

Independent Investigation

into the

Care and Treatment Provided to Ms A

by the

Dorset Healthcare University NHS Foundation Trust

Bournemouth Local Authority Social Services

and

Knightstone Housing Association

Commissioned by

NHS South West and the Bournemouth and Poole Adults Safeguarding Board

Investigation Managed by: the Health and Social Care Advisory Service

Report Authored by: Mr Jonathan Allen

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Ms A was commissioned jointly by NHS South West and Bournemouth and Poole Adult Safeguarding Board. The Investigation is pursuant to *HSG (94)27*¹ and the Bournemouth and Poole Adult Safeguarding Serious Case Review Policy and Procedure.² This Investigation was asked to examine the care and treatment received by Ms A in the years and months prior to the killing her mother, Ms B, on 25 of August 2010.

Ms A received care and treatment for her mental health condition from the Dorset Healthcare University NHS Foundation Trust in partnership with Bournemouth Local Authority Social Services from October 2001 through to the death of her mother in August 2010. She was also in receipt of supported accommodation from Knightstone Housing Association from December 2009 through to the killing of her mother in August 2010.

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 to 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 provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust, the Local Authority and Knightstone Senior Management Teams who have granted access to facilities and individuals throughout this process. The Senior Management Teams of all three organisations have acted in an exceptionally professional manner during the course of this inquiry process and have engaged fully with the root cause analysis ethos of this Investigation.

¹ Health Service Guidance (94) 27

² Bournemouth, Dorset and Poole Multi Agency Adult Safeguarding Policy and Procedure

2. Condolences to the Family and Friends of Ms B

The Independent Investigation Team would like to extend its condolences to the family and friends of Ms B. It is hoped that this report will provide a narrative to the events that occurred and address any of the outstanding questions that the family may still have. The Independent Investigation Team thanks the family for their involvement with this process and the assistance that they were able to provide.

3. Incident Description and Consequences

Background Information for Ms A

This background is predominantly drawn from a Psychiatric Court report on Ms A and a detailed history provided in an Independent Psychiatrist's report for a Mental Health Review Tribunal in 2007.^{3 4}

Ms A was born in Salisbury, Wiltshire, on 10 August 1971. Her mother and father separated when she was nine-years old. This was a few years after her younger sister had died from a brain tumour. She did well at school and went to University and gained a degree in art and ceramics. She first showed signs of mental health problems in 1995, when she was living in London. This led her to move back to her mother's home, where over the next few years her mental health problems started to materialise as a serious mental health disorder, and she commenced treatment under the care of local secondary mental health services. Over the next 15 years she received care and treatment from teams in London and more substantially in Dorset following a move back to the area to be close to her father.

Her illness developed into a serious and frequently remitting mental illness. Ms A did not sustain a significant period of stable mental health until 2008. This followed a two-year period of receiving inpatient rehabilitation. Following this she progressed over the next 18 months. She moved into her own supported flat, regained her driving licence and found some part-time paid work. This continued through to August 2010, when her mental health relapsed with tragic consequences.

Incident Description and Consequences

On 23 August Ms A's Housing Support Worker from Knightstone Housing called the Community Mental Health Team (CMHT) Duty Service to inform them that Ms A appeared unwell, and requested an assessment. The CMHT Team Leader, who took the duty call, asked the Housing Support Worker if Ms A was showing signs of relapse. The Housing Support Worker said she had not seen her unwell before so could not be

3 Confidential Psychiatric Court Report

4 Independent Psychiatrists Report for Mental Health Review Tribunal 9 May 2005 – records EH132 Vol 43 pp 2120 2123

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sure, but advised that she had never seen Ms A like this before. The CMHT Team Leader stated the team was about to go off duty, and advised he would discuss the concerns with a member of staff who knew Ms A, and arrange for her to be seen if necessary the next day.

The following morning there was further discussion within the team. The CMHT Team Leader discussed the call from the Housing Support Worker with a Community Psychiatric Nurse who had seen Ms A in the last five days. She advised that she had given Ms A her depot antipsychotic medication, and at that time she appeared well. The Housing Support Worker called the CMHT again to ask what progress had been made and was told that a plan was being put into place.

On 25 August a further call was made by the Knightstone Housing staff who continued to express concerns about Ms A's mental state. It was agreed that a CPN would go and assess Ms A later in the afternoon.

Later that afternoon a call was received by the CMHT from Ms A's mother expressing concerns about her daughter. When the Duty Worker tried to call Ms B back there was no reply. By this time Ms A had already killed Ms B.

It is reported by a colleague and friend of Ms A (who was an eye witness to the homicide) that Ms B had arrived at Ms A's flat in the early afternoon. She had not heard from her daughter for a couple of days as Ms A was not answering her telephone. Ms A's friend told Ms B that she could see Ms A in the flat and that she was pacing up and down, but would not answer the door. Ms B is reported to have knocked on the door in an insistent manner. When she did not get an answer she went downstairs and outside of the block of flats to telephone the Community Mental Health Team. Ms A came out of her flat with a knife and attacked her mother, stabbing her over 22 times. Following the attack she proceeded to walk through the streets of Boscombe, until she was apprehended by the Police.

Ms A was arrested and placed into medium secure psychiatric care under the powers of recall of her Section 17a Community Treatment Order. At her trial she was found guilty

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of manslaughter on the grounds of diminished responsibility, and placed on Section 37 of the Mental Health Act (1983 & 2007) with Section 41 Home Office Restrictions.

4. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS South West (the Strategic Health Authority, now NHS South of England) and the Bournemouth and Poole Adult Safeguarding Board to conduct this Investigation under the auspices of Department of Health Guidance *EL (94)27*, *LASSL (94)4*, and the Bournemouth and Poole Local Authority Adult Safeguarding Serious Case Review Protocol.

The HSG was 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 SHA 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.

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The purpose of an Independent Investigation is to thoroughly review 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 Team 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 Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team 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 the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

Adult Safeguarding Serious Case Review Requirements

The requirements for an Adult Safeguarding Serious Case Review as set out in the Bournemouth and Poole Adult Safeguarding protocol is to achieve the following.

1. Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults in vulnerable situations.
2. To review the effectiveness of procedures (both multi-agency and those of individual organisations).
3. To inform and improve local inter-agency practice.
4. To improve practice by acting on the lessons from serious case reviews and thereby developing best practice.

5. To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents, for example an Untoward Incident.

Where there are possible grounds for a Serious Case Review, a Domestic Violence Homicide Review, Safeguarding Children Serious Case Review, Multi-Agency Public Protection Review, Mental Health Service Review or other such formal review processes, then a decision should be made at the outset by the decision-makers involved as to which process is to lead and who is to chair with a final joint report being taken to the necessary commissioning bodies.

Criteria for a Serious Case Review

The Safeguarding Adults Board has the lead responsibility for conducting a serious case review. A serious case review should be considered in the following situations.

1. An adult in a vulnerable situation dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in his or her death. In such circumstances the Safeguarding Adults Board should always conduct a review into the involvement of agencies and professionals associated with the adult.
2. An adult in a vulnerable situation has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard adults in vulnerable situations.
3. Serious abuse takes place in an institution or when multiple abusers are involved. In these circumstances the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

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4. Financial, institutional or systemic abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a person's well-being and it is of a nature where there are serious negative outcomes for the individuals concerned.
5. Any other circumstance, which the Chair of the relevant Safeguarding Adults Board agrees should be the subject of a serious case review.

5. Terms of Reference

Terms of Reference for an Independent Investigation regarding the care and treatment of Ms A

“To review

- 1. The quality of health care commissioned and/or provided by the Trust, Local Authority, Housing Association and General Practitioner to include whether it complied with statutory guidance, statutory obligations, relevant department of health guidance, internal policies and adult safeguarding procedures.*
- 2. Whether the Care Programme Approach had been followed.*
- 3. Appropriateness of treatment and compliance with medication.*
- 4. Communication with the family including support to them as well as information that was available from them.*
- 5. Communication between the agencies involved in the support of Ms A.*
- 6. The quality of risk assessments, to include the frequency of such.*
- 7. Documentation, including recording of clear plans and risk assessments, decisions on frequency of contact and visits, actions taken and action taken to consider the appropriateness of a Community Treatment Order made in January 2009. In August 2010, whether the circumstances could or should have given rise to recall.*
- 8. The internal investigation (which was a local joint agency review), its recommendations and remedial action taken upon action plans.*
- 9. The learning points for improving systems of all relevant services, with practical recommendations for implementation.*
- 10. To report findings and recommendations to NHS Southwest and Chair of the Bournemouth and Poole Safeguarding Adults Board”.*

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Dorset Healthcare University NHS Foundation Trust, Dorset, Bournemouth or Poole Local Authorities, or Knightstone Housing Association. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Mr Jonathan Allen	Associate of the Health and Social Care Advisory Service. Chair and Report Author. Previous Director of Nursing and Director of Mental Health.
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Investigation Team Members

Dr Androulla Johnstone	CEO of the Health and Social Care Advisory Service. Nurse Team Member
Dr Liz Gethins	Locum Consultant Psychiatrist. Medical Team Member
Ms Jane Duncan	Local Authority Safeguarding Lead. Hampshire County Council. Safeguarding Team Member

Support to the Investigation Team

Mr Greg Britton	Administration
Mrs Fiona Shipley	Stenography Services

Independent Advice to the Investigation Team

Mr Ashley Irons	Solicitor. Capsticks
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7. Investigation Methodology

NHS South West (the Strategic Health Authority, now NHS South of England) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Ms A and all witnesses to this Investigation.

7.1. Communications with the Family of Ms A and Ms B

NHS South of England initially wrote to Ms A's sister and Ms B's sisters advising them of the Independent Investigation and offering to meet with them. A HASCAS representative and a Senior Officer from the Strategic Health Authority met with Ms B's sisters on 21 October 2011 and provided them with information about the Independent Investigation.

Ms A's sister lives overseas, HASCAS maintained initial email correspondence with her and she expressed a wish to set up a telephone interview. Subsequently the Investigation Team Leader emailed her on two occasions offering the opportunity to talk about the Investigation and her sister's care over the telephone. The Investigation Team Leader did not receive a response to either of these emails.

The Investigation Team Leader arranged a further meeting with Ms B's sisters to update them on progress, and to review any concerns or questions they had. This meeting took place on 18 June 2012. Ms B's sisters were updated on progress, and some questions they had for clarification were identified.

A Strategic Health Authority Senior Officer spoke to the father of Ms A on 1 June 2012. The Investigation Team Leader telephoned him on 6 June 2012. At this time he did not want to meet with the Investigation Team but requested to provide a written statement. Eventually the father of Ms A decided he would meet with the Investigation Team Leader. This meeting took place on 9 July 2012 at the HASCAS offices with the Nurse Member of the Investigation Team also present. Mr A's father was updated on the progress of the Investigation and he shared additional information pertinent to Ms A's care and treatment. The Investigation Team

is very grateful to family members for taking the time to share with us their recollections, observations and other information relevant to Ms A's illness and her care and treatment.

7.2. Communications with Ms A

NHS South West advised Ms A about the Independent Investigation *via* her solicitor in October 2011. The purpose of contacting Ms A was to inform her of the Independent Investigation and request her consent to access her clinical and social care records. Ms A gave her consent on 27 October 2011 and also asked to meet with the Investigation Team Leader. A HASCAS representative and a Senior Officer from the South West Strategic Health Authority visited Ms A in hospital on 25 November 2011 with the aim of providing her with information about the Investigation and to answer any questions pertinent to the Investigation. However during this visit Ms A was too unwell to participate in the interview.

Ms A's Solicitor advised the Investigation Team Leader that Ms A would like to meet with him in order to be informed about the Investigation and answer any questions the Investigation Team had for her. The Investigation Team Leader and a HASCAS representative met with Ms A and her Solicitor on 15 August 2012. Ms A was told about the Investigation terms of reference and requirements, and she was updated on the Investigation's progress. Ms A was asked if she had any particular issues she would like the Investigation Team to take into consideration. Ms A took the opportunity to state her specific concerns about her care and treatment. The points she raised included concerns:

- about having a part-time Care Coordinator;
- that the teams did not have enough information about her to understand her risks;
- about having told the Community Psychiatric Nurse that she had not been taking the additional Sulpiride medication her doctor had prescribed, as it made her sick. Ms A did not think this information was shared with anyone;
- that whilst she knew she was becoming unwell, and needed help, she was frightened of being readmitted to St Ann's Hospital because she had not liked previous admissions there;
- about not really wanting to live independently and that as she had to move on every two years she never felt settled.

The Investigation Team Leader confirmed that the report would address most if not all of these concerns. He also advised Ms A and her Solicitor about the publication of the report, and that

Ms A's Solicitor would have an opportunity to review the report prior to this event. Ms A was reassured that although the report would be published she and her family along with the staff involved would be anonymised within it.

7.3. Communications with the Dorset Healthcare University NHS Foundation Trust

NHS South West, the Strategic Health Authority informed the Dorset Healthcare University NHS Foundation Trust in October 2011 that they would be commissioning an Independent Investigation into the care and treatment of Ms A.

A Senior Officer from the Strategic Health Authority and a representative from The Health and Social Care Advisory Service held a start-up meeting with the Trust on the 21 October 2011. This meeting was attended by the Trust Director of Mental Health and Head of Patient Safety and Safeguarding. The Dorset Police Victim Liaison Officer and the Bournemouth Borough Council Safeguarding Lead also attended.

Further contact was maintained between the Trust, the Strategic Health Authority and HASCAS. Ms A provided her written consent and her health and social care records were released to HASCAS.

On 24 April 2012 a meeting was held between the Investigation Team Leader and the Trust Director of Quality and Head of Patient Safety and Safeguarding. The meeting was to prepare for the clinical witnesses workshop and interviews.

The workshop was held on 1 June 2012 and was well attended by the Trust and members from other agencies. The purpose of the workshop was to provide all witnesses with information about the Investigation process and why they were being called. Written information was also provided to prepare all witnesses for the Investigation and interview process.

The interviews were held the week commencing 25 June 2012, and an additional day was also held on 18 July 2012.

Between the first meeting stage and the formal witness interviews the Independent Investigation Team Leader worked with the Trust Liaison Person to ensure:

- all clinical records were identified and dispatched appropriately;

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- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

The Investigation Team Leader and Nurse Member of the Investigation Team met with the Trust Chief Executive and Executive Directors on 2 August 2012 to provide headline findings. At this meeting Trust Executives were invited to respond to the findings by writing recommendations and providing updates on what the Trust had achieved since the joint agency investigation had been finalised. They were also invited to provide other written information for the Independent Investigation report.

The draft report was sent to the Trust for factual accuracy checking on 3 December 2012. Relevant clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

7.4. Communications with Bournemouth Borough Council

The Investigation was jointly commissioned by the Independent Adult Safeguarding Board. The Independent Investigation Chair had an email exchange and telephone conversation with the Adult Safeguarding Board Chair to clarify terms of reference, expectations and alignment with Serious Case Review processes for the Adult Safeguarding Board.

The Safeguarding Board Chair also attended an interview with the Independent Investigation Team as a member of the joint agency investigation panel.

Additional email and telephone conversations were held with a number of Bournemouth Borough Council Staff to ensure this Investigation had access to notes and staff for the Leven House Service, as this service was managed and run by Bournemouth Borough Council at the time Ms A was a resident there.

Communications with NHS Bournemouth and Poole – Primary Care Trust (PCT)

A representative from NHS Bournemouth and Poole was involved throughout the Investigation. The Head of Patient Safety was a member of the joint agency investigation panel.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes. A total of 42 witnesses were interviewed formally.

Interviews were held on 25, 26, 27 and 29 June 2012. An additional interview day was held on 18 July 2012.

The table below provides a detailed account of which witnesses were seen on which day and by whom they were interviewed.

**Table One
Witnesses Interviewed**

Date	Witnesses	Interviewers
25 June 2012	Trust Chief Executive Trust Medical Director Trust Director of Mental Health Trust Director of Quality ***** Medical Director Director of Quality Head of Patient Safety and Safeguarding ***** Medical Director Director of Quality Head of Patient Safety and Safeguarding Head of Adult Services Independent Safeguarding Chair Police Sergeant Local Investigation Chair Local Authority Safeguarding Lead Mental Health Commissioning Lead *****	Investigation Team Chair Investigation Team Nurse Investigation Team Safeguarding Lead In attendance: Stenographer

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	<p>Head of Adult Services Assistant Medical Director Integrated Service Manager Service Manager Community Mental Health Team Leader</p>	
26 June 2012	<p>Social Worker 1/Care Coordinator 3 ***** Acute Inpatient Clinical Witness 1 Acute Inpatient Clinical Witness 2 Acute Inpatient Clinical Witness 3 Acute Inpatient Clinical Witness 4 ***** Consultant Psychiatrist 5 ***** Vocational Services Manger Ms A's Work Colleague/Friend ***** Clinical Psychologist 1</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Safeguarding Lead In attendance: Stenographer</p>
27 June 2012	<p>Care Coordinator 5 ***** Care Coordinator 4 ***** Associate Specialist ***** Leven House Manager Leven House Key Worker ***** Counselling Psychologist</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Safeguarding Lead In attendance: Stenographer</p>
29 June 2012	<p>Occupational Therapist ***** CMHT Team Leader/Duty Worker 3 ***** Duty Worker 1 Duty Worker 2 Duty Worker 4 ***** Social Work Assistant Practitioner ***** Nightingale Court Key Worker</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Safeguarding Lead In attendance: Stenographer</p>
18 July 2012	<p>Knightstone Housing Manager Housing Support Worker ***** Consultant Psychiatrist 4</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist</p>

	***** Trust Director of Nursing ***** Adult Safeguarding Lead ***** Senior Social Work Practitioner	Investigation Team Safeguarding Lead (safeguarding lead and senior social work practitioner only) In attendance: Stenographer
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Scott and Salmon Compliant Procedures

The Independent Investigation Team adopted Scott and Salmon compliant procedures during the course of its 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 work colleague, member of a trade union, lawyer or member of a defence organisation 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; and
- (h) that they will be given the opportunity to review clinical records prior to and during the interview.

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.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions

11 April 2012. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews. Using the Terms of Reference and the timeline as guidance, the Team also developed subject headings that required further examination.

25 June 2012 and the 18 July 2012. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and discuss additional evidence as it arose.

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Following completion of interviews the timeline was reviewed and an initial thematic analysis was completed to identify pertinent subject headings to support further root cause analysis.

20 July 2012. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety Agency (NPSA). This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the meeting and being able to present written, referenced briefings to Investigation Team Members. The 'Five Whys' process was also used.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair communicated with NHS South of England throughout the Investigation process. Communications were maintained in between meetings by email, letter and telephone.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon 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 learnt 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. A first draft timeline is constructed.
- 2. Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
- 3. Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. These include brainstorming and writing, consensus building techniques and analytical techniques such as the '5 Whys' and 'fishbone analysis'. The Investigation Team utilised most of these processes to process, interpret and make sense of the information presented.
- 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 Investigation Team seeks to avoid generalisations and uses 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.

8. Information and Evidence Gathered (Documents)

During the course of this Investigation an estimated 3,200 pages of clinical records have been read and over 3,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. GP records for Ms A
2. Trust clinical records for Ms A
3. Knightstone Housing records for Ms A
4. Leven House Records for Ms A
5. Court reports for Ms A
6. Joint Agency Investigation Report
7. Trust assurance and governance documentation
8. Secondary literature review of media documentation reporting the death of Ms B
9. Secondary literature review of external regulatory bodies pertaining to the Trust
10. Independent Investigation Witness Transcriptions
11. Trust Clinical Risk Policies, past and present
12. Trust Care Programme Approach Policies, past and present
13. Trust and Local Authority Safeguarding and Vulnerable Adult Policies, past and present
14. Local Authority Supporting People Eligibility Criteria
15. Trust and Local Authority Operational Policies, past and present
16. Trust Incident Reporting Policies
17. Trust Clinical Supervision Policy
18. Healthcare Commission/Care Quality Commission Reports for Trust services
19. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm*: a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006
20. Guidelines for the NHS: National Patient Safety Agency, Safer Practice Notice 10, *Being Open When Patients are Harmed*. September 2005
21. Refocusing the Care Programme Approach Policy and Positive Practice Guidance, Department of Health 2008

- 22.** Best Practice in Risk Management, Principles and evidence for best practice for the assessment and management of risk to self and others in mental health services. Department of Health 2007

9. Profile of the Dorset Healthcare University NHS Foundation Trust (Past, Present and Transition)

Dorset Healthcare University NHS Foundation Trust became a Foundation Trust in 2007 having been an NHS Trust since 1992. In 2010 the Trust was also awarded University status in recognition of its enhanced level of Partnership working with Bournemouth University which subsequently created a University Department of Mental Health.

Prior to July 2011 the Trust provided the following services in East Dorset:

- Secondary Care Mental Health services;
- Learning Disability Services;
- Drug and Alcohol Services;
- Community Brain Injury Services;
- Community Dental Services;
- Community Adult Asperger's Services;
- Primary Care Psychological Therapy Services.

The Trust also provided specialist services across the county of Dorset including:

- Children's and Young People's Emotional Services;
- Eating Disorder Services;
- Perinatal Services;
- Forensic Mental Health Services.

The Trust also provided a Steps to Well Being Service (IAPT) in Southampton. The Trust had an annual turnover of approximately £88 million and employed approximately 2,100 staff. During this period the Trust received good external ratings, being the only Trust to achieve the highest level ratings for quality and use of resources from healthcare regulators for eight successive years.

In July 2011 community health services provided by NHS Bournemouth and Poole Primary Care Trust (PCT) and Community Health Services including Mental Health Services and Prison Health Care provided by NHS Dorset PCT transferred to the Trust.

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At the time of writing this report the Trust's portfolio of services included 11 community hospitals, healthcare provision in four prisons and the full range of community services:

- District Nursing;
- Health Visiting;
- School Nursing;
- Podiatry;
- Speech and Language Therapy;
- Physiotherapy;
- Tissue Viability;
- Palliative Care.

The Trust annual turnover has increased to approximately £200 million and the staff count to approximately 5,000.

In respect of Mental Health the Trust is a demonstrator site for the Wellbeing and Recovery Partnership (WaRP), which is the primary vehicle for the Trust to drive and implement the recovery approach. This also includes the development of a Recovery Education College in partnership with the Dorset Mental Health Forum (a third sector organisation run by people with lived experience of mental health problems).

The Trust is also proactive in leading the Time to Change campaign across Dorset which aims to reduce the stigma and discrimination that people with mental health problems suffer. The Trust has commenced a major capital development to improve the facilities and environment provided at St Ann's Hospital, one of its main Acute Mental Health Inpatient units, including the provision of single *en suite* accommodation.

A number of the Trust services are accredited as Practice Development Units with Bournemouth University.

The Trust vision is "*providing care all of us would recommend to family and friends*". The Trust conducts a number of surveys, including real-time feedback to assess the delivery of this vision statement in practice.

Specific changes within Mental Health Services include:

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- a strategic partnership with Dorset Mental Health Forum;
- re-organisation of the Bournemouth Adult CMHTs;
- the roll-out of Community Treatment Order guidance and standards across the enlarged Directorate;
- commencing the roll-out of the same electronic patient record across the enlarged Mental Health Directorate;
- the roll-out of one Risk Assessment and Management Policy across the Directorate;
- a revised Management structure across the service to ensure continuity and consistent standards and best practice.

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Ms A and her care and treatment from mental health services.

10.1. Background Information for Ms A

Ms A was born in 1971. Ms A had a younger sister two years her junior and an elder sister. Her younger sister was diagnosed with a brain tumour at the age of two and a half and eventually died at the age of seven and a half. Ms A's parents noted that between the ages of five and six years Ms A became noticeably withdrawn. Nevertheless throughout the rest of her early childhood she was able to make friends easily and maintain relationships with peers. Ms A's parents divorced when she was nine years old. She however did well at school.

Ms A studied for a degree in ceramics at Bath and eventually moved to live with her boyfriend in London sometime in 1992. She split up with her boyfriend shortly afterwards, and moved into a rented house with friends, where she lived until 1995.

10.2. Mental Health Chronology of Ms A

In **1995** Ms A lost her job and faced a number of financial pressures and personal stressors. There is some mention within the clinical record of her being seen by a Psychologist in London at this time for anxiety and depression. She moved back to Salisbury to live with her mother at the end of 1995. In 1997 she was referred to the Salisbury Mental Health Team, because of continuing complaints of pain in the right side of her face for which medical investigation could not reveal a cause. The Psychiatrist (Consultant Psychiatrist 1) found Ms A to be depressed and thought that she may have had a cyclothymic personality. She was not prescribed medication at this

time, but was offered monthly follow-up appointments. She was seen regularly over the next three years by the Salisbury CMHT, and during this time the team noted the development of paranoid delusions in that she thought she had had one of her ovaries removed whilst she slept. She was treated successfully with antipsychotic medication.⁵

In the summer of **2000** Ms A decided to move back to London and was assisted by the Salisbury Mental Health Team to find supported accommodation in Brixton. She was transferred to the care of the Brixton Community Mental Health Team.⁶

By **September 2001** Ms A's mental health had broken down following a period of non-compliance with her medication. She had become paranoid about the area she was living in and was fearful for her safety and had moved back to Salisbury to live with her mother. There is a note within her clinical record of an altercation with a former work colleague earlier in 2001, where it is alleged she had gone to his house, accused him of stealing from her, bitten him and scratched words on his door with a scalpel. It is noted that he brought a private case against her following which she was bound over not to harass or go near him again.⁷

Ms A returned to London before the end of September as her mother could not cope with her behaviour at home. She saw her Psychiatrist (Consultant Psychiatrist 2) in Outpatients, and returned to her accommodation. She agreed to start taking medication again.

5 October 2001. Ms A's CPN from Brixton made an urgent referral to Bournemouth Borough Council Social Services. It was reported that Ms A had disappeared from her London address one week previously and it had been discovered that she was now staying with her aunt in Bournemouth. The Brixton services were concerned for her because of her history, but also because it had been reported that she had been wandering at night prior to leaving London.⁸

5 Trust notes p 482

6 Trust notes p 480

7 Trust notes p 473

8 Urgent referral form for Bournemouth Borough Council Social Services dated 5/10/2001. Clinical Records SHA392 Vol 10 pp 467-468

16 October 2001. The GP of Ms A's father made an urgent referral to the local mental health services covering Ringwood.⁹

17 October 2001. Consultant Psychiatrist 3 from the CMHT covering Ringwood completed a domiciliary visit at her father's house, and found Ms A to be deluded and guarded but not overly distressed. He prescribed Olanzapine and referred her to a Community Psychiatric Nurse (CPN) in his team.¹⁰

7 December 2001. Ms A was reviewed in Outpatients by Consultant Psychiatrist 3. Ms A had not taken her prescribed medication as she believed it would give her migraines. She remained unwell. Her prescription was changed to Risperidone with the hope her CPN could persuade her to take it.¹¹

On **13 January 2002** Ms A was seen in Outpatients by Consultant Psychiatrist 3. She was found to be much improved after being persuaded to start another antipsychotic, Sulpiride, for one week. She was advised to continue with medication and that she would be reviewed by Consultant Psychiatrist 3 in two months' time.¹²

31 May 2002. Ms A moved out of her father's house into Irving Road, a Richmond Fellowship supported hostel for people with mental health problems. Ms A's CPN/Care Coordinator (Care Coordinator 1) reported that relationships had become strained in her father's house.¹³ This has been verified at interview with her father, who had said that his relationship with his wife had become strained as a result of Ms A's behaviour in the house, which included extreme untidiness, staying in bed, and concerns about things going missing.

On **4 July 2002** Care Coordinator 1 referred Ms A to the Southbourne CMHT, as she had moved to Irving Road, and registered with a GP in this team's catchment area. The transfer letter noted that she had not experienced any delusional or paranoid thinking since being on medication, but had experienced lowered mood, associated with being

9 Letter from GP to Consultant 3 making urgent referral, SHA 392 Vol 10 p 476

10 GP letter from Consultant 3 SHA 392 Vol 9 p 466

11 GP letter from Consultant 3 SHA 392 Vol 9 p 465

12 GP letter from Consultant 3 SHA 392 Vol 9 p 464

13 Letter from CPN/Care Coordinator to Southbourne CMHT following move to Irving Road, dated 4/04/2012, SHA 392 Vol 10 p456

unwell. An early appointment was advised to prevent any risk of discontinuation of medication and relapse.¹⁴

Between **July 2002** and **June 2003** Ms A continued to live at Irving Road, and was regularly seen by her new CPN/Care Coordinator (Care Coordinator 2). Ms A worked as a volunteer in a charity shop and attended a pottery workshop. She was seen every three months in her new Consultant Psychiatrist's (Consultant 4) Outpatient Clinic by his junior doctors. During these clinic appointments she was noted as being free from psychotic symptoms, but as remaining low in mood. Her lowered mood appeared to be related to adjusting to the impact her mental illness had made on her life. As a result she was started on Venlafaxine an antidepressant medication, which was titrated to a therapeutic dose over the course of the year. She was also referred to a Clinical Psychologist to see if she could benefit from psychological work around managing the impact her illness had made on her life. Following the assessment the Clinical Psychologist (Psychologist 1) thought that there would be no obvious benefit to Ms A from psychological intervention at that time.¹⁵

23 and 25 June 2003. Ms A contacted her CMHT *via* housing support staff to advise them that she was feeling anxious and concerned about her mental health.¹⁶

25 June 2003. Care Coordinator 2 wrote to Ms A's GP advising that Ms A had started to display some breakthrough symptoms of psychosis. The GP was asked to increase Ms A's dose of Sulpiride from 300mg to 400mg per day.¹⁷

8 July 2003. Ms A was assessed in her accommodation by Consultant Psychiatrist 4 and Social Worker 1 (later Care Coordinator 3) after a report from her housing support staff that she had started to stay in her room, become irritable, and was not attending to her personal care. Consultant Psychiatrist 4 found her to be irritable and to have a belief that she had had a tooth removed while she was sleeping, and had also been abused. He thought that her mental state was deteriorating, but elicited an agreement from her to take an increased dose of medication and to see her clinical team on a regular basis. She

14 Letter from CPN 2 to Southbourne CMHT SHA Vol 392 Vol 9 pp 456-457

15 CMHT and psychologist letters SHA 392 Vol 9 pp 434-450

16 CMHT contact sheets, SHA 392 Vol 9 pp 203-208

17 Letter to GP from CPN SHA 392 Vol 9 p 438

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was offered an informal admission to hospital, which she declined. Consultant Psychiatrist 4 and Social Worker 1 agreed she was not detainable under the Mental Health Act (1983) at that time because she was willing to cooperate with treatment.¹⁸

6 August 2003. Following continued deterioration in her mental health Ms A was admitted to an acute admission ward at St Ann's Hospital. Consultant Psychiatrist 4 continued to be her doctor.¹⁹

11 September 2003. Ms A was discharged back to the care of the CMHT and to live at Irving Road. Her discharge summary reported a presentation of lethargy, suspiciousness, and delusional thinking about having a tooth removed and contracting AIDS. After three weeks of treatment Ms A was found to have responded well to her new level of medication (8mg Sulpiride) and was less preoccupied by assumptions and strange beliefs.²⁰

7 October 2003. A letter was sent from Occupational Therapist 1 offering Ms A a place with TORCH a therapeutic day programme offered at the Hahnemann House day centre.²¹

15 October 2003 to 21 May 2004. Ms A continued to make good progress and was seen regularly in Outpatients. She was also seen by a Trainee Psychologist for input on lowered mood and self-esteem issues.²²

6 June 2004. During a domiciliary visit from a CMHT Social Worker who had been sent from the CMHT following concerns raised about her mental health by staff at Irving Road (Social Worker 2), Ms A requested a psychiatric re-admission. She had stopped taking medication, was experiencing intrusive thoughts and was not sleeping. Admission was arranged for the next day.²³

18 Letter from Consultant 4 to GP, SHA 392 Vol 9 p 427

19 Ward Admission documents SHA 392 Vol 5 pp 214-219

20 Ward discharge summary SHA 392 vol5 pp 422-424

21 Letter from TORCH offering day programme appointment SHA 392, Vol 9 p 421

22 CMH T letters SHA 392 Vol 9 pp 404-532

23 Hand written note in CMHT records SHA 392 Vol 11 p 546

12 August 2004. Ms A was discharged back to Irving Road after a period of successful trial leave. The discharge plan included encouragement for Ms A to attend the day hospital and for a trial on Clozapine.²⁴

23 September 2004. Ms A started at the day hospital and commenced a trial on Clozapine.²⁵

2 December 2004. Ms A was discharged from the day hospital. The plan was for her to look for voluntary work and attend Hahnemann House for group work. At this time Ms A was continuing with Clozapine. She was to be followed up by Care Coordinator 2 (CC 2) and also in Outpatients.²⁶

6 December 2004. Ms A attended an Outpatients appointment. She complained of feeling drowsy most of the time but had no unusual thoughts or perceptions. Ms A was looking for voluntary work and was planning to start with a swimming group. She had not found Hahnemann House helpful and was reported to want to do something more constructive. She was spending time at her mother's house doing ceramics.²⁷

21 March 2005. Ms A was reviewed in the Outpatient Clinic. She was continuing to respond well to Clozapine. She reported still sleeping more than 12 hours a night and feeling anxious in the evening. She also reported sometimes having odd ideas when going to sleep and on waking. She was also experiencing nightmares. It was noted that she was on the Council list for independent accommodation, but Ms A stated she did not believe she was ready to live on her own.²⁸

1 July 2005. Irving House staff telephoned Care Coordinator 2 because they were concerned about Ms A's mental health. She appeared paranoid, agitated and self-isolating. However Ms A appeared a little better later in the morning. Care Coordinator 2 agreed she could go to her mother's house, and that he would see her after the weekend.²⁹

24 Discharge summary to GP SHA 392 Vol 9 p 386

25 Hand written note in records SHA 392, Vol 13 p 642

26 Hand written entry in day hospital continuation notes SHA 392 Vol 14 pp 675-676

27 Hand written entry from outpatients clinic SHA 392 Vol 14 p 677

28 Note from outpatients appointment SHA 392 Vol 14 p 685

29 Note in CMHT records by CC2, SHA 392 Vol 14 p 686

7 July 2005. Care Coordinator 2 visited Ms A at Irving Road and found her to be distracted and unkempt. Ms A reassured him that she was still taking her medication. It was agreed she would spend some additional days at her mother's house, and her Care Coordinator would see her again in 13 days.³⁰

13 July 2005. Ms A's father called Care Coordinator 2 because he was concerned about her mental health. Care Coordinator 2 agreed to do a home visit.³¹

14 July 2005. Care Coordinator 2 completed a home visit and found Ms A to be responding to paranoid thoughts. It was decided to make a referral to the Crisis Team.³²

15 July 2005. The Crisis Team assessed Ms A in the morning and found her to be acutely psychotic. Her vulnerability to abuse and exploitation was deemed to be high. It was not thought initially that Ms A needed Crisis Team intervention as she lacked insight. The Irving Road Team was advised that if Ms A deteriorated further an inpatient admission may need to be arranged.³³

16 July 2005. Irving Road staff called the Crisis Team as Ms A had refused her medication. They were concerned about her stopping and starting her Clozaril treatment. The Crisis Team advised not to give Ms A her medication over the weekend and agreed to visit and support pending a full medical review at the beginning of the week.³⁴

At 20.05 hours on **16 July 2005** Irving Road staff called the Crisis Team to inform them that Ms A had gone missing.³⁵

17 July 2005. Ms A was found by the Police wading into the sea with no clothes on. She was placed on a Section 136 of the Mental Health Act (1983) and admitted to St Ann's Hospital.³⁶

30 Note in CMHT records by CC2 SHA 392 Vol 14 p 687

31 Note in CMHT records by CC2 SHA 392 Vol 14 p687

32 Note in CMHT records by CC2 SHA 392 Vol 14 p 687

33 Note in CMHT records by CRHT SHA 392 Vol 14 p 688

34 Note in CMHT records by CRHT SHA 392 Vol 14 p 688

35 Note in CMHT records by CRHT SHA 392 Vol 14 p 691

36 Note in CMHT records by CRHT SHA 392 Vol 14 p 691

28 July to 18 August 2005. Weekly ward reviews initially recorded that Ms A continued to spend a lot of time in bed, and at other times would pace around the ward occasionally laughing to herself. The Clozapine was increased and escorted walks off the ward allowed. By 11 August Ms A appeared much better, asking to spend time out with her mother. Ms A had also stated that she did not want to return to Irving Road. Unescorted walks in the grounds and to shops were allowed.³⁷

27 August 2005. Ms A did not return from an unescorted walk off the ward. Ward staff reported her as a missing person to the Police at 21.15 hours when she had still not returned.³⁸

30 August 2005. Police contacted the ward to state that Ms A had been found living on Weymouth Beach. The Police did not think Section 136 powers were justified as Ms A was not apparently presenting a risk to either herself or others.³⁹

31 August 2005. Ms A's father found her on Weymouth Beach and reported that her mental health appeared to have deteriorated again. Ms A's mother called the ward to state how unhappy she was with the situation.⁴⁰

1 September 2005. Ward staff went to Weymouth Beach and encouraged Ms A to return with them. Ms A returned to the ward with the staff.⁴¹

Between **1 September** and **9 October 2005**, following her return to the ward, Ms A gradually improved and was granted a trial leave to Irving Road. On 19 September Irving Road staff contacted the ward to say Ms A's mental health had deteriorated again. She had stopped taking her Clozapine medication. On return to the ward she was responding to auditory hallucinations and spent most days pacing up and down laughing to herself.

