be asked about medical issues regarding service users, instead of taking a lead in team meetings and suggesting alternative treatment plans for some service users.

The lack of seeking forensic advice about Mr Y was a missed opportunity. The team assumed that as the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust had only a small community forensic service Mr Y would not be considered. They had included Mr Y in a list of patients with complex needs sent to the Medical Director who then decided which would be referred to the Multi-Agency Public Protection Arrangements Panel, but his name was not put forward. This prevented the team knowing the full extent of his forensic history.

Another factor which caused Mr Y not being seen for a medical review was that the staff of the Assertive Outreach Team tended to view him as someone they knew well, and as they did not have his full criminal and forensic history, they considered him to have 'mellowed' over the years and they liked what they saw as his 'charmer' behaviour when well.

Finally the care and treatment Mr Y received at Oakley Court from **28 October to 12 November 2008** was not as proactive as it might have been due to the lack of assertiveness in obtaining his clinical records from Bedford and viewing his time on the ward as a 'holding role' until he could be returned to the Weller Wing. Dr 4 explained that he did not consider reviewing Mr Y's diagnosis and did not make contact with Dr 7, his Bedford Consultant who had arranged his admission to Oakley Court to see what plan he would propose. This was a missed opportunity to make the 'temporary admission' to Oakley Court more valuable by being part of a larger wider treatment plan.

Mr Y was discharged from Oakley Court following a ward round on 12 November 2008 by the SHO in the absence of Dr 4. The SHO and Social Worker 1 considered that Mr Y was ready to return home, but this discharge was not implemented as planned. The originally, 'ideal' plan had been to discharge Mr Y from Oakley Court to a bed in Bedford where he was

well known and where he could have been discharged into the community, presumably with an appropriate care plan. There are no clinical notes of a formal mental state examination being undertaken at that time.

Conclusion

The Independent Investigation Panel concluded that the failure to communicate with Bedford and not to wait for 'the ideal discharge' through Bedford was a team factor and a communication factor. There was no evidence of Mr Y's clinical notes being sought from Bedford, nor of asking the Weller Wing when they anticipated having a bed for Mr Y. These issues contributed to Mr Y being discharged without the medical and nursing staff at Bedford, who knew him well, being able to assess whether he was ready to be discharged. This again contributed to Mr Y's full circumstances not being known, and the Oakley Court staff not having all the relevant information available to them. There were no factors identified in the clinical notes to indicate that Mr Y should not be discharged.

The Independent Investigation Panel concluded that the Assertive Outreach Team staff knew Mr Y very well, but they were unaware of the violence he could display, as they did not have access to all the offences he had committed until the Crown Court Hearing in Luton. They did have the opportunity to refer Mr Y to MAPPA and/or the Community Forensic Team, rather than assume that he would not meet their threshold for acceptance and treatment. Had Mr Y been accepted by MAPPA, or the Forensic Service, more information of his violent criminal record would have been known. This could have made a difference to his risk profile and its management. This was a team factor as the team did not act to find any additional information via MAPPA or the Forensic Service.

The Independent Investigation Panel concluded that the Management of Clinical Care contributed to staff not knowing as much about Mr Y as they should because they did not have access to his full criminal record. This contributed to Mr Y being discharged with the same care plan over several years, and no action taken about his substance misuse. This could have had an adverse effect on his overall mental health.

6. Referral from Community Mental Health Team to Assertive Outreach Team and the Role of Community Psychiatric Nurse and Care Coordinator

The Independent Investigation Panel considered that Mr Y was correctly referred by the Community Mental Health Team and was rightly accepted by the Bedford Assertive Outreach Team. Mr Y displayed the characteristics described as requiring the additional assertiveness the new teams were designed to bring. The staffing of the team was good and the caseload was limited to each care coordinator being responsible for 12 service users.

The Care Coordinator (Social Worker 1) worked well with Mr Y and helped him with practical difficulties as well as providing support in the community. The community psychiatric nurses worked well with Mr Y and his lack of depot injections and failed appointments improved, although Mr Y never fully engaged and disappeared from time to time. The Assertive Outreach Team often knew where to find Mr Y when he did miss his depot injection.

Table 8: 'List of Depot Injections (December 2006 to November 2008)' shows that in the 22 months from 22 December 2006 to 07 November 2008 Mr Y should have received 24 depot injections. He actually received 22 having missed those due in March and December 2007. This was a significant increase to his previous compliance since 2001, and a totally different set of figures from when he was being treated by the Community Mental Health Team and attended only two out of 20 outpatient appointments.

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The Independent Investigation Panel considered that the Assertive Outreach Team did the best they could in ensuring that Mr Y had his regular depot injections and in reviewing his mental health. This was largely achieved by frequenting the places where he was likely to be: his flat in Bedford, with his girlfriend in a nearby town or at the weekly Drop-In service. In this way the Care Coordinator, the Community Psychiatric Nurse and the Support Time Recovery Worker (STR Worker) managed to keep in touch, although he was at times able to avoid them by going to London or elsewhere.

There were two missed opportunities when Mr Y was not referred to MAPPA and also the lack of referral to substance misuse services. Referral to MAPPA may have provided more information about Mr Y's criminal and violent antecedents. Mr Y was known to regularly use illicit drugs and alcohol but he was seldom engaged in conversation about the need for him to

make contact with Healthlink, the local Bedford Substance Misuse Service. It is accepted by the Independent Investigation Panel that he would probably not have engaged given his previous responses to referral and mention of his misuse of drugs and alcohol.

Conclusion

The Independent Investigation Panel concluded that this issue was a team factor which again led to not all Mr Y's past history being known to the Assertive Outreach Team or the Inpatient Services in Bedford and Luton. This meant that not all of Mr Y's past history was known and thus the care plan was not as well founded had all the relevant past history been known.

7. Carer's Assessment

One difficulty for all the mental health services which worked with Mr Y was the lack of an independent informant who could verify or provide additional information to that provided by Mr Y. He had two girlfriends during the time he was with the Bedford and Luton Mental Health and Social Care Partnership NHS Trust. It would have been good practice to have, appropriately, involved these in assessing Mr Y's needs planning his care. Information provided by these friends might also have been used to corroborate the information supplied by Mr Y.

One of Mr Y's girlfriends lived in a nearby town. She provided him with considerable support when he needed to avoid difficult issues in Bedford. Whilst this girlfriend might not have considered herself to be a carer, because she was providing care, the Assertive Outreach Team should have offered her a Carer's Assessment to see if she required any assistance in helping Mr Y.

Conclusion

Had a Carer's Assessment been offered to the girlfriend of Mr Y it could have provided a unique opportunity to discuss him with somebody who knew him well, and who would be able to validate his version of events and some of his life history. His girlfriend may have known additional information or an alternative view of his situation. This could have been tried and was a team factor as the Carer's Assessment was not offered.

The Independent Investigation Panel saw this as a missed opportunity to discover additional information about Mr Y but as there was no way of knowing if his girlfriend would have seen herself as his carer, it has been classed as a Service Issue and did not contribute to the outcome.

The girlfriend was entitled to a Carer's Assessment and the Independent Investigation Panel considered this was a Service Issue as she should have been offered an assessment which could have identified that she required some support to meet her own needs.

8. Clinical Governance Processes.

From the information provided to it, it appears to the Independent Investigation Panel that the Department of Health 'New Ways of Working for all' (NWW) was not well understood by the Board of the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. It was evident from the discussions with some staff interviewed by the Independent Investigation that NWW caused some consultant psychiatrists to question their roles with the multidisciplinary teams making them reactive rather proactive in the way they worked.

The Trust Board (Bedfordshire) was struggling to improve the services it provided, but ultimately the failure to make improvements to the mental health services led to a decision to change the composition of the whole Board. The fact that the psychiatrists within the Assertive Outreach Team were not providing effective medical leadership should have been known.

It would have been good practice for Consultant 7 to have been made aware that Mr Y, who he had admitted to hospital two weeks earlier, had been discharged and whether he would like to medically review him as he was in Bedford. The Independent Investigation Panel is aware that prior to the manslaughter which took place three days after the discharge Mr Y had not displayed any overt signs of psychosis, and that after the homicide he again did not appear to be psychotic whilst on police bail in Progress House. This is at variance to the four forensic psychiatric reports provided to the Luton Crown Court.