During a ward round on **2 October** the team decided to change Ms A's medication to Risperidone to enable a transfer to Risperdal Consta depot injection. Following her

37 Notes in ward records SHA 392 Vol 15 pp 717-735

38 Notes in ward records SHA 392 Vol 15 p 743

39 Notes in ward records SHA 392 Vol 15 pp747-749

40 Notes in ward records SHA 392 Vol 15 pp 748-749

41 Notes in ward records SHA 392 Vol 15 p 750

change in medication her behaviour appeared to deteriorate further and the Risperidone was increased to the maximum dose and Sulpiride, another antipsychotic medication, was added.⁴²

9 and 10 October 2005. On the evening of 9 October Ms A was noted to attempt to put her arms around a male staff member and then later to be pacing and making stabbing motions with her arms. In the early hours of the morning of 10 October she pushed a fellow service user in the back, leaving red nail marks on her shoulder. She then attempted to stab yet another service user in the head with a cutlery knife, and then lunged at a member of staff. No serious injuries were incurred. Ms A required restraint and additional medication. When interviewed about the incidents, she reported she had been hearing voices, telling her to break the Ten Commandments so she could go to heaven. Risk assessments changed to record a high level of risk of harm to others and a high risk of vulnerability to abuse and exploitation.⁴³

12 October 2005. Ms A continued to display symptoms of psychosis, including an additional incident when she had attempted to put her hands around a member of staff's throat. In the ward review, following team discussion, Consultant Psychiatrist 4 felt it would be appropriate to apply for a Section 3 of the Mental Health Act (1983) as Ms A continued to be very unwell and did not appear to be able to understand and retain information.⁴⁴

20 October 2005. Ms A was recommenced on Clozapine as she had not improved on Risperidone.⁴⁵

November 2005. Ms A's mental state improved throughout November. Her Consultant and new Care Coordinator (Care Coordinator 3, previously Social Worker 1), agreed she should not return to Irving Road as they could not supervise her taking medication in this accommodation. As a result a placement at Leven House, group accommodation run by the Local Authority was considered. Ms A visited Leven House and was not happy to move there. Ms A also asked to appeal her Section as Consultant Psychiatrist

42 Mental Health Review Tribunal Report 3rd Jan 2006, SHA 392 Vol 31 pp 1531-1535

43 Notes in ward records, SHA 392 Vol 25 pp 1221-1225

44 Mental Health Review Tribunal Report 3rd Jan 2006 SHA 392 Vol 31 pp 1531-1535

45 Mental Health Review Tribunal Report 3rd Jan 2006, SHA 392 Vol 31 pp 1531-1535

4 had told her that as she was on a Section he could say where she had to live. By 1 December Ms A started to appear unwell again, pacing the ward and laughing to herself. Due to concerns that she was not taking her medication on the ward, staff started to crush the tablets to ensure compliance.⁴⁶

6 December 2005. Ms A was found to be missing from the ward in the evening; the Police and Ms A's family were informed. The Police returned her to the ward at 22.30 hours. Ms A had walked from St Ann's Hospital in Poole to Ringwood.⁴⁷

7 to 30 December 2005. Ms A continued to be recorded frequently as pacing up and down the ward and laughing to herself. On one occasion another patient complained that Ms A had kept coming to her in her bedroom hugging her very tightly. Ms A had to be asked to refrain from this behaviour. She remained on close observations throughout most of December. She continued to express a strong desire not to go to Leven House. Her Care Coordinator took her to see Devonshire Lodge, another supported housing project, where she could have her medication supervised. Ms A stated she would be happy to go to Devonshire Lodge. Ms A's behaviour and mental state appeared to improve following this, although the pacing, laughing and talking to herself continued throughout December.⁴⁸

January 2006. Ms A remained as an inpatient throughout January. Staff continued to report that she was pacing up and down the corridors laughing to herself, apparently in response to auditory hallucinations or other internal stimuli. She would not engage with or talk to staff, other than to respond to direct questions, or request things. Ms A infrequently attended Occupational Therapy as she was often not up in time to attend activities or groups. When not pacing, Ms A was reported to spend most of her time in her room either in bed resting or sleeping. She continued to have her Clozaril tablet given crushed in water, due to compliance concerns. Plans to go for trial leave at Devonshire Lodge continued to be progressed. Ward round and nursing notes recorded Ms A's risks to be low as long as she complied with medication.⁴⁹

46 Notes in ward records SHA 392 Vol 26 pp 1258-1299

47 Notes in ward records SHA 392 Vol 26 p 1300

48 Notes in ward records SHA 392 Vol 27 pp 1301-1330

49 Ward notes, SHA 392 Vol 27 and Vol p 28

February 2006. Trial leave at Devonshire Lodge was planned for the weekend commencing 3 February. On return from leave Ms A was noted to be very happy with Devonshire Lodge. She continued with overnight leave from 7 February and remained on leave over the course of February, attending the ward for review and to pick up medication. When on the ward Ms A continued to be observed pacing and on occasion laughing to herself.⁵⁰

1 March 2006. A printed copy of an electronic care plan dated 1 March and generated by Care Coordinator 3 was placed in Ms A's clinical record. This stated that Ms A had been sent on Section 17 leave to Devonshire Lodge. The care plan recorded that during this time she was to continue to work on a relapse plan and engage in Cognitive Behaviour Therapy with one of the Community Psychiatric Nurses in the team (CPN 4 – this CPN at a later date became Ms A's Care Coordinator). Ms A was also recorded as being required to attend Hahnemann House once a week to participate in groups and to attend the Clozapine blood testing clinic. The care plan documents early warning signs and relapse indicators. However all Ms A's risks were deemed to be low and her risk of aggression towards others, or risk of vulnerability from others was not recorded.⁵¹

2 March 2006. Ms A's mother contacted Care Coordinator 3 to discuss a request for a second opinion on Ms A's diagnosis. Care Coordinator 3 discussed this request with Consultant 4 and agreed to write to another Consultant for a second opinion.⁵²

9 March 2006. Care Coordinator 3 visited Ms A at Devonshire Lodge and discussed progress with Ms A and her landlady. Both agreed that Ms A had settled in well. Care Coordinator 3 also discussed Ms A's mother's request for a second opinion with Ms A. Ms A stated she was happy with her current diagnosis and treatment and did not want a second opinion.⁵³

16 March 2006. A ward review and Section 117 meeting was held with Consultant Psychiatrist 4, Care Coordinator 3 and a junior ward doctor present. It was noted that

50 Ward notes SHA 392 Vol p 28

51 CMHT notes SHA 392 Vol 29 pp 1418-1447

52 CMHT notes, SHA 392 Vol 31 p 1542

53 CMHT notes, SHA 392 Vol 31 p 1542

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Ms A was continuing to do well at Devonshire Lodge and it was agreed to discharge her from Section 3 of the Mental Health Act (1983). It was agreed that the current care plan should continue.⁵⁴

25 April 2006. Ms A was readmitted as an inpatient informally following deterioration in her mental health. At interview she was very delusional and distressed. She believed she was evil and had caused nuclear war, famine and pestilence. She also believed that her mother aborted her at birth, and that she (Ms A) had killed Jesus Christ and had been waiting 2000 years to die. On admission she was scared she would try to hurt someone. Ms A stated that she had kept taking her medication while at Devonshire Lodge and had not vomited it back. She also denied any use of illicit substances.⁵⁵

May and June 2006. Ms A remained very unwell throughout May and admitted to stopping taking medication five days prior to readmission. She refused to take medication on the ward, stating she did not want to take it anymore and that she was not mentally ill. Consultant Psychiatrist 4 reapplied for Section 3 of the Mental Health Act (1983). Following being placed on Section 3 of the Mental Health Act Ms A continued to refuse medication and on occasion required PRN (that is to say 'as required') antipsychotic and sedative medication administered by intramuscular injection. She continued to pace the ward and respond to internal stimuli. She had minimal engagement with staff, and she started refusing food and was drinking very little.

Consultant Psychiatrist 4 wanted to start her on Risperdal Consta depot injection, but the pharmacy was reluctant to agree to this due to Ms A's previous failure of a trial on oral Risperidone. The pharmacy eventually agreed a three-month trial which commenced towards the end of May. Ms A was also commenced on Risperidol Quicklets with an agreement to administer under restraint if she continued to refuse medication, due to high risks being presented predominantly through self-neglect.

Throughout June some small improvements were noted as Ms A's medication regimen was established. Ms A was less agitated and did not pace as much. Neither did she laugh to herself nor grimace as often as she had done previously. She was slightly more

⁵⁴ CMHT notes, SHA 392 Vol 31 p 1543

⁵⁵ Ward Records, SHA 392 Vol 32 pp 1554-1561

amenable on approach by staff, but still answered questions monosyllabically. However her diet and fluid intake had improved.

On 15 June 2006 Ms A was transferred to Nightingale House, a longer-term rehabilitation inpatient unit, due to pressures on acute inpatient beds. She remained at Nightingale House until 23 June when she was transferred back to St. Ann's.⁵⁶

27 July 2006. Ward round notes record that Ms A had started depot medication and was compliant with oral antipsychotic medication in suspension formulation. An improvement in her mental state was noted and an increase in Section 17 leave was given to allow off-ground leave with her father. A transfer to Nightingale House on a longer-term basis was discussed. Ms A expressed reluctance to be transferred to Nightingale House.⁵⁷

July to October 2006. Ms A was initially unsettled when she returned to the ward from Nightingale House. However in September she significantly increased her engagement with Occupational Therapy and her mental health is recorded as showing marked improvement. She was referred to Nightingale House for a rehabilitation placement. The rehabilitation Consultant Psychiatrist (Consultant 5) wrote to Consultant 4 advising him that while Ms A would be a suitable client for Nightingale House he could not accept her with immediate effect as the unit had no Occupational Therapy cover at that time.⁵⁸

30 October 2006. Ms A was transferred to Nightingale Court, an open rehabilitation unit, following agreement that she could continue to attend the Occupational Therapy department at St Ann's Hospital.⁵⁹

6 November 2006. Ward review notes confirm that Ms A had settled into Nightingale Court and had continued to attend Occupational Therapy at St. Ann's Hospital. Her

56 Ward Records SHA 392 Vols 31 and 32

57 Ward Records SHA 392 Vol 35 p 1705

58 Ward Records SHA 392 Vol 42 p 2061

59 Letter confirming Discharge arrangements SHA 392 Vol 36 p 1793

mental health was stable, although she was observed to isolate herself in her bedroom. She had also experienced some unwanted sexual advances from another service user.⁶⁰

11 December 2006. A Care Programme Approach Review meeting was held.⁶¹ It was recorded that Ms A:

- had minimal symptoms of psychosis evident;
- was compliant with medication, although she had refused her depot once, due to pain of the injection;
- was participating in psychology and occupational therapy;
- did not want to return to Devonshire Lodge and would like to move in with her mother;
- had insight into her illness and recognised the need to stay on her Section 3 as she knew without it she might stop taking her medication;
- would like to find opportunities to use her ceramics experience.

The plan was to continue with medication, and improve self-care and management of her bedroom space. A meaningful structure to Ms A's day was to be provided and plans for transfer to the community were to be commenced.

February 2007. Ward records note Ms A started pacing and laughing to herself. She had become predominantly uncommunicative, but at other times some pressure of speech was noted. Ms A expressed anxiety about moving on from Nightingale Court too soon. During the ward review it was agreed to restrict leave to escorted leave in the hospital grounds only. It was also agreed to increase medication and transfer her from Nightingale Court to Nightingale House to facilitate 30 minute observations.⁶²

March 2007. Ms A continued to be unwell. Consultant 5 convinced her to start a mood stabiliser (Sodium Valproate) in addition to her Risperdal medication.⁶³

April 2007. Ms A's mental state had still not improved and ward staff had a strong suspicion that she was not being compliant with the Sodium Valproate tablets so this

60 Ward Review notes SHA 392 Vol 37 p 1832

61 Ward review notes SHA 392 Vol 42 p 2058-2061

62 Ward notes SHA 392, Vol 39 pp 1910-1915

63 Clinical Records SHA 392 Vol 43 p 2106

was changed to a liquid preparation. Also as Ms A had relapsed on full dose of Risperdal Consta depot injection, and she refused to restart or comply with oral Clozapine, Consultant 5 and the Pharmacist decided to try her on traditional antipsychotic depot medication, Pipothiazine Palmitate (Piportil).⁶⁴

9 May 2007. An independent psychiatric report for a Mental Health Act Review Tribunal upheld Ms A's detention under Section 3 of the Mental Health Act (1983) and stated that Ms A was suffering from a Schizoaffective Disorder.⁶⁵

25 May 2007. Consultant 5 wrote an addendum to an earlier report for a Mental Health Act Review Tribunal in December. In this report he stated

*"... it is also apparent that marked affective changes are associated with her illness. She has recently shown a good response to the addition of Sodium Valproate, a mood stabiliser. In my opinion the affective features are sufficiently pronounced to suggest the category for schizoaffective disorder as a more complete description of her illness than schizophrenia".*⁶⁶

4 June 2007. A Care Programme Approach Meeting held in Nightingale House recorded that Ms A was making progress. However at this time she still had not recommenced unescorted leave and her level of compliance and engagement in treatment was still in question. The team set out a clear six-month plan at this time which included:⁶⁷

Risks

Ms A was to remain on Section 3 until she had progressed through the leave pathway to stage 5.

The team were to apply for a Supervised Discharge Order prior to Ms A being discharged from Section 3.

64 Clinical Records SHA 392 Vol 43 p 2111

65 Clinical Records SHA 392 Vol 43 pp 2120-2123

66 Clinical Records SHA 392 Vol 42 p 2100

67 Clinical Records SHA 393 Vol 42 pp 2052-2055

Physical Health

The monitoring of Ms A's physical health was to take place through six monthly checks of markers of metabolic syndrome.

Substance Misuse

The monitoring of Ms A's smoking and encouragement of attendance at a stop smoking clinic.

The screening for illicit substances was to take place regarding future relapse.

Mental State

The recording of the Brief Psychiatric Rating Scale was to take place every three months.

The reduction of Risperidone by 2mg every two weeks and Diazepam by 1mg every two weeks, the provision of liquid Sodium Valproate in divided doses, and the optimisation of the dose of Pipothiazine.

Ms A's engagement in individual clinical psychology sessions to discuss her illness and relapse prevention strategies was to be encouraged.

Ms A's engagement with her key worker in regular Cognitive Behaviour Therapy orientated psycho-educational sessions was to be encouraged.

Activities

Ms A's progressive engagement in activities on the unit was to be encouraged.

Recommencement of Ms A's Occupational Therapy Programme at St Ann's Hospital following risk assessment was to be arranged.

A referral to services in Hahnemann House was to be made.

Community

A referral was to be made to Leven House.

Ms A was to be enabled to progress through the leave pathway to level 5.

June to September 2007. Ms A experienced a positive period of recovery and moved back from Nightingale House to Nightingale Court. Ms A increased engagement in her

recovery plan and accepted proposals for discharge planning to Leven House, a staffed supported housing project.⁶⁸

September to November 2007. Ms A continued to maintain her recovery. Her mood stabiliser was changed to Lamtrogine but was stopped shortly afterwards because of the appearance of a rash. Sodium Valproate was restarted. Ms A was reported as being very anxious about the move to Leven House. Medication was increased due to Ms A's levels of anxiety. She also had concerns about a Leven House male resident's behaviour towards her. To help prevent Ms A relapsing plans for her transfer were slowed down. Forward plans were developed for Ms A to move into a studio flat at Leven House after Christmas. Ms A was also to be encouraged to build up her community-based activities as she prepared move out of hospital.⁶⁹

November 2007 to May 2008. Nightingale Court continuation records state that Ms A continued to progress with her recovery. However she had some episodes of poor sleep and was anxious about discharge. Ms A was low in mood due to her realisation about the impact of her illness on her life. Occasional suicidal impulses and thoughts were also recorded during this period. Ongoing support at this time was provided from ward and psychology staff. Some adjustment to medication was made to help her sleep and manage variations in mental state. Planning for trial leave and discharge to the studio flat in Leven House commenced in April and May.⁷⁰

May 2008 to January 2009. After a period of trial leave Ms A was discharged on extended leave under Section 17 of the Mental Health Act (1983 & 2007) to Leven House. The community plan in place included volunteering at a local service user-run bakery and café and attending some groups at Hahnemann House, a day centre which ran a range of therapeutic and rehabilitation programmes. She was also transferred to the care of the Southbourne Community Mental Health Team and CPN 4 became her community link/Care Coordinator. Although her Responsible Consultant was Consultant 4, Ms A asked to be seen by another doctor as she was fearful Consultant 4 would insist she went back on Clozapine. As a result an Associate Specialist was asked be responsible for reviewing Ms A's care in the Outpatient Clinic.

68 Ward Records SHA 392 Vol 48 pp 2350-2399

69 Ward Records SHA 392 Vol 49 pp 2400-2449

70 Ward Records SHA 392 Vol 50-54 pp 2450-2699

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Ms A is reported to have settled well into Leven House post-discharge. There were some concerns about another service user's sexual history and possible behaviour towards her. As a result Ms A moved from the studio flat in the Annexe into a room in the main part of the house to reduce her vulnerability.

Throughout the remainder of the year, despite occasional breakthrough psychotic symptoms and reporting that she occasionally felt lonely in the evening, Ms A sustained a period of stable mental health and continued to develop her activities in the community.⁷¹

January 2009. Ms A was continuing to do well, but it was recognised that she would benefit from remaining under the Mental Health Act in order to maintain compliance with her medication. Consultant 4 made an application for her to continue treatment on a Supervised Community Treatment Order (Section 17a of the Mental Health Act (1983 & 2007)). Ms A did not contest this plan.⁷²

April 2009. At review Ms A was reported as continuing to progress. She had her driving licence reissued and had started driving her mother's car. She had also started looking for paid work.⁷³

April 30th 2009. A review of placement in Leven House took place. Ms A's stable mental health was recorded as ongoing. She had bought herself a Smart Car and was looking into a voluntary position with an organisation helping young people with learning difficulties. She was noted to be having some difficulty keeping her room tidy. Ms A identified that she would like to find her own accommodation and move from Leven House, but in the review agreed she would stay at Leven for another six months.⁷⁴

4 May 2009. Ms A attended the Associate Specialist's Outpatient Clinic, and advised that she had stopped Sodium Valproate as it was giving her headaches.⁷⁵

71 Clinical Records SHA 392 Vol57 pp 2832-2828

72 Clinical Records SHA 392 Vol57 pp 2832-2828

73 Clinical Records SHA 392 Vol 60 p 2963

74 Clinical Records SHA 392 Vol 60 p 2963

75 Clinical Records SHA 392 Vol 60 p 2966

June 2009. Ms A went on holiday with her Mother to Sorrento and returned without any apparent problems⁷⁶

July to September 2009. Ms A continued on the Community Treatment Order and continued to accept depot medication. She asked her Care Coordinator to start helping her find independent accommodation. Ms A also asked for a referral to Psychology to come to terms with some of the things she thought when she was unwell, and support her move on.⁷⁷

September 2009. Ms A's Key Worker at Leven House raised concerns that Ms A was not ready for independent accommodation, as she continued to display symptoms of psychosis from time to time. The Care Coordinator was concerned that this issue had not been raised before.⁷⁸

October/November 2009. Queensland Lodge, a supported housing placement which provided independent flats and floating housing support, was identified as a suitable move-on placement. A period of leave commenced in November. Ms A purchased furniture and moved into Queensland Lodge at the end of November.⁷⁹

December 2009. Ms A settled into her new flat but reported finding it a bit lonely in the evenings. She also reported some intrusive thoughts to her Care Coordinator (Care Coordinator 5 – covering maternity leave for Care Coordinator 4). Additional oral Sulpiride antipsychotic medication was prescribed on a PRN (as required) basis. Ms A was asked if she would accept an increase in her depot injection dosage, but she didn't want this to happen. The Community Treatment Order was renewed in December. Ms A did not challenge the renewal of the Order. She stated that she recognised the benefit it had in helping her to continue to take her medication.⁸⁰

January 2010. Ms A continued to experience an increase in psychotic phenomena in the first half of January. This included intrusive thoughts about wanting to stab her boyfriend. Ms A's father was concerned that she was relapsing and got in touch with Consultant 5, who advised

76 Clinical Records SHA 392 Vol 60 pp 2968-2970

77 Clinical Records SHA 392 Vol 60 p 2969

78 Clinical Records SHA 392 Vol 60 p 2971

79 Clinical Records SHA 392 Vol 60 p 2975

80 Clinical records SHA 392 Vol 60 p 2976-2989

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that she was now under the care of Consultant 4, and passed the information and concerns on to him. During the latter few weeks in January Ms A's symptoms appeared to settle. Ms A had her first two appointments with a Counselling Psychologist and reported recognising that lots of things were going on in her life and consequently her levels of stress were high. Ms A's boyfriend's Care Coordinator reported concerns to Care Coordinator 5 that Ms A and her boyfriend were worried that Ms A might be pregnant. Care Coordinator 5 discussed this with Ms A who disclosed pregnancy tests were negative.⁸¹

February 2010. The Community Treatment Order was reviewed by Consultant Psychiatrist 4. He recognised that Ms A's mental health had been unsettled in January but had stabilised again in response to reducing stressors and the input of additional support. Risk assessment identified that the increase in stressors relating to taking on too much work, financial pressures, and adjusting to living alone, had brought on intrusive thoughts of stabbing her boyfriend and killing herself with a gun. Consultant 4 recorded that Ms A should be on a low threshold for recall due to her relapse risks. He recommended the Community Treatment Order should continue. This was not challenged or contested by Ms A, and was upheld when reviewed by Hospital Managers.⁸²

March 2010. Care Coordinator 5 handed care back to Care Coordinator 4. Ms A started intervention sessions with a Counselling Psychologist and discussed her extreme thoughts when unwell in order to try and come to terms with them. Ms A was concerned about her sleep pattern. Zopiclone was prescribed to help with sleep.⁸³

April 2010. Ms A continued with counselling sessions and was finding them helpful. She reported finding work at Crumbs, a supported employment project, stressful. Because her car was being repaired she was walking everywhere at this time. She told Care Coordinator 4 that she was not sure if she wanted to stay in the relationship with her boyfriend.⁸⁴

May 2010. Counselling sessions continued. Ms A continued to take medication and felt less agitated and was happier in her relationship with her boyfriend. Ms A talked about wanting to explore having her eggs frozen as she might want to have children in the future. Her GP

81 Clinical Notes SHA 392 Vol 2 pp 2892-2992

82 Clinical Notes SHA 392 Vol 60 pp 2786-2993

83 Clinical Notes SHA 392 Vol 59 p 2936

84 Clinical Notes SHA 392 Vol 60 pp 3000-3002

advised that normally embryos are frozen and then implanted, and that this is a very expensive process, and only done on the NHS in case of infertility.^{85 86}

June 2010. Counselling sessions continued. Ms A explored work opportunities, and the opportunity to do a Masters Programme in Ceramics at the University of Bath. She talked about being able to look back on her illness with less distress. She also reported that her boyfriend was starting to become unwell.⁸⁷

July 2010. Ms A attended her Outpatient appointment with Associate Specialist 1 and appeared to be progressing well. Associate Specialist 1 agreed to stop her antidepressant and discussed a change in anticholinergic medication for side effects. The change from Procyclidine to Orphenadrine was agreed with Consultant 4 later on in the month. It was noted in the letter sent to Ms A following her Outpatients appointment that if she experienced any changes in her mental health she should contact the Community Mental Health Team in office hours and the Crisis and Home Treatment Team out of hours.⁸⁸

5 August 2010. Ms A was seen by a Counselling Psychologist and she talked about her boyfriend being back in hospital and how his relapse had helped her develop more insight into her own mental health problems and what happened to her when she became unwell.⁸⁹

10 August 2010. Ms A attended an appointment with an Occupational Therapist. She reviewed objectives in relation to her paid and voluntary work. It was noted that she would like to work in the region of 20 hours a week. The Health and Disability Employment Advisor and Job Centre Plus referred her to Maximus job support services for help with CV, job search and job application skills.⁹⁰

13 August 2010. Ms A did not attend the appointment with her Care Coordinator for her depot injection.⁹¹

85 Clinical Notes SHA 392 Vol 60 pp 3004-3006

86 Clinical Notes SHA 392 Vol 60 pp 2786-2997

87 Clinical Notes SHA 392 Vol 60 pp2999-3001

88 Progress Notes SHA 392 Vol 3 pp 120-121

89 Progress notes SHA 392 Vol 2 p 95

90 Progress notes SHA 392 Vol 2 p 95

91 Progress notes SHA 392 Vol 2 p 96

19 August 2010. Ms A attended a session with a Counselling Psychologist. She talked more about her boyfriend's relapse, and she was recorded as being cautiously optimistic about the future. Ms A spoke about the responses of some members of her family to her illness. She stated that when she was unwell these responses maintained rather than alleviated her stress. She also discussed some issues of violence in her relationship with her first boyfriend. She agreed to review the psychology sessions she had already engaged in the following week. The plan was that the session after that would be the last one.⁹²

20 August 2010. It was recorded that Ms A's depot had been given to her by Care Coordinator 5 as a relief visit, following a missed depot on 13 August (notes later indicate that this was the date that it was entered on RiO, the electronic patient record system. The actual date the depot was administered was 16 August. Ms A also discussed with Care Coordinator 5 her birthday party which she had held in the gardens at Queensland Lodge and which had gone well. She said she was pleased her boyfriend was going to be discharged from hospital soon, and that he would have his own flat at Queensland Lodge. She was advised that she should be careful about taking on too many of her boyfriend's problems now she was so well. Ms A asked if she could have a further reduction in her depot injection, from 125mg to 100mg. Care Coordinator 5 advised her that this would have to be discussed with her doctor and she accepted her usual 125mg dose.⁹³

Monday 23 August 2010 12.38 hours. Ms A missed an appointment with the Occupational Therapist in Vocational Services. She did not telephone with a reason. The Occupational Therapist left a voice message on Ms A's answer machine.⁹⁴

23 August 2010 16.15 hours. A Housing Support Worker reported that she had gone to Ms A's flat, with a new Housing Support Worker to whom she was handing over Ms A's care. When she knocked on Ms A's door Ms A would not answer. The Housing Support Worker then tried to telephone Ms A and went into the car park to see if her car was there. Ms A then came to the door, but was unable to maintain eye contact and spoke monosyllabically. The Housing Support Worker reported that Ms A appeared very

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93 Progress notes SHA 392 Vol 2 p 96

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agitated. She asked Ms A if she felt unwell and whether she wanted her CMHT to be contacted. Ms A responded that she did, she was asked how long she had felt like this and Ms A responded “*today*”. She was also asked if she had slept the previous night and Ms A responded that she had not.⁹⁵

23 August 2010 16.30 hours. The Housing Support Worker called the Community Mental Health Team Duty Worker expressing concern about Ms A’s mental health. Initially she could not get through, but Duty Worker 1 called her back at 16.52 hours. The Housing Support Worker reported her concerns to Duty Worker 1 about Ms A’s mental state. Duty Worker 1 asked if she appeared to be at risk of suicide or self-harm. The Housing Support Worker responded that she had not asked those questions, but reiterated how unusual Ms A’s presentation was and that she thought someone should come out and see her. Duty Worker 1 advised that as Ms A did not seem to be at immediate risk, they would probably wait until Wednesday when her previous Care Coordinator (Care Coordinator 5) would be available. The Duty Worker also stated that as it was nearly 17.00 hours the team would not come out and see Ms A. The Housing Support Worker asked if the Crisis Team could come and see Ms A. She recorded that the Duty worker told her the Crisis Team would not normally come and do a visit unless the Community Mental Health Team had visited first.⁹⁶

Duty Worker 1 documented that the Housing Support Worker had not reported Ms A to be a risk of self-harm or that any other specific risks were evident. The Duty Worker recorded that the Housing Worker felt an assessment before Wednesday would be required. The Duty Worker agreed to discuss the case with a fellow Duty Worker in order to determine the action to be taken. The case was discussed with Duty Worker 2 (the CMHT Team Leader). It was agreed that Duty Worker 2 would follow things up the following morning and discuss the situation with the Care Coordinator 5 who had given Ms A her depot on the 16 August 2010. Duty Worker 1 identified at the end of her written record “*Patient is on a CTO*”.⁹⁷

24 August 2010 09.00 hours. The Housing Support Worker called the CMHT for an update on the plan regarding Ms A’s mental health. The Housing Support Worker was

95 Housing Association Notes SHA 392 Vol 1 pp 14-15

96 Housing Association Notes SHA 392 Vol 1 pp 14-15

97 Progress notes SHA 392 Vol 2 p 96

informed by the CMHT Duty Worker 3 that a plan was being put in place and that she would be kept informed.⁹⁸ This contact is not recorded in the CMHT records.

24 August 2010 11.49 hours. Duty Worker 2 (the CMHT Team Leader) recorded an attempted telephone call to the Housing Support Worker. He left a message for her to get back to him. He also recorded that he had talked to Care Coordinator 5 (Care Coordinator 5 had previous involvement with Ms A and had recently visited her to give her a depot injection). He recorded that Ms A had been seen on 20 August (this was an error as she had last been seen on 16 August) and at that time she had been well and concordant with medication. The Duty Worker ended the entry by saying that he would wait to act further once he had received a telephone call back from the Housing Support Worker.⁹⁹

24 August 2010 17.19 hours. The Housing Support Worker returned the call to Duty Worker 2 sometime between 1pm and 4pm. She reported that she had last seen Ms A the previous day and reiterated her observations of her behaviour. Duty Worker 2 confirmed that he was aware of the situation and was planning to send someone out to see Ms A the following day. He stated that the CMHT was aware Ms A had been a complicated case in the past, and that she could get irritable and agitated. He advised the housing staff to give her plenty of space until she could be seen the next day. The Duty Worker documented the plan to ask the Care Coordinator 5 to visit on 25 August.^{100 101}

25 August 2010 12.05 hours. A work colleague of Ms A attended Queensland Lodge as she had not heard from Ms A for a couple of days. When she went to Ms A's flat she could see her pacing and observed that she was not answering the door or responding to her. Ms A's work colleague contacted the Housing Support Worker, who in turn telephoned the Community Mental Health Team. She spoke to Duty Worker 3 and reiterated her observations from 23 August. Duty Worker 3 asked if the Housing Support Worker thought a home visit was required; she responded that she was not sure about the CMHT protocols. The Duty Worker then advised the Housing Support Worker that he wanted to discuss the situation with his colleagues, and that he would get back to her. Following this discussion it was agreed that Care Coordinator 5 would visit Ms A at

98 Housing Association Notes SHA 392 Vol 1 p 13

99 Progress notes SHA 392 Vol 2 p 97

100 Progress notes SHA 392 Vol 2 p 97

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some point later that afternoon. The Duty Worker also asked the Housing Support Worker if she had access to keys to open Ms A's front door. She advised that the Housing Association did not keep keys to residents' front doors.¹⁰²

At 12.50 hours Ms A's mother telephoned the Housing Support Worker and advised that she was also outside Ms A's front door. She asked the Housing Support Worker if she had keys to let her into Ms A's flat so she could make sure Ms A was alright. The Housing Support Worker advised that she did not keep keys to individual resident's flats, and any forced entry would have to result as a decision between the CMHT and the Police. The Housing Support Worker advised Ms A's mother to discuss the situation with the CMHT. Mrs A's mother informed her that she had already been in touch with the Duty Team.¹⁰³

At 13.40 hours Housing Support Workers were advised by the other residents that there had been a stabbing outside the property and that there was a Police presence around the Queensland Lodge property.¹⁰⁴

At 13.45 hours a third party confirmed to the housing support team that Ms A had stabbed her mother.¹⁰⁵

At 19.25 hours Duty Worker 3 (the CMHT Team Leader) confirmed in Ms A's clinical record that information had been provided through their involvement at the Police Station that Ms A had fatally stabbed her mother between 13.00 and 14.00 hours.¹⁰⁶

An eye witness account was given by Ms A's work colleague who witnessed the events of 25 August 2010.

Ms A's friend and colleague (Ms C) went to Ms A's flat on 25 August as Ms A had not turned up at work for a couple of days. When she got to the flat she found that Ms A would not answer her door, but she could see her pacing around her flat by looking through the letter box. Ms C telephoned her work and told them that she may be longer

102 Housing Association Notes SHA 392 Vol 1 p 13

103 Housing Association Notes SHA 392 Vol 1 p 13

104 Housing Association Notes SHA 392 Vol 1 pp 11-12

105 Housing Association Notes SHA 392 Vol 1 pp 11-12

106 Housing Association Notes SHA 392 Vol 1 p 11

than she thought. She then telephoned the Knightstone Housing Association Offices. Ms C was told that the Housing Support Office was aware of Ms A's situation, but that no one could disclose any further information due to resident confidentiality. At this point Ms A's mother arrived. She told Ms C that she had popped over because she had not heard from Ms A for a few days and was also concerned. Ms C told Ms B that her daughter was in her flat but would not answer the door or speak to her. Ms B proceeded to knock on the flat door demanding that Ms A let her in but to no effect.

Ms B contacted the CMHT Duty Team on her mobile telephone. Ms C then looked through the letter box again to check on Ms A and saw that she had got hold of a kitchen knife and had come to the door. Ms C stood back; she described Ms A as looking like a different person from the one she knew at this time. Ms C shouted at Ms B to ring the Police as Ms A had a knife. Whilst her mother was on the telephone, Ms A came into the back garden holding the knife. She walked towards her mother and stabbed her. Ms A then walked out of the garden into an alleyway and out on to the street.

Events Following the Homicide of Ms B

Ms A walked into Boscombe and was seen by several people to be covered in blood and carrying a large kitchen knife. One person stopped a Police car. The Police approached Ms A to arrest her and had to use an incapacitant spray as Ms A would not put the knife down when requested. She was detained at Bournemouth Police Station, following which she was assessed by mental health workers and detained under Section 2 of the Mental Health Act (1983 & 2007).¹⁰⁷

Ms A was transferred to an independent sector mental health high dependency unit in Hampshire on 25 August 2010. On 28 August she moved to an independent sector medium secure unit in Hertfordshire. Her Section was converted to a Section 3 of the Mental Health Act, and then changed by the Court, after an initial hearing, to Section 48/49.

107 Court Reports Police report section SHA 392 (not paginated)

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On 18 July 2012 Ms A's case was tried at Winchester Crown Court and she was found guilty of manslaughter on the grounds of diminished responsibility. She was placed on Section 37 of the Mental Health Act with Section 41 Home Office restrictions.¹⁰⁸

When interviewed by her Psychiatrist (Consultant 6) following admission to the medium secure unit, Ms A is reported as exhibiting a significant amount of psychotic experiences and cognitions. She understood she had stabbed her mother, but did not believe she was dead. She thought her mother would rise from the dead and come and see her. She believed she herself had risen from the dead after committing suicide earlier in the year. In later interviews she was able to describe that she felt very angry with her mother when she came to her flat, for knocking on the door and for insisting she came to speak to her. At this time she heard the voice of the man in London whom she had been bound over for harassing at the very beginning of her illness, telling her to get a big knife and stab her mother a lot. She felt compelled to do this.

The Psychiatrist concluded the homicide was caused by a rapid and acute deterioration to Ms A's mental health.¹⁰⁹

108 Progress notes SHA 393 Vol 4 pp151-200
109 Court Reports by Consultant 6 SHA 392 (not paginated)

11. Identification of Thematic Issues

Thematic Issues

This section of the report provides an overview of the key findings identified by the Independent Investigation Team.

11.1. Diagnosis

From 2000 to 2007 Ms A's primary diagnosis was Paranoid Schizophrenia. In 2007 whilst she was being treated in Nightingale House the Rehabilitation Consultant Psychiatrist (Consultant 5) altered her diagnosis to Schizoaffective Disorder. The change in diagnosis followed a relapse of her illness when Consultant Psychiatrist 5 observed a number of symptoms and signs that were consistent with this diagnosis.

On discharge to the Community Mental Health Team in July 2008 the working diagnosis of the Associate Specialist and the Care Coordinators working with Ms A reverted to Paranoid Schizophrenia. They stated they were not aware Ms A's diagnosis had been changed to Schizoaffective Disorder whilst in the rehabilitation service. However the Community Consultant Psychiatrist (her Responsible Clinician and Consultant 4) stated his differential diagnosis had always been Schizoaffective Disorder.

The Independent Investigation Team found no specific issues in relation to Ms A's diagnostic formulation.

11.2. Medication and Treatment

The Independent Investigation Team found that the medication Ms A was prescribed was appropriate for her diagnoses and within recommended therapeutic ranges. The Independent Investigation Team noted that Ms A discontinued the mood stabiliser she had been on for some years, without assertive attempts to encourage its continuation or a trial on another mood stabiliser. However the Investigation Team understood Ms A was always reluctant to take medication, and frequently wanted to either cease or reduce her dosage. She experienced significant extrapyramidal side effects from her antipsychotic medication. The treating teams tried hard over time to establish a medication regimen that would keep her well and also

minimise the side effects she experienced. They worked collaboratively with Ms A to try and establish her optimal level of medication.

Ms A had a number of episodes of psychological therapy and she appeared to find these periods of treatment helpful. Whilst with the Rehabilitation Service the psychological elements of Ms A's treatment were based on developing her insight into her illness, developing her coping mechanisms and working with her to develop a relapse management plan. When Ms A returned to live in the community she had a period of receiving weekly sessions with a Counselling Psychologist for several months. This gave her the chance to explore her feelings about her illness and its impact upon her life. This therapy ended shortly before the relapse that led to the killing of her mother.

The Independent Investigation Team found that psychological treatment helped develop Ms A's insight into her illness and understanding of her relapse signature. However the Independent Investigation Team did not see evidence to suggest that the work completed by the Clinical Psychologist at Nightingale Court transitioned effectively into Ms A's care and treatment plans when she moved back to the Southbourne Community Mental Health Team. There was no evidence of structured, formal family interventions. Family-based interventions are indicated for service users diagnosed with Schizophrenia and can assist family members to understand the illness in order to provide helpful levels of care and support.

11.3. Mental Health Act (1983 and 2007)

The Mental Health Act was used a number of times during Ms A's care and treatment. All Section application paperwork was available in the records, and there was evidence to demonstrate that Ms A's rights to information, second opinion and appeal were upheld in all episodes where she was detained or restricted by the application of the Act.

The Independent Investigation Team found that the use of a Community Treatment Order to support compliance with treatment whilst Ms A was in the community to be an appropriate use of this power, and observed that it was welcomed by Ms A and her family. However this Investigation concurred with the findings of the joint agency investigation which identified weak practice in the implementation of the Community Treatment Order in terms of effective planning and communication around the thresholds and requirements for revoking the Treatment Order and calling Ms A back into hospital.

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During the time Ms A was subject to a Community Treatment Order Consultant Psychiatrist 4 was her Responsible Clinician as defined by the Mental Health Act (2007). However during this period the majority of Ms A's medical review and treatment was completed by Consultant 4's Associate Specialist. In the 18 months prior to the homicide Ms A was seen for medical Outpatient reviews by the Associate Specialist on a three-monthly basis; the last of these sessions being held on 1 July 2010. This Investigation was told these Outpatient reviews were also considered to be Care Programme Approach Review Meetings. Consultant Psychiatrist 4 saw Ms A on two occasions, 30 December 2009 and 7 February 2010. The first of these was to renew her Community Treatment Order, and the second followed on from reports about her starting to show signs of relapse.

Prior to Ms A's transfer to the Southbourne CMHT she had requested not to see Consultant 4 as she was worried he would insist she went back on Clozapine or Risperdal medication. Consultant Psychiatrist 4 offered her the chance to see his Associate Specialist in the Outpatient Clinic instead, which she agreed to. At this time the Trust did not allow Associate Specialists to act as the Responsible Clinician for clients on Community Treatment Orders. This arrangement may have served to distance the Responsible Clinician from the active management of Ms A's case.

This Investigation found that Ms A was on a low threshold for recall to hospital. However what this actually meant in practice was not specified or documented in her care plans. This information was not shared with her supported housing provider.

When initial reports were received by the CMHT in August 2010 that Ms A was relapsing the Duty Team did not get in touch with the Responsible Clinician or the Associate Specialist, despite knowing she was on a Community Treatment Order. It took over 60 hours to decide to ask someone from the Community Mental Health Team to go out and assess Ms A. The Independent Investigation Team concluded this was not a reasonable response to a service user on a Community Treatment Order who was known to be vulnerable to rapid relapses and become a risk to herself and others when acutely unwell.

11.4. Care Programme Approach (CPA)

The Care Programme Approach did not assume the central position that both national guidance and Trust policy expected of it in the care and treatment of Ms A. This meant that clinical

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assessment (including risk assessment), care planning and decision making often occurred in isolation one from the other. The Care Programme Approach documentation appears to have been subject to the ‘Boiling Frog’ [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Ms A both her Care Programme Approach and risk assessment documentation remained largely unaltered over a nine-year period. It is a fact that changes to either Ms A’s presentation or circumstance largely failed to alter the content of the CPA documentation between 2001 and 2010. Whilst it can be said that Ms A’s risk factors and relapse indicators changed little over time the Independent Investigation Team made two observations.

First: whilst Ms A’s underlying presentation and problems remained the same over a nine-year period her circumstances did not. She transitioned between both health and social care facilities several times and both risk and clinical assessment and subsequent care planning should have been undertaken at these pivotal points on her care pathway in order to reflect her changing needs. This did not happen in either a timely or coordinated manner. Issues were often identified but it was not possible to see demonstrated a systematic and coordinated response. Instead documentation appears to have been subject to a ‘cut and paste’ approach which relegated the function of CPA to that of a basic commentary rather than being the cornerstone of care and treatment.

Second: it is a fact that Ms A’s underlying problems remained unchanged over a long period of time. This is well documented. A consistent feature is Ms A’s relapse indicators, her risk factors and her very low deterioration threshold. Every assessment made over a nine-year period alludes to the fact that Ms A, when well, presented with no risk (or low risk), but when unwell could be a significant risk to herself, to others and from others. It was also recognised that once she was in the community these risk factors would increase and that she would need a consistent level of monitoring and supervision. The Community Treatment Order was put into place in January 2009 for this very reason. The behaviour of Ms A was both known and predictable. This then makes it less acceptable that a more robust crisis and contingency plan was not developed as part of the Care Programme Approach process which was widely communicated to all members of the care and treatment team. Due to the fact that so much was

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known about Ms A it is of particular concern that no plan was in place to guide the actions of health and housing workers between 23 and 25 August 2010.

The Independent Investigation Team concluded that the Care Programme Approach was not delivered in accordance with Trust policy and procedure expectation. Communication and care coordination levels were of a poor general standard and assessment and care planning did not take place based upon either Mr. A's presentation or circumstances.

The absence of effective Care Programme Approach processes was contributory to the poor levels of clinical management Ms A received in August 2010. The days and hours before Ms B died provided a clear window into the observation that the family, the housing support staff and the clinical team, had not established a common understanding of Ms A's needs and risks, or a coherent plan of how to deal with her in relapse. In addition it demonstrated to the Independent Investigation Team that those involved in Ms A's care and treatment had not established a level of professional relationship that enabled them to work together effectively as a single multiagency team looking after Ms A's best interests.

11.5. Risk Assessment and Management

Ms A had a number of risk assessments completed at several key points in her treatment. Those which provided the most accurate assessment of her risks highlighted that when accepting treatment and mentally well she was a low risk for self harm, violence and abuse. However her risks of self-harm, violence and abuse were deemed to be significant if she stopped medication and/or started to relapse.

The risk screening documents extant in the clinical record were frequently incomplete and on occasion undated and unsigned. The documentation was inconsistent regarding the recording of historical risk factors. An early risk screen recorded in 2002 that Ms A had thoughts of violent actions towards others; this did not appear on a risk screen again until 2010 despite this remaining a persistent feature of Ms A's presentation. An example of this was her attack with a knife on a fellow patient in 2005; this was not recorded consistently on every repeat risk screen. Similarly her history of thinking about self-harm and her vulnerability were not consistently documented.

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Risk assessment documents were not always shared across all of the teams and agencies involved in Ms A's care. For example there is no evidence to suggest that risk assessment documentation completed by health services was shared with the supported housing providers. This was exacerbated by the absence of formal multi-disciplinary and agency CPA review processes, and the absence of sharing completed CPA care plans.

The most detailed Risk Assessment was completed by a Clinical Psychologist in 2007. This was known as a Gold Risk Assessment and was the full risk assessment format advocated by the Trust. The reason it was called a Gold Risk Assessment was because it was printed on yellow paper to help it stand out in the clinical notes. This was done by the Clinical Psychologist shortly before Ms A was transferred to Leven House from Nightingale Court. Another Gold Risk assessment document was completed in January 2010 by Care Coordinator 5 when Ms A had discussed intrusive thoughts of stabbing her boyfriend.

It is a fact that Ms A was subject to only two full risk assessments between 2003 and 2010. At all other times the Trust risk screening tool was used. This ran counter to Trust policy and procedure. Full risk assessments should have taken place in response to Ms A's changing mental state and also when she reached key stages on her care pathway. Risk assessment and formulation were weak and the resultant risk management plans were either non-existent or of a poor quality. A significant omission was the lack of planning around the management of Ms A's relapse indicators. These indicators had been consistently recorded within her clinical record for at least six years prior to the killing of her mother. It is a fact that once Ms A's mental health began to deteriorate in the summer of 2010 all prior work relating to her risk and the management of her relapse indicators were not taken into account, with fatal consequences.

11.6. Safeguarding of Vulnerable Adults

This Investigation found that vulnerable adult safeguarding procedures were never used in the care and treatment of Ms A. However the Investigation identified that for a significant proportion of the time Ms A was under the care of the Trust she met the criteria, set out in the local Adult Safeguarding policy, to be regarded as a vulnerable adult.

On occasions she was inadequately protected from harm. This was particularly manifest on 23 August 2010. At this time Ms A was displaying symptoms of a relapse in her serious mental illness and fluctuating levels of capacity. However despite this Ms A was unable to access the

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mental health services that should have been available to her. In the context of the safeguarding policy this constitutes neglect.

Several other concerns regarding other vulnerable adults were identified. Firstly Ms A's boyfriend had been identified as someone who might be regarded as a vulnerable adult. He was a service user, who had become dependent on Ms A. Ms A reported thoughts about stabbing her boyfriend in his sleep. The presence of these intrusive thoughts was taken seriously by the clinical team caring for Ms A and her Consultant Psychiatrist indicated that she should be on a low threshold for recall to hospital. However no safeguarding referral was made or formal plan put in place on behalf of her boyfriend.

Ms A's parents, especially her mother, have been identified by this review as potentially vulnerable adults in their role as carers. However many of the normal safeguards that should have been in place such as carers assessments, which would have reduced their overall vulnerability to emotional or physical harm, were not put in place.

Finally at the time Ms A was reported to be becoming unwell, her level of vulnerability had increased in that she clearly met the definition of a vulnerable adult. The Investigation concluded that not sending out someone to assess Ms A for around 36 hours constituted neglect as defined in the local safeguarding policy, as they did not provide the required health and social care services to meet her needs at that time, given her known risks and vulnerabilities and the concerns raised by the Housing Support Worker. The Investigation speculated that it may have been beneficial for the Housing Support Worker or her superiors to have raised a safeguarding concern as soon as they had concerns that the Trust's duty team or crisis team were not going to provide Ms A with the healthcare services they thought she required to keep her safe.

11.7. Referral, Admission and Discharge Planning

Whilst receiving services from Dorset Healthcare University NHS Foundation Trust Ms A underwent four admissions to, and subsequent discharges from, acute inpatient services. She also underwent a referral, admission to, and discharge from, the rehabilitation service, and a number of referrals and transfers to different community mental health teams, and supported housing projects and programmes.

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Ms A's admissions to acute inpatient care were always appropriate. This Investigation found that there appeared to be pressure to move Ms A on from inpatient care reasonably quickly, and on several occasions this led to her mental health deteriorating following discharge. This was often a result of Ms A's anxiety and stress related to being discharged to placements she did not want to go to and subsequent non-compliance with medication.

Levels of professional communication at points of transition through the service were often of a poor quality with significant information often not being passed between one service and another. This was compounded by the practice of not conducting CPA reviews or preparing risk assessments before significant transitions between services occurred.

11.8. Service User Involvement in Care Planning and Treatment

This Investigation concluded that whilst there was evidence of Ms A's day-to-day involvement in decisions this was often reactive rather than proactive. When Ms A was well staff would respond to her wishes and aspirations and supported her as she pursued her interests. When she was unwell staff reacted to Ms A's behaviour and level of illness.

Ms A appeared to be more proactively engaged with her team in planning her care than may have been the case. The teams working with her appeared to mistake reacting to her behaviours as service user involvement. However this was not service user involvement and engagement in which the service user and the professional staff were in open and transparent dialogue about how to best work together to meet the service user's needs.

This conclusion is evidenced by the lack of involvement and sharing of CPA care plan documentation. The CPA care plans should have been used as a vehicle to encourage conversations about care and treatment, and help shape changes in the care plans to meet the service user's needs in a more acceptable as well as more effective way. That these documents were not used in this way demonstrated a lack of proactive service user involvement.

11.9. Carer Assessment and Involvement

The Independent Investigation Team observed that Ms A's family had very little proactive intervention or direct support from the professionals involved in her care. Ms A's father received a carer's assessment right at the beginning of her care and treatment in Dorset and some years later was invited to participate in her relapse signature work. The mother, despite

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being offered family interventions on one occasion, never received any formal family interventions, and never received a carer's assessment throughout the 10 or more years Ms A was under the care of the Trust.

This Investigation concluded that the lack of family engagement, interventions and support was not in line with national recommended good practice, and was contributory to the mother's lack of knowledge about how to respond when Ms A was becoming unwell.

11.10. Housing

The Independent Investigation Team saw evidence that the Trust and Local Authority tried hard to meet Ms A's needs, preferences and safeguarding issues when trying to identify suitable accommodation for Ms A. The level of care taken in this area, and the careful steps taken to move Ms A through to increasing levels of independence was good practice.

However when Ms A was discharged to Leven House, the team could have taken more time to explore the alternatives to discharging her to a flat with a two-year tenancy and housing support provided *via* Supporting People funding. This may have been assisted by a multiagency review to ensure that a longer-term tenancy and viable support programme could be put in place prior to her next move.

11.11. Documentation and Professional Communication

The most significant issue identified within this report regarding multiagency and professional communication was the absence of a recognisable Care Programme Approach process. This severely impacted effective multiagency communication.

This Investigation found that there was an absence of information sharing protocols between the various third sector organisations involved in Ms A's care. As a result the third sector organisations were unclear as to what information they could reasonably expect to be shared with them.

The Independent Investigation Team noted that there was an absence of a regularly updated case summary, or reliable record of key information, which people used to orientate themselves to the case in an urgent or crisis situation. It was concluded that the absence of this information was not helpful to the duty team who tried to make decisions about how to

manage Ms A's case when they were contacted by the housing support worker on 23 August 2010.

11.12. Policy Adherence

The Investigation concluded that a number of key and interrelated policies and guidance documents were not well complied with. This was because of the way in which CPA and the Care Coordinator role operated in the Southbourne Community Mental Health Team. It appeared there was a strong Outpatient-based model of care and treatment, which was inconsistent with managing care through the Care Programme Approach. It was also clear that the role of the Care Coordinator had not been fully developed in line with the 2008 guidance in relation to Carer and Family Involvement and coordination of multiagency input into care planning and risk assessment.

Local policy lacked clear and concise direction on the minimum expectations of care coordination, care planning and risk management. Even though the Trust stated eight members of the CMHT had received training clinical witnesses noted that Care Coordinators were not regularly updated on the core skills they required to fulfil the requirements of the Trust's policies.

Other elements of national policy and guidance were not complied with either because of a lack of local understanding of resource availability or the unintended consequence of decisions to restrict access to service. This former meant family interventions were not available, and the latter meant Ms A did not get access to mental health services 24 hours a day, seven days a week when she required them. The Trust had a family work service available for CMHTs to refer to which was not taken advantage of in this case.

11.13. Overall Management of the Case

Ms A was in receipt of a comprehensive programme of care and support which was assisting her to move forward in terms of independent living and a fulfilled and meaningful life. However underpinning this should have been a robust safety net of care and treatment coordinated using the Care Programme Approach. The Investigation found this safety net was compromised which led to some significant gaps. The key weakness in the underpinning safety net of care was in the poor application of the Care Programme Approach. There was not an effective multi-agency/disciplinary approach to planning and reviewing care. Ms A's care

and treatment was delivered by mental health professionals and agencies working predominantly in isolation. This lack of care coordination, sharing of information and joint working, played a contributory role in the service's failure to respond to Ms A in a timely way. This was because people outside and within the team did not have a shared plan or knowledge of what to do if Ms A's mental health started to deteriorate. It may be further speculated that this also meant that the sort of trusting relationships between individuals working for different agencies which facilitate good care-giving were also absent.

While the underpinning safety net of care was weakened by the absence of an effective Care Programme Approach, the failure of the protective barriers put in place to respond quickly and effectively to relapse were most pertinent to Ms A not getting timely care when she relapsed. This Investigation saw that in principle there was a robust set of mechanisms in place to intervene in the event of relapse. However in the event of the relapse in August 2010 none of them worked. The Duty Team did not recognise that Ms A was relapsing from the information provided. The Community Treatment Order did not flag the need to involve the Responsible Clinician and initiate an emergency assessment. The Duty Team did not make use of the Crisis and Home Treatment Team. These were serious omissions in the care and treatment provided to Ms A.

11.14. Clinical Governance and Performance.

The Trust described a robust system of clinical governance, which appeared to be compliant with national standards. However to be effective clinical governance systems need to provide what is referred to in the National Audit Office report on NHS Governance – *Taking it on Trust* as the second line of defence. This second line of defence provides systems for detecting and closing gaps in service delivery that practitioners and local service managers, the first line of defence have missed. Evidence from our investigation found that the clinical governance system extant at that time may not have provided an adequate or robust second line of defence. The third line of defence, the independent assurances that the system of governance is working, in its turn did not appear to be aware that:

- supervision arrangements for practitioners were patchy and informal; no evidence was available that supervision arrangements supported practitioners to develop their practice in line with local and national policy and guidance;

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- audits and quality assurance systems, whilst evaluating compliance in practice against national standards and expectations, did not appear to detect issues relating to Ms A's care and treatment;
- findings from internal investigations were not being addressed within reasonable timescales;
- there was inadequate monitoring or follow up of whether staff had attended core areas of training, such as the Care Programme Approach and risk management. However the Trust asserts that 'Did not Attend' notifications were always sent to managers on a monthly basis from 2010.

Whilst the staff interviewed by this Investigation commented clearly on clinical supervision their experience did not reflect the overall Trust framework for clinical supervision. The Trust has a central list of clinical supervisors which staff can access via the intranet to identify a suitable supervisor. This list comprises in-house staff who have completed the Trust's approved Clinical Supervision for Supervisors course. As part of the Trust's Appraisal/Personal Development Review process managers should confirm that staff are in receipt of clinical supervision and discuss any development needs that have arisen during clinical supervision. This information also forms part of the PDR form which managers complete to confirm supervision is being received by clinicians as per Trust policy. The supervision policy requires the supervisor and supervisee to complete a supervision contract/agreement and then maintain supervision record sheets for each session. These should be filed in the individual's professional portfolio.

12. Further Exploration and Identification of Contributory Factors and Service Issues

In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the ‘Five Whys’ could look like this:

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)
- original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Ms A it would look like this:

- Ms A killed her mother (ask why?)
- Because she had an abnormality of mind which caused her to kill her mother.

These questions are overly simplistic and can prevent further exploration of the case and the services that were provided. Because it is so hard to predict or prevent these very serious events in mental health services, services are required to provide a level of care and treatment which is designed to support people to stay well, and respond in a timely way to when they look like they may be relapsing, whether or not they have a history which suggests one risk profile or another. Therefore this form of Root Cause Analysis has to look in detail at the individual patient’s case history and their assessed needs and risks, but also how over time services were delivered and compare them to expected service standards. The methodology used for doing this is described below.

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;

2. causal, contributory and service issue factors.

In the interests of clarity each thematic 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 ‘contributory factor’ and ‘service issue’ are used in this section of the report. They are explained below.

Causal Factor. 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 quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term ‘causal factor’ is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage Ms A effectively and that this as a consequence impacted directly upon the events leading to the death of her mother.

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 Team to conclude that it made a contribution to the breakdown of Ms A’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Ms B need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1. Findings Relating to the Care and Treatment of Ms A

The findings in this chapter analyse the care and treatment given to Ms A between the years of 2000 and 2010.

12.1.1. Diagnosis

12.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. Diagnosis is used in many different disciplines, with slightly different implementations on the application of logic and experience to determine the cause and effect relationships. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers/family/GP/interested or involved others, mental state examination and observation.

The process of reaching a diagnosis is assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. Psychiatry uses the ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to

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address some care, treatment and risk management issues. The nature of the individual's personality can also often shape the presentation of the illness.

The diagnosis reached in the case of Ms A was that of a Schizophrenic Disorder, Schizophrenia is described in Section F20.0 of ICD10 thus:

“The Schizophrenic Disorder is characterized in general by fundamental and characteristic distortions of thinking and perception and by inappropriate or blunted affect, clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve over the course of time. The disturbance involves most basic functions that give the normal person a feeling of individuality, uniqueness and self direction. The most intimate thoughts, feelings and acts are often felt to be known too or shared by others and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the inflicted thoughts, individual thoughts and actions in ways that are often bizarre.

The individual may see himself or herself as the pivot of all that happens. Hallucinations especially auditory are common and may comment on the individual's behaviour or thoughts. Perception is frequently disturbed in other ways. Colour or sounds may seem unduly vivid or altered in quality and irrelevant features of ordinary things may appear more unimportant than the whole object or situation.

Perplexity is common early on and frequently leads to a belief that everyday situations possess this special usually sinister meaning, intended uniquely in the individual. In the characteristic Schizophrenic disturbance of thinking, peripheral irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the fore and utilised in place of those that are relevant and appropriate to the situation. Thus thinking becomes vague, elliptical and obscure and its expression of speech is sometimes incomprehensible. Breaks and interpolations in the train of thought or frequent and thoughts may seem to be withdrawn by some outside agency.

Mood is characteristically shallow, capricious or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism or stupor Catatonia may be present. The onset, may be acute with seriously disturbed behaviour, or insidious, with a gradual development of hard ideas and conduct. The course of the disorder shows equally great variation and is by no means inevitably chronic or deteriorating (the course is specified by five character

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categories). In a proportion of cases which may vary in different cultures and populations the outcome is complete or nearly complete recovery. The sexes are approximately equally affected but the onset tends to be later in women”.

Ms A was initially diagnosed as having Paranoid Schizophrenia; this was later revised to a diagnosis of Schizoaffective Disorder and then reverted back to Paranoid Schizophrenia. The definition for Paranoid Schizophrenia in ICD10 is set out below.

“This is the commonest type of Schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid delusions usually complicated by hallucinations, particularly of the auditory variety and perceptual disturbances. Disturbances of affect, volition and speech and catatonic symptoms are not prominent. The examples of the most common paranoid symptoms are:

- A) Delusions of persecution, reference, exalted birth, special mission, bodily change or jealousy.*
- B) Hallucinatory voices that threaten the patient or give commands or auditory hallucinations without verbal form, such as whispering, humming or laughing. Hallucinations of smell or taste, or of sexual or other bodily sensations, visual hallucinations may occur but are rarely prominent.*

Thought disorder may be obvious in acute states but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than other varieties of Schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, certain anger, fearfulness and suspicion. ‘Negative symptoms’ such of blunting of affect and impaired volition are often present but do not dominate the clinical picture.

The course of Paranoid Schizophrenia maybe episodic, with partial or complete remissions, or chronic. In chronic cases the florid symptoms persist over years and it is difficult to distinguish discreet episodes. The onset tends to be later than in the hebephrenic and catatonic forms”.

Schizoaffective Disorder as defined by ICD 10 is set out below.

“These are episodic disorders in which both affective and schizophrenic symptoms are prominent within the same episode of the illness, preferably simultaneously but at least within

a few days of each other. Their relationship to typical mood (affective) disorders and schizophrenic disorders is uncertain. They are given a separate category because they are too common to be ignored....

Diagnostic Guidelines: A diagnosis of Schizoaffective Disorder should be made only when both definite schizophrenic and definite affective symptoms are prominent simultaneously or within a few days of each other, within the same episode of illness and when, as a consequence of this, the episode of illness does not meet the criteria for either schizophrenia or depressive or manic episode. The term should not be applied to patients who exhibit schizophrenic symptoms and affective symptoms only in different episodes of illness”.

12.1.1.2. Findings

Ms A presented to psychiatric services in 1997. She presented primarily with symptoms relating to low mood. By 2000 it became evident that she had also developed a paranoid psychosis with associated delusional beliefs, for example that she had been drugged, that an ovary had been removed, that she had caught syphilis from her cat. In 2001 she acted on a delusional belief that a work colleague was harassing her.¹¹⁰ She went to his house and scratched his front door with a sharp implement, her actions necessitating Police involvement.

From this time on until she was admitted to Nightingale House, Ms A was regarded as having a primary diagnosis of Paranoid Schizophrenia. She was admitted on the 8 June 2004 and was noted on admission to be “*vague and guarded*”, pacing the ward, “*laughing inappropriately at times*” and “*suspicious when approached by staff*”. Her concentration was poor; she had begun experiencing auditory hallucinations and was receiving “*religious messages*”.¹¹¹

When Ms A relapsed again in July 2005 she presented as being distracted and preoccupied “*whispering to herself*”. On 17 July 2007, after an episode of bizarre behaviour, she went missing from her accommodation; she had gone swimming with no apparent purpose. She had been found pushing sand up the beach “*burying through the sand*”, “*she believed she was a turtle*”.¹¹² Ms A expressed beliefs that people had been in her room; she was experiencing auditory hallucinations and believed that her teeth were the wrong way round. She felt angry and paranoid about her parents and believed that she was being tortured. There was ample

110 Trust Notes p 473

111 Trust notes pp 306-312

112 Trust Notes pp 693-694

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evidence of thought disorder and hostility in the clinical notes.¹¹³ Later in this admission Ms A became verbally hostile towards other patients and staff and attacked another patient, attempting to stab them with a cutlery knife, which she later explained by saying “*she wanted to break the Ten Commandments, so she would go to heaven*”. In 2008 she was readmitted believing that she had started nuclear wars and had “*broken the world’s heart*”, that she was evil and wanted to kill Jesus Christ and she was noted to be pacing and neglecting herself.

Ms A was transferred to Nightingale Court in October 2006 with a diagnosis of Paranoid Schizophrenia. This, initially, continued to be regarded as the primary diagnosis, but was ultimately reviewed by Consultant Psychiatrist 5 as evidenced in his Addendum Report for a Tribunal Hearing on 18 December 2006.¹¹⁴ He stated “*Ms [A] has a history of Paranoid Delusions, bizarre somatic experiences associated with a rapid decline in social and interpersonal functioning. It is also apparent that marked affective changes are associated with her illness. She has recently shown a good response to the addition of Sodium Valproate a mood stabiliser... In my opinion the affective features are sufficiently pronounce to suggest a category of Schizoaffective as a more complete description of her illness from Schizophrenia*”.¹¹⁵

Ms A was discharged to Consultant Psychiatrist 4’s care in the community in June 2008. For the purposes of reviewing her mental state she saw an Associate Specialist and she saw Consultant Psychiatrist 4 for review of her Supervised Community Treatment Order. In both Psychiatrists’ subsequent letters they refer to Ms A as having a diagnosis of Paranoid Schizophrenia, although the differential diagnosis of Schizoaffective Disorder is referred to.¹¹⁶ When Ms A’s mood deteriorated and she was seen at the Outpatient Clinic, the letters refer to her as suffering from Paranoid Schizophrenia and Depression.

At interview it was clear from the discussions with both of the Consultants that they had a good knowledge and understanding of the person that Ms A was, as well as her clinical presentation. Regarding her diagnosis Consultant 4 referred to her being “*somewhere on the spectrum*” between Paranoid Schizophrenia and Schizoaffective Disorder.¹¹⁷ There was recognition that she had a Paranoid Schizophrenic illness with an affective overlay. This

113 Trust Notes pp 1221-1222

114 Trust Notes p 2100

115 Trust Notes p 2055

116 Trust Notes p 2820

117 Interview Transcript

diagnosis guided the approach to her care and treatment. The Psychiatrists found it was essential that Ms A had anti-psychotic medication, and desirable that she took a mood stabiliser. The mood stabiliser was seen as having a dual purpose, that is to say augmenting the anti-psychotic medication as well as its function as a mood stabiliser. The Psychiatrists saw Ms A as requiring the full range of Multidisciplinary Team skills and the use of the Mental Health Act (1983 & 2007). They recognised that the way Ms A managed her illness was problematic for her and for those around her.

12.1.1.3. Conclusion

The Independent Investigation Team debated at some length as to whether the diagnostic difference of opinion between Consultant Psychiatrists 4 and 5, of Paranoid Schizophrenia or Schizoaffective Disorder, made a significant difference to the way in which Ms A's care and treatment was managed and her continued health, safety and wellbeing. It was concluded by this Investigation that Ms A's treating teams saw her in a wider context than just her diagnosis of Paranoid Schizophrenia and that they recognised the affective element to her presentation within the context of a wider diagnostic formulation. This Investigation was therefore of the opinion that ultimately this debate regarding her diagnosis had little effect upon the effectiveness of her care and treatment.

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (for example cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines. Specific

guidance is available from the National Institute of Health and Clinical Excellence (NICE) for the treatment of Schizophrenia.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as *“the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent”* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever possible it is good practice to seek the patient’s consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act (1983 & 2007) under a Treatment Order (Section 3 or 37) medication may be administered without the patient’s consent for up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Doctor (SOAD). The SOAD will also review those patients detained under a Supervised Community Treatment Order (SCTO). The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission (formerly the Mental Health Act Commission).

The patient’s ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation, that is to say do they remember to take their tablets at the prescribed time? Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals, for example, weekly or monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and/or who may be non-compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

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All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects, that is to say tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication or changing to a different type of medication.

For those patients whose symptoms do not respond adequately to treatment NICE guideline CG 82 gives the following advice:

“For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:

- *review the diagnosis*
- *establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration*
- *review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families*
- *consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.*
- *Offer Clozapine to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotic drugs. At least one of the drugs should be a non-clozapine second-generation antipsychotic”.*

Mood stabiliser medication is most commonly prescribed for those patients with a diagnosis of an affective (mood) disorder, either as a treatment to stabilise mood, for example in Bipolar Affective Disorder, or as an adjunct in someone who is not responding to monotherapy with, for example an antidepressant. Mood stabilisers are also used occasionally in Schizophrenia for the treatment of a concurrent mood disorder, for example in Schizoaffective Disorder, or as an adjunct to antipsychotic medication to increase potency/effectiveness.

National Institute for Health and Clinical Excellence (NICE) Guidelines for the Treatment of Schizophrenia

NICE first published Schizophrenia treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009. NICE guidance states that *“Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering”*.¹¹⁸

The 2002/3 Guidelines included the following:

1. *“In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist. Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency”*.¹¹⁹
2. *“It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia”*.¹²⁰
3. *“The services most likely to help people who are acutely ill include crisis resolution and home treatment teams, early intervention teams, community mental health teams and acute day hospitals. If these services are unable to meet the needs of a service user, or if the Mental Health Act is used, inpatient treatment may prove necessary for a period of time. Whatever services are available, a broad range of social, group and physical activities are essential elements of the services provided”*.¹²¹
4. *“The assessment of needs for health and social care for people with schizophrenia should, therefore, be comprehensive and address medical, social, psychological,*

118 NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care Issue 82 (2009) p 1

119 NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) p 8

120 NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) p 8

121 NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) p 9

occupational, economic, physical and cultural issues...Psychological treatments [to include]

- *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*
- *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*
- *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service user preferences should be taken into account, especially if other more efficacious psychological treatments are not locally available.*¹²²

12.1.2.2. Findings

Medication

During Ms A's years of contact with psychiatric services she was treated with a variety of medications in various combinations. She was treated with oral and depot antipsychotic medications and these included Risperidone, Olanzapine, Quetiapine, Sulpiride and depot Pipothiazine, and Risperdal. Non-compliance with oral medication was a constant theme during her contact with the mental health services, and depot medication was ultimately used to overcome this so that both Ms A and the treating team could be sure that she was having an adequate dose of antipsychotic medication.

A review of her medication provided evidence that she was treated with Risperidone during her first and second admissions, which helped her symptoms but she unfortunately did not respond completely.¹²³ Clozapine was tried in September 2004. She became well on this and remained on this medication for six months. However Ms A became non-compliant with the Clozapine leading her mental state to relapse and she was re-admitted. Consultant Psychiatrist 4 told this Investigation that he was of the impression that Ms A had been at her best when on Clozapine, and was of the opinion that it was very unfortunate that she could not be persuaded to comply.¹²⁴ She was re-commenced on Clozapine during her next admission but was again non-compliant and so was placed back on oral Risperidone. She was also non-compliant with

122.NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) pp 12-13

123 Trust Notes p 2111

124 Witness Transcript

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this and was prescribed the injectable depot Risperdal. However despite using a therapeutic dose of Risperdal, Ms A's mental state remained brittle and she relapsed. In 2007 the decision was made to try her on Pipothiazine depot given that she was refusing Clozapine, was non-compliant with oral antipsychotics, and continued to relapse on full therapeutic doses of the atypical depot.

Ms A's diagnosis was reviewed at about this time and Sodium Valproate, a mood stabiliser, was added to her medication regimen. The role of this particular medication was twofold in that it would stabilise and treat a possible affective component to her presentation and also act as an adjunct to her antipsychotic medication. There is certainly evidence to suggest that she improved on this medication regimen although it is impossible to be certain that the change in medication was wholly responsible for her improvement. Other positive components to the way Ms A's care and treatment was being managed at this time included recognising the degree of her fragility, setting a slower rehabilitation pace and providing psychology input. Each of these approaches may have contributed to her improvement.

When Ms A decided to stop her Sodium Valproate in May 2009 her mental state did not relapse in the aftermath, and when she did have a relapse in January 2010 she recovered without its re-instigation.¹²⁵ During reviews, for example November 2009 she was reminded that it appeared to have benefitted her, but she declined to re-start.¹²⁶ The Independent Investigation Team was of the opinion however that Ms A could have been more assertively encouraged to re-commence the Sodium Valproate.

Ms A's mental state relapse in January 2010 was managed by supplementing her depot antipsychotic with oral antipsychotic medication (Sulpiride) giving her a degree of control over the medication she was taking.

When Ms A's mood was low, both early in her presentation to psychiatric services as well as later, for example in 2010, she was also treated with antidepressant medication including Cipralex, Venlafaxine, and Escitalopram. She appeared to be more accepting of this type of medication, and it does not feature so prominently in the discourse around her compliance issues.

¹²⁵ Trust notes p 2891

¹²⁶ Trust notes p 2878

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Ms A's medication was reviewed regularly and compliance was consistently encouraged by all the team who worked with her, unfortunately Ms A appears to have had difficulties both accepting and complying with this advice. When she developed side effects she was prescribed appropriate medication and the dose of her medication was altered where possible. Ultimately the dose of her depot was reduced very slowly and very gradually during 2010 because of the development of serious and disabling side effects namely oro-facial dyskinesia.

At the time of the homicide Ms A had received her depot which was within the normal therapeutic range. However it would appear that given the fragility of her mental health, this alone was not enough to maintain her wellbeing.

It is clear from a review of the clinical record and from discussions with clinical staff that considerable work was undertaken with Ms A on the issues of concordance, compliance and insight. It is regrettable that this was not evidenced in a formal medicines management care plan, although ultimately the Independent Investigation Team does not believe that the absence of the said care plan contributed to the killing of Ms A's mother.

Psychosocial Treatment

Ms A had a number of episodes of psychosocial treatment, the first of these was provided by a Trainee Clinical Psychologist, shortly prior to her second admission. The Trainee Clinical Psychologist's discharge letter to Ms A's Care Coordinator advised that she had undertaken some cognitive behavioural type work with Ms A addressing how she dealt with the symptoms of psychosis. The letter informed the Care Coordinator that she had now finished her trainee placement, and would not be able to continue with Ms A's sessions and advised that the treating team may wish to consider referring Ms A to the Psychology Service once discharged from inpatient care.¹²⁷ There were no detailed records of the Trainee Psychologist's work with Ms A in the clinical records provided, therefore it is not clear whether this was a structured manualised programme of psychosocial interventions for psychosis as recommended in the NICE guideline for Schizophrenia.

There were a number of other attempts to engage Ms A in psychosocial interventions. Following her inpatient admission in 2004 she started at the day hospital in order to commence

127 Trust Notes p 400

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Clozapine; she also had an initial appointment in October with a Specialist Psychosocial Interventions Nurse. However after the initial meeting it is recorded that Ms A needed to be encouraged to re-engage with the psychosocial work being offered. One further meeting with the nurse is recorded in the notes.

During Ms A's fourth acute inpatient admission in November 2005, there were three individual sessions recorded in the notes which were focused on helping Ms A cope with disturbing thoughts through the use of mindfulness techniques.¹²⁸ However there is no review of this work in the ward round notes or records which follow the third session. It is not clear how many sessions were planned, or whether the third session was intended to be the final one.

In 2005 after Ms A had been transferred to the Nightingale rehabilitation service she is recorded as receiving in the region of 18 individual clinical psychology sessions between 29 November 2006 and 19 August 2007. These appeared to be delivered in two separate sets of nine weekly sessions. One set of sessions ran from 29 November 2006 to 7 February 2007. The second set ran from 17 June 2007 to 29 August 2007. In the summary letter from the Clinical Psychologist he explained that he worked with Ms A using a broad modified schema focused model. He stated that Ms A had a perfectionist/relentless standards schema, and as a result would set herself unattainable goals which in turn caused her distress. He identified that there had been some success in getting her to set more realistic goals for her future. A second area of work focused on Ms A's sense of bereavement for the loss of her pre mental illness life. The interventions reported were focused upon helping her to achieve a more balanced perspective and to restore a sense of hope. The third area worked on was the development of a relapse signature. This in turn led to exploration of previous symptoms, such as delusions and hallucinations, and how Ms A was coming to terms with these experiences. This appeared to be a structured approach to understanding and working on a range of problems associated with her psychosis.¹²⁹

Ms A received further psychological intervention from a Counselling Psychologist in 2010 while under the care and treatment of the Southbourne CMHT. She received a total of 13 individual sessions, which included two assessment sessions. The assessment sessions took

128 Trust Notes pp 1281, 1288, 1291
129 Nightingale House Psychology Notes

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place in January 2010 and the therapy sessions started in April continuing through to 19 August when the Counselling Psychologist had recorded that he had discussed with Ms A that their next session would be a review session with a view to bringing the sessions to an end.

The Counselling Psychologist reported that the therapeutic priorities were to:

- understand impulses and be able to control them;
- make sense of psychoses;
- address thoughts and feelings about family before, after and during illness;
- support improved self-esteem.

The notes from these individual therapy sessions typically record discussions about the current issues and challenges in Ms A's day-to-day life. They appeared oriented towards supporting her work on those issues, and as such the sessions appear to have been predominantly solution-focused. There is no evidence in these sessions of a manualised approach to working with Ms A's psychosis being used.^{130 131}

Family Interventions

This is explored in detail in the family and carer section of this report. It is therefore sufficient to state in this section, that whilst there was an occasional involvement of Ms A's family in ward rounds, Care Programme Approach review meetings, and statutory Mental Health Act nearest relative consultation meetings, these were not frequent or regular. Whilst in Nightingale House Ms A's father was invited, at her suggestion, to be involved in one session helping to develop her relapse signature and prevention plan. The Independent Investigation Team concluded that there were no recognisable family interventions recorded as described in the NICE guideline for Schizophrenia.

12.1.2.3. Conclusion

It is the conclusion of the Independent Investigation Team that Ms A's medication management was as optimal as it could have been given the resistance to the same from Ms A. The treating team worked hard to manage Ms A's compliance and worked with both concordance and medication issues. Ms A's medication side effects were reviewed regularly and responded to with a collaborative approach. This was good practice.

¹³⁰ Trust notes pp 2883, 2884, 2984, 3004, 3005,3007, 3008, 3009,

¹³¹ Trust electronic progress notes p 96

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This Investigation concluded that a more assertive approach could have been used when Ms A decided to discontinue taking the Sodium Valproate, particularly as this was a condition of her Community Treatment Order at the time. However it is unlikely that the absence of the mood stabiliser was contributory to her eventual relapse.

It was unfortunate that Ms A did not comply with treatment and with Clozapine in particular. The Investigation Team noted that whilst the use of Piportil may have been regarded as less than ideal, the treating team had been left with few other options given Ms A's non-compliance with oral medication and the limited efficacy of trials of several other classes of antipsychotics at therapeutic doses.

An important lesson for learning is the difference between medication compliance and medication adherence. The term compliance tends to reflect medicine taking from the prescriber perspective, whereas the term non-adherence recognises the patient's perspective and autonomy in the decision about taking or not taking their medicines. It is estimated that non-adherence with prescribed medicines is between 30–50% and that this may be higher amongst patients with mental health problems. Medication adherence can be increased through discussion between the prescriber and the patient in order to establish shared understanding of realistic treatment goals.

Throughout Ms A's time as a service user with the Trust the issues regarding her medication compliance were consistent. It was recognised that Ms A would be vulnerable to relapse if she ceased to take her medication and this was always identified as being one of the most significant risks around her continued health, safety and wellbeing. It is a fact that no medicines management care plan was explicitly put into place in order to manage this risk. It is evident that the decisions made at various stages during her treatment to crush medication, supply liquid medication, administer depot injections, and to ultimately place Ms A on a Community Treatment Order, were all a response to her non-compliance. It would have been good practice to have developed a detailed and robust medicines management plan to support her ongoing education and adherence. It is the conclusion of this Investigation that this was a notable omission in the care and treatment of Ms A.

Psychosocial Treatment

The Independent Investigation Team found that over the 10 years Ms A received treatment from the Trust she received individual psychological treatment on three separate occasions.

The first was provided by a Clinical Psychology Trainee in 2004. From the brief summary letters provided, these sessions appeared to be evidence-based Cognitive Behavioural Therapy sessions, of which Ms A was said to have been benefitting. It would appear that these sessions were not brought to an end in a planned way, but as a result of Ms A being admitted to hospital and the trainee finishing her placement

The second period of psychosocial interventions was provided whilst Ms A was in the Nightingale Rehabilitation Unit between 2006 and 2008. The psychology work was evidence-based and completed through a structured programme of work with Ms A. During this Investigation it was found that Psychology notes were not integrated with the main clinical record. Whilst this is not unusual practice when service users are undergoing in-depth psychological therapy it can become problematic if significant assessments are conducted which are then not accessible to the rest of the treating team. Since the introduction of the RiO electronic patient record in the Trust the practice of psychologists maintaining separate records has ceased.

The third occasion was a period of weekly counselling session in 2010. Although this was not an evidence-based treatment for someone with Schizophrenia, it appeared to be supportive to Ms A at this stage in her recovery. It helped her explore and deal with a range of day to day issues and decisions in her life at that time which bolstered her coping skills. It also provided her with a space to discuss a number of longer-term on-going emotional issues including her thoughts and feelings about her illness.

During the course of Ms A's care and treatment with the Trust there was no planned or constructive effort to provide Ms A's family with interventions as recommended in NICE guidance. This was a significant omission and made a contribution to difficulties that the family had, and still do have, in understanding Ms A in the context of her mental illness. During the course of this Investigation it became evident that there were family dynamic issues. These issues were often identified within the clinical record but were never addressed. Whilst it can only be a matter of speculation it is possible that the way Ms B routinely

confronted her daughter when unwell, and particularly on the morning that she met her death, may have inadvertently placed her in a position of increased vulnerability. Had a structured family-focused series of interventions been considered Ms B may have been able to understand her daughter's mental illness better. As has already been stated, whether this made a contribution to Ms B's death can only remain a matter for speculation. However this omission was poor practice perpetuated over a seven-year period.

- *Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicine's management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.*
- *Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.*

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

12.1.3.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could 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.

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At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.¹³² The main purpose of the Mental Health Act (1983 and 2007) is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.¹³³ There is a requirement to ensure that care and treatment are provided in the least restrictive environment possible and all other alternatives are considered prior to assessment under the Act.

Ms A was detained under/subject to the following Sections of the Mental Health Act (1983 and 2007).

Section 136 of the Mental Health Act (1983 and 2007) allows a Police Officer to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special section 136 suite). The Mental Health Act states:¹³⁴

“136. (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an [approved mental health professional] and of making any necessary arrangements for his treatment or care.

132 Mental Health Act Commission 12th Biennial Report 2005-2007

133 http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034

134 Mental Health Act (1983, 2007) Code of Practice

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection”.

Section 3 of the Mental Health Act (1983 and 2007) is an admission for treatment order for a period of up to six months. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 4 is an emergency order that lasts up to 72 hours. It is implemented by just one doctor and an AMHP, in an emergency in which there is not time to summon a second suitable doctor in order to implement a Section 2 assessment order or Section 3 treatment order. Once in hospital, a further medical recommendation from a second doctor would convert the order from a Section 4 emergency order to a Section 2 assessment order. Section 4 emergency orders are not commonly used.

Section 17 of the Mental Health Act (1983) allows the Responsible Clinician (RC) to give a detained patient leave of absence from hospital, subject to conditions the RC deems necessary. This includes a requirement to take medication whilst on leave and to reside at a particular address, among others. Although the RC can require a patient to take medication while on Section 17 leave, treatment cannot be forced on the patient whilst they are in the community. There is no limit to the duration of Section 17 leave provided the original authority to detain remains in force.

Section 17a Supervised Community Treatment Order

The Mental Health Act 1983 was amended in 2007 to include provision for Supervised Community Treatment (Section 17A). The changes came into force in November 2008. The purpose of Supervised Community Treatment (SCT) is to increase the range of options for

mental health treatment in the community. SCT is implemented through the making of a Community Treatment Order (CTO). It is a contract between the patient and clinicians which can be tailored to the personal needs of the patient. SCT is particularly designed to support people with a history of non-compliance, relapse and re-admission cycles. Only those patients who have been detained in hospital for treatment (Section 3, Section 37) are eligible for SCT. Patients on SCT remain under compulsion and are liable to recall to hospital for treatment. When considering if a patient should be made liable for SCT, the Responsible Clinician and Approved Mental Health Professional must agree the following criteria are met:

- a) *“The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment*
- b) *It is necessary for his health or safety or for the protection of other persons that he should receive such treatment*
- c) *Subject to his being liable to being recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital*
- d) *It is necessary that the Responsible Clinician should be able to exercise the power, under Section 17E(1) below to recall the patient to hospital and*
- e) *Appropriate medical treatment is available for him”*.¹³⁵

Conditions should be decided by the Responsible Clinician (who has a duty to consult with the patient and other parties) and the Approved Mental Health Professional. The CTO must specify that the patient makes themselves available for the purposes of being examined in connection with the CTO’s extension, and review by the SOAD (Second Opinion Doctor, regarding consent to medical treatment. The patient may be recalled to hospital if they fail to comply with these two conditions. Other conditions are then set and are tailored to the individual patient’s needs, for example the patient must reside at a certain address, must take a certain medication and must abstain from alcohol or illicit drugs. Once conditions are agreed, they can only be changed by the Responsible Clinician. The Responsible Clinician may recall a patient on SCT to hospital if in his/her opinion:

- a) *“The patient requires medical treatment in hospital for his mental disorder and*
- b) *There would be a risk of harm to the health or safety of the patient or other persons if the patient were not recalled to hospital for that purpose” (ibid).*

135 Mental Health Act Code of Practice (1983, 2007)

If a patient is recalled, that is to say the CTO is revoked (because the Responsible Clinician is of the opinion that the Section 3 conditions are satisfied and an Approved Mental Health Professional agrees with that opinion) and the effect is that the patient is subject to detention in hospital for treatment as if they had never been discharged.