Conclusion

This was an Organisational and Strategic Factor as the Clinical Governance Arrangements did not identify that some of the psychiatrists in the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust were becoming unsure of their roles, and had found it difficult to adjust to the outcomes of New Ways of Working. This led to less involvement with the service users of the Assertive Outreach Team and a lack of medical review and positive challenging of the care plans to highlight additional or alternative care and treatment. The Independent Investigation Panel concluded that this lack of full involvement by the two psychiatrists in the Assertive Outreach Team and at Oakley Court was a contributory factor to Mr Y not being reassessed and was a factor in his mental health deteriorating.

Conclusion Summary

It is difficult to determine to what level of causality these seven contributory factors played in the events leading to the death of Mr R.

The Oakley Court staff knew that the mental health of Mr Y had improved during his 15 day admission and that he wanted to return to Bedford. They should have known about his full forensic history but did not, and neither did the Weller Wing staff nor those of the Assertive Outreach Team. The period of admission to Oakley Court had the characteristics of a 'holding operation' and apart from medication and observation there was no shared treatment plan agreed with the Bedford team.

The Oakley Court Consultant Psychiatrist (Dr 4) did not consider his role to include making a diagnosis or re-diagnosis, but to provide medication to reduce the aggression and restlessness displayed by Mr Y during the first few days on the ward. Once the medication had started to have an effect from **07 November 2008**, when Mr Y was more cooperative, less elated and had started to interact with staff and other service users more appropriately. At this point Dr 4 began to consider discharge for Mr Y.

Dr 4, his SHO and Social Worker 1 considered Mr Y to be well by **12 November 2008** and therefore decided that he could be discharged home without first going to the Weller Wing at Bedford. They knew from his response to medication that Mr Y was improving but there is no evidence that a full mental state examination was undertaken prior to his discharge.

Mr Y may have managed to mask his symptoms and behaviour to make himself appear more mentally well than he was. The staff did know that he had responded to his medication and this was a usual occurrence when he was admitted to hospital as he took the medication as prescribed. They knew that he still used illicit drugs and alcohol which had an effect on his mental health. As Dr 6 had concluded in 2004 Mr Y was known to present a risk of becoming aggressive when he was ill or under the influence of illicit drugs and alcohol, but they could not predict when, where, what or to whom this aggression would be directed.

Mr Y was seen at the Drop-in Club on 16 November where he took his medication and was noted to be relaxed and sociable.

The discharge certainly contributed to the breakdown in Mr Y's mental health but the Independent Investigation Panel did not conclude that it directly caused the death of Mr R. Mr Y was discharged on 12 November and seen to be well on 13 November at the Drop-in. He was not seen the next day and then the homicide took place the following day, 15 November in the evening. Other factors such as drug use or alcohol use could have occurred in the intervening period. This area of uncertainty raises sufficient doubt to lead the Independent Investigation Panel to say the discharge was a contributory factor but not a causal factor.

Unusually the Independent Investigation Panel know that Mr Y was arrested and questioned by the police on 19 November 2008 and was later released on Police Bail to Progress House where he had had respite care in the past. The Assertive Outreach Team supported the staff at Progress House to care for Mr Y and during this period of time he underwent several mental health state examinations and no evidence of psychosis was identified.

This additional knowledge further supports the Independent Investigation Panel's conclusion that Mr Y's mental state could vary extremely rapidly, as he was calm on 13 November 2008 and again by 21 November 2008. Such variation does mean that there is sufficient doubt about the exact psychiatric state of Mr Y at the time of the incident to preclude being certain that the discharge from Oakley Court did of itself lead directly to the homicide.

15. Bedford and Luton Mental Health and Social Care Partnership NHS Trust response to the Incident and the Internal Investigation. (now South Essex Partnership NHS Trust)

This section of the Independent Investigation Report examines the Internal Investigation undertaken by the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust.