Section 117 of the Mental Health Act (1983 and 2007) places a duty on Local Authorities and health services to provide required 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, psychological therapy, crisis planning, accommodation, and help with managing money. The purpose of Section 117 is to prevent someone needing to go back to an inpatient unit. Services should ensure immediate needs are met and should also support people in gaining the skills they require to cope with life outside hospital.

12.1.3.2. Findings

Section 136

Ms A was placed on Section 136 of the Mental Health Act (1983 and 2007) on 17 July 2005. This was a result of being found by the Police swimming with no clothes on in the sea, after going missing from her supported accommodation at Irving Road.¹³⁶

Ms A was admitted as an informal patient to St Ann's Hospital on the same day.¹³⁷ The written record is not clear about the exact chain of events in terms of removal from the beach to a place of safety, and the assessment which led to her being admitted informally to the ward.

There was one other mention of Section 136 in Ms A's records. In September 2005 Ms A failed to return to the ward and was found several days later by the Police on Weymouth Beach.¹³⁸ Despite concerns being raised about her mental health by the ward staff and her family, the Police did not believe on this occasion her presentation warranted the use of Section 136.¹³⁹ Following this decision the ward staff took several days to agree to send

136 Trust notes p 691
137 Trust notes p 692
138 Trust notes p 747
139 Trust Notes p 747

someone to try and convince Ms A to come back to the ward.¹⁴⁰ There was no record of the ward team considering the use of Section 4 of the Mental Health Act. Ms A was eventually persuaded to return to the ward as an informal patient.

Section 3

Ms A was placed on Section 3 of the Mental Health Act twice. The first time she was placed on this Section was in October 2005 when she attempted to stab a fellow patient. This followed a lengthy period of instability and non-compliance with medication. The second was in May 2006 two months after she had been discharged from her previous Section 3 when she moved into Devonshire Lodge.

Section 117 aftercare

Ms A was eligible for Section 117 aftercare when discharged from her Section 3 in 2006, and when discharged from Nightingale Rehabilitation Service whilst still on Section 3 in 2009. She remained eligible for Section 117 aftercare on a continuous basis up until the time that she killed her mother in August 2010.

There are records of three reviews which were referred to as Section 117 meetings. The first was a meeting which occurred on 16 March 2006, two weeks after being discharged on Section 17 leave to Devonshire Lodge. This was a ward round meeting attended by Consultant Psychiatrist 4, a Ward Doctor and Care Coordinator 3 who was also an Approved Social Worker. Neither Ms A, any member of her family or the housing provider are recorded as present at this meeting. The notes recorded that Ms A was doing well at her placement at Devonshire Lodge and that she was being referred for further day-care support services with Hahnemann House. The notes then recorded the recommendation to discharge her from Section 3 of the Mental Health Act.¹⁴¹

The second Section 117 meeting occurred in the Nightingale Recovery service on 4 June 2007. This was an Integrated Care Programme Approach and Section 117 meeting. It was attended by Consultant Psychiatrist 5, Care Coordinator 3, several ward nurses and the junior ward doctor. This meeting reviewed her recent relapse whilst on Nightingale and set out a plan for moving Ms A towards discharge. The plan included referral to a supported housing provider

140 Trust Notes p 750

141 Trust notes p1543

and building up a range of community based activities and interventions. The likelihood that Ms A would require a Supervised Treatment Order on discharge was also discussed.¹⁴²

The third Section 117 discharge meeting was held on 13 June 2008. It was chaired by Consultant Psychiatrist 5 and attended by the Manager and Keyworker from Leven House (to where she was being discharged), Care Coordinator 4 and the Nightingale Court Keyworker. The meeting record indicates that all discharge plans and support arrangements were discussed in a thorough way, and a clear plan for Ms A's discharge was put in place. There was no documented involvement from either Ms A or members of her family at this meeting.¹⁴³

No further Section 117 meeting documentation was extant in Ms A's clinical record. Of particular note was the absence of a formal Section 117 review meeting at the time Ms A moved from Leven House to Queensland Lodge in November 2009.

Section 17

Section 17 leave was used on many occasions to facilitate home leave to her mother's and father's homes whilst Ms A was detained under the Mental Health Act. Her Section 17 leave documents indicated that risk assessments had been completed prior to her going on leave. In fact there was no evidence that these risk assessments were completed.

There were also two uses of Section 17 leave to facilitate discharge to supported accommodation placements. On the first occasion this was used to facilitate discharge to Devonshire Lodge. As described earlier in this chapter, Ms A was discharged from Section 3 within a few weeks of discharge from the acute in patient ward, and therefore the protective powers of recall from leave back to the ward were lost. The use of Section 17 leave to support a carefully managed discharge after an acute period of mental illness is relatively common practice. The Mental Health Act Code of Practice recognises this as an appropriate practice, but recommends decisions to use Section 17 rather than apply for a Section 17a or complete discharge should be carefully documented.

Extended Section 17 leave was used by Consultant Psychiatrists 5 and 4 to support Ms A's discharge to Leven House. She remained on Section 17 leave until she was placed on a Section

142 Trust notes p 2055

143 Trust notes p 2706

17a Supervised Community Order seven months after being discharged from the Nightingale Service.

Section 17a Community Treatment Orders

Ms A was placed on a Supervised Community Treatment Order on 14 January 2009. She had two episodes of being detained in hospital under Section 3 of the Mental Health Act, and had been on Section 17 in the community for seven months prior to the application for Section 17a being made. She had a severe and enduring mental illness and had an established relapse and readmission pattern associated with risks to herself, and to some degree others, which were present when she relapsed. Ms A had a significant history of relapse associated with non-compliance with medication.

The application for the Community Treatment Order was completed on 24 December 2008 and gave the following conditions:¹⁴⁴

- 1) to follow up regularly with the Care Coordinator and Community Mental Health Nurse from East Bournemouth locality CMHT (Southbourne sector);
- 2) to be concordant with depot medication Pipartil and oral medication, including Sodium Valproate as per care plan;
- 3) to attend regular reviews with doctors in the Outpatient Clinic as per care plan;
- 4) to reside at Leven House supported accommodation.

Ms A was discharged from hospital and subject to the Community Treatment Order from 14 January 2009. The application for review by a Second Opinion Approved Doctor (SOAD) was completed on this date and she was seen by, and given a SOAD certificate, on 23 January 2009.^{145 146}

Consultant Psychiatrist 4, when interviewed during this Investigation, referred to the patients he had on Community Treatment Orders as those who had significant risk profiles and were patients for whom there was a low threshold for alert, response and review, particularly with regard to relapse and risk.¹⁴⁷ Ms A was regarded as requiring a high level of supervision and

144 Trust Notes p 2836

145 Trust Notes pp 2832-2833

146 Trust Notes pp 2830-2831

147 Interview transcript

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management. However Consultant 4 had not documented this in a plan of care, or provided written guidance in her notes on what should be done if Ms A started to relapse.

Ms A recognised the value of being on a Community Treatment Order. For her it provided psychological boundaries and containment which enhanced her capacity to comply with medication and to work with the team. When renewal of her Community Treatment Order was discussed with her by Care Coordinator 4 in May 2009 Ms A said that if she did not stay on it she probably would not always accept her depot injection.¹⁴⁸

In May 2009 Ms A stopped taking her Sodium Valproate of her own volition and without prior discussion with the treating team because of migraines (the clinical aspects of this are dealt with in the section on medication).

Compliance with oral Sodium Valproate was one of the conditions on her Community Treatment Order. The fact that she had stopped taking it only came to light at an Outpatient appointment. It is unclear from the records if this was discussed with the Responsible Clinician (Consultant Psychiatrist 4). At interview both the Associate Specialist and Consultant Psychiatrist 4 said it would have been discussed informally or in one of the CMHT team meetings.^{149 150} There was no record of this being discussed in the CMHT meeting minutes.

When interviewed by this Investigation Clinical Witnesses said that the priority for the team was for Ms A to remain engaged and compliant with the depot antipsychotic medication. Ms A's mental state did not appear to have been affected by the withdrawal of the Sodium Valproate.

Ms A was seen accompanied by her mother at the Outpatient Clinic on 30 December 2009 when her Community Treatment Order was renewed. Her CTO was also reviewed by the Hospital Managers on 16 September 2009 and 10 March 2010¹⁵¹ who agreed that the CTO should continue.¹⁵²

148 Trust Notes p 2967

149 Interview transcript

150 Interview transcript for Consultant

151 Trust Notes p 2932

152 Trust Notes p 2937

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In January 2010 Ms A disclosed she had thoughts of stabbing her boyfriend when he was sleeping. This had followed a period of concern about her mental health deteriorating. When discussed by Care Coordinator 5 with the Associate Specialist, it was noted that Ms A should be on a low threshold for recall.¹⁵³ What this actually meant in terms of what sort of behaviour should trigger recall, and how a recall would practically be conducted was not documented.

Ms A's mental state deteriorated suddenly between 23 and 25 August 2010. The Duty Staff and Team Leader who received the calls from the Housing Support Worker on these days did not contact Ms A's Responsible Clinician or her Associate Specialist at any time over those two days to inform them that Ms A might be relapsing and might need to be considered for recall to hospital. Neither the Duty Team nor the CMHT Team Leader, who was also on duty, prioritised Ms A for assessment. The CMHT Team Leader told this Investigation that it was a busy time, with many demands on the team, and he was not given enough information from the Housing Support Worker to indicate Ms A was at significant enough risk to require an emergency assessment.¹⁵⁴

The CMHT Team Leader contacted Care Coordinator 5, on 24 August 2010. He informed her that the Housing Support Worker had raised some concerns about Ms A's wellbeing. Care Coordinator 5 told him she had seen Ms A on the 16 August and given her her depot injection and that she had appeared well at that time. Care Coordinator 5, although not Ms A's Care Coordinator at this time knew, Ms A very well. Earlier in the year she had completed her gold risk assessment, when she had expressed thoughts about stabbing her boyfriend. She did not inform the Team Leader about Ms A's previous risk behaviours, or remind him that she had been identified as being on a low threshold for recall earlier in the year.

It was clear in the records that the staff involved knew Ms A was on a CTO. It was also clear at interview with members of the team, that they knew what the CTO was for and that it meant Ms A should be seen quickly if she relapsed.¹⁵⁵ The Responsible Clinician advised the Investigation that Ms A was one of the few patients he had on a CTO. He stated he would have seen her that day if he had known there were concerns. He informed the Investigation Team that he kept an emergency session available each day for this purpose.¹⁵⁶

153 Clinical Records p 2991

154 Interview Transcripts

155 Interview Transcripts

156 Interview Transcripts

12.1.3.3. Conclusions

The Independent Investigation Team found that the Mental Health Act in its broadest terms was used in an appropriate manner and at the right times in Ms A's care. This Investigation found no evidence that the formal legal and administrative requirements of the Mental Health Act were not completed to the standards required by the law or Mental Health Act code of Practice. However this Investigation found that in a number of areas the clinical practices involved in supporting Ms A when she was subject to the Act were not as robust as they should or could have been.

Section 136

Section 136 was used in 2005 to bring Ms A into hospital after she was found swimming in the sea naked, and behaving in a bizarre way on Boscombe beach. She was subsequently admitted to hospital informally. One month later she left the ward and did not return. She was found by the Police several days later living on Weymouth Beach. She was not thought by the Police to meet the criteria for Section 136. Eventually staff went from the ward and convinced her to come back informally. This Investigation concluded that in this situation it would have been clinically safer and more legally sound to send a doctor and social worker out to assess her for emergency admission under the Mental Health Act. This is because the staff who went to see her had no legal recourse if they had found her unwell and reluctant to return to hospital. Alternatively if Ms A had initially consented and then in transit withdrawn her consent the staff would have had been placed in a very difficult situation with no legal powers to ensure her safe return to hospital.

Section 117

The Independent Investigation Team found that three Section 117 meetings were held throughout the 10 years Ms A was cared for by the Trust. The first was in 2006 when being discharged from St. Ann's Hospital, the other two both occurred in Nightingale Court in 2007 and 2008. It would appear that the first Section 117 discharge meeting met the minimum standards for an effective discharge meeting in that the Consultant and Care Coordinator were present; however the absence of the involvement of Ms A or her family was not good practice. The second and third meetings involved more people and demonstrated evidence of careful and thoughtful multiagency planning. Again the absence of direct input from Ms A or her family was not in line with either local or national policy expectation at that time.

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This Investigation concluded that the service should have called a Section 117 discharge planning meeting when Ms A's discharge from Leven House was being planned in November 2009. That this did not happen was an omission on the part of the Trust and its staff. This Investigation concluded that it was symptomatic of the generally poor coordination and planning of care that is identified in other sections relating to this period of time in Ms A's care.

Section 17

Section 17 was used twice to facilitate discharge from hospital. The Independent Investigation Team considered that in the first instance in 2006 Section 17 leave could have been used for longer to maintain a more robust legal hold on Ms A in the early stages of her discharge from what had been a very long admission, and her first detention on Section 3 of the Mental Health Act following an episode of assaultive behaviour.

In the second instance the investigation concluded it was appropriate to use Section 17 leave prior to conversion to a Section 17a Supervised Community Treatment Order.

Section 17a

Ms A met the criteria for Supervised Community Treatment and therefore use of the Community Treatment Order was appropriate. However members of the treating team did not make the link between this and the expected need to respond accordingly in the event of signs of relapse. This failure meant that Ms A being on a Community Treatment Order did not provide the safety net that it was intended to. Had clinicians responded in accordance with expected practice when Ms A's mental state was first reported as deteriorating, she would have been reviewed within 24 hours of concerns being expressed about her mental state. It is probable that she would have been recalled to hospital. That this did not happen was a serious omission, which will be considered as part of the overall management of care later in this report.

12.1.4. The Care Programme Approach

12.1.4.1 Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.¹⁵⁷ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*.¹⁵⁸

*“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 specialist mental health services” (Building Bridges; DoH 1995).*¹⁵⁹

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 positive outcomes for service users by enabling effective coordination between services and joint identification of risk 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 the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and to 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;

¹⁵⁷ The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

¹⁵⁸ Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

¹⁵⁹ Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

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- 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 Care Coordinator 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.

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.

Dorset Healthcare University NHS Foundation Trust CPA Policy (in operation during the time Ms A received her care and treatment (2008-2010))

The content of the policy was agreed between five statutory agencies across Dorset and agreed by the Dorset-wide CPA Steering Group. The policy stated that training was in place for all staff including medical staff.

“Individuals with a wide range of needs from a number of services, or that are at most risk, should receive a higher level of co-ordinated support. These individuals will receive their care under the Care Programme Approach (CPA)”.¹⁶⁰

Key Principles as Stated in the Policy

- *“is person centred, promoting choice and recovery*
- *is consensual and based on partnerships between the Service User, Carers and other agencies as fully as possible*
- *recognises Carers vital contribution to the support to aid a person's recovery and should be involved as fully as possible in all aspects of care planning*
- *clarifies responsibility for implementation*
- *ensures clear assessment and management of risk, to promote safety*

160 Trust CPA Policy (2008-2010) p 5

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- *provides an effective co-ordination of care from a number of agencies and services*
- *promotes recovery and social inclusion, including the use of community resources*
- *promotes services that are gender and diversity sensitive”*.¹⁶¹

“...there should be ongoing review with formal multidisciplinary, multi-agency review at least once a year, but likely to be needed more regularly (where there are major changes in Service Users’ circumstances or when other information comes to light), and at the end of the episode of care a HoNOS rating scale should be completed”.¹⁶²

“The care plan will reflect the assessment detail, including risk, and has the following functions:

- *is a description of the process of care planning*
- *it summarises identified needs and how they are to be met*
- *it is a formal record setting out what is going to be done, why, when and by whom*
- *it provides information to the Service Users and Carers to enable them to contact the service at any time*
- *includes clear indicators of relapse, contingency and crisis plans where the Service User is on CPA”*.¹⁶³

The policy also stated that *“A Care Programme Approach review will not always require a multi disciplinary meeting. The time, place and attendance at a review will be determined by:*

- *the needs and preferences of the Service User, and those of the Carer (where appropriate)*
- *statutory and procedural obligations*

In the case of Section 117, there must be evidence of social services and Responsible Clinician/Approved Clinician consultation and agreement...In circumstances where a meeting is not necessary; the Care Coordinator must ensure that:

- *full consultation is made with parties involved in the wellbeing of an individual, including the Service User and/or carer*
- *and that this is documented and the revised care plan circulated”*.¹⁶⁴

¹⁶¹Trust CPA Policy (2008-2010) p 7

¹⁶²Trust CPA Policy (2008-2010) p 11

¹⁶³Trust CPA Policy (2008-2010) p 22

The Care Coordinator Role

The role of the Care Coordinator was listed as follows:

- *“Assess the needs of the Service User, in partnership with other members of the multi-disciplinary team, where appropriate*
- *Use professional skills collaboratively to co-ordinate/facilitate the care of the Service User, liaising with other involved professionals, the Service User and Carer(s) and other service providers*
- *To assess eligibility of local authority funding under Fair Access to Community Care Services ...To seek approval for funding from their community care budget where needs have been identified*
- *To provide support and care in a positive, assertive manner, in a way that is as acceptable to the Service User as possible*
- *To work with Service Users to identify the range of services available and agree the appropriate personalised care plan offering choice where available*
- *Ensure that the care plan is implemented effectively, review progress and adjust the plan as required*
- *To act as a consistent point of contact for Service Users, Carers and other professionals*
- *Ensure that Section 117 aftercare needs are reviewed at each review where applicable*
- *Continually assess and manage risk, in accordance with the Clinical Risk policy*
- *Ensure that HoNOS reviews are completed and recorded electronically*
- *Assess and review the needs of Carers, where the carer is unpaid and provides regular and substantial care...Consult with and support Carers*
- *To maintain contact with the Service User, as agreed in the care plan, until they are transferred to another lead professional/Care Coordinator or discharged...”*¹⁶⁵

The Independent Investigation Team found the policy to be evidence-based and fit for purpose. However the policy was very long and several witnesses to this Investigation suggested that a shortened version would be useful in the clinical setting.

164Trust CPA Policy (2008-2010) p 24

165Trust CPA Policy (2008-2010) p 32

12.1.4.2. Findings

Background Events (November 2001-30 October 2006)

Irving House

Between November 2001 and 17 July 2005 Ms A lived within the Trust catchment area and received an Enhanced Level of CPA largely in a community setting. During this period seven CPA reviews/sets of documentation were completed. The dates are as follows:

- 27 November 2001 (Care Coordinator 1);
- 15 May 2002 (Care Coordinator 1);
- 18 June 2003 (Care Coordinator 2);
- 22 October-20 November 2003 CPA forms were completed over a four-week period (Care Coordinator 3);
- 25 May 2004 (Care Coordinator 3);
- 21 October-2 December 2004 CPA forms were completed over six-week period (Care Coordinator 3);
- a CPA form 'C' was completed on 15 July 2005 (Care Coordinator 3).

Between May 2002 and 17 July 2005 Ms A lived at Irving House which was a supported living accommodation. The Independent Investigation Team found that Irving House also conducted regular reviews of Ms A's needs and that both health and housing support workers appeared to work closely together.¹⁶⁶

The content of the CPA documentation during this period is significant in that it accurately encapsulated Ms A's mental health problems and presentation in an insightful manner which was to maintain relevance. Ms A's risk was identified under three main domains: risks to self; risks to others; and risks from self neglect and vulnerability. The factors relevant to the exacerbation of risk were identified, as were Ms A's relapse indicators. Care plans and contingency and crisis plans were also developed. The CPA format lent itself to good communication practice as there were specific forms for GP and 'Out of Hours' Team liaison; these completed reviews were shared in an appropriate manner.

Ms A's relapse indicators during this period were listed as being:

- withdrawal from family and friends/deteriorating family relationships;

¹⁶⁶ Trust Records pp 188-197, 173-178, 74-78

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- increased paranoia and fear;
- reduced self-care;
- wandering around;
- isolatory behaviour;
- disorientation;
- irritability;
- non-compliance (in general).

Factors known to exacerbate risk were noted to be:

- a lack of medication compliance;
- isolative behaviour;
- poor insight;
- paranoia.

In July 2003 Ms A's mental health appeared to deteriorate. She was neither eating nor drinking well and was experiencing breakthrough symptoms of her psychosis. This deterioration led to a risk assessment being completed in July 2003 and following this she was admitted for a period of time to St. Ann's Hospital as an informal patient on 6 August 2003.

On 11 September 2003 Ms A was discharged from St. Ann's Hospital however no CPA review took place until some six weeks later on 22 October 2003 when a GP CPA summary form was sent out. The CPA review process appears to have continued until 20 November 2003 when more documentation was completed. The content of the documentation remained largely unaltered from previous reviews but it was noted that further work needed to take place in order to help Ms A and her family understand her mental health problems and needs better. The documentation made available to this Investigation did not appear to be complete.

On 25 May 2004 a *full* CPA review took place (this appears to have been the only formal CPA review to have been held during this period). Ms A and her mother were present as were Ms A's Care Coordinator and Social Worker.¹⁶⁷ The content of the CPA remained largely unaltered from that of previous reviews. Neither Ms A nor her mother had their views recorded on the formal documentation and Ms A did not sign the CPA plan. However Ms A's

167 Trust Records pp 85-90, 547-548

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relapse indicators were detailed and a crisis and contingency plan was developed. No medical team members were present as part of the review and it is not clear how they were kept informed of the Care Programme Approach process.

On 7 June 2004 Ms A was admitted to St. Ann's Hospital following a rapid deterioration in her mental health. An integrated CPA referral and registration form was completed on the 8 June on the ward, and on 12 August 2004 when Ms A was discharged a 'St Ann's Hospital Discharge Pathway' was completed.¹⁶⁸ No CPA review was conducted until 21 October 2004 when integrated CPA forms 'A', 'B', and 'C' were completed. The content of the documentation remained similar to that of previous reviews with the addition of Cognitive Behaviour Therapy and Clozapine being made to the treatment plan.¹⁶⁹ On 2 December 2004 the integrated form 'D' (for the GP) was completed and presumably sent.

From 1 July 2005 Ms A's mental health deteriorated once again and on 17 July she was admitted to St. Ann's Hospital. Two days prior to her admission the integrated CPA forms 'C' and 'B' were completed by the Crisis Team. Ms A was assessed as suffering from a psychotic episode and it was noted she had probably not been taking her medication. The main risks that she presented with were those of self neglect.¹⁷⁰

Between November 2001 and 17 July 2005 there were several areas of good practice in relation to CPA process found by this Investigation. It was evident that CPA documentation was being completed and that work had been undertaken to ensure that Ms A was understood in the context of her mental illness. Risk screens were completed, relapse indicators identified and basic care, crisis and contingency plans were developed. It would also appear that the Care Coordinator liaised on a regular basis with workers from Ms A's supported housing facility and also the ward during periods of admission. Communication with the GP and Out of Hours Services took place and Ms A and her mother were also involved in the CPA process. Areas of CPA practice that did not adhere to extant Trust policy and procedure included:

- CPA reviews not being held at the time of admission and discharge;
- CPA reviews not being held when a rapid change in the risk profile or mental state was noted;

¹⁶⁸ Trust Records pp 69-73

¹⁶⁹ Trust Records pp 558-571

¹⁷⁰ Trust Records pp 599-605

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- risk assessments as part of the CPA process did not progress beyond the basic screen stage even when risks were noted to be raised;
- risk screens conducted by other members of the treating team (notably the Psychiatrists) did not always concur with either CPA review assessments or CPA reviews;
- CPA reviews appeared to be conducted in a fairly informal manner sometimes taking several weeks to complete.

Admission to St. Ann's (July 2005-30 October 2006)

Ms A was admitted to St. Ann's Hospital on the 17 July 2005. The following CPA activity took place while she was an inpatient.

- 27 September 2005 a handwritten CPA assessment form 'C' was completed;
- 29 November 2005 CPA forms 'B' and 'C' were filled in by Care Coordinator 3;
- 5 January 2005 a handwritten note states that a CPA took place on this day but no CPA paperwork exists for this review;
- 1 March 2006 CPA forms 'A' and 'B' were filled in by Care Coordinator 3 (this meeting was designated as also being a Section 117 aftercare planning meeting);
- 16 March 2006 CPA forms 'A' and 'B' were completed by Care Coordinator 3.

On 27 September 2005 a CPA form 'C' was completed in which Ms A's presenting problems were identified. The plan was to improve Ms A's cognitive skills and to increase the Clozapine to a therapeutic level. The Care Coordinator shared this information with the Keyworker at Irving House who was listed as being the Carer. This paperwork does not appear to represent a full CPA review.¹⁷¹

Between 27 September 2005 and 29 November 2005 there was an identified increase in Ms A's risk behaviour. She was sexually uninhibited and had stabbed a fellow patient with a cutlery knife in response to command hallucinations on 10 October 2005. Ms A had also been violent towards staff. The Police were notified of this event and an entry was made in the clinical record that a 'Gold' risk assessment needed to be undertaken.¹⁷² However it would appear that this did not happen and a CPA review was not considered even though all three of the risk domains had been rated as being significant on the risk screen documentation. On 29

171 Trust Records pp 611-616

172 Trust Records pp 1105-1108, 1221

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November CPA forms 'A' and 'B' were completed by the Care Coordinator. It is not clear whether this was a continuation of the process commenced on 27 September 2005. All Ms A's risks were deemed to be low. It is not clear who was involved in the CPA review (or even if it was a review) but it may have been generated by a ward round which had been held two days earlier.¹⁷³ Most of the recorded information remained the same as for previous reviews. Ms A's comments and views were not included.

On 5 January 2006 a handwritten note within the clinical record states that a CPA review took place. There was no extant documentation given to this Investigation for this review. The clinical record states that a ward round was held on this day. All Ms A's risks were deemed to be low.¹⁷⁴

Between 7 February 2006 and 25 April 2006 Ms A was granted Section 17 leave for a trial period at Devonshire Lodge. During this time Ms A periodically attended the ward rounds and collected her medication. During these visits she appeared to pace up and down and on occasion was seen to be laughing to herself. No CPA review or risk assessment was undertaken prior to this period of leave taking place. It would appear that Ms A experienced a change of Care Coordinator during this period in that two new Community Psychiatric Nurses appeared to have taken on this role. However on 1 March a care plan was generated by the original Care Coordinator (Care Coordinator 3).

The care plan generated on 1 March 2006 contained similar information to that of previous CPA reviews. It was recorded that Ms A was going to work on her relapse plan and that one of the Community Psychiatric Nurses involved with her care in the community was designated as taking over the Care Coordinator role. Care Coordinator 4 was to conduct Cognitive Behaviour Therapy with Ms A. Care Coordinator 3 continued to liaise with Ms A, her mother and the workers at Devonshire Lodge. On 16 March a CPA review, Section 117 aftercare meeting and ward round took place. The CPA documentation content remained the same as for those completed at previous reviews. The crisis plan stated "*contact CMHT, contact Devon Lodge*". It was agreed to discharge Ms A from Section 3 of the Mental Health Act (1983).¹⁷⁵

173 Trust Records pp 1456-1469

174 Trust Records pp 1345-1346

175 Trust Records pp 931, 946-956

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On 26 April 2006 Ms A was readmitted informally to St. Ann's Hospital following deterioration in her mental health. Ms A was delusional and voicing concerns that she might harm other people. Between this date and her discharge from St. Ann's Hospital on 30 October 2006 no other CPA documentation was completed and no CPA reviews appear to have taken place. Risk screens were conducted periodically but no full risk assessments were completed even though Ms A was identified as presenting a high risk to herself and to others during this period. The reader is asked to note that the management of Ms A's risk will be specifically examined in the next section of this report.

The Independent Investigation found that during this period CPA reviews were not held at the points on the patient care pathway specified by the extant Trust policy documentation. Of particular note is the extended leave period to Devonshire Lodge. Changes in Ms A's presentation and risk profile did not prompt a full risk assessment and did not lead to a change in her care plan. By this stage the content of the CPA documentation appears to be 'static' as entries remain virtually unchanged over time regardless of changes to Ms A's mental state and situation.

Care Programme during Admission to Nightingale House (30 October 2006-11 July 2008)

On 30 October 2006 Ms A was transferred to Nightingale House, a Trust-provided inpatient rehabilitation unit. CPA reviews were held and CPA documentation developed on the following dates:

- 11 December 2006 Care Coordinator 3 held a CPA review. The Consultant Psychiatrist and another Co-Worker were present;
- 14 December 2006 it was written in the clinical record that a CPA review was needed following an event during which Ms A had been verbally abused by a male friend;
- 4 June 2007 a CPA review meeting was held which also served as a Section 117 aftercare meeting;
- 8 November 2007 Care Coordinator 3 visited Ms A to say that he would be transferring her care to Care Coordinator 4;
- 24 November 2007 a CPA review was held and the documentation completed by Care Coordinator 3;

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- 16 January 2008 a CPA review was held and the documentation completed by Care Coordinator 4;
- 8 February 2008 Care Coordinator 4 wrote to his Team Leader to say that Ms A presented a significant risk and that a 'Gold' risk assessment should be completed;
- 25 March 2008 Care Coordinator 4 wrote that once Ms A was discharged to Leven House a new Care Coordinator would be found from the receiving Community Mental Health Team;
- 13 June a discharge planning meeting which also served as a Section 117 review was held. This did not appear to be a CPA review;
- 31 July 2008 a CPA review was apparently held, the only documentation for this is held in the Leven House record. This was conducted by Care Coordinator 5.

On 11 December 2006 a CPA was held. The Consultant Psychiatrist, Care Coordinator 3 and a Co-Worker were present. Neither Ms A nor her mother attended this meeting. Objectives for the next six months were set. Ms A's risks under all domains were deemed to be low. Assessments such as Lunsers and the BPRS were indicated, however the documentation of these assessments in Ms A's clinical record were found to be often undated and incomplete and it was not possible to judge whether these were conducted at this stage.¹⁷⁶ On 16 December 2006 Ms A was verbally abused by a male friend and it was written in her clinical record that a CPA was required in order to prevent a similar event from occurring again. This does not appear to have taken place.¹⁷⁷

On 4 June 2007 a CPA review was held. Care Coordinator 3, the Consultant Psychiatrist, the Clinical Psychologist, a Junior Doctor and a Ward Nurse were present. Between the time of this review and the previous review held on 11 December 2006 Ms A had been significantly unwell. She had not been eating or drinking. She had been unwilling to take her medication and her self-care had deteriorated. Despite this her risks were generally deemed to be low. A Tribunal was to be held later that same day and therefore the CPA review also served the function of a Section 117 planning meeting. The recommendation was that Ms A would continue on Section 3 of the Mental Health Act (1983) and then progress on to a Supervised Treatment Order following her discharge which was planned to be for Leven House at some point in the future. Ms A's risks were deemed to be low despite her presentation during the

¹⁷⁶ Trust Records pp 2058-2061
¹⁷⁷ Trust Records pp 1805-1808

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previous six months and the plan was to provide more structure to her day. Nursing and medical reports were prepared for this review.¹⁷⁸

On 24 November 2007 a CPA review was held. Care Coordinator 3 had informed Ms A two weeks previously that her case would be transferring to a different Care Coordinator in the New Year. During the interval between this review and the previous review in June Ms A had been expressing thoughts of consistently wanting to harm both herself and others. Her risks however were deemed to be low. Ms A's thoughts of consistently wanting to harm both herself and others were not mentioned in the CPA review documentation. The documentation content remained largely unaltered from previous reviews. It is not clear who attended the review. It appears that neither Ms A nor her mother were present. Ms A did however receive a copy of the documentation.¹⁷⁹

On 16 January 2008 another CPA review was held with Care Coordinator 4. The plan was for Ms A's risk to be formulated with the use of the 'Gold' risk assessment tool at some point over the next six months. A mood monitoring scale was to be used to assist in understanding Ms A's suicidal ideation and to support her medical management. The risk assessment plan noted that Ms A:

- experienced fleeting thoughts of suicide;
- was a high risk of relapse because of her rapid deterioration cycle;
- when unwell had thoughts of wanting to stab nurses with the depot injection needle.

The plan was also to continue with Ms A's Wellness and Recovery Plan (WRAP) and to stabilise her sleep pattern.¹⁸⁰ These records are held in the Leven House record system only.

On 8 February a Care Coordinator who held the case for a brief period of time wrote to his Team Leader to say that Ms A presented with high levels of risk and that a 'Gold' risk assessment was indicated. There was no mention of these high levels of risk in the CPA review held four weeks previously and no record of the 'Gold' risk assessment being conducted at this stage.¹⁸¹

178 Trust Records pp 2053-2055

179 Trust Records pp 1954-1966

180 Leven House Notes pp 59-67, 210

181 Trust Records p 2473

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On 13 June 2008 a discharge planning meeting was held; this meeting also served as a Section 117 review. Those present were Care Coordinator 3, Care Coordinator 4 and the Consultant Psychiatrist. At this stage the plan was to discharge Ms A to the Community Mental Health Team and to Leven House on 27 June 2008. It was written that care plans were deemed to require updating. At this stage no risk assessment had been conducted and there was no specific discharge plan. Neither was there any evidence of involvement from Ms A and her family.¹⁸²

On 28 June 2008 a 'Gold' risk assessment was completed by the Clinical Psychologist. Ms A's current risks were deemed to be low, however the assessment identified that Ms A's stable risk profile was predicated upon the maintenance of her often fragile mental health. The plan was largely based upon Ms A's status as an inpatient and did not realistically look forward to what the monitoring processes would be once she was discharged into the community. There was no evidence in the clinical record that this plan was shared with the Community Mental Health Team to whom she was being discharged or to Leven House (this assessment is discussed in detail in subsection 12.1.5 below).¹⁸³ A ward round was held on 27 June 2008 whereupon it was decided that Ms A presented with a low level of risk across all domains.¹⁸⁴

Ms A was discharged from Nightingale House on 11 July 2008. During Ms A's time at Nightingale House the CPA reviews held and documentation developed do not appear to have adequately represented the complexity of her presentation which was often problematic during this period. Risk assessment and ward-based care planning did not translate over to the CPA process. This is of particular note during the period that Ms A was being prepared for discharge from Nightingale House. Extant Trust policy expectation would have been for a full CPA review to have taken place and for care planning processes to have been amended and developed in keeping with Ms A being managed by a community-based team instead of a ward-based team. Unfortunately risk assessments and risk assessment plans were predicated upon Ms A remaining an inpatient and this was a serious flaw in the discharge process at this time. The Independent Investigation Team also noted that the content of the CPA documentation remained largely unaltered from documentation produced as early as 2002. Whilst this Investigation acknowledges the accuracy of the early CPA assessments the expectation would have been for a more dynamic approach to have been taken with regards to

182 Trust Records pp 2706-2711

183 Trust Records pp 2766-2771

184 Trust Records pp 2716-2717

emergent risk assessment and management plans in accordance with Ms A's changing circumstance.

Care Programme Approach Following Discharge from Nightingale House

Following Ms A's discharge into the community the following CPA reviews were held and CPA documentation developed on the following dates:

- 31 July 2008 a CPA review was held by Care Coordinator 4;
- 10 October 2008 CPA documentation was completed by Care Coordinator 4;
- 25 June 2009 CPA documentation was completed by Care Coordinator 4;
- 29 July 2009 a full risk screen was completed by Care Coordinator 4;
- 22 October 2009 a CPA was due on this date but no extant documentation was available to this Investigation;
- In December 2009 Ms A was moved to Queensland Lodge and the Care Coordinator visited every two weeks in order to provide support at this juncture;
- 1 January 2010 CPA documentation was completed;
- 19 January and 25 February 2010 (two dates on the same form) a full risk assessment was conducted by Care Coordinator 5;
- 25 March 2010 a CPA review was held;
- 4 May/7 June 2010 a CPA review was held/care plan developed by Care Coordinator 5.

On 31 July 2008 a CPA review appears to have taken place. There are no documents contained within the extant Trust-held record, but documentation from this review remains part of the Leven House-held record for Ms A. Ms A's risks were deemed to be low across all fields apart from the risk of suicide which was assessed to be significant. The content of the CPA documentation remained largely unaltered from that of previous CPA reviews. Care plans stated that:

- Ms A increased community activities to prevent her from becoming bored;
- Ms A's mental health was optimised and that relapse prevention work continued;
- Ms A would eventually have the opportunity to move to a more independent level of supported housing accommodation.

The plans were non-specific. They relied heavily upon the Care Coordinator liaising with the staff at Leven House and the major identified intervention was the administration of Ms A's

depot injection at four-weekly intervals. The ‘Gold’ risk assessment was alluded to, but it remained unclear how the risk plan was going to be put into place to the extent indicated in the plan. No plans were put into place to address Ms A’s identified suicide risk. No full risk assessment was conducted as indicated at this stage.¹⁸⁵ It is difficult to ascertain from the extant clinical record whether or not Ms A was followed up within seven days of her discharge as required by the Trust CPA policy.

On 10 October 2008 CPA documentation was completed and forms ‘A’ and ‘B’ were completed. The content of the documentation remained the same as that recorded in CPA reviews several years previously. Ms A’s risks were deemed to be low apart from her risk of suicide which was still deemed to be significant. Once again neither Ms A’s views of the CPA care plan to meet her needs or those of her mother were recorded. The crisis and contingency plan was to increase community support. The Care Plan, which was largely unaltered from that developed on 31 July stated:

- Need 1: Increased Community Occupation. Objective 1: Increase Community Activity. The actions were identified as being “...[Ms A] attends CRUMBS weekly...[Ms A] attends BRIDGES weekly...[Ms A] spends time with her befriender regularly...[Ms A] has a good relationship with her family and sees them often...[Ms A] takes part in the badminton group run...every Monday”.
- Need 2: Continued Treatment of Mental Illness. Objective 2: Optimise Mental Health and Develop Relapse Prevention. The actions were identified as being “Gold risk form has been completed ...Care Coordinator to visit on a regular basis to monitor and assess ... [Ms A’s] mental health, medication efficacy and side effects. CCO and ... [Ms A] to spend time discussing her feelings around moving on. CCO to look at further occupational activities that ... [Ms A] may be interested in. CCO to liaise regularly with the staff at Leven House ... [Ms A] to attend regular outpatient’s app with Dr... CPN to administer depot injection 4 weekly”.
- Need 3: Supported Accommodation. Objective 3: Opportunity to Move on. More Independent Accommodation Increased Self Direction. The actions were identified as being “staff and ... [Ms A] to build a therapeutic relationship ... [Ms A] to feel confident to discuss with staff at Leven any feelings or concerns she may have. ... [Ms A] to continue with her daily activities”.¹⁸⁶

185 Leven House Notes pp 45-58

186 Trust Records pp 2750-2763

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No care plan was developed to address Ms A's identified increased risk of suicide. On 16 October 2008 the Care Coordinator conducted a risk screen. On 28 November 2008 a care plan was developed to address Ms A's risk of suicide. The plan was to offer regular informal chats; for Ms A to complete a 'WRAP' (a Wellness and Recovery Action Plan); for Ms A to continue to attend psychology sessions and for Ms A to engage with staff and Occupational Therapy sessions for distraction. Ms A was to also attend a TORCH recovery group.¹⁸⁷

On 25 June 2009 CPA documentation was completed by Care Coordinator 4. Once again the documentation remained largely unaltered from previous CPA reviews. The information that Ms A had been placed on a Community Treatment Order was added into the Care Plan, however this had occurred six months earlier and no actions were cited in relation to this. At this time all of Ms A's risk factors were deemed to be low.¹⁸⁸

Following the completion of the CPA documentation a full risk assessment was completed by Care Coordinator 4. The information recorded in this risk assessment was not accurate; it did not reflect Ms A's known relapse indicators. The issue is examined in subsection 12.1.5. below.

The next CPA review was due on 22 October 2009. There is no extant documentation recording that this review took place. In December 2009 Ms A moved from Leven House to a supported living flat. This was in order to promote her independence further. This move was one which challenged Ms A and created a great deal of anxiety for her. It would have been usual for a CPA review to have been held at such a significant juncture in her care pathway.

On 1 January 2010 CPA form 'C' was completed. The form stated that Ms A had recently moved from Nightingale House to Leven House. This was a clear example of a 'cut and paste' approach to the CPA documentation as this referred to an event which had taken place over two years before. The content of the CPA documentation remained unchanged and did not reflect the significance of Ms A's recent move to a flat of her own.¹⁸⁹

Ms A experienced difficulties settling into her new accommodation and on 19 January 2010 Care Coordinator 5 undertook a full risk assessment. Ms A's risk to others was assessed as

¹⁸⁷ Trust Records pp 1945 and 2765

¹⁸⁸ Trust Records pp 2735-2749

¹⁸⁹ Trust Records pp 2732-2734

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being significant as she had reported having intrusive thoughts about wanting to stab her boyfriend. However, no risk formulation or management plan was developed rather the treating team placed a great deal of reliance upon the Community Treatment Order as a method of addressing the risks associated with Ms A. It was documented that if she continued to have intrusive thoughts Ms A could contact the Crisis Team. It does not appear that this information was sent on to the GP or any other members of the disparate care and treatment team. However a Community Mental Health Team meeting was held on 22 January 2010 and Ms A's risks were discussed. It was documented that Ms A had a low threshold and that if her mental health continued to deteriorate she would require recall into hospital.¹⁹⁰

On 25 March 2010 it was recorded in the progress notes that a CPA review had taken place, but no documentation appears to have been completed.¹⁹¹

A risk assessment was conducted by Care Coordinator 4 on 6 April 2010 and all Ms A's risks were deemed to be low providing she stayed well. Between 4 May and 7 June 2010 a CPA review appears to have taken place and care plan drawn up. Care Coordinator 5 was once Ms A's Care Coordinator. It was not recorded who else was present at the review. The problems and actions were listed as follows:

- Problem 1: Paranoid Schizophrenia. The plan was to assess and monitor early warning signs of relapse.
- Problem 2: move from supported to independent living accommodation. Knightstone Housing was to offer floating support and Ms A was to maintain social and occupational activities.
- Problem 3: Ms A was on a Community Treatment Order. The action was for the Care Coordinator to explain the Community Treatment Order to Ms A and for Ms A to take her prescribed medication.
- The crisis plan was for Ms A to have the telephone numbers of the Community Mental Health Team and Crisis Team and for her to call them if she was relapsing.
- Relapse indicators were identified as increased psychotic and paranoid thoughts, disengagement from her care plan, failure to accept her medication, low mood or elation and thoughts of suicide.

190 Trust Records pp 2786, 2989, 2991

191 Trust Records p 93

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- The contingency plan stated that Ms A was on a Community Treatment Order and could be recalled back into hospital.

Copies of the plan were circulated to the GP, the Consultant Psychiatrist, Ms A and her mother. Housing was not identified on the circulation list.¹⁹² This is the last recorded CPA review and care plan prior to the killing of Ms A's mother on 25 August 2010.

The Independent Investigation Team found that from the time of Ms A's discharge from Nightingale House the Care Programme Approach (namely assessing Ms A's needs regularly and at times of significant change, and putting in place care plans to meet her identified need and risk management planning to address her identified risks) did not meet the standards set out in the Trust's CPA policy. CPA reviews did not occur in a regular, planned manner or in a timely manner in response to key events on Ms A's care pathway; neither did the CPA process run in synchronisation with risk assessments nor Outpatient Reviews held by the Community Mental Health Team Psychiatrists. This meant that Ms A's care and treatment was not planned in a manner that addressed her identified needs and was largely uncoordinated. Even though there was a great deal of activity, this did not translate into meaningful and planned engagement which was developed in response to Ms A's identified needs and risks.

The Role of the Care Coordinator

Between 2001 and August 2010 Ms A had six individual Care Coordinators. In the two years prior to the killing of Ms A's mother Care Coordinator 4 and Care Coordinator 5 were responsible for coordinating Ms A's care with Care Coordinator 5 standing in for Care Coordinator 4 during periods of extended leave. This may have caused some issues regarding continuity as assessments and reviews were, at times, begun by one Care Coordinator and completed by another. At interview the Independent Investigation Team were interested to note that Care Coordinators 4 and 5 had substantially different views about Ms A. One described her as extrovert and fun loving, the other referred to her as withdrawn, private and not very communicative. These views do not appear to reflect changes in Ms A's mental state as each Care Coordinator held their individual impressions of Ms A consistently over time. How this impacted upon the CPA process cannot be known, but it would appear that the

¹⁹² Trust Records pp 2857-2858

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relationship Ms A had with her Care Coordinators may have been disrupted by continuity issues.

The context section above sets out the role of the Care Coordinator. The role includes:

- clinical and risk assessment (in partnership with the multidisciplinary team);
- care and risk management planning (in partnership with the multidisciplinary team);
- crisis and contingency planning;
- communication and liaison with all agencies and health and social care professionals;
- communication and liaison with the Service User and their Carers;
- the maintenance of documentation;
- the management and monitoring of care plans and risk.

The Independent Investigation Team observed that the role of the Care Coordinator, when viewed through the single lens of this Investigation, was at times underdeveloped. This was a consistent feature throughout Ms A's time with the Trust but became more evident from the time that she was admitted to St. Ann's Hospital in July 2005. From this time the CPA process did not assume the central platform around which care and treatment was planned and coordinated that good practice would indicate. The CPA process often lapsed behind ward rounds and Outpatient reviews. Risk assessments at times occurred prior to CPA reviews, but were not incorporated into the assessment or documentation, or took place after the CPA review and assessments were not amended accordingly. The impressions that this gives is of a Care Programme Approach that was not integral to the way the treating teams worked and that the Care Coordination role was not developed to the full extent possible.

Involvement of Service User

Ms A's involvement in decisions about her care and treatment is examined in some depth in a separate chapter. However it is suffice to state here that she was undoubtedly involved in her care and treatment. However it was evident that at times she disagreed with the course of action taken by her treating teams. This is not unusual particularly when a Service User, such as Ms A, experiences regular and significant deterioration of their mental health with a subsequent loss of insight and capacity. It was evident that Ms A was listened to with respect and that every effort appears to have been made to support her in both recovering and maintaining her mental health. With regards to CPA it was not evident that care plans and

review documentation were sent to her on a regular basis, although copies of letters from her outpatient appointments were. The extant CPA records printed up in hard copy in the clinical records did not record that her care plans had been shared with her and none of her printed care plans carried her signature or comments, even though there was a space for them.

Professional Communication and Involvement with Other Agencies

Close examination of the clinical record suggests that CPA reviews often took place as a solitary activity where Care Coordinators reviewed Ms A's needs for care and treatment as single members of the treating team. Interestingly this practice became more apparent during the last two years that Ms A was with the Trust. Earlier practice appears to have been of a more multidisciplinary and inclusive nature. Witnesses observed that this occurred following a change in which two teams had been integrated, which in turn had resulted in larger case loads.

Between 11 July 2008 and the killing of Ms A's mother on 25 August 2010, CPA reviews appear to have been little more than a paper exercise with either few, or no, members of Ms A's disparate care and treating team, other than the Care Coordinator, being involved. CPA documentation is often incomplete and it is not possible to determine which members of the care and treating team were involved in the CPA process by reading the CPA documentation or any other part of the clinical record. During the course of this Investigation many clinical witnesses and housing care workers were interviewed. It was a consistent feature of concern for them that the Care Programme Approach did not provide the facility for them to either give or to receive information about Ms A. This poor standard of information exchange took on a high level of relevance when Ms A's mental health deteriorated rapidly in the days prior to the killing of her mother. It was evident at this stage that the Care Coordinators did not know the Housing Association policies and procedures well and that the Housing Workers did not know how best to access crisis intervention for Ms A. The Care Programme Approach process should have developed a robust and clearly communicated crisis and contingency plan. When a crisis occurred no one appeared to know what to do and the subsequent delays that ensued were to the ultimate detriment of Ms A's mental health, safety and wellbeing, and that of her mother.

This Investigation found that Outpatient reviews, risk screens and assessments, and changes to either Ms A's presentation or circumstances did not influence the content of the CPA documentation or the approach taken by either Care Coordinators 4 or 5.

Involvement of Carers and Family Members

The involvement of Ms A's family in her care and treatment is covered in detail in a separate chapter. However it is important to note in this subsection that the Trust CPA policy in place at the time Ms A received her care and treatment made explicit the role of the Care Coordinator in relation to Carers who provide "*regular and substantial care*" to a service user.¹⁹³ What was not made explicit was how the Care Programme Approach should relate to close family members and the next of kin whose involvement with a service user was intact and ongoing. The words 'family', 'relatives', 'next of kin' do not feature prominently in the policy documentation extant during the time that is the subject of this Investigation.

Throughout the time that Ms A received her care and treatment from the Trust there was infrequent and limited involvement of Ms A's mother and father in planning and reviewing her care and treatment. Furthermore there was limited consideration of their ongoing needs for support and intervention.

Following Ms A's discharge from Nightingale House on 11 July 2008 there was only one face to face contact recorded with Ms A's family which was when Ms B attended Consultant Psychiatrist 4 outpatient's appointment with Ms A in December 2009 to review whether Ms A should continue on Supervised Community Treatment.

12.1.4.3. Conclusions

The Care Programme Approach did not assume the central position that both national guidance and Trust policy expected of it in the care and treatment of Ms A. This meant that clinical assessment (including risk assessment), care planning and decision making often occurred in isolation one from the other. The Care Programme Approach documentation appears to have been subject to the 'Boiling Frog' [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the

193 Trust CPA Policy (2008-2010). p 32

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inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Ms A both her Care Programme Approach and risk assessment documentation remained largely unaltered over a nine-year period. It is a fact that changes to either Ms A's presentation or circumstance largely failed to alter the content of the CPA documentation between 2001 and 2010. Whilst it can be said that Ms A's risk factors and relapse indicators changed little over time the Independent Investigation Team made two observations.

First: whilst Ms A's underlying presentation and problems remained the same over a nine-year period her circumstances did not. She transitioned between both health and social care facilities several times and both risk and clinical assessment and subsequent care planning should have been undertaken at these pivotal points on her care pathway in order to reflect her changing needs. This did not happen in either a timely or coordinated manner. Issues were often identified but it was not possible to see demonstrated a systematic and coordinated response. Instead documentation appears to have been subject to a 'cut and paste' approach which relegated the function of CPA to that of a basic commentary rather than being the cornerstone of care and treatment. Witnesses told the Investigation that Torex the computer system which preceded RiO was difficult to work with and had limited functionality for putting in free text commentary.

Second: it is a fact that Ms A's underlying problems remained unchanged over a long period of time. This is well documented. A consistent feature is Ms A's relapse indicators, her risk factors and her very low deterioration threshold. Every assessment made over a nine-year period alludes to the fact that Ms A, when well, presented with no risk (or low risk), but when unwell could be a significant risk to herself, to others and from others. It was also recognised that once she was in the community these risk factors would increase and that she would need a consistent level of monitoring and supervision. The Community Treatment Order was put into place in January 2009 for this very reason. The behaviour of Ms A was both known and predictable. This then makes it less acceptable that a more robust crisis and contingency plan was not developed as part of the Care Programme Approach process which was widely communicated to all members of the care and treatment team. Due to the fact that so much was known about Ms A it is of particular concern that no plan was in place to guide the actions of health and housing workers between 23 and 25 August 2010.

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The Independent Investigation Team concluded that the Care Programme Approach was not delivered in accordance with Trust policy and procedure expectation. Communication and care coordination levels were of a poor general standard and assessment and care planning did not take place based upon either Mr. A's presentation or circumstances.

The absence of effective Care Programme Approach processes was contributory to the poor levels of clinical management Ms A received in August 2010. The days and hours before Ms B died provided a clear window into the observation that the family, the housing support staff and the clinical team, had not established a common understanding of Ms A's needs and risks, or a coherent plan of how deal with her in relapse. In addition it demonstrated to the Independent Investigation Team that those involved in Ms A's care and treatment had not established a level of professional relationship that enabled them to work together effectively as a single multiagency team looking after Ms A's best interests.

- *Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.*
- *Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.*

12.1.5 Risk Assessment

12.1.5.1 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 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 management is supported by a positive organisational strategy and philosophy as well as efforts by 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;*

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- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed”*.¹⁹⁴

As long as a decision is based on the best evidence, information and clinical judgement available, 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.

Dorset Healthcare University NHS Foundation Trust Policy (2004, 2008, 2010 and 2011)

The Trust Clinical Risk assessment policies and processes were (and are) aligned closely with those for the Care Programme Approach. The CPA policy stated that *“A good risk assessment depends crucially on the assessor having taken an adequate history and made an appropriate assessment. Where possible, and appropriate, information should be sought from the Service User’s Carer and other information or sources. Information from previous records should be sought...The CMHT Operational Policy provides guidance as to the importance of multi-disciplinary team discussion where a Service user poses a significant risk or is not responding to the treatment outlined in the care plan”*.¹⁹⁵

The Trust risk policy relevant to this Investigation was initially developed in 2004, amended in 2008, reviewed in 2009, 2010 and November 2011. The policy states that in order to be effective it has to be delivered by appropriately trained and supported clinicians working in conjunction with all other relevant clinical Trust policies and guidelines.

The policy documentation supported the Trust ethos of positive risk management and acknowledged that it is not possible to completely eliminate risk. It was written:

¹⁹⁴ Best Practice in Managing Risk; DoH; 2007

¹⁹⁵ Trust CPA Policy (2008-2010) p 39

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- *“Best quality risk assessments occur with the full involvement of the multi-disciplinary Team.*
- *Risk assessment must pay particular attention to the experience and opinions of both the service user and their carers.*
- *Risk assessment informs risk management and there should be a direct follow-through from assessment to management.*
- *Risk management must recognise and promote the patient’s strengths and should support recovery.*
- *The risk assessment involves clinicians making a judgement about risk in both the short-term (over one month) and the medium term.*
- *The documentation of risk should include the reasons why decisions are made about the degree of risk and also the management plans.*
- *A consultant psychiatrist must be included in all clinical decision making for service users who may pose a risk to children”.*¹⁹⁶

Trust Policy Guidance Prior to the Introduction of RiO (Trust Electronic Record System)

The policy stated that all service users should receive a risk screen within two weeks of the first contact with services, at each ICPA review, following leave/admission, transfer, discharge, or when significant changes to mental state occurred. This risk screen had three fields:

- suicide;
- harm to others;
- self neglect/vulnerability to abuse.

Following assessment, risks were recorded as being either *“low/minimal”* (when risk was thought to be either low or absent) or *“significant”* (when risk was thought to be at least moderate). The clinician was required to make a judgement about whether risks were deemed to be *“current”* (over the following month) or *“medium term”* (over the longer term).

196 Trust Risk Policy p 2 (post RiO)

The policy stated that if any one of the three risk domains were identified as being significant, in either the current or medium term, then a full risk assessment was indicated (the ‘Gold’ Risk form).¹⁹⁷

The policy stated that if a significant risk was identified then the Care Coordinator was required to complete a full risk assessment within four weeks (this changed in 2010 when the full assessment of risk was replaced with the RiO assessment form). At the point of discharge from an inpatient facility the ‘Gold’ risk assessment should be completed by the Named Nurse and Care Coordinator. Following the completion of the full risk assessment the formulation was expected to lead to an “*explicit management plan which sets out:*

- I. *[What] specific treatment and interventions can best reduce the risk?*
- II. *The management plan needed to reduce the risk*
- III. *Arrangements for monitoring the risk*
- IV. *An explanation as to why decisions have been made*
- V. *The limitations of the risk management plan i.e. risk factors which cannot be reduced, together with the reasons for this*

The management plan should identify circumstances under which risk is likely to be increased and the actions needed to reduce risk. These should include:

- I. *frequency and content of contact:*
- II. *arrangements for promoting compliance and engagement with treatment*
- III. *pharmacological, psychological and social interventions*
- IV. *medical treatments and management of physical conditions/pain*
- V. *plans to manage environmental factors (e.g. access to weapons or means of self-harm, need for single room, risk of falling)*
- VI. *actions to manage stressors and any specific risk triggers*
- VII. *communications (including crisis contacts)*
- VIII. *a contingency plan (incl. plans in the event of loss of contact with services) and poor compliance*
- IX. *advance statements where appropriate.*

197 Trust Risk Policy pp 4-5 (pre RiO)

Policy Guidance Post the Introduction of RiO (Trust Electronic Record System)

Following the introduction of RiO (the Trust electronic record system) the five areas of risk to be assessed were:

- *“Harm to self*
- *Harm from others*
- *Harm to others*
- *Accidents*
- *Other risk behaviour”*¹⁹⁸

The main difference between pre and post-RiO practice was the change from a two tier system (the risk screen and the full ‘Gold’ risk assessment process) to a single electronic risk assessment form. A risk assessment was advised at:

- the point of entry into service;
- on admission, leave, transfer and discharge from inpatients services;
- on readmission from unauthorised leave;
- at ICPA reviews;
- on transfer to different parts of the service;
- when downgrading a risk from ‘significant’ to ‘low’;
- when there were other significant changes in circumstances;
- when the difficult to engage patients’ policy was followed;
- when likely to resume/have contact with children.¹⁹⁹

Most of the post-RiO risk policy guidance remained the same as the pre-RiO policy guidance with the exception of the risk assessment documentation format. The Independent Investigation Team found the policy to be evidence-based and fit for purpose.

13.1.5.2. Findings

Events History (November 2001 to 11 July 2008)

Between 27 November 2001 and the 25 June 2008 Ms A had no formal documented risk assessment which met the expectations of either local or national policy. The Trust clinical record shows that she received a total of 19 documented risk screens on the following dates:

¹⁹⁸ Trust Risk Policy p 2 (post RiO)

¹⁹⁹ Trust Risk Policy p 2 (post RiO)

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- 4 April 2002 (risks of harm to self and others were deemed to be low and the risk of self neglect was deemed to be moderate; this screen did not allow for the assessment of medium term risk);²⁰⁰
- 9 July 2002 (risk of harm to self was not recorded, her risk of harm to others was deemed to be low and the risk of self neglect was deemed to be moderate);
- 15 April 2003 (a risk assessment is referred to but only the addendum is in the clinical record);²⁰¹
- 2 July 2003 (a risk assessment was conducted by the Irving House Workers in conjunction with the Community Mental Health Team; the full assessment is not in the clinical record but was conducted because Ms A had gone missing);²⁰²
- 6 August 2003 (following Ms A's admission to St. Ann's Hospital two risk screens were completed. Both deemed her risk to self and others to be low, one considered her risk of self neglect to be low and one considered this to be high);²⁰³
- 14 August 2003 (risks of harm to self and others were deemed to be low and the risk of self neglect was deemed to be moderate; this screen did not allow for the assessment of medium term risk);
- 11 September 2003 (Ms A was discharged from hospital; her risks were all deemed to be low);²⁰⁴
- 21 March 2004 (all risks were deemed to be low in a discharge letter to the GP);²⁰⁵
- 8 June 2004 (Ms A was admitted informally to St. Ann's Hospital. All of her risks were deemed to be low on admission, however the risk screen deemed the risk of neglect to be high);²⁰⁶
- 23 September 2004 (all risks were deemed to be low. It was apparent the assessor did not have access to accurate information);²⁰⁷
- 2 December 2004 (all risks were deemed to be low, not all of the fields were filled in appropriately);²⁰⁸

200 Trust Records p 543

201 Trust Records pp 35-42

202 Trust Records pp 35-36 and 273-275

203 Trust Records pp 214-224

204 Trust Records pp 422-424

205 Trust Records p 807

206 Trust Records pp 69-70

207 Trust Records p 629

208 Trust Records p 574

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- 16 July 2005 (a risk screen was conducted by the crisis team who determined Ms A's risks of self harm and to others was low but that her risk of self neglect was significant);²⁰⁹
- 17 July 2005 (Ms A was admitted into hospital under a Section 136; the risk screen indicated that Ms A was a low risk to herself and to others but was a significant risk of self neglect and vulnerability. It is important to note that the forensic assessment history on the admission form stated that Ms A had been convicted of common assault and criminal damage and had used a bladed article. None of this information was entered onto the risk screen; no medium term risks were assessed);²¹⁰
- 28 July 2005 (the risk screen deemed all risks to be low. A handwritten note elsewhere in the clinical record stated "*while in hospital*");²¹¹
- 22 September 2005 (Ms A's risks of harm to self and to others was deemed to be low, but her risk of vulnerability remained significant);²¹²
- 8 December 2005 (all risks were deemed to be low although Ms A was losing weight as she was not eating well);²¹³
- 25 April 2006 (Ms A had been discharged from Section 3 of the Mental Health Act and was on leave to supported accommodation; she was readmitted to hospital on this date due to a deterioration of her mental state. Her risk of suicide was assessed as being low, her risk to others and of self neglect and vulnerability to be significant. No full risk assessment was conducted);²¹⁴
- 1 December 2006 (all risks were deemed to be low);²¹⁵
- 9 February 2007 (all risks were deemed to be low although it was noted that in the medium term Ms X's risks of self neglect could be significant. At this time Ms A was on 30 minute observations and required an escort at all times if she left the ward).²¹⁶

Ms A's risk was also documented as part of the Care Programme Approach process on the following dates:

- 27 November 2001 (risks of harm to self and others were deemed to be low and the risk of self neglect was deemed to be moderate);²¹⁷

209 Trust Records p 598

210 Trust Records pp 595 and 692-701

211 Trust Records pp 715-718

212 Trust Records pp 777-780

213 Trust Records pp 1302-1302

214 Trust Records p 1562

215 Trust Records p 1726

216 Trust Records pp 1913-1915

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- 18 June 2003 (risks of harm to self and others were deemed to be low and the risk of self neglect was deemed to be moderate);²¹⁸
- 25 May 2004 (risks of harm to self and others were deemed to be low and the risk of self neglect was deemed to be moderate);²¹⁹
- 8 June 2004 (all risks were deemed to be low);²²⁰
- 2 December 2004 (all risks were deemed to be low);²²¹
- 15 July 2005 (risks of self neglect were noted);²²²
- 29 November 2005 (all risks were deemed to be low);²²³
- 6 March 2006 (all risks were deemed to be low);²²⁴
- 11 December 2006 (all risks were deemed to be low);²²⁵
- 4 June 2007 (all risks were deemed to be low).²²⁶

Between November 2001 and 11 July 2008 Ms A's risk was considered at ward rounds and periodic risk screens were also conducted (as listed above). Therefore risk is mentioned within Ms A's clinical record on a regular basis, if only in a minimalistic manner. It would appear from the extant clinical record that only one full 'Gold' risk assessment was conducted prior to Ms A moving to Leven House and this took place on 25 June 2008. It is evident from reading through the clinical record that the need for a 'Gold' risk assessment is often mentioned and advised, but there is no record that this took place apart from this single time. It would appear that full, formal risk assessment as advised by the Trust policy was not a part of usual clinical practice. At all other times risk screening, even when significant risk was indicated, prompted no further action which also went against Trust risk policy guidance. Risk-based citations in the clinical record were often at odds with the way Ms A presented and the concerns that the treating teams had. After a careful examination of the clinical record it appears that concerns about risk rarely appeared to prompt the development and implementation of a management plan.

217 Trust Records pp 173-178

218 Trust Records pp 74 and 78

219 Trust Records pp 89-90

220 Trust Records pp 69-70

221 Trust Records pp 577-578

222 Trust Records pp 599-602

223 Trust Records pp 1456-1469

224 Trust Records pp 1402-1416

225 Trust Records pp 2058-2061

226 Trust Records pp 2053-2055

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The ‘Gold’ risk assessment which was conducted on 25 June 2008 formed part of the discharge planning for Ms A when she moved from Nightingale House (a Trust inpatient unit) to Leven House (a community-based supported living accommodation). This assessment was comprehensive. However the subsequent plan developed to ensure Ms A’s continued health, safety and wellbeing was largely predicated upon 24-hour monitoring by nursing staff which appears to have presumed Ms A continued in an inpatient setting rather than a community-based home.

Events Between 11 July 2008 and the killing of Ms A’s Mother on 25 August 2010

Following Ms A’s discharge into the community on 11 July 2008 her risks were all deemed to be low.²²⁷ A risk screen was conducted on 16 October 2008 and Ms A’s risks continued to be identified as low. On 14 January 2009 a Community Treatment Order was commenced in order to:

- *“To prevent further deterioration of mental state*
- *To keep patient safe in the community*
- *To reduce risk of violence and self neglect”*²²⁸

On 13 July 2009 Ms A’s Consultant Psychiatrist wrote as part of the Community Treatment Order renewal process that its continuation was necessary in order to provide a rapid response to Ms A if she were to relapse. Whilst all of her risks were thought to be low at this time they were deemed to be significant in the medium term if Ms A was to relapse or stop her medication.²²⁹

On 29 July 2009 Care Coordinator 4 completed a risk screen. It was evident that a significant amount of information on this screen was not correct²²⁸ and the assessor did not appear to know Ms A well.²³⁰

In December 2009 Ms A moved from Leven House to Knightstone House in order to live in an independent flat. A great deal of the information on the Supported Housing Panel Assessment sheet filled in at this time was not correct. None of Ms A’s past risks to other people or of

227 Trust Records pp 2719-2721

228 Trust Records pp 2821 and 2926

229 Trust Records pp 2820, 2943-2949

230 Trust Records p 2764

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suicide were mentioned.²³¹ This was a serious omission at this stage as Ms A's social isolation problems and relapse indicators were not appropriately noted as requiring ongoing support. This form was completed by a Social Worker and Care Coordinator 5.

In January 2010 Care Coordinator 5 conducted a full risk assessment. Ms A had been experiencing breakthrough symptoms and had told her Psychiatrist that she was experiencing thoughts of suicide. She had recently moved to a flat of her own. The risk assessment identified that Ms A had disturbed sleep and intrusive thoughts of wanting to stab her boyfriend whilst he slept beside her. She also had thoughts of wanting to shoot herself but had no gun. It was recognised that her recent move had reduced the support available to her and she was rendered more vulnerable to self-neglect. The protective factors reducing Ms A's current levels of risk were noted to be:

- the Community Treatment Order;
- depot medication;
- supported accommodation with a two-year tenancy;
- increased contact with the Care Coordinator;
- regular contact with family;
- structured activities;
- visits from a Knightstone worker weekly to assist with tenancy issues.²³²

Ms A's historic risk was accurate with the exception of her previous convictions for common assault and criminal damage. Relapse indicators were included but her risk of self neglect was largely omitted. The risk management plan did not link the identified risks and protective factors together and was developed in a very basic manner. The actual strategy for managing Ms A's risks was not established during this process and the crisis and contingency part of the assessment was left blank. There is no evidence to suggest that this risk assessment was shared with any other member of Ms A's treating team (the GP, Knightstone House etc.). The assessment was signed on 25 February by the Care Coordinator. The Independent Investigation Team found the quality of this assessment to be poor and not fit for purpose.

On 6 April 2010 Care Coordinator 4, who was once again managing Ms A's care, conducted a risk assessment. Risks were considered to be low providing Ms A stayed well. There was no

231 Trust Records pp 2883-2885

232 Trust Records p 2787

crisis or contingency plan developed. This was the last full assessment that Ms A received from the Trust.²³³

The Housing Workers at Queensland Lodge conducted a comprehensive risk assessment on the 8 July 2010.²³⁴ During this assessment Ms A discussed her continued thoughts about wanting to harm people. Ms A said she needed help and support from the Community Mental Health Team for this. The Housing Association deemed Ms A's risk for violence and aggressive behaviour to be medium at this stage. It is not clear whether this assessment was shared with the Community Mental Health Team; if it was it appeared to have made no discernible difference to the way that Ms A was managed by them.

Self Harm, Neglect and Vulnerability

Throughout the time that Ms A received her care and treatment from the Trust it was acknowledged she could often be at significant risk of self harm, self-neglect and vulnerability when unwell. It was a long-standing feature of risk assessments whilst Ms A was an inpatient that this risk was generally thought to be low when she was in hospital, but would become significant once back in a community setting. There are several examples of Ms A becoming vulnerable and being at risk of self neglect. Four representative examples are given below.

Example One: between 27 August and 1 September 2005 Ms A was due to go on leave to Irving House whilst still an inpatient at St. Ann's Hospital. A risk assessment conducted four weeks earlier had noted that Ms A's risks were deemed to be low provided she remained in hospital. She went missing and was later found by Police swimming naked out to sea at Weymouth. Ms A said that she was trying to swim the channel. At the time of her discovery by the Police she had been missing for 48 hours. The Consultant Psychiatrist leading her care was not informed until she had been missing for over two days. Ms A stayed on the beach for several more days as there were problems about bringing her back to Dorset. Discussions were ongoing between the Police and the ward team. The Weymouth Police did not think that she could be brought back under a Section 136 as they did not think she was a danger to herself. Eventually two members of the ward staff went to collect her. In the event Ms A was absent from the ward for six days. A missing person's report was filled in but no risk assessment was undertaken and once Ms A returned to the ward no further assessments took place to ascertain

233 Trust Progress Records pp 169-172

234 Knightstone Housing Association Records

her levels of risk.²³⁵ The Independent Investigation Team considers this event to have been a near miss. In subsequent ward rounds held a week and then two weeks later, it was recorded that all of Ms A's risks were low but that her risk of vulnerability would be high if she were to be discharged. No plans were put into place to conduct a full risk assessment or to mitigate against the risk if she were to go absent from the ward again.²³⁶

Example Two: on 6 October 2005 Ms A was seen to be pulling down her skirt in the ward corridor and exposing herself. Later that day in the ward round all of her risks were deemed to be low. During this period it was understood that Ms A was becoming psychotic. A few days later she became violent and attacked three people on three separate occasions (please see below for the other risk events associated with this time period).²³⁷ No risk assessment was conducted during this period even though it was recommended in a ward round that a 'Gold' risk assessment was indicated. A risk screen was eventually conducted on 13 October 2005 which determined all of Ms A's risks to be high, however no full risk assessment was undertaken.²³⁸

Example Three: during May 2006 Ms A experienced a significant setback to her mental health. On 25 April 2006 she had been readmitted to hospital from an extended period of leave to Devonshire Lodge. She had been assessed on her return to hospital as having a low level of risk of suicide and significant levels of risk regarding harm to others and self-neglect.²³⁹ The risk screening and management processes for this period appear to have been both confusing and inconsistent. On 27 April 2006 Ms A was deemed to be a low risk across all fields in the clinical notes.²⁴⁰ Between the 1 May and 16 May 2006 all of Ms A's risks were deemed to be low. However she was recommenced on a Section 3 of the Mental Health Act (1983) on 17 May 2006 "*because she has previously assaulted people in response to auditory hallucinations and is now refusing medication. This increases risk of worsening mental illness and in turn risk of assault*".²⁴¹ This decision to place Ms A on a Section 3 of the Mental Health Act would imply that risks of some kind had to be present. As the days continued Ms A continued to refuse her medication and her mental state declined. She was hostile and

235 Trust Records pp 743-75, 751-752, 911-926

236 Trust Records pp 757-774

237 Trust Records p 1221

238 Trust Records pp 1071, 1230, 1231 1236-1237, 1221

239 Trust Records p 1562

240 Trust Records pp 1573, 1574-1575

241 Trust Records p 2081

uncooperative and was refusing to eat or drink whilst pacing continually up and down the ward. During this stage all of her risks were deemed to be low.²⁴²

By 31 May 2006 Ms A was described as having dry and blistered lips and being dehydrated. A fluid balance chart was initiated and a haloperidol was being considered in an attempt to sedate her.²⁴³ On 1 June 2006 it was noted in the ward round that Ms A was “*not doing too well*” however a risk assessment described all of her risks to be low apart from her risk of harm to others which was deemed to be significant.²⁴⁴ No plan was put into place even though it was noted in the clinical record that an assertive approach needed to be taken. On 7 June 2006 it was written that Ms A appeared to be improving, however on 13 June 2006 she was still reported to be spitting out food and refusing medication. Even so her risk in the clinical record was deemed to be low whilst in hospital. During this period Ms A was transferred to Nightingale House for a few days due to bed shortages. No risk assessment was undertaken prior to this move taking place even though she was acutely ill at the time. On 14 June 2006 Ms A was deemed to be a low risk against all domains. On this day the Consultant Psychiatrist wrote a report for a Mental Health Act Tribunal which stated Ms A’s risk of “*further violence would be significant. Her risk of vulnerability to exploitation and self harm would also be significant*” if she came off her medication.²⁴⁵ At this time Ms A was not taking her medication. Her risk levels should have been understood more fully and documented appropriately. She had become physically unwell as a result of her psychiatric condition.

In summary, during this period Ms A was severely dehydrated and psychotic. Her risks however were all deemed to be low because she was in hospital. During this period, whilst in hospital, she lost a great deal of weight and became very weak physically, she also stopped taking her medication and her mental state continued to deteriorate. It is difficult to understand how risks were deemed to be low, and how the treating team’s duty of care with regards to Ms A’s safety and wellbeing was being fulfilled.

Example Four: on 14 November 2007 (whilst at Nightingale House) Ms A told ward staff that she had impulsive thoughts of wanting to commit suicide by sticking a knitting needle in her ear. The plan was to discuss this urgently with her Consultant Psychiatrist (Consultant

242 Trust Records pp 1612-1616

243 Trust Records p 1624

244 Trust Records pp 1626-1629

245 Trust Records p 1480

5).²⁴⁶ Ms A continued to express these thoughts and on 5 December, as she had expressed intense thoughts about this, it was decided that an urgent review was needed and a plan developed in order to keep Ms A safe.²⁴⁷ No risk screen, assessment or management plan is contained within the clinical record for this period. At the ward round on 14 December 2007 Ms A's risk of suicide was deemed to be low, nevertheless the use of all knitting materials was to be supervised and she was only allowed to have escorted leave. However the following day Ms A went on overnight leave with her mother. It is not clear whether Ms A's mother was informed of Ms A's suicidal thoughts.²⁴⁸ The management strategy during this period appears to have been muddled and contradictory.

Potential Risk to Others

Throughout the time that Ms A received her care and treatment from the Trust it was acknowledged she could often be a significant risk of violence and assault towards other people. It was a long-standing feature of risk assessments whilst Ms A was an inpatient that this risk was generally thought to be low whilst she was well and continued on her medication, but would become significant once back in a community setting if her mental health deteriorated. There are several examples of Ms A becoming either violent or expressing the desire of wanting to harm other people; these thoughts were of a persistent nature and if asked Ms A would usually admit these thoughts were often in her mind. Concerns about Ms A's risk of violence towards other people, coupled with the fact that she had a rapid deterioration signature when her mental health relapsed, was the main reason for her being placed on a Community Treatment Order. Examples of Ms A's violent and aggressive behaviour are given below.

Example One: in March 2001 a former friend of Ms A took out a private court case against her. Subsequently Ms A was bound over to keep the peace. Ms A had allegedly bitten this former friend, daubed slogans on his front door and also attacked the front door with a scalpel. At this time Ms A was deemed to be psychotic and suffering from a relapse of her mental illness. At an early stage it was written in Ms A's clinical record under forensic history:

- *“criminal damage;*
- *common assault;*

246 Trust Records pp 2452-2453

247 Trust Records p 2526

248 Trust Records pp 2540-2542

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- *bladed article;*
- *“breach of the peace”*.²⁴⁹

Whilst Ms A was not routinely violent and aggressive it was known that when unwell she could become confused and act in a violent and impulsive manner.

Example Two: in October 2005 Ms A experienced a relapse of her mental illness whilst an inpatient at St. Ann’s Hospital. She was clearly exhibiting psychotic symptoms and on 9 October 2005 was observed to be making stabbing motions with her arms On 10 October 2005 Ms A was aggressive towards a member of staff and grabbed and pushed a fellow patient with enough intensity to leave fingernail marks on her shoulder.²⁵⁰ Later, on this day, Ms A attacked another patient with a metal cutlery knife and stabbed her in the head. Whilst the other patient was not harmed seriously the Police were called and Ms A was placed on level three observations.²⁵¹ On 12 October 2005 Ms A attacked a member of staff by chopping him several times across the throat; breakaway techniques had to be used. Earlier that day she had been observed once again to be making stabbing gestures with her arms and had lunged out at another member of staff.²⁵²

One issue of note here is the rapid deterioration that Ms A experienced. Six days earlier she had been assessed as presenting with no risks. Another issue of note is the assumption written frequently in the clinical record that Ms A presented with no risk whilst in hospital and compliant with her medication. Here was an example of her taking her medication and being in hospital but still presenting with a high level of risk to others. No full risk assessment was undertaken, which was clearly indicated, and no risk management plan appears to have been put into place. It was noted that Ms A had attacked her fellow patients and members of staff in response to command hallucinations.²⁵³

Example Three: on 23 June 2007 it was recorded that Ms A had persistent thoughts about wanting to stab nurses with the needle of her depot injection. These thoughts persisted for

249 Trust Records pp 692-701

250 Trust Records p 1221

251 Trust Records pp 1105-1108

252 Trust Records pp 1071, 1230, 1231

253 Trust Records p 2081

several months. The plan was to administer the depot to Ms A with two members of staff being present; her risks were all deemed to be low.²⁵⁴

Example Four: in January 2010 Ms A said that she had intrusive thoughts about wanting to stab her boyfriend whilst he slept beside her. A few weeks earlier she had also expressed fleeting thoughts about wanting to stab people who mattered to her.²⁵⁵ This was discussed at a Community Mental Health Team meeting. A risk assessment deemed her risk to be significant. No management plan was forthcoming.

The issue to be noted here when examining these four examples is that Ms A could become violent when unwell. She had consistent residual thoughts about wanting to stab people and when unwell on two previous occasions had used a bladed weapon. It was known that Ms A's mental health could deteriorate rapidly and this was the reason why she had been placed on a Community Treatment Order. It would appear however that despite being a service user with the Trust for nine years a minimal amount of work was conducted to formulate her risk around acts of impulsive violence which appeared to have been driven by command hallucinations. This was a significant omission.

12.1.5.3. Conclusions

Throughout the nine-year period that Ms A received her care and treatment from the Trust her risks were usually assessed as being low, even when her clinical presentation suggested this was not correct. On the occasions when Ms A was identified as having significant levels of risk, both in the present and medium term few attempts were made to ensure that a full risk assessment and formulation was undertaken. The Independent Investigation Team noted that there were a wide range of consistent problems with the way risk assessment was conducted. These are noted below.

- The persistent use of risk screening tools as the only systematic method of recording and formulating risk even though the need for a full risk assessment was often indicated.
- The persistent failure to follow risk screening and risk assessment through to the risk planning and management stage. This meant that risks were often identified but no plan was prepared to manage the risk.

254 Trust Records p 1953

255 Trust Records pp 2867 and 2991

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- The failure to coordinate risk assessment with the Care Programme Approach process, changes to Ms A's mental state and circumstance, and major milestones on her care pathway.
- The failure to acknowledge that a managed risk is still a risk. For the majority of the time Ms A's risks were being managed in either hospital or supported living settings. When she was subject to a high level of monitoring and supervision her risks were generally deemed to be low. However these risks were only low because they were being managed. There was a failure to recognise that Ms A's underlying condition and latent risk remained consistent and largely unchanging and changes to her personal circumstances required an increased level of care planning and supervision on the part of her treating team.
- Risk assessment was not a multidisciplinary activity. Individual team members would often make comments about risk in the clinical record on the same day, but come to different risk assessment conclusions. It was evident that a high degree of inconsistency was present which is indicative of a uni-professional approach being taken.
- The information on risk assessments was often either incomplete or incorrect. It would appear that no regular review took place and new workers to the case often did not familiarise themselves with Ms A's full psychiatric history.
- Risk information was communicated poorly by Care Coordinators 5 and 6. This was evident in the case of the Leven House, Crumbs and Knightstone House workers who had no detailed understanding of Ms X's risk factors and relapse indicators.
- The recording of risk assessment was poorly conducted over the whole of the nine-year period and would indicate that no systematic process was followed. Medically generated clinical records tended to make simple statements like 'all risks low', and nursing clinical entries were of a similar nature. Risk screens and risk screen boxes and standard letters to the GP tended to be of a 'tick box' nature which offered no information or management strategy. It remains unclear as to how Ms A's treating teams actually formulated and managed her risk over time.
- There was an over reliance, from January 2009, on the Supervised Community Treatment Order to manage Ms A's potential risks. The over reliance was due to the fact that no management plan was put into place about how the Community Treatment Order was to be activated if either Ms A's mental state declined or if she found herself

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in a crisis situation. Crisis and contingency plans were either absent or non-specific. It is a fact that once Ms A's mental health broke down on 23 August 2010 there was no clearly documented crisis or contingency plan available to either the Housing Workers or the Community Mental Health Team. This was a serious omission which led to the circumstance whereby Ms A's mental health was allowed to deteriorate to a point where she became a risk to other people.

Summary

The risk assessment and risk management processes that Ms A was subject to were not in keeping with either local or national policy expectation. Assessment was rudimentary and few attempts were made to develop a formulation which would have ensured Ms A continued to be managed in a robust manner.