The Internal Investigation was completed in July 2009. This report had been commissioned by the Interim Chief Executive of Bedfordshire & Luton Mental Health and Social Care Partnership NHS Trust. It was an internal review written in accordance with the Trust's Policy and Procedures for Reporting Adverse Incidents. The Terms of Reference were to:

- review the care, treatment and services provided by the Trust to the service user. This should include an overview of previous history and a detailed analysis of the 12 months prior to the alleged offence.

- compile a comprehensive chronology of events leading up to the alleged incident and where appropriate establish the circumstances of the incident itself.

- review the appropriateness of the treatment, care and supervision of the service user in light of any identified health and social care need.

- review the adequacy of risk assessments including specifically the risk of the service user harming himself or others. This will include the training staff had received on risk assessment.

- comment on the adequacy of the communication between the various professional teams and agencies involved with the service user, including governance arrangements that support clinical practice.

- review and assess compliance with local policies including the national guidance statutory obligations where the appropriate use of the Mental Health Act including admission, discharge and the granting of leave.

- make recommendations and identify lessons learnt to be considered for implementation.

The Internal Investigation was undertaken by the Interim Director of Integrated Governance and Executive Nurse, the Interim Director of Inpatient and Emergency Services, the Medical Director and the Serious Untoward Incident Coordinator. This group had considerable experience in undertaking Internal Investigations and their work was done to a good standard. The interviewing of witnesses was conducted well as the notes of their interviews demonstrate.

The Internal Investigation conducted, what the Independent Investigation Panel considered, a thorough investigation which had interviewed the key staff working with Mr Y and had examined the relevant clinical records, whilst concentrating on the contact and care provided by the Assertive Outreach Team between November 2007 and 15 November 2008.

The Internal Investigation made the following 12 recommendations as a result of its work and findings:

1. When undertaking risk assessments and developing risk management plans there should be evidence that risk has been appropriately re-assessed in light of any possible change in influencing factors.

2. Any discharge from hospital must be in accordance with the CPA policy where all relevant staff are advised of discharge arrangements.

3. The Trust should develop a system to ensure that care plans and risk assessments transfer with the client from community to inpatient services.

4. Doctors must make appropriate and full risk assessments on all patients admitted to the acute units and these must be recorded in the clinical notes. If these risks are

deemed moderate / high, repeat assessments must be carried out on a regular basis and entries made accordingly. These must be monitored by the supervising consultant and any deficiencies discussed with the junior doctor.

5. The Panel recommends that all patients in the Assertive Outreach Team must have a medical review at least once every six months.

6. The Trust should remind staff about the importance of sound, clinical contemporaneous record keeping. This should focus on recording clear unambiguous evidence of mental ill health and response to treatment and therapeutic intervention. This should also include undertaking spot audits on the quality of record keeping and clinical assessment with the medical notes.

7. A unified Assertive Outreach Team model and policy is implemented across the Trust as soon as practically possible

8. The Trust should continue to ensure staff receive appropriate training in risk assessment and risk management in line with the Department of Health Best Practice Guidance.

9. The Trust should undertake an audit of the communication pathway to assure itself relevant clinical communications are being maintained. This should include as a minimum:
    - information provided on admission;
    - information provided on discharge;
    - communication with the multidisciplinary team about changes in the care plan or risk management plan.

10. The Trust should undertake a facilitated review of the Assertive Outreach Team to assure itself the team is utilising new and innovative practice in line with contemporary mental health care.

11. We recommend the Trust and mental health commissioners consider whether the current service and access to Community Forensic Services is sufficient.

12. The Trust should review the role and function of the Assertive Outreach Team in the context of a broader review of community services.

Conclusion

The Internal Investigation was well conducted and produced an easy to understand and thorough examination into the care and treatment Mr Y had received from the Trust. The Independent Investigation Panel endorses the recommendations made by the Internal Investigation, and indeed found very similar issues. The Independent Investigation, as is always the case, takes a wider perspective of the service user's care and treatment, commencing when they were first involved in mental health services and also having access to Primary Care Records.

The Independent Investigation interviewed more people, and a range of medical staff, and as a result did make some different recommendations to the Internal Panel

Staff Response to the Internal Investigation

The staff interviewed did not appear to have been involved with the implementation of the recommendations of the Internal Investigation, and some of the medical staff appeared to have been marginal to the process.