The Consultant Psychiatrist who was Ms A's Responsible Clinician at the time she killed her mother had a sound understanding of Ms A's psychiatric condition and of her latent risk. On the basis of this knowledge he placed Ms A on a Community Treatment Order. The expectation was that any deterioration of her mental state would be monitored and an instant recall into hospital would be made if her mental health relapsed. This plan was not, however, implemented.

Unfortunately the culture of risk assessment and risk management was weak. Risk assessments appeared to be 'tick box' processes which did not always engage actively with either Ms A's current presentation or social circumstance. The risk assessment process was neither multidisciplinary nor multi-agency. Communication between the disparate members of the care and treating team appeared to be weak. The main problem was that Ms A did not have a comprehensive crisis and contingency plan in place which was known and understood by everyone working with her. Despite all of the care and treatment activity that was taking place around Ms A when her mental health deteriorated it was evident that the safety net put in place around her was largely illusory and when tested failed to operate in a timely manner. This was to the ultimate detriment of Ms A's health safety and wellbeing and that of her mother.

- ***Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The***

consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.

12.1.6. Safeguarding

12.1.6.1. Context

National Context

Safeguarding Adults is a responsibility placed on Local Authorities by Section 7 of the Local Authority and Social Services Act (1970). Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies, the NHS and the Police, to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

The Department of Health issued its guidance *No Secrets*²⁵⁶ in 2000. This guidance notes:²⁵⁷
“The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety”.

Following national consultation in October 2008, the Department of Health published a document which tied existing systems of Clinical Governance into Adult Safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue.

By 2010, Local Authorities were expected to have an Adult Safeguarding Board/Committee and a safeguarding framework/procedure in place. Social care staff would be expected to be trained in this area of work and familiar with adult safeguarding policies and procedures.

²⁵⁶ DoH (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

²⁵⁷ Department of Health (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, DH, London

There was a clear expectation from the Department of Health that *No Secrets* would apply to all statutory agencies; however it took sometime before it was fully implemented in the NHS. In the preamble to the *Safeguarding Adults: A National Framework of Standards* it is noted that:

“All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: ‘the Right to life’; Article 3: ‘Freedom from torture’ (including humiliating and degrading treatment); and Article 8: ‘Right to family life’ (one that sustains the individual).

*Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services”.*²⁵⁸

Local Policy

The Bournemouth Dorset and Poole Multi-Agency Adult Safeguarding Policy uses the term ‘Adult at Risk of Abuse’ in preference to vulnerable adult. This policy echoes the national guidance defining a person at risk of abuse as:

“an adult aged 18 or over years or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself from significant harm or exploitation”.

An adult at risk may therefore be a person who:

- is frail due to age, ill health, physical disability or cognitive impairment;
- has a learning disability;
- has a physical disability and/or a sensory impairment;
- has mental health needs including dementia or a personality disorder;
- has a long-term illness/condition;
- misuses substances or alcohol;
- is a victim of domestic violence or abuse;

²⁵⁸ Association of Directors of Adult Social Services (2005) *Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work* pp 4-5

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- is a carer such as a paid or unpaid family member/friend who provides personal assistance and care to adults and is subject to harm;
- is unable to demonstrate the capacity to make a decision and is in need of care and support;
- is aged 18 or over and is continuing within the Special Education system.²⁵⁹

The policy emphasises that this list is not exhaustive. It also notes that a person should not be considered vulnerable or at risk merely because s/he fits into one of these categories. Vulnerability is seen as related to how able an individual is to make and exercise his/her own informed choices, free from duress, pressure or undue influence of any sort and protect themselves from harm, neglect or exploitation. The policy adds that people with capacity can also be at risk.

The policy identifies what sort of actions and omissions might constitute abuse. These are listed below:

- hitting, injuring or restraining;
- threatening, intimidating or humiliating;
- sexual attention or activity that is not wanted;
- not giving the correct medicine;
- not providing food or clothing;
- not arranging the right care;
- keeping someone on their own;
- stealing or misusing money or property;
- pressure about wills or inheritance;
- treating someone less favourably because of race, ethnicity, religion, age, gender, disability or sexual orientation.

Where a safeguarding concern exists the local policy has a seven-stage response process, which runs from raising an alert and responding to that alert, through to multiagency investigation of concerns and developing plans, to first and second stage reviews of safeguarding plans and arrangements.

²⁵⁹ Bournemouth Dorset and Poole Local Authorities, Multi Agency Safeguarding Adults Policy and Procedures

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The policy identifies that when safeguarding is working effectively the following things are in place:

- all staff have a basic understanding of safeguarding and can make a prompt referral to the right place in order to elicit a response;
- staff who deal directly with safeguarding will pick up the referral and respond to it (within a short agreed timescale, for example four hours in an emergency situation) in order to ensure the safety of the individual;
- immediate action/referral to the Police if necessary will take place where a crime has been committed; they may well lead the process if this is required;
- a strategy planning meeting will be called involving all those who have knowledge of the case to agree what is known and what further investigation should happen (this would usually happen within seven days) and a protection plan will be put in place, after discussion with the individual;
- investigation would occur;
- case conferences will take place at specific intervals both to hear the outcomes of the investigation and to monitor the protection plan; again the views of the individual should be sought throughout the process;
- the case would be closed once the issue had been resolved and ongoing safety assured.

Mental Health and Safeguarding

It is recognised that in the context of safeguarding adults, people with mental illness can have fluctuating mental capacity to make decisions in relation to their own safety. The Mental Capacity Act (2005) and the Mental Health Act (1983/2007) are available to help protect the individual who may be vulnerable, lack capacity to make an informed decision or present a risk to themselves or others.

12.1.6.2. Findings

Adult Safeguarding in Dorset, Bournemouth and Poole in Mental Health Services

This Investigation found that the policy in place in 2010 comprehensively covered all of the issues that it would be expected address. It was noted that the policy has subsequently been updated and a new version was published in July 2011. All staff interviewed across all the agencies demonstrated knowledge of adult safeguarding and all had been given access to training.

In relation to mental health services, a member of the CMHT expressed the view that the threshold for making a safeguarding referral was high. This witness was of the view that effective Care Coordination, through the CPA process, supported many people with issues of vulnerability. In addition, the client group served by the CMHT often lived with high levels of risk and therefore it was sometimes difficult for staff to establish the threshold for making a safeguarding referral.

This view is not unique to Bournemouth. The Department of Health consultation on *No Secrets* guidance highlighted that the responses they had received reported a view that everything mental health staff do is about adult safeguarding.

Safeguarding, however, gives an opportunity for formal recognition of vulnerability and provides access to a multi-agency response. In addition, for those people who are isolated, it offers connection with professionals other than mental health workers who may be able to offer a different perspective and level of support.

Safeguarding Referrals in Bournemouth and Poole

In 2010/2011 Bournemouth Borough Council received 1025 safeguarding alerts which converted to 650 formal referrals for full investigation within the meanings defined in the policy,²⁶⁰ 105 (16%) of these related to mental health. The national average for mental health referrals is 23%. This meant that the proportion of mental health alerts which turn into referrals was lower than expected. There may have been a number of potential reasons for this;

- multiple alerts received for each actual case;
- safeguarding alerts were made inappropriately;
- that the decision makers in the CMHT were discounting too many alerts as not meeting their threshold for safeguarding.

Safeguarding Ms A

Throughout the time that Ms A received services there was no evidence that she was ever the subject of a safeguarding referral. In discussion with members of staff who cared for and treated her, there was a prevailing view that Ms A was able to manage her life, when well, and

²⁶⁰ Figures exclude alerts/referrals where key client info (age, client group or gender) are missing

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that systems were in place through CPA and the Community Treatment Order, to work with her to detect when she was becoming ill and recall her to hospital.

When asked about Ms A as a vulnerable adult, none of the interviewees believed that Ms A presented in a way that required a safeguarding referral to be made on her behalf. All of the staff who worked directly with her commented on her insight into how her illness affected her. This was best summed up by a Consultant Psychiatrist who stated Ms A was “... *articulate, intelligent and seemed to have a remarkable degree of insight*”.

In addition, the Independent Investigation Team heard that Ms A had recognised the need to be both placed on Section 3 and also to be subject to a Community Treatment Order (CTO). Again, the Consultant Psychiatrist stated that Ms A “*retained awareness to put things in place to protect her...when things got difficult*”.

Ms A also had good family support provided by both her mother and her father and this was described by staff working with her. Both parents, at various points, had attended appointments with her or spoken to members of her treating team. It was recognised by staff that her relationship with her mother was strained at times and there was an understanding that her mother struggled to accept her daughter’s diagnosis.

Throughout the interview process, some staff identified that there were risks recognised in relation to Ms A in terms of self neglect and possible suicide. This risk identification was based on Ms A’s struggle to accept her illness in its entirety and live with the consequences of this in terms of her ability to function at the same level that she had in her pre-morbid state. However, these risks were perceived as minimal when Ms A was well.

Ms A’s risk to Other Vulnerable Adults

Throughout the interviews, little evidence was presented to the Independent Investigation Team that services had considered whether Ms A might be regarded as a potential perpetrator of abuse, despite evidence to suggest that Ms A could present risk of violence to others.

The treating team recognised that when Ms A relapsed, it happened very quickly and she became very ill. In addition, they knew she had a history of non-compliance with her medication, which placed her at risk of relapse.

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Staff believed they had a plan for managing Ms A's potential relapse. This involved the prescription of depot antipsychotic injections, the application of a Community Treatment Order, a significant degree of monitoring of her mental state by her Care Coordinators and psychotherapy. They described the fact that they had a very low threshold for recall of Ms A to hospital if there was any indication that she was becoming unwell.

Staff described knowledge of a previous incident of Ms A using a cutlery knife against a fellow patient in 2005 and conversations they had had with her when she described having fleeting thoughts about wanting to stab those "*who mattered to her*" when she was unwell.²⁶¹ It is a matter for speculation whether the main reason staff had for discounting the possibility that Ms A would act on these thoughts was the level of insight Ms A had when describing these thoughts. In addition, in one instance she had experienced these feelings as a result of her boyfriend's snoring and she was able to take action to remove herself from the room.²⁶²

Whilst the rationale described by staff for not considering Ms A a risk to others was understandable, there was no evidence of them considering the rights of the individuals who were close to Ms A, or the need to safeguard them, in their decision making.

In the case of Ms A describing a wish to stab her boyfriend, the Care Coordinator stated that she did discuss this with Ms A's boyfriend's Care Coordinator.²⁶³ However there is no evidence that any action was taken to discuss this with Ms A's boyfriend; or any evidence that consideration was given to his status as a vulnerable adult despite the fact that he was a service user. This Investigation concluded it would have been reasonable, given Ms A's level of insight, to facilitate a safeguarding discussion, in line with the local safeguarding protocol, involving Ms A and her boyfriend regarding the thoughts Ms A was having and ways in which they could both respond. This would have been a reasonable adult safeguarding response.

Were Ms A's Parents at Risk?

The local safeguarding policy recognises that carers can be at risk of abuse and harm as a result of their caring role, irrespective of whether they have capacity. This Investigation has found earlier in this report that Ms A's mother and father were given little if any support or

261 Letter from Consultant 4 to GP following outpatients and CTO review 04/01/2010 SHA 392. Vol 58, p 2867

262 Entry in notes following care coordinator home visit, SHA 391 Vol 60. p 2991

263 Transcript of interview

education about Ms A's illness, and they received very limited information from the services that would have helped them in their role as carers for Ms A.

Additionally Ms A's mother who provided a significant amount of care and support to Ms A was never offered a carer's assessment. It is not possible for this Investigation to know, if Ms A's mother felt vulnerable or at risk in her role as a carer for Ms A, and if she had what safeguarding measures could have been put in place. However it is a fact that Ms A's mother saw a lot of her daughter. When Ms A became unwell, and consequently a potential risk to those around her, it was highly likely that Ms A's mother and father would continue to support her and try to help her on a daily basis, as they had done throughout her illness and therefore be at heightened risk themselves.

It was identified in the context section that mental health services nationally argued that they did not need separate arrangements for safeguarding because everything they do relates to safeguarding. However safeguarding policies offer an oversight mechanism and promote interagency risk management. They are there to ensure timely intervention in the event of an abusive situation emerging. They are also there to hold the services to account when plans, services or supports that should have been in place to protect potentially or actually vulnerable people, have not worked as they should have done.

In this instance there is no evidence in the clinical records available to the Independent Investigation that consideration was given to whether Ms A's parents might be considered as vulnerable adults; neither was there any evidence that consideration was given to what services or interventions might have been put in place to ensure they were effectively safeguarded from harm in their role as carers.

Safeguarding Procedures and the Events of 23 to 25 August 2010

This Investigation considered whether on 23 August 2010, when the Housing Support Worker was concerned for Ms A's safety and the Southbourne Community Team stated they were not going to send someone to assess Ms A, should the worker have made an urgent safeguarding referral? At that point Ms A met the definition of a vulnerable adult, in that she was over 18, had a mental illness and may have been unable to look after herself or protect herself from significant harm or exploitation. In addition she was presenting with a number of dynamic factors that were increasing her short term vulnerability. These included:

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- fluctuating mental capacity associated with her mental illness;
- increasing communication difficulties because she no longer trusted those around her;
- not getting the right care and support because services did not respond to her changing level of need;
- increasing isolation and exclusion because of her withdrawn, uncommunicative behaviour.

It is unclear why the Housing Support Worker or her superiors did not think about using stage 1 of the Vulnerable Adults Safeguarding route. The Independent Investigation Team was told that Knightstone Housing Association staff had all had Adult Safeguarding training. It is clear that Ms A meet the criteria to be regarded as a vulnerable adult and she was potentially being put at risk as the care available to her at that time met the local Safeguarding Policy definition of Neglect: failing to provide access to health or social care.

12.1.6.3. Conclusion

This Investigation concluded that vulnerable adult safeguarding procedures were not used in the care and treatment of Ms A. However the Investigation identified that for a significant proportion of the time Ms A was under the care of the Trust she met the criteria, set out in the Local Adult Safeguarding Policy, to be regarded as a Vulnerable Adult.

On occasions she was inadequately protected from harm. This was particularly manifest on 23 August 2010. At this time Ms A was displaying symptoms of a relapse in her serious mental illness and fluctuating levels of capacity. However despite this Ms A was unable to access the mental health services that should have been available to her. In the context of the safeguarding policy this constitutes neglect.

Several other concerns regarding other vulnerable adults were identified. Firstly Ms A's boyfriend has been identified as someone who might be regarded as a vulnerable adult. He was a service user, who had become dependent on Ms A. Ms A reported thoughts about stabbing her boyfriend in his sleep. The presence of these intrusive thoughts was taken seriously by the clinical team caring for Ms A and her Consultant Psychiatrist indicated that she should be on a low threshold for recall to hospital. However no safeguarding referral was made or formal plan put in place on behalf of her boyfriend.

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Ms A parents, especially her mother, have been identified by this review as potentially vulnerable adults in their role as carers. However many of the normal safeguards that should have been in place, such as carers' assessments, which would have reduced their overall vulnerability to emotional or physical harm, were not put in place.

Finally: at the time Ms A was reported to be becoming unwell, her level of vulnerability had increased in that she clearly met the definition of a vulnerable adult. This Investigation concluded that not sending out someone to assess Ms A for 36 hours constituted neglect as defined in the local safeguarding policy, as they did not provide the required health and social care services to meet her needs at that time, given her known risks and vulnerabilities and the concerns raised by the housing support worker. This Investigation considered that it may have been beneficial for the Housing Support Worker or her superiors to have raised a safeguarding concern as soon as they had concerns that the Trust's duty team or crisis team were not going to provide Ms A with the healthcare services they thought she required to keep her safe. This is a learning point for the Housing Association.

12.1.7. Referral, Transfer and Discharge Planning

12.1.7.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

12.1.7.2. Findings

2000 to 2003

In the initial stage of her psychiatric illness Ms A moved between living in London, living in Salisbury with her mother, and living in the New Forest with her father. During these moves the psychiatric services providing her care successfully managed her transfer from one service

to the other. They were able to keep surprisingly consistent contact with her, even though she did not always let them know that she was moving. That contact was facilitated to some degree by her parents contacting services. However it was also a result of the clinical staff making the effort to contact services in the area Ms A had moved to. When Ms A moved from Salisbury to London in 2000 her Psychiatrist sent an extensive transfer letter to the receiving team.²⁶⁴ Similarly when she moved to the New Forest from London, her team went to some lengths to find where she was. They contacted the local services and provided relevant information to make sure Ms A continued to receive psychiatric care, supervision and treatment. This was consistent with enhanced CPA, which required that if a patient moved locations the Care Coordinator did not give up his role until the individual was safely placed with local services.

2003 to 2006

Ms A had four acute inpatient admissions during this period. Each of these followed a period of non-compliance with medication, which was followed by Ms A becoming increasingly unwell over a relatively short time period. The services involved with Ms A typically responded within 24 hours of being alerted that she was becoming unwell, and carried out assessments for admission to hospital. This met local policy expectations in that someone on enhanced CPA should receive an assessment within 24 hours if there were concerns that they were becoming unwell.

Ms A was good at convincing the assessing team that she would start to comply with treatment. On at least two occasions they gave her the benefit of the doubt and did not admit her to hospital. In 2003 she was monitored closely and when things did not improve she was admitted in a timely manner. In 2005 when she was assessed again for an admission to hospital she said she was going to stay for some days with her mother to try to calm down. This meant that her mental health was not closely monitored, as her mother lived outside of the CMHT catchment area. Ms A's mental health deteriorated to the level that required the Police to use a place of safety order.

2006 onwards

From 2006 onwards Ms A moved through acute inpatient care to rehabilitation services and onwards into community supported housing. These moves were appropriate responses to Ms

²⁶⁴ Trust Notes p 484

A's needs and her level of functioning. The clinical team took note of Ms A's requests and preferences when making their decisions about the appropriate level of care and support to be provided. However it was observed that there was an absence throughout this period of a thorough implementation of the Care Programme Approach and risk management processes. A Care Programme Approach review is typically used by services when considering or planning discharge. Such a multidisciplinary, comprehensive review is of particular importance when a service user is being discharged after a prolonged inpatient admission. Part of the function of the CPA review is to ensure that all the relevant information is available to inform the care plan and that all the relevant parties, including the service user and his/her carers and family, are aware of the contents of the care plan. Where this does not happen planning is likely to be less effective and important information less effectively communicated increasing the likelihood that care will be less well coordinated and less effective. This approach to discharge planning and transfers of care is a core tenet of the Care Programme Approach, clinical risk management and the Mental Health Act.

Conclusions

Ms A had a relatively large number of admissions, transfers and discharges in the years under consideration. When Ms A moved around the country practitioners across the different Trusts worked hard to keep each other informed of her whereabouts, and ensured that local services picked her up. This was good practice and in keeping with the Care Programme Approach policy requirements.

The Independent Investigation found that Ms A's assessments for admission to hospital typically occurred in a timely manner and were in keeping with the urgent referral criteria set out in the Trust's CMHT operational policies. The Investigation also found that practitioners were willing to give Ms A the benefit of the doubt, and did not admit her immediately if she promised she would take her medication. However even with quite close monitoring Ms A would often not keep to her promises to take medication and would relapse further. On occasions this led to her presenting a risk to herself and others. The Independent Investigation Team acknowledges that this presented a challenge to the clinicians as they had to take into consideration Ms A's preferences, ensure that she was treated in the least restrictive environment possible and uphold her rights to liberty.

Finally the Independent Investigation Team found that appropriate decisions were made about the level of care and support required to meet Ms A's needs. However there is no evidence in the clinical records available to this Investigation that these decisions were based on the comprehensive assessment of needs and risk required by the Care Programme Approach. Both national guidance and local policy indicate that it is good practice to hold a CPA review at transition points. Failing to do this in Ms A's case meant that her risks were not comprehensively assessed, and her family and carers from other agencies were not fully apprised or engaged in supporting Ms A to effectively maintain her mental health.

12.1.8. Service User Involvement in Care Planning and Treatment

12.1.8.1. 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) stated 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"*. It also stated that it would *"offer choices which promote independence"*.

12.1.8.2. Findings

The evidence provided to the Independent Investigation Team demonstrated that Ms A was involved in decisions about her care and treatment. The clinical notes document her involvement in discussions about her medication, access to occupational therapy, psychological treatment, education and employment, and accommodation and housing throughout the time she was receiving care and treatment from the Trust. Ms A was consulted and informed about her rights when she was placed on a Section of the Mental Health Act.²⁶⁵

265 Clinical Records

However her Care Programme Approach care plans, which were recorded on the Trust's patient administration system, did not reflect this level of engagement and involvement. This Investigation did not find any evidence that these care plans were shared with Ms A. The printed copies of Ms A's care plans in the medical records did not carry her signature or her comments, despite there being spaces which were labelled for this purpose.²⁶⁶

It was noted that when Ms A was not effectively consulted, or did not agree with a particular course of action being taken, she would either be non-compliant with the plan, or, particularly in relation to transitions in care settings or accommodation, start to show signs of relapse.²⁶⁷

It was noted that Ms A was thought by the team to be intelligent and articulate with a high level of insight into her illness. However, despite Ms A's level of insight and intelligence, she did not always make good decisions and was at times ambivalent about certain aspects of her future plans and aspirations. Some clinical witnesses to this Investigation suggested that at times too much confidence was placed upon Ms A's ability to make decisions. They felt that she was not always as insightful or capable as was often thought. The fact that Ms A was considered not to be a 'typical rehabilitation' patient and was somehow 'special' may have 'blinded' members of the treating teams, at times, to her actual levels of ability. For example Ms A placed extra demands on herself, resulting in her feeling stressed and pressured, at the time she was living in Leven House and planning to move Queensland Road, by taking on extra volunteering and work responsibilities. In her relapse plan and wellness and recovery action plan, it had been documented that she tended to take on too much and placed herself under a lot of pressure. This observation does not always appear to have been considered when planning care with Ms A.

12.1.8.3. Conclusions

This Investigation concluded that whilst there was evidence of Ms A's day-to-day involvement in decisions, this was often reactive rather than proactive. When Ms A was well staff would respond to her wishes and aspirations and supported her as she pursued her interests. When she was unwell staff reacted to Ms A's behaviour and level of illness.

²⁶⁶ Clinical Records
²⁶⁷ Clinical Records

Ms A appeared to be more proactively engaged with her team in planning her care than may have been the case. The teams working with her appeared to mistake reacting to her behaviours as service user involvement. However this was not service user involvement and engagement in which the service user and the professional staff were in open and transparent dialogue about how to best work together to meet the service user's needs.

This conclusion is evidenced by the lack of involvement and sharing of CPA care plan documentation. The CPA care plans should have been used as a vehicle to encourage conversations about care and treatment, and help shape changes in the care plans to meet the service user's needs in a more acceptable as well as a more effective way. That these documents were not used in this way demonstrated a lack of proactive service user involvement. A more proactive approach to service user involvement in care planning, may or may not have made a difference to the outcomes of Ms A's treatment and care. However it is a learning point for the Trust that service user involvement in decisions about treatment and care requires more than reacting to the circumstance the service user presents with. It requires the active engagement of a service user in proactively considering the plans of care and treatment being put in place for them.

12.1.9. Carer Assessment and Involvement

12.1.9.1. 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) stated 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 as 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"*.

Carer involvement

The recognition that all carers require support, 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 provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person's 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 (1999) stated that all individuals who provide regular and substantial care for a person on CPA 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.

12.1.9.2. Findings

Throughout her care and treatment Ms A retained close relationships with her mother and father. Her mother was more frequently involved with Ms A's care as Ms A often went to her mother's house for periods of time. She also went on two foreign holidays with her mother in the two years preceding the events of August 2010. Although this Investigation heard from some witnesses that on occasion there could be tension between Ms A and her mother, it was identified as nothing more than one would expect between a mother and daughter.

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Ms A's father was most involved in her care and treatment in 2001 when she first moved to the Bournemouth area, as at this time she was living in with her father and his wife. Ms A's father supported his daughter to access local services in Hampshire where they lived. He received a carer's assessment at this time which identified that he and his wife were not coping well with Ms A living with them and that this was not tenable going forward.²⁶⁸ Ms A was assessed by a Social Worker who recommended that she move to supported accommodation.

This was the only time a carer's assessment is documented in the notes for either Ms A's mother or father.

Below is a breakdown from the records of what the Independent Investigation was able to find out about how professional staff involved Ms A's mother and father in their daughter's care and treatment.

Whilst living at Irving Road prior to her first admission. There is only one documented incident of carer involvement during this period. Ms B attended an Irving Road review meeting in March 2003. This meeting was attended by Ms A's housing support staff and her keyworker. Ms A's Mother asked questions about Ms A's medication.²⁶⁹

During the first admission to St. Ann's Hospital in 2003. There are records that Ms A's parents visited on a number of occasions. On one occasion her father became tearful. However there are no records of any support or further involvement at this time.²⁷⁰

Between admissions 2003-2004. On 25 May 2003 there is a hand written record of a CPA review meeting that Ms B attended with her daughter, Care Coordinator 2, a CPN and a student psychologist.²⁷¹ Ms B is not recorded as making any contribution to this meeting, or being offered any specific support or interventions. There is no other mention of Ms A's parents in the clinical records during this period.

2004 admission and aftercare. During this admission there were a number of records about Ms A's parents visiting the ward. On most occasions these records were about Ms A's parents raising a question or a concern. For example it is noted that Ms A's mother raised concerns

268 SHA 392 Vol 4 p 177
269 SHA 392 Vol 11 p 535
270 SHA 392, Vol 5 p 230
271 SHA 392, Vol 11 p 547

about a period of diarrhoea and vomiting that did not look like it was being effectively treated.²⁷² She also raised concerns about the general lack of progress Ms A was showing. At no time during this admission is there any record that Ms A's parents were invited to a ward round or met directly with Ms A's medical team. On one occasion Ms B's concerns that Ms A was not improving was mentioned at a ward round.²⁷³

2004 to 2005 community care. There is no further contact with Ms A's family recorded in the clinical notes until June 2005 when Ms A's father contacted the community mental health team to express concern that Ms A appeared to be becoming unwell again.²⁷⁴ This eventually led to her admission under Section 136 of the Mental Health Act.

2005 admission. Most contacts between staff and Ms A's family during this admission are reactive contacts regarding Ms A absconding,²⁷⁵ and Ms A's mother raising concerns about the care and treatment provided to her daughter. Ms A's mother is recorded as attending one ward round on 8 September 2005 where she is recorded as raising concerns about Ms A's lack of progress. Consultant 4 proposed that Ms A might benefit from family intervention and that he would refer her for this. There is no evidence that this referral was ever made or that any effective intervention was offered.²⁷⁶

Ward staff phoned Ms B when Ms A stabbed a fellow patient. This was to inform the family of the incident. There was no evidence of further discussion or intervention.²⁷⁷

Transfer to Nightingale House. The only family involvement or discussion around Ms A's transfer to Nightingale House which is recorded in the clinical notes was when Ms B called the ward and asked why Ms A had been transferred to Nightingale House.²⁷⁸ There was no record of this being discussed with family members first.

Nightingale House and Nightingale Court. There are regular records of Ms A's father and mother visiting and taking Ms A out on escorted leave. There are also records of them talking to and asking nursing staff questions from time to time. On a number of occasions Ms A's

272 SHA 392 Vol 7 p 331

273 SHA 392 Vol 7 p 349

274 SHA 392, Vol 14 p 687

275 SHA 392, Vol 15 p 745-745

276 SHA 392, Vol 16 p 778

277 SHA 392 Vol 25 p 1223

278 SHA 392 Vol 33 p 1646

parents' questions and comments are recorded as being shared in the ward round. However Ms A's parents are never recorded as being at the ward round or as being involved in her care planning. The only exception to this is when Ms A asked her Clinical Psychologist to include her father in a relapse planning meeting, which he attended.

Leven House and Queensland Lodge. There is no evidence of any significant proactive interaction between the care team and the family throughout Ms A's care while she was in Leven House or Queensland Lodge. There is a record of Consultant 4 meeting with Ms A and Ms B on 30 December 2009 when he was renewing Ms A's Community Treatment Order. Ms B is recorded as being in favour of Ms A continuing on the Community Treatment Order and as understanding the importance of Ms A continuing to take her medication. It is also noted in this meeting that Ms A spoke about fleeting thoughts of harming people close to her but there was no evidence of this being pursued in any depth, or of the Consultant seeking her mother's views.²⁷⁹

In February 2010 shortly after Ms A moved to Queensland Lodge Ms A's father contacted Consultant 5, as he feared his daughter was becoming unwell again. This interaction was made up of a couple of emails and a telephone call in which Consultant 5 advised him on how to contact the Crisis Team.²⁸⁰

12.1.9.3. Conclusions

The joint agency investigation panel concluded that Ms A's family, although involved in supporting Ms A throughout her illness, had very little proactive interaction with the professionals involved in Ms A's care.

There was no evidence that Ms A's parents were involved in assessing their daughter's needs or developing her care plans as the Best Practice guidance recommends. Care plans and clinicians' views of risks were not regularly shared with the family, nor did clinicians spend adequate time understanding Ms A's parents' views of her illness.

The family were not provided with the education or support recommended within NICE guidelines, although on one occasion Ms A's mother was offered a family intervention. There

²⁷⁹ SHA 392, Vol 60 p 2979
²⁸⁰ SHA 392, Vol 60 p 2986

was no evidence, however, that this was followed through. Ms B may have also benefited from a carer's assessment as she was carrying a great deal of responsibility as the named nearest relative.

- ***Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.***

12.1.10. Housing

12.1.10.1. Context

Supporting People

Supporting People is a United Kingdom government programme helping vulnerable people in England live independently and keep their social housing tenancies. It is run by local government and provided by the voluntary sector. It was launched on 1 April 2003. The Office of the Deputy Prime Minister wrote on the introduction of the scheme that “*On 1 April 2003 the Supporting People programme was launched. The programme is committed to providing a better quality of life for vulnerable people to live more independently and maintain their tenancies. The programme provides housing related support to prevent problems that can often lead to hospitalisation, institutional care or homelessness and can help the smooth transition to independent living for those leaving an institutionalised environment. The Supporting People programme provides housing related support services to over 1.2 million vulnerable people. The programme is delivered locally by 150 Administering Authorities, over 6,000 providers of housing related support, and an estimated 37,000 individual contracts*”.²⁸¹

Supporting People Client Groups

Supporting People is a wide and varied programme that reaches out to a range of vulnerable members of society. Client groups include:

281. <http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

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- people with mental health issues;
- people who have been homeless or rough sleepers;
- ex-offenders and people at risk of offending and imprisonment;
- people with a physical or sensory disability;
- people at risk of domestic violence;
- people with alcohol and drug problems;
- teenage parents;
- elderly people;
- young people at risk;
- people with HIV and AIDS;
- people with learning difficulties;
- travellers;
- homeless families with support needs.

The Office of the Deputy Prime Minister has the main responsibility for the *Supporting People* programme. It allocates a *Supporting People* grant to Administering Authorities and monitors their performance. Administering Authorities (unitary authorities and counties in two tier areas) are responsible for implementing the programme within their local area. The Administering Authorities contract with providers and partner organisations for the provision of *Supporting People* services. A Commissioning Body (a partnership of local housing, social care, health and probation statutory services) sits above an Administering Authority and plays a key role in advising and approving a *Supporting People* strategy.²⁸²

“In October 2003, the Government commissioned RSM Robson Rhodes LLP to undertake an Independent Review of Supporting People as a result of the significant and late growth in costs by £400 million between December 2002 and April 2003. The Independent Review was asked to consider the value for money and the variation in unit costs and services across local authorities. The Independent Review concluded that: ‘£1.8 billion is too much to pay for the legacy provision... It is important that the cost of the legacy provision is brought in line with the proper market rate for good quality strategically relevant housing services. It is also important that efficiency savings are optimised and secured as early as possible to release funds for new provision’. A programme of work has been developed to take forward many of

282.<http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

*the recommendations. This focuses on improving how Administering Authorities, service providers and commissioning bodies manage and deliver value for money”.*²⁸³

12.1.10.2. Findings

Ms A was placed in Local Authority funded supported housing from around 2001, when she first moved into Irving Road. The Independent Investigation Team understands that this was initially funded directly from the community care budget as the Irving Road accommodation was registered as a care home. At some point it deregistered as a care home and, as a result, the care and support services it was able to offer to its residents changed significantly. At this point residents received Housing Benefit to pay for their accommodation, and were eligible for housing and related support only from the staff of the Housing Association under the Supporting People programme.

When Ms A was first admitted to Irving Road they were able to monitor and manage her medication. However following the changes in funding this was no longer the case. This led to her clinical team looking for a different placement and after her third admission Ms A was a very brief discharge to Devonshire Lodge.

In 2008 following Ms A’s prolonged period in Nightingale House recovery service, the service revisited her being discharged to Leven House. Ms A had previously rejected this option based on her perception of the other service users. On this occasion she was more accepting and initially a self-contained flat in the annexe was considered. In the end, however, she was accommodated in a single room in the main building, as it was felt she might be vulnerable to sexual harassment or exploitation in the annexe from at least one other service user, as the annexe was less well supervised. The view was that the Leven House accommodation would only be available for a maximum of two years as it was part of a Supporting People scheme, which was focused on moving people on to fully independent accommodation. Ms A currently asserts as a result of her knowing this time horizon, she felt some pressure to move on again and find somewhere new to live before too long. Within a few months of moving to Leven House, she was asking about independent flats, and started looking for herself but found most private landlords were not willing to take tenants on housing support. Ms A’s Care

283. <http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

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Coordinator wrote to the housing panel on her behalf asking them to review her eligibility for support with finding ‘a lifelong tenancy’.

Ms A was moved to an independent flat in Queensland Road after 18 months at Leven House. This was a short-term two year assured short-hold tenancy with housing support funded through Supporting People. Ms A was pleased to be in her own flat but told the Independent Investigation that knowing it was only for two years she could never feel properly settled. She also stated that she felt lonely in her own flat. The Independent Investigation noted that Ms A had a history of becoming unwell in the face of uncertainty about her future accommodation. The Independent Investigation concluded that a more assertive conversation about staying at Leven House until a more long-term accommodation solution could be found, may have been beneficial, particularly given that the CTO required Ms A to live at Leven House as one of its conditions.

The Independent Investigation noted that Ms A’s placement and support in Queensland Road was funded *via* housing benefit and Supporting People and that the expectation was that she would move to more independent accommodation within two years. However because she was discharged with Section 117 discharge rights, she may have not been eligible for this under the Bournemouth Borough Council eligibility criteria, which states:

*“Under the Mental Health Act 1983 Section 117(2) there is a joint duty to be exercised by health and local authorities to provide ‘aftercare’ services to various categories of people who have previously been detained in hospital under a Section. Supporting People will no longer fund people in ‘aftercare’ under Section 117 and from 1 April 2009 support will become the responsibility of health and community care services for service users that are new to Supporting People funded schemes”.*²⁸⁴

Being accepted and placed in a scheme which was set up to provide accommodation for people with Supporting People funding for two years may have prevented the community and health care services taking more time to try and find a lifelong tenancy.

284 Bournemouth Supporting People Eligibility Criteria effective date 28/05/2009

12.1.10.3. Conclusions

The Independent Investigation Team saw evidence that the Trust and Local Authority tried hard to meet Ms A's needs, preferences and safeguarding issues when trying to identify suitable accommodation for Ms A. The level of care taken in this area, and the careful steps taken to move Ms A through to increasing levels of independence was good practice.

However when Ms A was discharged to Leven House, the team could have taken more time to explore the alternatives to discharging her to a flat with a two-year tenancy and housing support provided *via* Supporting People funding. This may have been assisted by a multiagency review to ensure that a longer-term tenancy and viable support programme could be put in place prior to her next move.

Ms A's own statements to this Investigation made it clear that the pressure to move on from her flat within a two-year period was causing her concern. It cannot be known how this concern impacted upon her mental health. Finding long-term tenancies for people who are eligible for Section 117 aftercare is a service issue the Trust and Local Authority partners should seek to remedy.

- *Service Issue Two. The lack of availability of long-term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.*

12.1.11. Documentation and Professional Communication

12.1.11.1. 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”.*²⁸⁵

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 litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*²⁸⁶

Professional Communication

*“Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion”.*²⁸⁷

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 agency alone²⁸⁸. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.²⁸⁹ 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.

285 <http://www.medicalprotection.org/uk/factsheets/records>

286 Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286

287 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p 121

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

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

12.1.11.2. Findings

Interagency Communication

A key finding of this Investigation is the lack of a consistent level of professional communication. How the Trust and its partners communicated is discussed within the Care Programme Approach, the Risk Management and the Transfer, Admissions and Discharges subsections of this report.

This Investigation found that there were no agreements or protocols for communication between the Trust and some of the third sector agencies that it worked with. The Independent Investigation Team was told by the staff at Crumbs (a sheltered employment facility) who had worked with Ms A that they did not have either risk or care plan information shared with them. This was echoed by staff from Knightstone Housing Association.

Professional Communication

This Investigation found that the quality of professional communication was inconsistent. The medical records were maintained in good order. There was a reasonably clear and legible chronological record of the treatment and care Ms A had received although there were occasions where this was not the case and as was discussed in the chapter in risk, some documents were not properly completed or signed.

Following outpatient appointments, letters were sent to Ms A's GP and copies placed within the clinical record and the summary plan from the meeting was sent to Ms A.

At the time Ms A received her care and treatment from the Trust most of her records were paper-based, as her care was delivered by multiple professionals and agencies. This meant a number of services kept their own notes of her care and treatment with the result that not all staff involved in Ms A's care had access to the most up to date information about her.

In one instance it became clear one of the psychologists who had worked with Ms A had kept an independent set of notes which, despite the homicide and the joint agency investigation, were not disclosed until after the start of the Independent Investigation. The Trust should reassure itself that it does not have other sets of clinical records unaccounted for.

While there were periodic reports which summarised Ms A's care and treatment history for mental health review tribunals, the Trust did not have a process of keeping an up to date summary of her care plans, treatment and risk assessments, in an easy to access place. The Trust did have a computerised patient information system and this captured core biographical information, CPA care plans, risk information and relapse signature information. However, professionals in the Trust told the Independent Investigation that this system was not well used. When these electronically stored records were examined by this Investigation it was apparent that they were printed out periodically but few if any amendments were ever made.

This Investigation heard from multiple Trust witnesses how significant the introduction of RiO, a full electronic patient record system, had been in improving professional communication in terms of maintaining an effective clinical record which all involved could access. However it was also acknowledged that in August 2010, the system had only been introduced and there was a period of transition, during which there was some disruption to the availability of information.

12.1.11.3. Conclusions

The most significant issue identified within this report regarding multiagency and professional communication was the absence of a recognisable Care Programme Approach process. This severely impacted effective multiagency communication.

This Investigation found that information sharing protocols were not in place between all third sector organisations involved in Ms A's care. As a result some third sector organisations were unclear as to what information they could reasonably expect to be shared with them.

The Independent Investigation Team noted that there was an absence of a regularly updated case summary, or reliable record of key information, which people used to orientate themselves to the case in an urgent or crisis situation. It was concluded that the absence of this information was not helpful to the duty team who tried to make decisions about how to manage Ms A's case when they were contacted by the Housing Support Worker on 23 August 2010.

- *Service Issue Three. There were no information sharing protocols in place between all third sector organisations involved and the Trust. This prevented 'joined up' working both in ongoing care and crisis, situations.*

12.1.12. Compliance with National and Local Policy

12.1.12.1. Context

Evidence-based practice has been defined as “*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients*”. National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 13.1.13. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures in full where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.12.2. Findings

Governance and Dissemination of Policies

This Investigation found that the Trust had a full set of clinical policies and a system of governance which ensured consultation, version control and periodic review. A number of policies, for example the Care Programme Approach and Risk Management policies, were very lengthy documents, in excess of 100 pages each. They provided a lot of information about best practice and detailed guidance replicated from national policy and guidance documents. Neither of these policy documents had a clear summary or quick guide at the front which told practitioners what they were required to do. It is a frequent finding and complaint that policies are too long to be digestible or useful in clinical practice. Staff often request quick guides to the policies' key expectations and requirements.

The Investigation found that the Trust did offer training in key policy areas including Care Programme Approach, Risk Management, Mental Health Act, and Vulnerable Adults Safeguarding. However the Investigation also noted from information collated for the joint agency investigation that at the time of the incident many staff involved in the care and treatment of Ms A had not attended training, or their training was out of date in a number of these key areas. The investigation was told that the CMHT team was busy and that a number of staff were part-time, which meant it was not always easy to release staff for training.

Policy Non-Compliance Themes

Involvement of Ms A's family

The National Service Framework, the Care Programme Approach and NICE guidance all recommend that wherever possible the service user's family and carers are involved in planning and evaluating their care and treatment. NICE guidance also states the interventions family members might be offered to help them understand their relative's illness and support them more effectively.

Family Involvement

Throughout Ms A's care and treatment with the Trust involvement of Ms A's family was suboptimal. They were rarely involved or consulted about Ms A's care, and staff typically only engaged with them in a reactive way when specific incidents or events occurred. Ms A's

parents were not necessarily easy to engage; staff described Ms B as challenging,²⁹⁰ and Ms A's father told this Investigation he did not necessarily feel he needed any help from the services.²⁹¹ The fact that they lived outside of the Trust's catchment areas may have presented another barrier to engagement.

The Care Coordinators did not appear to see it as their role to liaise with the family members proactively, and in this way were not acting in compliance with policy expectations.

Family Interventions

The Trust at this time did not appear to have a service which provided evidence-based family interventions, to families when service users were in the general adult or rehabilitation services.

Multidisciplinary and Agency Involvement in CPA and Risk

National Care Programme Approach policy and clinical risk management guidance requires that service users' care plans recognise the services and support being provided by different professionals and agencies. It requires that these professionals and agencies work together to develop and review the care plan, risk assessment and risk management plan. In addition the services involved should have access to copies of the documents to guide their involvement and their local care planning.

This Investigation found that these practices were not evident in the Southbourne Community Mental Health Team. The team had established a system in which the Care Coordinator reviewed the care plan and risk assessment on his/her own and a medical Outpatient appointment could be booked as a CPA review meeting. However even these arrangements were not reliable; in Ms A's case from 2008 onwards there was no evidence that any of the three-monthly medical outpatient appointments were considered to be a CPA review meeting.

The care plan on the Torex patient administration systems was reviewed by the Care Coordinator on a three-monthly basis but there was no evidence that input from the other agencies involved in Ms A's care was sought by the Care Coordinators who were involved at this time.

290 Clinical witness transcripts

291 Notes from interview with Ms A's Father

Risk assessments were completed or revised following risk events rather than at each CPA review and were also uni-disciplinary. Different documentation on clinical risk was completed by the Care Coordinator, the Associate Specialist and the different agencies involved. These working practices appeared to be developed over time as a way of being able to tick the Trust's CPA audit boxes, but did not require the team to fully adopt the Care Programme Approach and move away from their Outpatient led model of practice.

24 Hour Seven Days a Week Access to Services

The National Service Framework for Adult Mental Health Services requires that services are available 24 hours a day seven days a week for people with serious mental health problems. The Trust had a 24-hour crisis and home treatment service available and therefore was compliant with this standard in relation to service structure. The Trust management team told this Investigation that the operational policy of this service was to provide assessments and home treatment to people experiencing an acute mental health crisis.

It was clearly documented in Ms A's care plan for many years and it was documented in the letter to her GP following her outpatient review in July 2010 that she should use the crisis and home treatment team if she became unwell out of hours. However it is a fact that when Ms A was found to be unwell by her Housing Support Worker in August 2010, that she was denied access to the crisis service and in effect denied access to 24 hour seven days a week mental health services. This Investigation was told that not referring patients to the crisis team unless the CMHT had seen them first had become usual practice in the organisation to prevent the CMHT leaving all their urgent or emergency assessments to the end of the day and then passing them on to the crisis team. This Investigation was told by senior managers in the Trust that this was not an agreed part of the operational policy for the Crisis and Home Treatment Team.

12.1.12.3. Conclusion

This Investigation concluded that a number of key and interrelated policies and guidance documents were not well complied with because of the way in which CPA and the Care Coordinator role operated in the Southbourne Community Mental Health Team. It appeared that CPA had been compromised so that it did not disrupt the established Outpatient-based model of practice. It was also clear that the role of the Care Coordinator had not been fully

developed in line with the 2008 guidance in relation to Carer and Family Involvement and coordination of multiagency input into care planning and risk assessment.

Local policy lacked clear and concise direction on the minimum expectations of care coordination, care planning and risk management. It was also noted that care coordinators were not regularly updated on the core skills they required to fulfil the requirements of the Trust's policies.

It was concluded that other elements of limited policy compliance resulted from services not being available, as in the case of family intervention services or because of the unintended consequences of an operational decision which had not been through the scrutiny of the Trust's governance system. This was the case for the decision that the Crisis and Home Treatment Team was not available to service users who had not yet been assessed by their CMHT.

Developing easily read and followed policies, and ensuring compliance with these policies in practice is critical to ensuring a safe, high quality service. As a point for internal assurance the Trust should satisfy itself that it has robust controls in place for ensuring that policy is complied with to the fullest extent, and that unauthorised local changes to practice, which are not in keeping with agreed policy, are not allowed to proceed unchecked.

- *Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.*

12.1.13. Overall Management of Treatment and Care

This subsection draws together the most important strands and issues identified in the previous chapters. It provides an overview of what the investigation thought were the critical strengths and weaknesses in the care and treatment that was provided. In particular it looks at the factors that might have contributed to, or were at the root cause of the events that led Ms A not receiving timely care and treatment when she started to relapse.

12.1.13.1. Findings

Ms A had a serious and enduring mental illness which had a 15 year history of frequent relapse and remission. Ms A was understood by the mental health services looking after her to be at particular risk of relapse if she failed to take her antipsychotic medication, and at times of significant stress. At the time of the relapse in August 2010, she had a number of known risks which could become manifest when she was unwell. These included suicidal thoughts, behaviours which made her highly vulnerable such as swimming naked in the sea, and violent thoughts and acts towards others.

As a result of her illness and risk behaviours Ms A had been through a three-year period of more or less continuous inpatient treatment. In August 2010 she was in her second year of receiving services in the community and had graduated from a staffed hostel to living in an independent flat. At this time Ms A was receiving a number of services, which appeared to be providing a comprehensive package of community care. Although the purpose of the services provided were never articulated in this way, it can be inferred that they were threefold:

- to continue to develop her skills and capabilities to live her life successfully in the community;
- prevent another relapse of her illness;
- respond rapidly if she started to relapse to prevent her putting herself or others at risk.

Protective Measures

Developing her skills and capabilities

Ms A was supported to continue to develop her skills and live independently in the community by being given help with her housing and employment. Her housing support was provided by Knightstone Housing Association. They provided support with practical day to day issues such as paying bills and looking after her accommodation.

She was also supported with her employment and education interests *via* Crumbs which was a supported employment scheme. This included regular sessions with an Occupational Therapist. This area of her care and treatment appeared to work well for her. She had good relationships with the staff and made close friendships. However the care she received from these providers and the staff involved in delivering it did not appear to be integral to the coordination, management and review of her care through the Care Programme Approach.

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These providers were not involved by her Care Coordinator in developing or reviewing her care plans as part of a multidisciplinary/multiagency approach

It is also important to acknowledge that the individuals providing these services were an important resource for detecting early signs of relapse. It was of concern that information about Ms A's relapse signature was not shared with these individuals. When Ms A's housing and employment services independently called in with concerns about her mental health between 23 and 25 August 2010 the CMHT duty team were not able to join these together or give these concerns sufficient weight to instigate an emergency assessment of her mental health.

Risk Management and Relapse Prevention

Whilst Ms A was known to present a number of risks to herself and others, it was understood and documented in several places that these were only present when she was unwell. This is often the case with serious psychiatric illnesses such as Schizophrenia. Therefore the general approach and organisation of psychiatric services is geared towards preventing relapse. Ms A had a set of care and treatment arrangements in place which were meant to help reduce the likelihood of a relapse occurring. These included:

- antipsychotic depot medication;
- a Community Treatment Order;
- Care Programme Approach and Care Coordination;
- Outpatient appointments and CPN visits;
- supported accommodation.

These were broad preventative measures which assisted Ms A to stay well. However in August 2010 these measures, when tested, did not offer the protection they were intended to.

Depot Medication

Although Ms A continued to accept her depot medication, she often experienced break-through symptoms when experiencing high levels of stress. On 23 August 2010 when Ms A was reported to appear unwell, the duty team appeared to interpret the fact that she had had her depot medication seven days previously as reassurance of her continued compliance with

medication. They did not consider that Ms A had a history of previously relapsing on a full therapeutic dose of antipsychotic medication.

Community Treatment Order

The Community Treatment Order had two parts to play. The first of these parts was to provide a framework through which Ms A could be compelled to continue with treatment, and the CTO was found to be effective in ensuring Ms A continued to take her medication. The second part (which will be discussed below in more detail) was as a risk flag and vehicle to ensure rapid admission to hospital could be effected when required.

Care Coordination and Care Programme Approach

Care Coordination is the critical component in the successful delivery of the Care Programme Approach. Those in the role of Care Coordinator were in place to support Ms A and monitor her mental health. They also had the responsibility to ensure everyone involved in Ms A's care was up to date with developments in her care plan. In addition they provided a point of contact for anyone involved in providing care if they were concerned about Ms A. Ms A had a Care Coordinator who worked part-time with the Trust and who had had periods on maternity leave. Ms A's Care Coordinator's absences had been covered by one of her colleagues.

This Investigation found significant gaps in the quality of the process of care coordination and in the products the Care Coordinators should have developed. They did not provide the required level of proactive coordination between informal carers, non-statutory agencies and health service staff. Nor did they ensure there were operationally viable risk, crisis and contingency management plans in place, which everyone involved had access to, so they could assist Ms A effectively when relapsing or in a crisis.

On the two days before, and on the day Ms A stabbed her mother, a number of people, including her mother, tried to get help for Ms A; however they were unclear who they should telephone for assistance. Over the three days that Ms A's mental health was breaking down her regular Care Coordinator was on annual leave.

Care Coordinator 5 who knew Ms A was available and was spoken to on the 23 August and asked for advice. She reported that Ms A had been well and accepted her medication when she saw her last on the 16 August 2010. Although the Care Coordinator knew Ms A's history and

risks she did not indicate to the duty team, that they should be concerned or put in place an emergency assessment. This was a significant missed opportunity to share critical longer-term risk information with practitioners who were less familiar with Ms A.

Outpatient Appointments and Community Psychiatric Nurse (CPN) Visits

Appointments with the Psychiatrist and visits from the CPN, who was also Ms A's Care Coordinator, were opportunities for prescribing, giving Ms A her medical treatment, and monitoring the effectiveness of that treatment. She was seen regularly by her CPN and on a three-monthly basis in Outpatients by the Associate Specialist. However these two professionals rarely saw her together or with other members of the treating team. This Investigation was told that they would update each other in the weekly team meeting about any concerns, or that they would discuss things as required in the team base. However there was only evidence of discussion between the CPNs (Care Coordinators) and the Associate Specialist about Ms A as a reaction to specific requests or incidents. They did not proactively meet to jointly review her care, how she was responding to treatment and to consider on-going treatment and care, as a result of their shared observations. In short the Care Programme Approach was not being activated.

Supported Accommodation

In 2010 Ms A was living in a flat that was provided on an assured two-year tenancy, and she was provided with a Housing Support Worker who saw her on a regular basis. This was to help with a range of issues to do with maintaining her tenancy such as keeping the flat tidy, paying bills and so forth. The housing support staff also acted as another point of contact to determine whether her mental health was deteriorating or not.

Ms A had settled into her flat well after an initially difficult transition in which she had a period of time displaying some signs of relapsing mental health. However she continued to report feeling lonely living on her own, and she did not feel that she was able to fully settle in the property because she knew she would have find somewhere else to live within two years. This was not recognised as a potential risk to Ms A's mental health and wellbeing.

The Housing Support Worker noticed Ms A's mental health was breaking down on 23 August 2010 and tried to get mental health services to help her immediately. Unfortunately the services were slow to respond. The supported housing team did not appear to have adequate

relationships with the service or knowledge of routes of escalation to effectively deal with this issue when they became concerned about Ms A's mental health and safety and the mental health team were not responding quickly enough.

Rapid Response to Relapse

In addition to the general measures for preventing relapse there were specific measures in place for detecting and responding to Ms A when she was actually experiencing a relapse. These measures were:

- the recognition of relapse signature and production of a relapse management plan;
- the use of a Community Treatment Order;
- access to the Crisis and Home Treatment Team.

Unfortunately these measures were not broken down into a useful and easily understood range of actions that would be required to take place in the event of either a relapse or a crisis.

Relapse Signature and Relapse Management Plans

Ms A's relapse signature had been documented in her medical records since 2004, and had not materially changed in six years. The key information was reiterated in a 'Gold' risk assessment that was completed by Care Coordinator 5 earlier in 2010 when Ms A had thoughts of stabbing her boyfriend.

A crisis/relapse management plan that was documented in all of Ms A's CPA documents from 2004 forward, recorded the need to:

- increase community support;
- arrange home visit or Outpatient appointment;
- refer to the Crisis and Home Treatment Team if required (this element of the plan was changed in 2008 and instead of specifying the Home Treatment Team, it stated an out of hours telephone number that should be called).

This plan had never been developed in more detail over time even though her Care Coordinators and other staff involved had a far greater understanding of the speed at which Ms A could relapse and the risk she could present to herself and others when unwell. This Investigation noted that this plan was overly concise and gave no advice on the urgency with which these interventions should be made, or in response to what type of behaviours.

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This Investigation found Ms A's relapse signature information and plans regarding what to do if she appeared to be relapsing were not shared with colleagues in housing, her mother or colleagues in the Crumbs supported employment placement.

Irrespective of this on 23 August 2010 the Housing Support Worker recognised Ms A was not well and called the CMHT Duty Team. The Duty Team Worker who took the call from the Housing Support Worker and the CMHT Team Leader with whom she discussed the call did not recognise that Ms A might be relapsing and therefore become a significant risk to herself or others. The table below compares information from the relapse signature that was on record (and available to the duty team) with the information the duty team were given by housing on 23 August 2010.

Table Two

Relapse Signature	Information From Housing Support Worker
Difficulty sleeping/sleeping too much	Not sleeping for last two days
Agitation and restlessness	Was pacing up and down and cleaning flat
Cessation of medication	
Increased isolation and withdrawal	Not attended her supported employment placement and her appointment with her Occupational Therapist (additional information left as answerphone message)
Feeling " <i>I can't trust people</i> " and avoid talking to staff	Would not talk or respond to Housing Support Worker

The Independent Investigation Team noted that the duty team should have recognised that Ms A was relapsing and should have considered implementing the relapse plan such as it was. In the event the duty team and the CMHT Team Leader discussed the case among themselves, and delayed taking a decision to send someone out to assess or arrange additional support for Ms A.

Use of Crisis Team Out of Hours

It was documented in Ms A's relapse management plan for many years, and in her CPA documentation and on her most recent outpatient review letter (ibid) that if she was experiencing signs of relapse outside CMHT hours the Crisis and Home Treatment Team should be involved in providing her care. In addition to this it is a requirement of the National Service Framework to provide access to 24 hour seven days a week services for people in receipt of secondary care for serious mental health problems. This Investigation found it of significant concern that when the Housing Support Worker contacted the CMHT duty team to inform them about Ms A appearing to be unwell, they advised that they would not be able to assess her because of the time of the day. When the Housing Support Worker asked if the Crisis Team could see Ms A the Duty Team Worker stated that they would not assess a service user if the CMHT had not been to see them first. This Investigation was told in interviews with clinical witnesses that this was common practice in the Trust at that time. This was to prevent CMHT's leaving assessments until 17.00 hours and then handing them over to the Crisis Team. The Independent Investigation Team noted that this was not in keeping with national guidance and requirements for a service user known to the service and receiving services under the Care Programme Approach, let alone on a Community Treatment Order. The Independent Investigation Team was told by Trust Management that this was not in keeping with Trust policy and there should not have been any barrier to Ms A being seen by the Crisis Team.

Community Treatment Order

The use of the Community Treatment Order as mentioned earlier has two functions; one is to provide a legal framework to compel a patient to continue receiving treatment. The other is to act as a risk flag, and a mechanism to intervene quickly if someone's mental health is breaking down.

The Duty Team Worker who took the initial call on 23 August 2010 from the Housing Support Worker knew Ms A was on a CTO, she made a particular point of recording this in the notes. During interviews the Independent Investigation Team found that everyone understood that this meant Ms A should be of particular concern if she were to relapse, and that she should have been assessed rapidly. Care Coordinator 5, who was consulted by the duty team, was involved earlier in the year following concerns about Ms A thinking about stabbing her

boyfriend, and had documented in her notes that she was on a low threshold for recall to hospital.

However despite the information above, this Investigation found that no one involved in managing the situation between 23 and 25 August 2010 considered that because she was on a Community Treatment Order they had an enhanced duty of care, for which they should have contacted and informed her Responsible Clinician and arranged an emergency face-to-face assessment without further consideration. That neither of these actions happened was a serious omission. The Responsible Clinician told this Investigation that if he had been informed he would have assessed Ms A that same day and that he kept a spare appointment each day for the purpose of emergency assessments, although the Community Team Leader stated that this was not common knowledge to the team. It also has to be noted that he had not made a clear plan as her Responsible Clinician of what he expected to happen in the event of a relapse.

12.1.13. 2. Conclusions

Ms A was in receipt of a comprehensive programme of care and support which was assisting her to move forward in terms of independent living and a fulfilled and meaningful life. However underpinning this should have been a robust safety net of care and treatment coordinated by using the Care Programme Approach. The Independent Investigation Team found this safety net was compromised which led to some significant gaps in that care, crisis and contingency plans were updated rarely and communicated poorly. This was compounded by the absence of an effective multi-agency/disciplinary approach to planning and reviewing care. Ms A's care and treatment was delivered by mental health professionals and agencies working predominantly in isolation. This lack of care coordination, sharing of information and joint working, played a contributory role in the service's failure to respond to Ms A in a timely way between 23 and 25 August 2010. This was because people, both outside and within the team, did not have a shared plan or knowledge of what to do if Ms A's mental health started to deteriorate.

Whilst the underpinning safety net of care was weakened by the absence of an effective Care Programme Approach, the failure of the protective barriers put in place to respond quickly and effectively to relapse, were most pertinent to Ms A not getting timely care when she relapsed. This Investigation saw that in principle a set of mechanisms were in place to intervene in the event of relapse. However when a relapse occurred in August 2010 none of these mechanisms

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worked as they were poorly constructed and poorly communicated. The duty team did not recognise that Ms A was relapsing from the information available to them. The Community Treatment Order did not flag the need to involve the Responsible Clinician and initiate an emergency assessment. The duty team did not make use of the Crisis and Home Treatment Team.

This Investigation has tried to make sense of why the plans in place failed to protect Ms A and her mother. It was a fact, as the joint agency investigation found, that there was not a well-documented plan of how to respond to the Community Treatment Order. It was also a fact that the duty team arrangements at the time meant that different people were assigned to duty on different days, which presented a risk of information being lost in the handover process. Whilst the findings of the joint agency investigation were pertinent and well made, it was evident to the Independent Investigation Team that the presence of the CTO alone should have triggered the need to discuss the case with the Responsible Clinician, and this did not happen. It was also evident that the CMHT Team Leader was informed of Ms A's relapse on 23 August 2010 and continued to manage the situation by taking decisions about the case on 24 of August 2010. Therefore it did not make any difference in this case that there were different duty workers on different days.

The CMHT Team Leader sought advice from the Ms A's previous Care Coordinator, (Care Coordinator 5) who had recently seen Ms A to administer a depot injection. Following this he took the decision whether or not to send someone out to either assess Ms A or to involve the Crisis and Home Treatment Team. In all respects he had assumed responsibility for this case. When asked about why the Responsible Clinician had not been informed he said it was just not in his mind to do so. However it is also acknowledged there was no clear guidance in Ms A's relapse plans to do this. When asked why he had not sent someone to assess Ms A as an urgent assessment, he said he was not able to establish that she was at risk, and that his team were very busy with other assessments and crises at that time. It is unfortunate that when he consulted with Care Coordinator 5 who knew Ms A well, that she did not emphasise the latent risks Ms A could display when she relapsed, or emphasise to him that Ms A had a low threshold for recall.

When asked at interview about the decision not to use the Crisis Team the CMHT Team Leader said they would not have seen Ms A without his team making an assessment first. It

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was not helpful that this 'custom and practice' view of when and how the Crisis and Home Treatment Team could be used had become a constraint to providing appropriate access to 24-hour services.

However despite these constraints it was the CMHT Team Leader's decision, based on the information that he had available to him, that Ms A could wait until 25 August 2010 for an assessment. This was when her Care Coordinator would be available to see her. He did not recognise from the information available to him that Ms A was experiencing a serious relapse in her illness and therefore required a more urgent assessment.

The Independent Investigation Team had the difficult task of assessing whether this decision in light of what he did know or what he should have known, had a causal relationship to the events on 25 August 2010. Causality is not just based on whether the event could have been reasonably predicted but also whether it could have been reasonably prevented. This Investigation found that this decision had a direct causal relationship to the failure to intervene in Ms A's deteriorating mental health and the consequent killing of her mother on 25 August. The case for causality is set out below.

Knowledge. The CMHT Team Leader knew Ms A was on a CTO and understood that this meant she had particular risks if she relapsed. While it was not predictable that she would kill her mother or anyone else, it was known she could be a risk to herself and others when she relapsed. There was information both available and documented about her relapse signature. The information given to the CMHT Duty Worker was a close enough match to Ms A's relapse signature to have identified that her mental health was deteriorating. As a senior and experienced mental health practitioner, responsible for the management of a Community Mental Health Team and the supervision of other practitioners the CMHT Team Leader should have known that his first duty with a relapsing CTO client was to consult with the patient's Responsible Clinician.

Opportunity. 36 hours elapsed between the CMHT duty team being informed of Ms A's deteriorating mental health and the death of Ms B. The Trust's own policy on emergency assessments is to see a patient within four hours of referral. Even if the team had been busy at the time of referral, there was ample opportunity within the 36 hours to have instructed an assessment and intervention.

Means. The Community Treatment Order provided the means to intervene rapidly and have Ms A recalled to hospital. There should have been access to the Crisis and Home Treatment Team if required. These means were available to effect rapid assessment and support for Ms A but they were not utilised.

The Independent Investigation Team concluded that the failure to manage Ms A's relapse between 23 and 25 of August 2010 was due to a combination of factors. First: there was a poor adherence to a Care Programme Approach ethos which would have ensured that a coherent Crisis and Contingency plan was in place that had been communicated widely to all members of the CMHT, Housing Association, and Ms A's mother. In the absence of such a plan, which had Multidisciplinary/Multiagency agreement and sign up, any crisis or relapse that Ms A experienced could not be guaranteed to be managed in an effective and timely manner. Crisis and Contingency planning was weak, and the first time it was tested in a true emergency situation it failed. Second: the CMHT was under a significant amount of pressure compounded by problematic Duty systems and access to Crisis Teams. Third: there was a lack of assertive management of Ms A by CMHT practitioners between 23 and 25 August 2010 which was contrary to what was known, and what should have been known, about her risk profile and relapse signature at the time.

Consequently the Independent Investigation Team concluded that whilst the killing of Ms B could not have been predicted a serious untoward incident of some kind was foreseeable based upon Ms A's previous behaviour when experiencing a psychotic episode. It was the conclusion of this Investigation that the killing of Ms B was preventable and that had a rapid response (as indicated to be required in her clinical record) for Ms A been forthcoming then this tragic incident would probably not have occurred.

- ***Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.***

- *Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours or sooner.*
- *Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.*
- *Causal Factor One. Not providing an assessment and suitable intervention within 24 hours or sooner ensured Ms A's mental health continued to deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.*

12.1.14. Clinical Governance and Performance

12.1.14.1. Context

*“Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish”.*²⁹²

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

²⁹² Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

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Clinical Governance in the NHS has been integrated since 2008 into a framework of Quality Governance. Quality governance is defined as the structures, processes, systems and methods by which Trusts ensure:

- Patient Safety;
- Patient Experience;
- Clinical Effectiveness.

NHS Trusts annually have to produce an annual set of quality accounts which report alongside their statutory board report what the Trust is doing to ensure they are improving in these three areas. There are a number of statutory reporting requirements, and this includes any inspections and outcomes from Care Quality Commission assessments of the essential minimum standards.

The Care Quality Commission is charged with providing an inspection regime which inspects all health and social care providers against the national minimum standards of care. These reflect quality regulations for health and social care providers laid out in the Health and Social Care Act 2007.

12.1.14.2. Findings

The Trust provided the Independent Investigation Team with the following overview of how its clinical/quality governance systems have evolved over the recent years.

In 2010/11 the Trust was registered with the Care Quality Commission with no restrictive conditions. The Trust was recognised by the National Patient Safety Agency as a Trust with high reporting of incidents with the majority being classed as low risk reflecting an open culture to patient safety. The Trust also had an open reporting culture with Commissioners.

A Director with responsibility for quality has been in place from 2010, working with the Medical Director, Lead for Patient Safety and Safeguarding, Clinical Governance Facilitators and Customer Services Coordinator to monitor and report on key aspects of clinical governance.

The Clinical Governance and Quality Committee is Chaired by a Non-Executive Director and meets monthly. Included within the Committee's remit was reviewing incidents, Root Cause

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Analysis of Serious Adverse Incidents, compliments/complaints, implementation of NICE guidance, audit programme and individual clinical governance reports from directorates.

The Trust Board received monthly Quality Reports detailing information related to clinical governance under the headings of Quality of Service, Patient Safety and Patient Experience.

All incidents were reported on a monthly basis from ward/team to the Directorate and the Executive Management Team (EMT). There was an established Serious Untoward Incident Panel with senior manager membership to review serious incidents and to make appropriate Trust-wide recommendations.

The Trust was successfully reassessed in August 2010 against the Level 1 NHS Litigation Authority Risk Management Standards for Mental Health and Learning Disability Trusts. A Level 1 assessment confirms that the Trust has robust policies and procedures in place to reduce risks and deliver quality care to service users, whilst also protecting staff and visitors.

An annual Clinical Audit Programme was in place and the Trust participated in national clinical audits. The Trust produces an annual Quality Account/Report consulting with partners and stakeholders in agreeing priority areas for improvement for the subsequent year.

A robust process for implementation of guidance from the National Institute of Health and Clinical Excellence (NICE) was in place whereby all NICE publications are reviewed monthly to determine applicability to the Trust. Where publications are applicable a Clinical and Managerial lead is identified to undertake a baseline assessment against the guidance and to develop an action plan where required. Progress on the action plan is then monitored via the EMT until signed off as complete.

In addition to the above the Trust's clinical governance processes have been enhanced over the last two years to include:

- The Non-Executive and Board Directors carrying out a comprehensive programme of visits to Trust wards/teams to monitor the quality of services feeding back any areas for improvement which are reported to the Board Quality, Clinical Governance and Risk committee.

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- A Quality Strategy outlines the Trust's vision and programmes for quality improvement and how these will be measured.
- There is a Quality, Clinical Governance and Risk committee of the Trust Board where information is scrutinised in detail to gain further assurance.
- The Trust has set up a physical health panel alongside the mental health panel chaired by a Non-Executive Director to review serious incidents relating to physical health services in order to meet the needs of the enlarged organisation and ensure a culture of continuous learning.
- The roll out of one unified incident reporting system across the enlarged organisation enabling the analysis and scrutiny of incidents, trends and learning
- An annual Clinical Audit Programme is in place for the enlarged Trust and the Trust continues to participate in a number of national clinical audits each year, allowing benchmarking with other organisations.
- The Trust continues to be registered with the Care Quality Commission with no restrictive conditions and has been subject to periodic inspections to ensure that essential standards of quality and safety are being met. Action plans are produced following these visits to ensure any findings are acted upon and lessons learnt have been circulated to staff.
- The Trust has introduced patient outcome measures to help understand the impact of its services on people's outcomes.
- The Trust has implemented real-time patient feedback devices to survey patients and be able to gather and respond quickly to the experience of patients.
- The Trust achieved 95% of Trust staff having received their Information Governance training by the end of May 2012.

Care Quality Commission (CQC)

The Care Quality Commission inspected Trust community mental health services in October 2011 and found them to be fully compliant, except for a minor concern about the premises for the provision of child and adolescent mental health services.²⁹³ These services have now been revisited and found to meet fully all requirements.

293 CQC (2011) CQC compliance report following unannounced visit to services registered under Trust HQ

The National Community Mental Health Survey

The National Community Mental Health Patient Survey published in August 2012 reported that the Trust's scores were about the same across all items scored by other Trusts. However some scores of relevance to this case included scores which were less than seven out of 10 in areas such as access to crisis care, understanding care plans, setting goals, care reviews and involving family and friends.²⁹⁴

Annual Quality Accounts

The Trust has published annual quality accounts on their web site and these have provided a report on the statutory quality data required by the Department of Health guidance to providers. In addition the publication highlighted information and initiatives taken to improve the quality of patient care. The Trust also reported its position on CQC outcomes using a graphical scoring system which was different from that used by the CQC web site, for example the Trust used three green ticks for fully compliant, two green ticks for minor concerns, and one green tick for moderate concerns. The CQC system only uses one green tick for compliance and grey and red crosses for different levels of concern. The Independent Investigation Team were concerned that this may cause confusion for stakeholders, service users and carers trying to compare the findings reported in the Quality Accounts and those reported on the CQC web site.²⁹⁵

Clinical Supervision

The Trust had a good clinical supervision policy, however clinical witnesses informed this Investigation that there was not always the opportunity to attend formal supervision, but meetings such as team meetings, and corridor conversations provided many informal opportunities. This represents an obvious departure from Trust policy expectation.

Training and Development

All clinical witnesses interviewed by the Independent Investigation Team confirmed they had access to mandatory training and continuous professional development opportunities. However the Independent Investigation Team was told by clinical witnesses that training in the Care Programme Approach, Care Coordination, and risk assessment and management was not regularly updated. The Independent Investigation Team saw from training records collected by

²⁹⁴ CQC (2012) National Community Mental Health Patient Survey
²⁹⁵ 2011/2012 Quality Accounts

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the Internal Investigation that training in key areas of CPA, risk management and the new Mental Health Act was not robust or wide spread or up to date within the team involved in Ms A's care. For example her Care Coordinator, her Consultant, and the CMHT Team Leader were not recorded as having attended training in:

- the clinical risk update training;
- the CPA risk management in mental health training;
- violence risk assessment training.

Neither Care Coordinators 4 nor 5 are recorded as having attended the CPA – Assessment and Care Planning Skills training.

Care Coordinator 5 and the CMHT Team Leader, the Associate Specialist and some of the duty team had attended Care Programme Approach training, although for most of these members of staff this training was more than four years old.

Clinical Audit

Clinical witnesses informed the Independent Investigation Team that they were aware of a range of clinical audits carried out by the clinical governance department. However the Independent Investigation Team was concerned that although it was told clinical audits had occurred on the Trust's Care Programme Approach practices, these had not identified that the Care Programme Approach practices in the Southbourne CMHT were not compliant with either local or national policy good practice expectations.

Learning from Incidents

Clinical witnesses described clear processes for the dissemination of learning from incidents and complaints. The Independent Investigation Team was shown an online system through which lessons from incidents were disseminated to teams. However review of the recommendations of the joint agency investigation of this incident and progress against findings more than 12 months on, found that not all findings had led to recommendations, and for those which had led to recommendations, only a few of these had been satisfactorily addressed.

Staffing and Resources

Many clinical witnesses told this Investigation that services had felt stretched at the time of the incident in 2010. The CMHT Team Leader informed the investigation that he was responsible for three geographical sectors each of which had higher than average levels of deprivation. The Team Leader had managerial and supervisory responsibility for up to 24 staff who between them had a combined caseload of around 1200 patients. Some practitioners stated to this Investigation that they felt more stretched and compromised in terms of time to do their job properly than they have ever experienced before. This may be a significant mitigation factor when trying to understand why systems and processes may not have been adhered to in an optimal manner.

12.1.14.3. Conclusion

The Trust described a robust system of clinical governance, which appeared to be compliant with national standards. However to be effective clinical governance systems need to provide what is referred to in the National Audit Office report on NHS Governance – *Taking it on Trust*²⁹⁶ as the second line of defence. This second line of defence provides systems for detecting and closing gaps in service delivery that practitioners and local service managers (the first line of defence) have missed. Evidence from this Investigation found that the clinical governance system extant at that time may not have provided an adequate or robust second line of defence. The Trust did not appear to be aware that:

- supervision arrangements for practitioners were patchy and informal;
- audits and quality assurance systems were not evaluating compliance in practice against national standards and expectations;
- findings from internal investigations were not being addressed within reasonable timescales;
- there was inadequate monitoring or follow up of whether staff had attended core areas of training, such as the Care Programme Approach and risk management.

These weaknesses in the Trust's clinical and quality governance system meant that suboptimal practice in critical areas such as the Care Programme Approach and Risk Management continued over a long period of time.

296 National Audit Office (2009) *Taking it on Trust: a review of how boards of NHS Trusts and Foundation Trusts get their assurance.*

13. Findings and Conclusions Regarding the Care and Treatment Ms A Received

13.1. Findings

13.1.1. Diagnosis

From 2000 to 2007 Ms A's primary diagnosis was Paranoid Schizophrenia. In 2007 while she was being treated in Nightingale House the Rehabilitation Consultant Psychiatrist (Consultant 5) altered her diagnosis to Schizoaffective Disorder. The change in diagnosis followed a relapse of her illness when Consultant Psychiatrist 5 observed a number of symptoms and signs that were consistent with this diagnosis.

On discharge to the Community Mental Health Team in July 2008 the working diagnosis of the Associate Specialist and the Care Coordinators working with Ms A reverted to Paranoid Schizophrenia. They stated they were not aware Ms A's diagnosis had been changed to Schizoaffective Disorder whilst in the Rehabilitation Service. However the Community Consultant Psychiatrist (her Responsible Clinician and Consultant 4) stated his differential diagnosis had always been Schizoaffective Disorder. The Independent Investigation Team found no specific issues in relation to Ms A's diagnostic formulation.

13.1.2. Medication and Treatment

The Independent Investigation Team found that the medication Ms A was prescribed was appropriate for her diagnoses and within recommended therapeutic ranges. The Investigation Team understood Ms A was always reluctant to take medication, and frequently wanted to either cease or reduce her dosage and she experienced significant extrapyramidal side effects from her antipsychotic medication. The treating teams tried hard over time to establish a medication regimen that would keep her well and also minimise the side effects she experienced. They worked collaboratively with Ms A to try and establish her optimal level of medication. However the investigation did not find evidence of intervention which explored and worked on her attitudes and understanding of the importance of adhering to her medication plans.

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Ms A had a number of episodes of psychological therapy and she appeared to find these periods of treatment helpful. Whilst with the Rehabilitation Service the psychological elements of Ms A's treatment were based on developing her insight into her illness, developing her coping mechanisms and working with her to develop a relapse management plan. When Ms A returned to live in the community she had a period of receiving weekly sessions with a Counselling Psychologist for several months. This gave her the chance to explore her feelings about her illness and its impact upon her life.

The Independent Investigation Team found that psychological treatment helped develop Ms A's insight into her illness and understanding of her relapse signature. There was no evidence of structured, formal family interventions as recommended within NICE guidelines. This Investigation concluded this was an important gap in her treatment.

- *Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicine's management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.*
- *Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.*

13.1.3. Mental Health Act (1983 and 2007)

The Independent Investigation Team found that the Mental Health Act in its broadest terms was used in an appropriate manner and at the right times in Ms A's care. This Investigation found no evidence that the formal legal and administrative requirements of the Mental Health Act were not completed to the standards required by the law or Mental Health Act Code of Practice. However we found that in a number of areas the clinical practices involved in supporting Ms A when she was subject to the Act were not as robust as they should or could have been.

Section 136

Section 136 was used in 2005 to bring Ms A into hospital after she was found swimming in the sea naked, and behaving in a bizarre way on Boscombe beach. She was subsequently admitted informally. One month later she left the ward and did not return. She was found by the Police several days' later living on Weymouth Beach. She was not thought by the Police to meet the criteria for Section 136. Eventually staff went from the ward and convinced her to come back informally. This Investigation concluded that in this situation it would have been clinically safer and more legally sound to have sent a doctor and social worker out, who could have assessed her for emergency admission under the Mental Health Act if required.

Section 117

It was found that three Section 117 meetings were held throughout the 10 years Ms A was cared for by the Trust. The first was in 2006 when being discharged, the other two both occurred in Nightingale Court in 2007 and 2008. It would appear that the first Section 117 discharge meeting met the minimum standards for an effective discharge meeting in that the Consultant and Care Coordinator were present; however the absence of the involvement of Ms A or her family was not good practice. The second and third meetings involved more people and demonstrated evidence of careful and thoughtful multiagency planning. Again the absence of direct input from Ms A or her family was not in line with either local or national policy expectation at that time.

This Investigation concluded that the service should have called a Section 117 discharge planning meeting when Ms A's discharge from Leven House was being planned in November 2009. That this did not happen was an omission on the part of the Trust and its staff, while the Investigation Team viewed this as predominantly a service issue, they took the view that it was symptomatic of the generally poor coordination and planning of care that is identified in other sections relating to this period of time in Ms A's care.

Section 17

Section 17 was used twice to facilitate discharge from hospital. The Independent Investigation Team considered that in the first instance in 2006 Section 17 leave could have been used for longer to maintain a more robust legal hold on Ms A in the early stages of her discharge from what had been a very long admission, and her first detention on Section 3 of the Mental Health Act following an episode of assaultive behaviour.

In the second instance this Investigation concluded it was appropriate to use Section 17 leave prior to conversion to Section 17a Supervised Community Treatment Order.

Section 17a

Ms A met the criteria for Supervised Community Treatment and therefore use of the Community Treatment Order was appropriate. However members of the treating team did not make the link between this and the expected need to respond accordingly in the event of signs of relapse. This failure meant that Ms A being on a Community Treatment Order did not provide the safety net that it was intended to. Had clinicians responded in accordance with expected practice when Ms A's mental state was first reported as deteriorating, she would have been reviewed within 24 hours of concerns being expressed about her mental state. It is probable that she would have been recalled to hospital. That this did not happen was a serious omission, which will be considered as part of the overall management of care.

13.1.4. Care Programme Approach (CPA)

The Care Programme Approach did not assume the central position that both national guidance and Trust policy expected of it in the care and treatment of Ms A. This meant that clinical assessment (including risk assessment), care planning and decision making often occurred in isolation one from the other. The Care Programme Approach documentation appears to have been subject to the 'Boiling Frog' [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Ms A both her Care Programme Approach and risk assessment documentation remained largely unaltered over a nine-year period. It is a fact that changes to either Ms A's presentation or circumstances largely failed to alter the content of the CPA documentation between 2001 and 2010. Whilst it can be said that Ms A's risk factors and relapse indicators changed little over time the Independent Investigation Team made two observations.

First: whilst Ms A's underlying presentation and problems remained the same over a nine-year period her circumstances did not. She transitioned between both health and social care facilities several times and both risk and clinical assessment and subsequent care planning should have been undertaken at these pivotal points on her care pathway in order to reflect her

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changing needs. This did not happen in either a timely or coordinated manner. Issues were often identified but it was not possible to see demonstrated a systematic and coordinated response. Instead documentation appears to have been subject to a 'cut and paste' approach which relegated the function of CPA to that of a basic commentary rather than being the cornerstone of care and treatment.

Second: it is a fact that Ms A's underlying problems remained unchanged over a long period of time. This is well documented. A consistent feature is Ms A's relapse indicators, her risk factors and her very low deterioration threshold. Every assessment made over a nine-year period alludes to the fact that Ms A, when well, presented with no risk (or low risk), but when unwell could be a significant risk to herself, to others and from others. It was also recognised that once she was in the community these risk factors would increase and that she would need a consistent level of monitoring and supervision. The Community Treatment Order was put into place in January 2009 for this very reason. The behaviour of Ms A was both known and predictable. This then makes it less acceptable that a more robust crisis and contingency plan was not developed as part of the Care Programme Approach process which was widely communicated to all members of the care and treatment team. Due to the fact that so much was known about Ms A it is of particular concern that no plan was in place to guide the actions of health and housing workers between 23 and 25 August 2010.

The Independent Investigation Team concluded that the Care Programme Approach was not delivered in accordance with Trust policy and procedure expectation. Communication and care coordination levels were of a poor general standard and assessment and care planning did not take place based upon either Mr. A's presentation or circumstances.

The absence of effective Care Programme Approach processes was contributory to the poor levels of clinical management Ms A received in August 2010. The days and hours before Ms B died provided a clear window into the observation that the family, the housing support staff and the clinical team, had not established a common understanding of Ms A's needs and risks, or a coherent plan of how deal with her in relapse. In addition it demonstrated to the Independent Investigation Team that those involved in Ms A's care and treatment had not established a level of professional relationship that enabled them to work together effectively as a single multiagency team looking after Ms A's best interests.