In interviews it was ascertained that the recommendations of the Internal Investigation had been implemented. The only one where there was concern was Recommendation 10 as the staff interviewed did not appear to be aware of a "*facilitated review of the Assertive Outreach Team to assure itself the team are utilising new and innovative practice in line with contemporary mental health care".*

It was understood that this could have been because it was included within a wider review of community mental health services and may have been part of a plan still under consideration to include the Assertive Outreach function within the Community Mental Health Teams.

The Internal Investigation also identified that "*the clinical notes for inpatient care and medical notes make little reference to the service user's mental state. However, during the course of admission there is evidence that he appeared to improve and was involving himself*

in the therapeutic programme on the ward." The details of the components of the therapeutic programme available on the ward were not specified in any detail.

The Independent Investigation Panel also identified during the course of reviewing the inpatient notes that the record keeping in relation to the initial and ongoing medical assessments was barely satisfactory. Risk assessments were not updated and also the quality and comprehensiveness of the recording on the CPA documentation was generally poor.

The one recommendation the Independent Investigation Panel has added is that greater attention should have been given to his substance misuse problem and the effect this had on his mental ill health. Healthlink was mentioned on very few occasions and there is no evidence that Mr Y ever attended. It is accepted that Mr Y was unlikely to accept ongoing help from Healthlink, but the effort should have been made and followed up by the Assertive Outreach Team.

It is accepted that would have been difficult as there was no formal dual diagnosis service within the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust and therefore no real opportunity to tackle the drug and mental health issues together.

The 'de-skilling' or side-lining of the medical members of the Assertive Outreach Team prevented Mr Y receiving the benefit of regular six monthly reviews and the possible outcomes of structured reflective practice when new approaches could have been identified. He was also denied the access to a forensic opinion despite his serious criminal record showing several instances of violence. The local community Forensic Service was described as being relatively small and therefore had quite tight acceptance criteria. Their opinion would have been useful given Mr Y's forensic history and would have uncovered the 'forgotten' attack on the two schoolgirls with a knife. The same information could have been gained had he been referred to MAPPA.

16. Notable Practice

The Independent Investigation Panel identified the following examples of good practice:

- the diligent way in which the Assertive Outreach Team sought to track where Mr Y might be residing when he failed to attend for his depot, or missed another appointment with the care coordinator, which ensured that he received 22 out of a possible 24 injections;
- the apparent effectiveness of the Drop-In facility in an accessible area of Bedford and its location in a building which was used by a wide clientele when functioning as the West Indian Club;
- the caring attitude of the staff working with Mr Y who all 'liked' him and treated him with respect;
- the care and attention of the staff in trying to help Mr Y obtain suitable accommodation;
- the level of support they provided to Mr Y while he was at Progress House subject to Police Bail. They effectively 'policed' his bail and ensured that his mental state was under constant review;
- the thorough risk assessment in December 2004 where Mr Y's likelihood of being involved in a serious untoward incident of some sort was 'predicted'.

17. Lessons Learnt

It would be foolish to assume that a comprehensive appreciation of the functioning of a service can be gleaned from the examination of a single case, no matter how detailed that examination might be. However the examination of a single case can enable one to identify lessons which, if learned and used to inform future practice, might improve services generally.

Louis Appleby (2007), the then National Director of Mental Health commented:
"Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life - a job, a decent place to live, friends and a social life." [113]

The delivery of care provided to Mr Y, for much of the time he was under the care of the Bedford and Luton Mental Health and Social Care Partnership NHS Trust was characterised by its persistence and flexibility. Mr Y appears to have had a good relationship with those providing his care and, to a significant extent, he used the service as he felt it suited his needs. Giving the changing role of health services as identified by Louis Appleby this could be seen as good practice. At the same time the Care Programme Approach emphasises the importance of delivering a planned and co-ordinated service based on the, on-going, assessment of the individuals needs and the evaluation of the efficacy of the interventions provided to meet those needs.

The importance of Clinical Records

Perhaps one of the most fundamental and importance disciplines in providing sound and safe clinical care is the maintaining of accurate and up to date clinical records. Mr Y's care illustrates at least two important issues relating to record keeping:

1. Clinical notes, if they are to be useful need to be readily available. Where this is not the case it is difficult for those individuals providing care to carry out an accurate assessment and formulate a plan which is consistent with the longer term, on-going treatment aims of the individual.

[113] Appleby. L (2007) *Breaking down the barriers: the clinical case for change.* Department of Health

2. Good clinical notes are more than a chronological record of events. They record the integration of new information and record the current understanding of an individual's problems which, in its turn, informs care plans and interventions.

Good clinical record keeping not only records new information but integrates this with existing information. This process facilitates reflective practice and facilitates the on-going reviewing of the understanding of the service user's problems and needs. The availability of current, integrated information supports accurate assessment leading to the most appropriate and effective ways of addressing the individual's needs being put in place.

Corroboration and Sharing Information

Along with the recording of information goes the collecting and sharing of information. Those caring for Mr Y were not aware of the extent of his criminal activity nor the extent of his history of violence. Access to this information may have altered the assessment of the risk Mr Y posed or a different appraisal of the factors which triggered his dangerous behaviour. This different appraisal may, in its turn, have influenced the decisions made about the interventions that were offered to Mr Y. Good practice suggests that whenever possible and appropriate corroborative information should be sought to improve the understanding of an individual's behaviour and to test current formulations. Appropriate, mutual sharing of information with other agencies can, similarly, not only result in a better understanding of an individual's needs and the risks he poses and is exposed to, but can also facilitate collaborative co-working.

Assessment and Care Planning

The above observations point to the importance of a system of robust and on-going assessment and care planning. CPA provides the framework for this in Mental Health Services. One of the cornerstones of CPA is that the assessment is comprehensive; issues in one area of an individual's life impact on those in other areas. Those caring for Mr Y were diligent in ensuring that he received the prescribed treatment for his mental health problems, they also tried to help him address his accommodation issues but, although they noted the importance of his alcohol and substance misuse problems, there is no evidence in his clinical records that there was a clear plan, delivered in a concerted manner, with its efficacy evaluated on a regular basis, in place to address this problem. It is clear that Mr Y himself did not display any motivation to address his substance misuse problem. However if the formulation of Mr Y's problems included the identification of the impact of his substance

misuse on his mental state and behaviour then the same diligence that was show in addressing his other needs ought to have been evident in addressing his substance misuse problems. The co-morbidity of mental health and substance misuse problems is not an uncommon occurrence in mental health services and staff have to be equipped to identify and address these co-existing problems. If this is not done the likelihood of a successful outcome is significantly reduced.

It is widely recognised that discharge is a point of particular vulnerability and it is for this reason that protocols are normally put in place relating to the discharge process. It is often said that discharge planning should begin at the point of admission. What is certainly true is that there needs to be clarity as to why an individual is being admitted to hospital and what the goal of the admission is. This plan should inform the inpatient assessments and interventions should be planned to meet the identified goal. Discharge should be planned in this context. This planned assessment, goal orientated intervention and coordinated discharge did not characterise Mr Y's final hospital admission. What appeared to be a sensible plan for his discharge, being discharged via the Weller Wing in Bedford, was set aside without appropriate assessments being undertaken, although it was evident that Mr Y's mental health had improved significantly since his admission.

Reflective Practice

Mr Y's case illustrates the importance of reflective practice. As noted above this is in part achieved through regular reviews and reviewing diagnoses and formulations based on new information. It is also one of the functions of the multi-disciplinary team. Each discipline brings to the table a different set of skill and a differing emphasis as to what is important. While it is the responsibility of the organisation to ensure that an appropriate set of skills are available within a team to enable it to deliver an effective and efficient service, it is the responsibility of the individual professionals to ensure that their skills are appropriately employed and they have an appropriate input into the formulation and understanding of the individual's difficulties.

Governance

Finally while it is the responsibility of the organisation to ensure that it has in place a set of policies and procedures that are fit for purpose it is the professional responsibility of clinical staff to comply with these policies. Good governance suggests that there needs to be a

mechanism in place which enables the organisation to identify when policies and procedures are not being followed and to address this issue in a timely manner.

18. Recommendations

Documentation and Record Keeping

1. The Senior Management of SEPT should conduct an audit of the files of the Assertive Outreach Team, and other Community Mental Health Teams, to ensure that:
    - the recording is complete and that there is an up to date risk assessment and management plan;
    - there is a clear summary of the main features of the situation easily identifiable within the case record which highlights the history of the patient;
    - the latest care plan is in place and there is an up to date section describing any relapse signature the patient usually displays.
    - the audit should be carried out on a 'spot' basis every six months on a selection of case records. Audit should assure both compliance to policy and quality of content.

Diagnosis and Medication

2. The Assertive Outreach Team must formally review all patients regularly. The Review must include the psychiatrist, care coordinator, community psychiatric nurse and any other member of the team actively involved in the patient's care plan. (It is understood that this now occurs after the Internal Investigation). The review should include updates to the;
    - Psychiatric history;
    - Risk assessment and risk management plan;
    - CPA review documentation and care plans.

    The Trust should put in place an audit or other appropriate mechanisms to assure itself both that these regular reviews are taking place and that they are of an acceptable quality.

3. When a patient has both mental health and substance misuse problems both issues must be addressed so that the inter-relation between them can be fully understood and so both can be actively treated. The interrelation between the two conditions needs to be fully explored and a diagnosis agreed. This requires:

    - a clear diagnostic formulation;
    - a care and treatment plan that is evidence based and in accordance with NICE guidelines;
    - a multidisciplinary approach that delivers a sound medical and psycho social model which is duly discussed and documented;
    - where there are concerns regarding carers, children, vulnerable adults etc. the multidisciplinary team works in accordance with extant Trust policy guidelines to work with all other relevant agencies.

    In line with best practice guidance the Trust must ensure that staff have appropriate and updated training to be able to delver a high quality and effective service to those service users who have both mental health and substance misuse problems

Care Programme Approach, Risk Assessment and Risk Management

4. When a patient is discharged from hospital there must be a formal discharge Care Programme Approach Meeting so that all staff involved in the care and treatment plan are fully aware of the current situation and the role they have in fully implementing the Care Plan. Section 117 requirements must also be addressed at the Discharge CPA**.**

    The following issues must be covered at the Discharge CPA Meeting:

    - the team which is to provide the on-going community care should always be present at the discharge meeting and the service user's care co-ordinator identified prior to discharge;
    - immediate follow up arrangements should be identified. Arrangements should normally be made for the service user to be seen within seven days of discharge;
    - the Trust should put in place an audit or other appropriate mechanisms to assure itself both that these discharge meetings are taking place and that they are of an acceptable quality.

5. When a patient has a significant forensic history the consultant psychiatrist and the care coordinator must examine the full history of the case to ensure that all the relevant information is available for a full and comprehensive risk assessment and management plan. Risk assessment requires:

- proactive and dynamic working;
- an established therapeutic relationship and continuous engagement with the service user to ensure the assessment is as full as possible;
- a sound multi agency involvement with the case in order to ensure relevant collateral information is gathered.

The service users risk history should be regularly updated and readily available to all relevant clinicians.

The Trust should put in place an audit or other appropriate mechanisms to assure itself that:

- risk histories are being recorded and are of an acceptable quality;
- that risk assessments are being undertaken in line with best practice recommendations;
- that risk management plans of an acceptable quality are in place and readily available to those who need to access them;
- that staff receive appropriate and regular training to be able to undertake risk assessments and draw up risk management plans;
- that service users and relevant others are appropriately involved in the assessment and drawing up of plans and informed of the risk management plans.

6. When a patient has a significant forensic history the multidisciplinary team should consider referring the patient to the local MAPPA to ensure that the safety of the public is made a priority.

It is strongly recommended that the local MAPPA is approached by the local SEPT Forensic Service to consider the establishment of a regular local sub-MAPPA Meeting so that people who fall below the full criteria for inclusion within the MAPPA

arrangements can be discussed at a separate forum so their risks can be shared and where appropriate a multi-agency plan can be developed.

Management of the Clinical Care – Inpatient and Community Services

7. When a patient is admitted to an acute psychiatric admission ward which is not the usual placement for their geographical area, it should be clear from the beginning that the relevant clinical case records will be sent to that ward within 12 hours if they have not been sent with the patient. The ward staff should ensure that:

    - the patient is offered the same treatment and therapeutic interventions as the other patients on the ward;
    - that there is a care plan for the patient and that the stay <u>does not become</u> a "holding position" until a bed becomes available in the patient's home area;
    - the consultant and care manager of the patient are contacted within 24 hours to seek their views on the care and treatment the patient should receive, to ensure that the care is as seamless as possible;
    - there is a formal transfer meeting when a bed does become available and the patient can be transferred to his/her home area.

8. The Assertive Outreach Team must ensure that their patients are receiving a full and comprehensive service based upon a detailed needs assessment and the development of a care plan. The multidisciplinary team skills should be considered for every patient so that all options are considered when agreeing an appropriate care plan. The plan and the individual team members working with patients should also be reviewed on a regular and planned basis and whenever the patient's life circumstances change significantly to ensure the Care Plan is still fit for purpose.

Lack of a Carer's Assessment and Involvement

9. The SEPT should ensure that all carers of patients with mental ill health are offered an assessment of their needs in their own right.

    Carers should be involved, when appropriate, in order to gain corroborative information and to understand the needs of the service user.

The Trust should put in place an audit or other appropriate mechanisms to assure itself carers are being appropriately involved in the assessment of needs and care of the service user and that their own needs are being appropriately assessed and met

Clinical Governance Processes

10. The Independent Investigation Panel would have made recommendations for the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust regarding Clinical Governance, but having discussed the issues with the South Essex Partnership NHS Trust is assured that the necessary changes have been made and are working well.

However the Independent Investigation would recommend that the Trust, in consultation with its commissioners, assures itself that:

- the recommendations of the internal investigation continue to be implemented;
- appropriate standards are being used to audit the implementation and effectiveness of the recommended changes to services and practices;
- the changes to services and practices are achieving the desired outcomes of improving the quality and safety of services.

19. Glossary

Assertive Outreach Team	A specialist community mental health team which specialises in providing care and treatment to people with a mental illness who find it hard to engage with services and have complex needs.
Caldicott Guardian	A senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing.
Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach	The national systematic process to ensure that assessment and care planning occur in a timely and user centred manner.
Depot Injection	This is an injection into the muscle by which certain antipsychotic medication is administered, and which is then slowly released into the body over a number of weeks.
D-dimer Tests	Imaging scans to help exclude, diagnose and monitor diseases and conditions that can cause a tendency for the blood to clot inappropriately. Used to make sure there are no dangerous side effects from medication.
Doppler Ultrasound Scan of the Legs	A scan which examines the lower limbs for arterial blood flow (circulation) and to check there is no evidence of venous thrombosis (blood clots).
Fluoxetine	Trade name Prozac. It is an oral drug which is used to treat depression.
Haloperidol	This is a major tranquilizer used to treat psychosis.
Lorazepam	A sedative and anti-anxiety drug.
Mental Health Act 1983 and 2007	These Acts cover the assessment, treatment and rights of people with a mental health condition.
Modecate	A drug which is used in the treatment of psychotic illness, particularly schizophrenia, as it reduces the over-activity of the brain by dampening the effect of dopamine in the brain.
National Patient Safety Agency (NPSA)	The NPSA leads and contributes to improved and safe patient care by informing, supporting and influencing the health

	sector. This is in part achieved by the publication of best practice guidelines.
Paranoid Schizophrenia	This is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid delusions usually accompanied by hallucinations, particularly of an auditory nature, and perceptual disturbances.
Psychosis	This is a loss of contact with reality, usually including false ideas about what is taking place.
Risperidone Consta	A medication used for the treatment of schizophrenia and for the longer-term treatment of Bipolar Affective Disorder.
Strategic Health Authorities (SHAs)	These were created in 2002 to manage the local NHS on behalf of the secretary of state. There were originally 28 SHAs but they reduced to 10 in 2006. They are responsible for making plans to improve health services in their area and to ensure that services are of good quality and that national priorities are reflected in local health service plans.