- *Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.*
- *Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.*

13.1.5. Risk Assessment and Management

The risk assessment and risk management processes that Ms A was subject to were not in keeping with either local or national policy expectation. Assessment was rudimentary and few attempts were made to develop a formulation which would have ensured Ms A continued to be managed in a robust manner.

The Consultant Psychiatrist who was Ms A's Responsible Clinician at the time she killed her mother had a sound understanding of Ms A's psychiatric condition and of her latent risk. On the basis of this knowledge he placed Ms A on a Community Treatment Order. The expectation was that any deterioration of her mental state would be monitored and an instant recall into hospital would be made if her mental health relapsed. This plan was not, however, implemented.

Unfortunately the culture of risk assessment and risk management was weak. Risk assessments appeared to be 'tick box' processes which did not always engage actively with either Ms A's current presentation or social circumstances. The risk assessment process was neither multidisciplinary nor multiagency. Communication between the disparate members of the care and treating team appeared to be weak. The main problem was that Ms A did not have a

comprehensive crisis and contingency plan in place which was known and understood by everyone working with her. Despite all of the care and treatment activity that was taking place around Ms A when her mental health deteriorated it was evident that the safety net put in place around her was largely illusory and when tested failed to operate in a timely manner. This was to the ultimate detriment of Ms A's health safety and wellbeing and that of her mother.

- ***Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.***

13.1.6. Safeguarding of Vulnerable Adults

This Investigation found that vulnerable adult safeguarding procedures were not used in the care and treatment of Ms A. However this Investigation identified that for a significant proportion of the time Ms A was under the care of the Trust she met the criteria, set out in the local Adult Safeguarding policy, to be regarded as a vulnerable adult.

On occasions she was inadequately protected from harm. This was particularly manifest on the 23 August 2010. At this time Ms A was displaying symptoms of a relapse in her serious mental illness and fluctuating levels of capacity. However despite this Ms A was unable to access the mental health services that should have been available to her. In the context of the safeguarding policy this constitutes neglect.

Several other concerns regarding other vulnerable adults were identified. Firstly Ms A's boyfriend had been identified as someone who might be regarded as a vulnerable adult. He was a service user, who had become dependent on Ms A. Ms A reported thoughts about stabbing her boyfriend in his sleep. The presence of these intrusive thoughts was taken seriously by the clinical team caring for Ms A and her Consultant Psychiatrist indicated that she should be on a low threshold for recall to hospital. However no safeguarding referral was made or formal plan put in place on behalf of her boyfriend.

Ms A parents, especially her mother, have been identified by this review as potentially vulnerable adults in their role as carers. However many of the normal safeguards that should

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have been in place such as carers' assessments, which would have reduced their overall vulnerability to emotional or physical harm, were not put in place.

Finally: at the time Ms A was reported to be becoming unwell, her level of vulnerability had increased in that she clearly met the definition of a vulnerable adult. This Investigation concluded that not sending out someone to assess Ms A for 36 hours constituted neglect as defined in the local safeguarding policy, as services did not provide the required health and social care services to meet her needs at that time, given her known risks and vulnerabilities and the concerns raised by the Housing Support Worker. This Investigation speculated that it may have been beneficial for the Housing Support Worker or her superiors to have raised a safeguarding concern as soon as they had concerns that the Trust's duty team or crisis team were not going to provide Ms A with the healthcare services they thought she required to keep her safe.

13.1.7. Referral, Admission and Discharge Planning

Ms A had a relatively large number of admissions, transfers and discharges in the years under consideration. When Ms A moved around the country practitioners across the different Trusts worked hard to keep each other informed of her whereabouts, and ensured that local services picked her up. This was good practice and in keeping with the Care Programme Approach policy requirements.

The Independent Investigation Team found that Ms A's assessments for admission to hospital typically occurred in a timely manner and were in keeping with the urgent referral criteria set out in the Trust's CMHT operational policies. This Investigation also found that practitioners were willing to give Ms A the benefit of the doubt, and did not admit her immediately if she promised she would take her medication. However even with quite close monitoring Ms A would often not keep to her promises to take medication and would relapse further. On occasions this led to her presenting a risk to herself and others. The Independent Investigation Team acknowledges that this presented a challenge to the clinicians as they had to take into consideration Ms A's preferences, ensure that she was treated in the least restrictive environment, and uphold her rights to liberty.

Finally the Independent Investigation Team found that appropriate decisions were made about the level of care and support required to meet Ms A's needs. However there is no evidence in

the clinical records available to the Independent Investigation that these decisions were based on the comprehensive assessment of needs and risk required by the Care Programme Approach. Both national guidance and local policy indicated that it is good practice to hold a CPA review at key transition points. Failing to do this consistently in Ms A's case meant that her risks were not comprehensively assessed, and her family and carers from other agencies were not fully apprised or engaged in supporting Ms A to effectively maintain her mental health.

13.1.8. Service User Involvement in Care Planning and Treatment

This Investigation concluded that whilst there was evidence of Ms A's day-to-day involvement in decisions, this was often reactive rather than proactive. When Ms A was well staff would respond to her wishes and aspirations and supported her as she pursued her interests. When she was unwell staff reacted to Ms A's behaviour and level of illness.

Ms A appeared to be more proactively engaged with her team in planning her care than may have been the case. The teams working with her appeared to mistake reacting to her behaviours as service user involvement. However this was not service user involvement and engagement in which the service user and the professional staff were in open and transparent dialogue about how to best work together to meet the service user's needs.

This conclusion is evidenced by the lack of involvement and sharing of CPA care plan documentation. The CPA care plans should have been used as a vehicle to encourage conversations about care and treatment, and help shape changes in the care plans to meet the service user's needs in a more acceptable as well as more effective way. That these documents were not used in this way demonstrated a lack of proactive service user involvement. A more proactive approach to service user involvement in care planning, may or may not have made a difference to the outcomes of Ms A's treatment and care. However it is a learning point for the Trust that service user involvement in decision about treatment and care requires more than reacting to the circumstance the service user presents with. It requires the active engagement of a service user in proactively considering the plans of care and treatment being put in place for them.

13.1.9. Carer Assessment and Involvement

The joint agency investigation concluded that Ms A's family, although involved in supporting Ms A throughout her illness, had very little proactive interaction with the professionals involved in Ms A's care.

There was no evidence that Ms A's parents were involved in assessing their daughter's needs or developing her care plans as the Best Practice guidance recommends. Care plans and clinicians' views of risks were not regularly shared with the family, nor did clinicians spend adequate time understanding Ms A's parents' views of her illness.

The family were not provided with the education or support recommended within NICE guidelines, although on one occasion Ms A's mother was offered a family intervention. There was no evidence, however, that this was followed through. Ms B may have also benefited from a carer's assessment as she was carrying a great deal of responsibility as the named nearest relative.

- *Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.*

13.1.10. Housing

The Independent Investigation Team saw evidence that the Trust and Local Authority tried hard to meet Ms A's needs, preferences and safeguarding issues when trying to identify suitable accommodation for Ms A. The level of care taken in this area, and the careful steps taken to move Ms A through to increasing levels of independence was good practice.

However when Ms A was discharged to Leven House, the team could have taken more time to explore the alternatives to discharging her to a flat with a two-year tenancy and housing support provided *via* Supporting People funding. This may have been assisted by a multiagency review to ensure that a longer-term tenancy and viable support programme could be put in place prior to her next move.

Ms A's own statements to this Investigation made it clear that the pressure to move on from her flat within a two-year period was causing her concern. It cannot be known how this concern impacted upon her mental health. Finding long-term tenancies for people who are eligible for Section 117 aftercare is a service issue the Trust and Local Authority partners should seek to remedy.

- *Service Issue Two. The lack of availability of long term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.*

13.1.11. Documentation and Professional Communication

The most significant issue identified within this report regarding multiagency and professional communication was the absence of a recognisable Care Programme Approach process. This severely impacted effective multiagency communication.

This Investigation found that there was an absence of information-sharing protocols between the various third sector organisations involved in Ms A's care. As a result the third sector organisations were unclear as to what information they could reasonably expect to be shared with them.

The Independent Investigation Team noted that there was an absence of a regularly updated case summary, or a reliable record of key information, which people could use to orientate themselves to the case in an urgent or crisis situation. It was concluded that the absence of this information was not helpful to the duty team who tried to make decisions about how to manage Ms A's case when they were contacted by the Housing Support Worker on 23 August 2010.

- *Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented 'joined up' working both in ongoing care, and crisis situations.*

13.1.12. Policy Adherence

This Investigation concluded that a number of key and interrelated policies and guidance documents were not well complied with. This was because of the way in which CPA and the care coordinator role operated in the Southbourne Community Mental Health Team. It appeared there was a strong Outpatient-based model of care and treatment, which was inconsistent with managing care through the Care Programme Approach. It was also clear that the role of the Care Coordinator had not been fully developed in line with the 2008 guidance in relation to Carer and Family Involvement and coordination of multiagency input into care planning and risk assessment.

Local policy lacked clear and concise direction on the minimum expectations of care coordination, care planning and risk management. It was also noted that care coordinators were not regularly updated on the core skills they required to fulfil the requirements of the Trust's policies.

Other elements of national policy and guidance were not complied with because of resource availability or unintended consequences of decisions to restrict access to service. The former meant family interventions were not available, and the latter meant Ms A did not get access to mental health services 24 hours a day, seven days a week when she required them.

- *Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.*

13.1.13. Overall Management of the Case

Ms A was in receipt of a comprehensive programme of care and support which was assisting her to move forward in terms of independent living and a fulfilled and meaningful life. However underpinning this should have been a robust safety net of care and treatment coordinated using the Care Programme Approach. This Investigation found this safety net was compromised which led to some significant gaps. The key weakness in the underpinning safety net of care was in the poor application of the Care Programme Approach. There was not an effective multi-agency/disciplinary approach to planning and reviewing care. Ms A's care and treatment was delivered by mental health professionals and agencies working predominantly in isolation. This lack of care coordination, sharing of information and joint working, played a contributory role in the service's failure to respond to Ms A in a timely way.

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This was because people outside and within the team did not have a shared plan or knowledge of what to do if Ms A's mental health started to deteriorate. It may be further speculated that this also meant that the sort of trusting relationships between individuals working for different agencies which facilitate good care giving were also absent.

While the underpinning safety net of care was weakened by the absence of an effective Care Programme Approach, the failure of the protective barriers put in place to respond quickly and effectively to relapse, were most pertinent to Ms A not getting timely care when she relapsed. This Investigation saw that in principle there were a set of mechanisms in place to intervene in the event of relapse. However in the event of the relapse in August 2010 none of them worked. The duty team did not recognise that Ms A was relapsing from the information provided. The Care Coordinator when she was consulted did not alert the team to Ms A's risks. This meant she was not prioritised for assessment. The Responsible Clinician had not produced an operational plan which told staff what to do if Ms A relapsed. Therefore the Community Treatment Order did not flag the need to involve the Responsible Clinician and initiate an emergency assessment. The duty team did not make use of the Crisis and Home Treatment Team. These were serious omissions in her care and treatment

This Investigation found that the decision not to instruct an assessment within 36 hours had a causal relationship to the failure to intervene in Ms A's deteriorating mental health and the consequent attack on her mother on 25 August. The case for causality is set out below.

Knowledge. The CMHT Team Leader knew Ms A was on a CTO and understood that this meant she had particular risks if she relapsed. While it was not predictable that she would kill her mother or anyone else, it was known she could be a risk to herself and others when she relapsed. There was information both available and documented about her relapse signature. The information given to the CMHT Duty Worker was a close enough match to Ms A's relapse signature to have identified that her mental health was deteriorating. As a senior and experienced mental health practitioner, responsible for the management of a Community Mental Health Team and the supervision of other practitioners the CMHT Team Leader should have known that his first duty with a relapsing CTO client was to consult with the patient's Responsible Clinician.

Opportunity. 36 hours elapsed between the CMHT duty team being informed of Ms A's deteriorating mental health and the death of Ms B. The Trust's own policy on emergency

assessments is to see a patient within four hours of referral. Even if the team had been busy at the time of referral, there was ample opportunity within the 36 hours to have instructed an assessment and intervention.

Means. The Community Treatment Order provided the means to intervene rapidly and have Ms A recalled to hospital. There should have been access to the Crisis and Home Treatment Team if required. These means were available to effect rapid assessment and support for Ms A but they were not utilised.

Consequently the Independent Investigation Team concluded that whilst the killing of Ms B could not have been predicted, a serious untoward incident of some kind was foreseeable based upon Ms A's previous behaviour when experiencing a psychotic episode. It was the conclusion of this Investigation that the killing of Ms B was preventable and that had a rapid response (as indicated to be required in her clinical record) for Ms A been forthcoming then this tragic incident would probably not have occurred.

- *Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or not getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.*
- *Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours.*
- *Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.*

- ***Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.***

13.1.14. Clinical Governance and Performance

The Trust described a robust system of clinical governance, which appeared to be compliant with national standards. However to be effective clinical governance systems need to provide what is referred to in the National Audit Office report on NHS Governance – *Taking it on Trust* as the second line of defence. This second line of defence provides systems for detecting and closing gaps in service delivery that practitioners and local service managers (the first line of defence) have missed. Evidence from our investigation found that the clinical governance system extant at that time may not have provided an adequate or robust second line of defence.

The Trust did not appear to be aware that:

- supervision arrangements for practitioners were patchy and informal;
- audits and quality assurance systems, whilst evaluating compliance in practice against national standards and expectations, did not appear to detect issues relating to Ms A's care and treatment;
- findings from internal investigations were not being addressed within reasonable timescales;
- there was inadequate monitoring or follow up of whether staff had attended core areas of training, such as the Care Programme Approach and risk management. However the Trust asserts that 'Did not Attend' notifications were always sent to managers on a monthly basis from 2010.

Whilst the staff interviewed commented clearly on their clinical supervision experiences these did not fully reflect the overall Trust framework for clinical supervision. The Trust has a central list of clinical supervisors which staff can access via the intranet to identify a suitable supervisor. This list comprises in-house staff who have completed the Trust's approved Clinical Supervision for Supervisors course. As part of the Trust's

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Appraisal/Personal Development Review process managers should confirm that staff are in receipt of clinical supervision and discuss any development needs that have arisen during clinical supervision. This information also forms part of the PDR form which managers complete to confirm supervision is being received by clinicians as per Trust policy. The supervision policy requires the supervisor and supervisee to complete a supervision contract/agreement and then maintain supervision record sheets for each session. These should be filed in the individual's professional portfolio.

13.2. Conclusions

This Investigation concluded that Ms A was in receipt of a comprehensive package of care, which was supporting her to achieve recovery and independence. The recovery support services and supported housing available to Ms A were impressive, and they together with statutory mental health teams were working towards Ms A's recovery.

Unfortunately this Investigation found that despite these strengths there were some serious underlying weaknesses in the underpinning safety net of care. Significant omissions existed in relation to risk assessment and management and the limited way in which the Care Programme Approach and Care Coordination was put into practice. The test of a good package of care and treatment cannot depend solely upon the quality of provision when things are going well and a service user is in a state of recovery. The test also has to apply when a service user relapses and enters a state of crisis. In the case of Ms A the care and treatment package that worked well when she was in recovery, failed to provide for her continued health, safety and wellbeing when in relapse.

14. Trust and Local Authority Initial Response to the Incident and the Joint Agency Review

14.1. Investigation Process and Findings

The requirements for local investigations into serious patient safety incidents is set out in both the Trust's policy and national best practice guidance from the National Patient Safety Agency.²⁹⁷ National best practice guidance is specific to the most serious patient safety incidents, whereas the Trust policy outlines procedural guidance and policy requirements for all adverse incidents in the organisation including those that are deemed as serious.

National best practice guidance states in the event of any serious incident an initial internal management review should occur within 72 hours of the incident occurring. In the context of the serious incidents that this guidance covers, there is a requirement to follow the 72 hour report with an internal mental health NHS Trust investigation. This should usually be completed with 90 days.

The aim of the 72-hour review is to ensure any immediate clinical or managerial action is taken to ensure safety or make any necessary or urgent changes to policies or procedures. A record of the review and actions taken needs to be retained by the Trust. The best practice guide further advises on specific actions a Trust should ensure it takes in support of its initial 72-hour review. These include:

- the Chief Executive or nominated Executive Director should appoint a senior clinical or manager to;
 - arrange for immediate actions to ensure immediate safety;
 - secure and preserve all documentary, electronic or material evidence;
 - agree with the Police who will contact the victim and suspected perpetrator's family;
 - identify and provide support to witnesses;

²⁹⁷ National Patient Safety Agency (2008) Independent Investigation of Serious Patient Safety Incidents in Mental Health Services Good Practice guidance

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- apply safeguarding policies and procedures on behalf of any children or vulnerable adults involved in incidents;
- identify staff to conduct the management review;
- report to third parties in line with local protocols and policies;
- establish an investigation oversight group for the most serious incidents.

The guidance advises that a stage 2 internal management investigation should happen for the most serious of cases, and this should be supervised by a serious incident oversight group. The investigation should follow a structured process such as Root Cause Analysis, and the staff involved trained in these techniques. The guidance also states the final report should:

- be simple and easy to read;
- have an executive summary, contents and index page;
- state the title and current status of the document;
- disclose the basis upon which confidentiality has been breached;
- disclose methodology used;
- identify root causes and recommendations;
- ensure conclusions are evidenced and reasoned and that recommendations are implementable;
- include a description of how patients, families and victims have been engaged and supported during the process.

The Trust policy in 2010 provided more specific guidance about internal processes, timescales and expectations. At the time there was an expectation of an initial 24-hour report and a more comprehensive report prepared within 20 days of the event occurring. The policy described that all serious adverse events were reviewed and overseen by a panel which met monthly. This panel was responsible for agreeing investigations and signing-off investigation reports on behalf of the board, and preparing summary reports for the board. The most serious incidents are referred in the policy as requiring root cause analysis. The panel was chaired by a Non Executive Director and membership included the Medical Director, Director of Quality and the Trust's Clinical Risk Management Lead.

The policy provided additional guidance on areas such as the report and the process of root cause analysis and how to develop action plans.

14.2. Findings

Initial Reporting and Management of the Incident

The local management team provided a clear report of the incident to the Trust risk management team within 24 hours of the event occurring. This was followed up by a 72-hour report, which set out everything that had been done, or was currently being planned to be done in the aftermath of the incident.²⁹⁸

The 72-hour report provided the details that were known of the incident, and information about what had occurred since. It covered key areas identified in the good practice guide checklist.

For example it reported:

- that the Director of Mental Health attended a Gold meeting (high level major incident planning meeting) with the Police on the morning of 26 August;
- details of key people involved in investigating and managing the incident and investigation;
- who was involved from the police and providing victim and family support;
- details of others involved and who was providing them with support;
- the immediate actions that had been taken in terms of reporting and seizing evidence;
- it identified that the Trust Serious Adverse Incident Panel would be leading on the investigation.

The CMHT Team Leader who had significant clinical involvement in the decision making associated with the events was asked to be the liaison point for the Police, and was involved in debriefing staff involved in the incident from the housing association.

Joint Agency Investigation Process: Appointment of Panel

The establishment of the joint agency investigation was coordinated by the Trust's Serious Adverse Incident Panel, which commissioned the investigation as a full root cause analysis investigation. The SAI panel also approved proposals for membership of the investigation panel. The joint agency investigation panel had 10 members in total and was chaired by a previous Non-Executive Director of the Trust, who was also the Independent Chair of the

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Trust's Serious Adverse Incident Panel. The other members of the investigation panel included:

- the independent chair of the Bournemouth and Poole Safeguarding Council;
- an independent psychiatrist from another Trust;
- the Trust's Director of Quality;
- a Detective Superintendent – Dorset Police;
- the Trust Lead for Patient Safety;
- the Trust Associate Nurse Executive;
- the Trust Medical Director;
- the Social Services, Service Manager for Safeguarding Adults;
- the Primary Care Trust Head of Patient Safety.

The investigation was also commissioned as the Trust's management review as part of the Vulnerable Adult Safeguarding serious case review process.

The joint agency investigation panel included representatives of some of the services involved but not all. There were multiple representatives from a number of organisations and none from others. For example it had three Trust Executives, and the Trust's Patient Safety Lead. It also comprised the Safeguarding Board Chair and Local Authority Safeguarding Manager. However it did not have any representation from Knightstone Housing or from Crumbs.

An independent psychiatrist was appointed to the panel. The good practice guidance states; *"It may be necessary for the Trust investigation team to obtain external advice on certain issues; however, it should be unusual for individuals from outside the employment of the Trust to be members of the investigation team"*.²⁹⁹

All panel members were involved in reviewing medical records, reading witness statements, policies and procedures and staff training records. The panel also interviewed 13 witnesses

The Joint Agency Investigation Terms of Reference

The terms of reference required the panel to:

299 NPSA (2008) Independent Investigations of serious patient safety incidents in mental health, good practice guidance p10

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- apply the structure and process of a full root cause analysis at level 2 as set out in National Patient Safety Agency Guidance;
- complete a detailed chronology of the events from the first point of contact with mental health services to the time of the alleged incident to assist in the identification of care and service delivery problems;
- review the quality of the health and social care DHUFT and the police provided, and whether this adhered to policy and procedure;
- examine the extent and adequacy of the collaboration and communication between the agencies involved in the provision of services to Ms A;
- review and consider any previously reported incident involving Ms A through the Trust's incident/accident/near miss reporting processes;
- examine the adequacy with which Miss As risk was assessed and whether actions consequent upon the assessments were appropriate and within the local and national guidelines;
- examine the appropriateness of the training and development of those involved in Ms A's care;
- examine how Ms As prescribed treatment and care plans were:
 - documented;
 - agreed with Ms A;
 - communicated with and between the relevant agencies and Ms A family and/or carers;
 - carried out and complied with by Ms A.

The terms of reference did not cover consideration of the Care Programme Approach, Diagnosis, Medication and Treatment and the use of the Mental Health Act

Report findings

This 94 page report comprised 54 pages which covered the methodology and the chronology, three pages which reported the findings, three pages of recommendations and 24 pages of appendices.

The findings section identified six care and service delivery problems, six contributory factors and no root causes (see table below). The findings section of the report contained limited

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exploration of the evidence considered or deliberations made by the panel to reach their conclusions. Definitions of care and service delivery problems, contributory factors or root causes were not provided within the report.

Table Three: Findings

Care and Service Delivery Problems	Contributory Factors	Root Causes
The full risk assessment had not been fully transferred to her electronic record.	Full information about a prior event not involving the Metropolitan Police was not in the health records.	Even though some important aspects of Ms A's risk history were not included in the risk summary and assessment. The review panel did not believe that the risk of Ms A stabbing her mother was foreseeable.
Less focus on evaluation of symptoms and exploration of risk issues because of framework of social inclusions and recovery.	Full risk information not transferred to new electronic information system (RiO).	
Delay in face to face assessment from first reported concerns from Knightstone Housing.	The CMHT duty system had different workers from the team allocated each day, problems of continuity between shifts.	
No clear guidance in notes on what low threshold for recall meant in practice. The warning relapse indicators should have been set out in the crisis and contingency management plan.	Care plan did not provide sufficient detail to guide workers as to the appropriate response in a crisis. Did not record speed of relapse, triggers for immediate action.	
Housing staff not involved in CPA review and were not provided with plan to identify and manage relapse.	The CMHT staff did not place sufficient weight on the information provided by the Housing Support Worker.	
No information in notes about support provided to Ms As befriended before or after the incident.	Informal discussions about the need for an immediate visit to Ms A were not documented.	

Despite the lack of information on how the panel reached their findings the local and Independent Investigations concurred on most of the issues identified as playing a part in events that occurred. However there are clear differences in judgements about the contribution each of the issues made to Ms A becoming unwell and stabbing her mother.

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The Independent Investigation Team was not able to establish the basis by which the joint agency investigation panel categorised their findings into care or service delivery problems and contributory and causal factors. It was noted that the local panel concluded that there were no root causes on the basis that that it could not have been foreseen that Ms A would stab her mother. This is not consistent with definitions of a Root Cause used by the National Patient Safety Agency.

Members of the joint agency investigation panel reflected that they had found it difficult as a group to take a decision to identify individuals where they had felt that practitioners involved at the time should have practiced differently from the way in which they did.³⁰⁰ When asked about how the concerns the panel had would then be fed back to individuals if not clearly identified in the investigation report, the response was that they hoped individuals would pick up the issues for themselves from the report and that it would be picked up through supervision.

Recommendations from the Joint Agency Investigation

The internal investigation made five recommendations:

1. improved risk documentation, processes and training;
2. ensuring care plans for recall of patients on CTOs are developed;
3. improved information sharing in CPA reviews between all relevant support agencies;
4. changes to the Duty system, introducing dedicated workers, and ensuring work should either be completed or passed to the crisis team and not carried forward to the next day;
5. review of support and governance arrangements for the befriending service.

The Independent Investigation Team heard evidence that two of these actions had been progressed:

- risk assessment training and documentation had been reviewed and changed in line with the implementation of the RiO electronic patient information system;
- the duty system had been changed in line with the recommendations.

300 Transcript from interview with internal investigation panel

The other three recommendations had not yet been fully addressed at the time the joint agency investigation panel were interviewed. Outstanding issues were:

- the Trust's recent audit of Community Treatment Orders indicated that less than 50% of patients on Community Treatment Orders had care plans in place which detailed arrangements for recall;³⁰¹
- this Investigation was told by third party partner organisations that the Southbourne CMHT still did not include them in Care Programme Approach reviews or share care plans with them;³⁰²
- this Investigation heard there were still problems regarding some of the governance arrangements between third sector organisations and the Trust. For example the Trust and Crumbs did not have an agreement for sharing relevant information when service users became employees of, or volunteers with Crumbs.

Conclusions

The Independent Investigation Team found that the Trust's local investigation had followed an incident reporting, management and investigation process that was in keeping with its own policy and in line with national guidance, and which was completed within the required timelines

This Investigation was not able to find evidence of a serious adverse incident oversight group, and concluded that a number of people who were on the joint agency investigation panel may have been more appropriate to have been on an investigation oversight group instead.

14.3. Progress against the Trust Local Investigation Action Plan

The local joint agency review made a number of recommendations that have been implemented and which are detailed below.

Table 4

Area	Recommendation
Risk Documentation	Dorset HealthCare University NHS Foundation Trust should provide renewed training to staff in the use of the risk tools on RiO (the electronic patient record). This should focus on the importance of the risk progress notes and also on ensuring that the risk plan in the

301 Trust CTO audit March 2012

302 Transcript from supported housing staff

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	electronic patient record is at least of an equivalent standard to the previous full assessment of risk (gold risk form) that was previously used.
	Dorset HealthCare University NHS Foundation Trust should ensure that there is a clear acknowledgement of the continuing importance of careful risk management and assessment included in staff training on the use of recovery principles. This should be seen as supportive and not in opposition to recovery principles.
Community Treatment Orders	Dorset HealthCare University Foundation Trust should provide training and guidance to staff as to the standard required for care plans for those patients identified as being at significant risk to either themselves or others, including all patients on a Community Treatment Order. This guidance should cover the following: <ul style="list-style-type: none"> i. Early warning signs and triggers for relapse ii. Actions to be taken if warning signs are present including the position of named individuals who may be at risk iii. Sharing and receiving risk information between housing support staff and third sector providers
	These standards to be audited
	Training programme delivered
Information Sharing	Dorset HealthCare University Foundation Trust staff should ensure that Care Programme Approach reviews are informed by all relevant support agencies, including primary care, housing and the third sector. Audit to be carried out to ensure that this is happening
	DHUFT and Dorset Police should provide joint advice and training to staff as to the thresholds for sharing risk related information. This should also include guidance on the sharing of Section 136 information
Duty System	DHUFT should institute a common policy and procedure for the operation of duty systems within CMHTs. These should include: <ul style="list-style-type: none"> i. Dedicated workers to operate the duty system ii. Clarity that work undertaken by the duty team should be completed that day or passed on to the CMHT or Crisis Team. Work should not be carried forward to the next day by the duty team iii. Clarity for families and external organisations as to how to contact CMHTs via the duty system
	The duty system standards to be audited
Befriending Service	There should be a review of the support and governance arrangements for the Befriending Services to clarify the links between befrienders and the CMHT and to ensure befrienders are provided with clear information about who to contact for advice and support

In addition to the above the following action and developments have also taken place that will have addressed some of the findings of this review:

Team Workload

A plan to restructure the Team providing services to Ms A has now been achieved. The restructure followed a caseload review and analysis of referral rates. This has led to the provision of a more equitable and manageable workload across the CMHT's.

Clinical Supervision

The Trust undertook an audit in 2011/12 to ensure staff were receiving supervision as per Trust policy, at a minimum frequency of once every quarter. Managers were sent quarterly reports to identify staff for whom there was no central record to ensure that they were receiving supervision for updating on the central Trust database.

The supervision policy requires the supervisor and supervisee to complete a supervision contract/agreement and then maintain supervision record sheets for each session. These should be filed in the individual's professional portfolio.

The new integrated Workplace Induction Checklist has recently been updated to contain a checkbox for 'Clinical Supervisor identified (as appropriate)' to ensure new starters identify a clinical supervisor as part of their three-month probationary period.

Training

The modules within the CPA pathway for care coordinators comprise Risk Management, CPA, Assessment & Care Planning, HoNOS and Payment by Results. This learning pathway is not mandatory for staff within CMHTs but is available for new care coordinators as agreed between the manager and member of staff depending on an assessment of their own learning and development needs. It was detailed in the old DHC mandatory training policy in 2010 as being priority training after staff have completed their mandatory training if they don't already have those skills.

A learning pathway for mental health staff is currently being agreed across the integrated Trust for launch in April 2013; this will comprise the above modules for new starters to complete within their first 12 months of employment. Staff within mental health services are required to undertake a minimum of six hours of risk training every three years. To support this a Clinical Risk Update one-day training programme has been available for staff to attend since end 2008. Central training records are available if required for relevant staff.

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The Learning and Development (L&D) Service sent Did Not Attend (DNA) reports to managers on a monthly basis in 2010. However, this process has been revised to avoid any unnecessary time lag. As a result the L&D Service now notifies managers on the day (or as soon as the attendance sheet is received) if staff DNA'd a training programme. This system would have been in place to advise managers if staff DNA'd the Clinical Risk Update training session in 2010.

Education for Service Users and Carers

In partnership with The Dorset Mental Health Forum, the Trust has become a national demonstration site with the Centre for Mental Health for Implementing Recovery through Organisational Change (ImRoc). As part of this programme a Recovery Education Centre (REC) has been developed to help people who access services and their carers to understand their experiences. The REC delivers courses, workshops and seminars at venues across the DCH area. The courses are designed and delivered by a Peer Specialist and a qualified mental health professional. The aim of the courses is to provide education to enable individuals to take care of themselves more effectively and to support carers in understanding a range of issues. There are currently 24 different courses which include: Early Warning Signs, Medication Management, Knowing Your Way Around Services – Making the Most of the Care Programme Approach, Managing Unusual Experiences, Coping in a Crisis, Change – Understanding the Stages of Recovery and Supporting Someone's Recovery.

15. Notable Practice

At the time of the incident Ms A was receiving a comprehensive care package. This included regular support from the Care Coordinator, individual psychological therapy; a regular (quarterly) Outpatient review by medical staff; regular depot medication and ongoing review of medication; floating housing support from a Housing Association; support to assist with finding and maintaining voluntary work provided by the Vocational Rehabilitation Centre and ongoing support from her befriender.

Ms A's care was appropriately provided under a Community Treatment Order. The team had worked with Ms A so that she was accepting of this and recognised the value of the Order. Although there were a number of changes of Care Coordinator and it is acknowledged that there were some differing views about her, Ms A's care was provided by a multi-disciplinary team, many of whom had known her for several years. This meant that Ms A had received a continuity of care. The team were able to engage with Ms A and work with her in a positive way.

Following the incident the Trust proactively worked with the Primary Care Trust, Local Authority and Safeguarding Board to carry out a joint review.

16. Lessons Learned

Clinical Policy and Process

Ms A received a good general quality of care and treatment from treating teams who over the years were sensitive to her needs. However this care and treatment did not always follow national good practice guidance or local policy expectation. When Ms X was in a stage of recovery the approach taken by the multidisciplinary team was on the whole appropriate. However it did not take into account adequately enough the fact that Ms A had a severe and enduring mental illness which would predispose her to the possibility of future relapse. It was known that when Ms A was in a state of relapse she would become a risk to both self and others. The essential safety nets of care, such as the Care Programme Approach, Safeguarding, risk assessment and crisis and contingency planning were not in place in a manner robust enough to support Ms A when unwell. The real test of policy, process and system is not so much when a person is well and at their least challenging, but when a person is unwell and often difficult to engage. In the case of Ms A these essential safety nets of care failed to operate sufficiently well when she reached a state of crisis. The lesson for learning is that evidence-based practice provides the basis for safe and effective care and treatment. When clinical teams depart from this practice the ongoing health, safety and wellbeing of service users is compromised.

Professional Communication

In keeping with the findings of most other *HSG (94) 27* Investigations since 1994 this Investigation also found that the failure to provide appropriate and consistent levels of professional communication impacted negatively upon the quality of the care and treatment Ms A received. It was apparent that communication was often poor at the multidisciplinary team level and also at the interagency level. The relatively poor application of the Care Programme Approach made a distinct contribution to this aspect of care in that there was no formally constructed forum where decisions could be both made and shared. The lesson for learning is that professional communication is not simply a matter of maintaining the clinical record but is an active part of professional life which must be pursued with diligence. Additional responsibilities are placed upon Care Coordinators and senior members of clinical teams to ensure that communication opportunities are taken full advantage of and that

additional care and attention is paid to the interfaces between primary and secondary care and the third sector.

Carer Involvement and Support

Ms A was fortunate in having two loving and supportive parents who remained actively involved with her. However neither her mother nor her father were incorporated into her care and treatment plans by her clinical teams. No considerations were given to the following:

- education;
- family focused therapy;
- assessment and support;
- risk assessment;
- information sharing;
- care planning.

This was poor practice as the family were an ever-present protective factor in Ms A's life which was seemingly overlooked by each clinical team over the years. This was a serious omission and represents a lack of carer focus. The lesson for learning is that carers and families must be worked with in a collaborative manner especially when they are identified as being a keystone for a service user's recovery. Families can be placed at risk, both emotionally and physically, when caring for loved ones with mental illness and their needs should be both identified and managed as a matter of priority.

Medicines Management

Service users with known histories of medication non compliance should always have a medicines management care plan in place when living in the community. Clinical staff should always be aware of the difference between the concepts of medication non-compliance and medication non-adherence and seek to develop a medicines management plan that will be effective and that ensures that the service user, and any preferences or concerns that they may have, are central to any plan and long-term treatment strategy.

17. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Dorset Healthcare University NHS Foundation Trust and Bournemouth Local Authority Social Services to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this investigation process.

17.1. Recommendations

Recommendations 1 and 2: Medication and Treatment

- *Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicines management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.*
- *Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.*

Recommendation 1. The Trust will provide training to Community Mental Health Team staff on Medicines Management Planning; this will cover compliance and non-adherence and will incorporate motivational interviewing skills. The Trust will instruct clinicians of the importance of documenting the reason behind decisions to change treatment, either medication or psychological and social intervention, so that not only is the decision recorded but the reasons underpinning the decision are recorded.

Recommendation 2. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 3: The Care Programme Approach

- *Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.*
- *Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.*

Recommendation 3. The Trust will review the Care Programme Approach Policy including the specific requirements for Patients on Community Treatment Orders. The Trust will provide training to all staff of Community Mental Health Teams on the revised policy. The

Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- holistic needs assessments are conducted;
- care plans are developed, monitored and reviewed;
- carers and service users are involved fully (where appropriate) in the process;
- primary care practitioners are sent copies of all relevant documentation;
- specific management plans are in place when a person is placed on a Community Treatment Order.

Recommendation 4: Clinical Risk Assessment and Management

- *Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.*

Recommendation 4. All staff from Community Mental Health Teams will be trained in the revised Clinical Risk Policy. The Trust will review and ensure that clear guidance and protocols are in place with partner agencies to ensure that information pertaining to increased risk and significant change is communicated in a robust manner and documented in the RiO record. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- risks are assessed at a frequency in accordance with Trust risk and CPA policy documentation;
- all identified risks are managed by comprehensive risk plans;
- relapse and crisis and contingency plans are updated in accordance with service user need and are communicated widely to all members of secondary and primary care-based care and treating teams.

Recommendation 5: Carer Assessment and Involvement

- *Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.*

Recommendation 5. The Trust will ensure that each Community Mental Health Team has a Carer's Lead to champion the needs of Carers and their families. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 6: Housing

- *Service Issue Two. The lack of availability of long-term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.*

Recommendation 6: The Trust will work with the Local Authority to participate in a scoping exercise of housing need, reviewing need against current provision. The Trust will work with the Local Authority to use this information to develop a Mental Health Housing Strategy to include a strong focus on individuals with severe and ensuring mental health needs.

Recommendation 7: Documentation and Professional Communication

- *Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented 'joined up' working both in ongoing care, and crisis situations.*

Recommendation 7. The Trust will develop new Information Sharing Protocols for each Third Sector Organisation that jointly provides care with the Trust. These protocols to be audited for effectiveness as part of an ongoing audit process.

Recommendation 8: Policy Adherence

- *Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.*

Recommendation 8. The Trust will review its systems for informing teams of new/revised Policies and Procedures. The Trust will develop a revised management and clinical supervision policy that takes account of adherence to new Policies and Procedures.

Recommendations 9, 10, 11, 12: Overall Management of the Case

- *Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.*
- *Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours or sooner.*
- *Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.*
- *Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to deteriorate, thereby ensuring that*

she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.

Recommendation 9. The Trust will ensure that all Community Mental Health Teams are instructed of the referral routes to the Crisis and Home Treatment Team and of the role that Duty Workers have in managing patients who require urgent assessment or intervention. The Trust will ensure that all Service Users on Community Treatment Orders are discussed as a minimum on a monthly basis within Team Meetings and that a record of the discussion is recorded in the RiO system. The Trust will also review all Operational Policies and care pathways to ensure that referral and access to Crisis Team is made explicit to:

- primary care workers;
- secondary care workers;
- third sector workers;
- services users;
- carers and families.

Recommendations 10 and 11 set by the Local Authority

Recommendation 10. The Safeguarding Adult Board (SAB) and the Trust at Board/leadership level to understand and define the relationship between adults at risk by reason of their mental health issues and those at risk within the broader definition and therefore oversight of adult safeguarding. The SAB to communicate and train relevant staff when that understanding has been reached and agreed.

Recommendation 11. The SAB to debate and agree the extent to which adult safeguarding protocols and procedures are/should be the backstop for service failures elsewhere in the system.

18. Glossary

Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders
Bipolar Disorder	The current term ‘bipolar disorder’ is of fairly recent origin and refers to the cycling between high (manic) and low (depressive) episodes (poles).
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user’s care and treatment plan when working with the Care Programme Approach
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user-centred manner
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies
DNA’d	This means literally ‘did not attend’ and is used in clinical records to denote an appointment where the service user failed to turn up
Enhanced CPA	This was the highest level of CPA that a person could be placed on prior to October 2008. This level requires a robust level of supervision and support
Extrapyramidal	Extrapyramidal symptoms include extreme restlessness,

involuntary movements, and uncontrollable speech

Mental Health Act (1983 & 2007)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines
Olanzapine	A drug used for treating patients with schizophrenia and manic episodes associated with bipolar disorder
Paranoid Schizophrenia	Paranoid schizophrenia 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 the auditory variety, and perceptual disturbances
Primary Care	Primary care refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. About 90% of people's contact with the NHS is with these services
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others
Schizophrenia	Schizophrenia is a mental disorder characterised by a

disintegration of the process of thinking and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking, and it is accompanied by significant social or occupational dysfunction

Schizoaffective Disorder

Schizoaffective disorder most commonly affects cognition and emotion. Auditory hallucinations, paranoia, bizarre delusions, or disorganised speech and thinking with significant social and occupational dysfunction are typical. The division into depressive and bipolar types is based on whether the individual has ever had a manic, hypomanic or mixed episode. Symptoms usually begin in early adulthood, which makes diagnosis prior to age 13 rare. Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder. There has been a controversy about whether schizoaffective disorder is a type of schizophrenia or a type of mood disorder. Today, most clinicians and researchers agree that it is primarily a form of schizophrenia

Secondary Care

Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP)

Service User

The term of choice of individuals who receive mental health services when describing themselves

SHO (Senior House Officer)

A grade of junior doctor between House officer and Specialist registrar in the United Kingdom

Specialist Registrar

A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant

