An independent investigation into the care and treatment of a person using the services of the former Norfolk and Waveney Mental Health Partnership NHS Trust

Ref 103/2006

Date July 2011

This is the report of an independent investigation commissioned by East of England Strategic Health Authority to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent investigation of adverse events in mental health services"* issued in June 2005. The guidance replaces paragraphs 33 – 36 in HSG (94)27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.
The requirement is for an independent investigation of the care and services offered to mental health service users (MHSUs) involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The independent Investigation Team members were:

- Mr Alan Crabtree, Chair 2007 – April 2010;
- Dr Kiki O'Neill-Byrne, Consultant Psychiatrist, Oxleas NHS Foundation Trust;
- Mr Malcolm Thomas, Independent CPN;
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  In April 2010 Mr Crabtree had to step down from this investigation owing to ill health. Consequence UK Ltd was commissioned by the EOE SHA, to conduct the analysis of the information gathered during the investigation and to deliver the final investigation report. It was agreed by both parties that no further information gathering would be undertaken unless absolutely necessary. The EOE SHA considered that sufficient volume of information had been gathered.

Acknowledgements
The Investigation Team wishes to thank the following for their assistance in the conduct of the investigation:

- the family of the victim, Mr Rayner;
- the friends and neighbours of the MHSU;
- the parents and brother of the MHSU;
- Norfolk Constabulary; and,
- Norfolk and Waveney Mental Health NHS Foundation Trust (formerly Norfolk and Waveney Partnership (N&WMHP) NHS Trust) and its staff

List of acronyms used in the report

Acronym	Full Title
CMHT	Community mental health team
Cons FP	Consultant Forensic Psychiatrist who provided evidence to the Crown Prosecution Service
Cons PA1	The MHSU's first adult services consultant psychiatrist in September 1999
Cons PF1	The MHSU's forensic psychiatrist at the medium secure unit 1993 -1997
Cons PF2	The MHSU's forensic psychiatrist at the medium secure unit 1997 -1999
Cons PA 1 – Cons PA10	The Consultant Psychiatrists who had clinical contact with the MHSU
CMHN	Community mental health nurse
CPA	Care Programme Approach
CRHT	Crisis resolution and home treatment service
CPN A1 – CPN A8	The community psychiatric nurses who had contact with the MHSU
DH	Department of Health
FCP-CP	Forensic Consultant Psychiatrist for the Crown Prosecution 2006 – 2007
IIT	Independent Investigation Team
MDT	Multi-disciplinary team
MHA	Mental Health Act (1983)
MHP	Mental health professional
MHRT	Mental Health Review Tribunal
MHSU	Mental health service user
RCA	Root cause analysis
section 117	Section 117 after-care under the Mental Health Act
SHA	Strategic Health Authority
SHO	Senior house officer
TM1	CMHT team manager 1999 – 2000
TM2	CMHT team manager 2001 – 2005
TM3	CMHT team manager February 2006 – date of the incident

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EXECUTIVE SUMMARY

This report sets out a summary of the findings of the independent Investigation Team (IIT) regarding the care and management of a mental health service user (MHSU) by the former Norfolk Mental Health Trust/Norfolk and Waveney Mental Health Partnership NHS Trust (N&WMHP) for the period May 1999 through to May 2006.

Adverse event overview

On 24 May2006, the MHSU was visited by his friend Mr Rayner. Mr Rayner had gone to the MHSU's home to undertake some work on his vehicle. The MHSU had a ramp and car pit that he was able to use. When Mr Rayner arrived at the MHSU's home he went to the workshop at its rear. On entering this, the MHSU hit him over the head with a heavy object and then decapitated him. The incident shocked the local community not only because of its violent nature but because the MHSU and Mr Rayner were firm friends. Both were active members of the community. At the time of the incident the MHSU was suffering from a relapse of his mental health disorder.

Main conclusions

The death of Mr Rayner, and the manner of his death, has deeply affected his family, the local community in which he lived, his friends, the family of the MHSU, and the MHSU himself. At the time of the incident the MHSU had been without medication since 24 April 2006, having previously attended for this on 31 March 2006. Unmedicated his relapse was predictable. That he might harm someone if he remained unmedicated was also predictable. Sixteen years prior to the attack on Mr Rayner, the MHSU had attacked his father who sustained a near fatal injury. He had also, in the same time period, attended at a public house near to his home at the time with the intent to cause harm to a person he knew. These incidents occurred in 1990 the last time the MHSU had been without medication.

It is the contention of the IIT there were a number of lost opportunities in the care and management of the MHSU. Had different actions been taken at these points the death of Mr Rayner on 24 May 2006 may not have occurred. The most significant lost opportunities, in the opinion of the IIT were:

- The decision to grant the MHSU an absolute discharge from the Mental Health Act (1983) in 1997. This meant that the previous condition of medication compliance was removed.
- That the care plan devised for the MHSU by the forensic service was not continued as intended 'when his care was fully transferred to general adult mental health services from the forensic service in January 2000.

- The absence of a documented risk management and crisis intervention plan for the MHSU.
- The lack of an appropriately assertive plan of action when the community mental health team became aware that the MHSU was going to remain medication non-compliant (May 2006).
- That the clinical team in May 2006 gave too much weight to the MHSU's wishes and insufficient weight to his past risk history when unmedicated. This meant that the clinicians were insufficiently assertive in their efforts to achieve a face-to-face assessment with him after 5 and 18 May respectively. Consequently there was no opportunity for them to determine whether or not he displayed any psychopathology.

It is absolutely clear to the IIT that had the MHSU not been allowed to extend the time gaps between his medication doses between January 2006 and 31 March 2006, and be without medication from 21 April through to the 24 May this incident may not have occurred. The primary care service cannot be criticised for not alerting specialist mental health services about the increased time period between depot administrations January to March 2006. The primary care service did what was asked of it. When the MHSU did not attend for his medication, and was non-contactable, primary care team members promptly contacted the MHSU's community mental health team (CMHT).

With regard to the MHSU's absolute discharge from section 37/41 of the Mental Health Act decision made by the Mental Health Act Review Tribunal was premature. However, the decision was made eight and a half years prior to the incident. Although the actions required of the community mental health team (CMHT) would have been clear cut had the MHSU remained subject to a conditional discharge, there were sufficient risk indicators available to the CMHT in the weeks leading to the incident for there to have been a more assertive approach once the MHSU was known to be unmedicated and not engaging in the recommended treatment plan for him.

Components of a more assertive approach should have been:

- proactive contact with the MHSU's parents to find out if they had any concerns about their son;
- attendance of Cons PA10 and the MHSU's CPN, CPN-A8, at the home of the MHSU to conduct a face-to-face assessment as soon as possible after their meeting on 18 May, ideally on the same day;
- a direct request from the mental health professionals that the MHSU accept immediate re-medication to prevent relapse and the clear risk to the MHSU of his loss of liberty and the lifestyle he had attained; and

- organisation of a mental health assessment under the Mental Health Act if the MHSU did not make himself voluntarily available for this when requested to do so.

Overall conclusion

It is the overall conclusion of the IIT that the death of Mr Rayner on 24 May, may not have occurred had the decisions and actions of the clinical team been different between 5 and 24 May. However preventability of his death is by no means certain.

Absolute avoidability of this was dependent on the MHSU being treated in hospital either on a voluntary or a detained basis prior to this date.
There is however no guarantee that had the MHSU's mental state been assessed at any time between 5 and 24 May 2006, that a hospital admission would have been the outcome of this.

The variables that would have impacted on the conduct of any assessment of the MHSU's mental state and its outcome were:

- He may have gone "underground" if pressed to make himself available for a mental health examination. Had this occurred the MHSU would have been 'invisible' to mental health services.
- He may, if more assertively approached, have made himself available to Cons PA10 and CPN-A8, and presented appropriately, displayed no signs of psychopathology, and agreed to more frequent contact with his mental health professionals.
- Any decision that the MHSU required an assessment of his mental state under the auspices of the Mental Health Act, would have had to have been supported and arranged by an Approved Social Worker, who had, and has, the responsibility for ensuring that the law is complied with. Except in the most urgent cases it is considered good practice to plan a Mental Health Act assessment so that professionals known to the service user are present. The planning of an assessment therefore can take a number of days.
- The presentation of the MHSU at the time of his assessment. The outcome of a MHA assessment cannot be predetermined. There are defined criteria that have to be met before an individual can be detained in hospital against their will. Although the MHSU had a serious risk history, he had been stable on a relatively low dose of medication in the community for 16 years, and it is possible that had he been assessed under the MHA (1983) he may not have met the criteria for compulsory detention in hospital.

Although the IIT considers it unlikely that the MHSU would not have displayed any signs of psychopathology at all during a detailed mental state examination

his family believes that he had the capability to deliver a convincing performance of well health.

Cons PA10 and CPN-A8 recognise that they should have been more assertive with the MHSU, and should have insisted on meeting with him on a frequent basis to monitor his mental state. However, Cons PA10 does not accept that an assessment under the Mental Health Act should have been a core component of the MHSU's risk management plan if he did not agree voluntarily to an assessment of his mental state. For Cons PA10 signs of psychopathology would have had to have been present to warrant such an assessment.

The IIT do not agree with this at all. The MHSU's past history of violence with intent to cause harm ,when unmedicated, meant it was imperative that assessment of the MHSU's mental state occurred on a frequency to enable early identification of signs of psychopathology after it became clear that he did not want to re-engage with medication on 5 May 2006.

It is the strongly held view of the IIT that had the MHSU not agreed to the necessary assessments, had they been promoted, then the criteria necessary for the conduct of an assessment under the MHA (1983) would have been met, with there being a possibility that a hospital admission would be required as a consequence, thus justifying the full assessment process.

However, what the IIT wish to make very clear is that it cannot say what the outcome of any such assessment would have been in terms of compulsory treatment for the MHSU. What it can say is that by not following up the MHSU more assertively including making strident effort to conduct an assessment of the MHSU's mental state, there were lost opportunities for changing the subsequent course of events. Whether more assertive efforts would have precipitated an equally tragic outcome, or have avoided tragedy altogether cannot be speculated upon.

Recommendations

The IIT has seven recommendations for Norfolk and Waveney Mental Health NHS Foundation Trust.

Recommendation 1: The Trust must ensure that its clinical staff engaged in the assessment of, and care planning for service users have a comprehensive understanding of the concept of insight.

Recommendation 2: All mental health practitioners, including medical staff, must understand the thresholds for assessment under the Mental Health Act

(MHA) and the thresholds for the compulsory detention of an individual under the MHA.

Recommendation 3: Norfolk and Waveney Mental Health NHS Foundation Trust must ensure that its medical staff, when providing reports to a mental health review tribunal (MHRT), follow the guidance for such reports as set out by the MHRT.

Recommendation 4: Norfolk and Waveney Mental Health NHS Foundation Trust needs to ensure that the care management and risk management plans developed by its staff contain a sufficient quality of information to minimise the loss of organisational memory over time about long term service users with a significant risk history.

Recommendation 5: Norfolk and Waveney Mental Health NHS Foundation Trust must have a robust system for the registration and tracking of all service users on section 117 after-care regardless of their MHA status.

Recommendation 6: The Trust must satisfy itself that the operational policies for all inpatient and community services set out what should happen when primary care services, or another agency, contact the trust about a patient currently in receipt of mental health services.

Recommendation 7: Norfolk and Waveney Mental Health NHS Foundation Trust must satisfy itself that its mental health practitioners are complying with all current standards applicable to the involvement of, and support for, families and carers. In addition the IIT suggests that the Trust adds a section to its website, under carers, entitled “What I can expect?”. The Trust may also want to consider relabeling its current “Carer” tab to “Families and Carers” to maximise accessibility of the information.

1.0 INTRODUCTION

This is a tragic case, and the manner of Mr Rayner's death was particularly violent. The death of Mr Rayner has affected his family, his friends, and the local community in which he lived. The death of Mr Rayner has also affected the MHSU. Mr Rayner and the MHSU were firm friends and the MHSU deeply regrets his death.

The investigation into the care and management of the MHSU was first commissioned by the EOE SHA in 2007. This was the year that the IIT first met with the family of the MHSU, the family of Mr Rayner and friends and neighbours of Mr Rayner and the MHSU. Following these meetings there was a delay in the further progression of the investigation because the MHSU initially did not consent to the release of his medical records to the IIT. There followed protracted correspondence between the Lay Chair, the Trust and the Department of Health before the records were eventually released in the summer of 2008. This delay in the procurement of the relevant documents, upon which progression of the investigation depended, was a significant contributor to the length of time this investigation has taken to be concluded.

The remainder of this chapter sets out an overview of the MHSU's contact with the specialist mental health services in Norfolk between 1985 and May 2006. On the whole the MHSU received a good standard of care from mental health services up to and including January 2000.

The time period of greatest importance was January 2000 to 24 May 2006.

A detailed analysis of the MHSU's contact with specialist mental health services between these dates is presented in chapter four of this report. The fine detail of the MHSU's care and treatment is therefore not presented in this chapter. This chapter intends to provide the reader with a comprehensive overview so that chapter four can be read in the context of this.

1.1 Overview of the MHSU 1985 – 28 September 1990

There is no childhood history of mental health illness for the MHSU. His parents found him to be a bright, likeable and normal boy who was very creative. The MHSU's first hospital admission occurred in 1985 when he was 33 years old. His admission lasted for 21 days. Prior to his admission to hospital the MHSU presented with symptoms of paranoia, hallucinations and depression. He gave a history of the symptoms having been present for up to three years with increasing severity in the month prior to admission. Immediately prior to admission, the MHSU reported having wanted to go and

drown himself or knife himself. He subsequently told his brother that he had taken an overdose of tablets.

The MHSU settled quickly with treatment but his reluctance to take medication was noted during this admission.

Within one month of discharge from hospital the MHSU had been admitted again. It transpired that he had stopped his medication within this period. A second admission to hospital was required. Following this the MHSU remained relatively stable and was discharged from mental health services in September 1985. He was re-referred in February 1986, and managed in the community until November 1986. During the nine month period of community support the MHSU was re-medicated with flupentixol (40mg) on a fortnightly basis. It was the gradual non-compliance with his medications that led to his relapse.

Again the MHSU was quickly stabilised on flupentixol depot injections. He was discharged from hospital on 6 January 1987 and by 15 January was already trying to negotiate a reduction in his medication regime. He was readmitted to hospital on 23 January 1987 with further evidence of suicide ideation. He was subsequently discharged on 9 March 1987. Notably in the discharge letter attention was drawn to the MHSU's lack of insight into his illness and his likelihood of future non-compliance with medication.

By 26 March 1987 the MHSU was wishing to stop his medication. His then consultant strongly advised maintaining it for at least one year. The MHSU did agree to this but negotiated a reduction in the dosage of flupentixol to 75mg fortnightly.

By the middle of July the MHSU had stopped taking his medication, having negotiated further reductions in this in the intervening period.

His next, and fifth, admission in three years occurred in April 1988. The MHSU self presented to the hospital with florid symptoms of psychotic relapse. He had gone to the hospital because he believed the hospital was the centre of his control. He absconded from the ward on two occasions and as a result was detained in hospital under section 2 of the Mental Health Act (1983) (MHA). He settled on medication and was subsequently discharged home after two successful weekend leave periods.

By the beginning of August the MHSU had again stopped all of his medications. He remain stable and reasonably well until January 1989 when he was arrested by the police and admitted to hospital under section 2 of the MHA. He was subsequently discharged in March and readmitted in May for a further month. The impetus for the admissions was a deterioration in the

MHSU's mental health including paranoid ideas, persecutory thoughts and thoughts of self harm. He was discharged on oral medication on this occasion.

His eighth admission occurred on 25 July 1990. He was admitted following an incident in which he had allegedly visited a local pub and fired two arrows into the dart board from a homemade crossbow. It was alleged that he had made the crossbow in order to protect himself from two men. He absconded on 2 August and remained at large until 28 September when he was arrested following an attack he made on his father with a knife causing a pneumothorax. The MHSU's father escaped further injury by locking himself in his car. The MHSU was arrested and remanded at Norwich Prison before being transferred to Rampton Hospital on 8 November.

1.2 November 1990 – January 2000

During this period the MHSU was initially treated in Rampton Hospital. During his first month in Rampton he told professionals that he was not unwell, he did not need medication and that he still intended to kill his father. He confirmed that were he at liberty he would not take medication voluntarily.

In 1991, in preparation for his trial, following his assault on his father, his responsible consultant psychiatrist wrote:
"[The MHSU]…was anxious to go to a Regional Secure Unit. His superficial willingness to take medication and his denial of symptoms must be seen in the light of this desire to leave Rampton Hospital. His past history would indicate that he is unreliable in taking medication in the community…

"In my opinion he will require to be on medication for the rest of his life…

"It is also clear that because of his lack of compliance to medication in the past he could not be trusted to take it again in the future. If his illness were to relapse because of failure to take medication he would once more become potentially extremely dangerous…a restriction order would not only place a restriction on his discharge from hospital, but would also allow the medical authorities and the Home Office the opportunity to recall him to hospital should he default from medication after any subsequent conditional discharge in to the community."

By June 1991 the MHSU's mental state was much improved. So much so that following a case conference, a consultant psychiatrist at the Norvic Clinic (the regional medium secure unit) concluded that the MHSU was sufficiently stable to warrant a transfer on trial leave from Rampton hospital to the Norvic Clinic. An assessment by the Norvic clinic nursing team concurred with this view. On 25 June 1992 the MHSU commenced trial leave to the Norvic Clinic.

The MHSU progressed well at the Norvic Clinic, quickly being awarded escorted ground leave and progressing through to unescorted ground leave, escorted leave out of the grounds and eventually overnight leave with his family. Although the MHSU progressed remarkably well, his relationship with medication was questionable. He reported not getting along with his medication at all, and had persistent complaints about side effects. Consequently the MHSU's medication was changed in February 1993 to flupentixol depot injections (20mg) fortnightly. He had been prescribed flupentixol 200mg weekly as an oral preparation. He was also prescribed procyclidine for the side effects he experienced.

The MHSU progressed well at the Norvic Clinic and in October 1993 he was granted comprehensive unescorted leave. His detention however was upheld.

In April 1994 the MHSU was discharged to Highlands Hostel, contained within the grounds of the Norvic clinic.

From April 1994 to May 1995 the MHSU's records show that he settled well in the hostel and that there were no issues of concern about him. He sold his house in his home village and bought another in a village near Norwich. He also applied for a driving licence and a three year licence was awarded him in March 1995.

Sometime in the early summer of 1995 the MHSU applied to the Home Office for a conditional discharge. This was not granted and the MHSU was encouraged to apply for a mental health review tribunal. This occurred on 27 September 1995, when with the support of his clinical team the MHSU was given a conditional discharge and discharged to live in his new home.

1.3 Forensic community follow-up 28 September 1995 – 31 January 2000

The forensic service maintained close follow up of the MHSU in the community. The backbone of the care plan was regular home visits and the involvement of the MHSU and his family in this.

The MHSU's family were invited to all Care Programme Approach (CPA) meetings and attended almost all of these.

The MHSU's progress was so exemplary that his clinical team supported his application for an absolute discharge in 1997. There were no dissenting opinions about this. All of the professionals who provided reports to the mental health review tribunal were 100% supportive. An absolute discharge was therefore awarded in September 1997.

From this moment on there was a natural progression to discharging the MHSU from the forensic service into the care of general psychiatric services. This process commenced in March 1998 and culminated in January 2000.

From March 1999 members from the general adult community mental health team covering the area in which the MHSU lived attended the section 117 after-care and CPA meetings. From September 1999 the general adult community mental health nurse also undertook some joint visits with the forensic community psychiatric nurse (CPN) and then shared the visits on an alternate visit basis.

The final forensic CPN visit was undertaken on 11 January 2000.

1.4 General adult psychiatric follow up January 2000 – December 2003

Over this period the MHSU was initially followed up at home on a two weekly basis. When his CPN, who was on secondment, left the team to return to his 'home' team on 23 March 2000, the MHSU was asked to attend at the team base for his depot injections.

The MHSU attended regularly for his depot injections. There were no concerning features about his presentation at any time. By December 2003 the frequency of his injections had reduced from fortnightly to three weekly. This time interval appeared to be sufficient.

In December 2003 to further the MHSU's progression into normal living, something he was very keen for, his care coordinator arranged for him to receive his depot injections at the GP surgery. Because the MHSU was self supporting in every other way and required no other support from the mental health team or from social services, he was discharged from the CPN case load.

1.5 January 2004 – April 2006

This was an uneventful period for the MHSU. He attended every three weeks for his depot injections at his GP surgery and every six months for his outpatient appointments with his psychiatrist. In July 2005 a new consultant psychiatrist on reviewing the MHSU's previous records determined that it would be prudent for the MHSU to re-engage with a CPN care coordinator and to be seen in outpatients on a more frequent basis than six monthly. The more frequent medical contact was initiated immediately. A CPN care coordinator was appointed in February 2006.

With regard to the MHSU himself, nothing untoward was noted with him until he did not attend for his depot injection on 21 April 2006.

When the primary care team were unable to make successful contact with the MHSU they notified specialist mental health services that the MHSU had not attended for his injection. This notification occurred on 25 April. The community mental health team told primary care that the MHSU was not on their caseload any more. The primary care team therefore wrote to the MHSU's consultant psychiatrist alerting him to the missed medication and the MHSU's non-availability.

1.6 27 April – 24 May 2006

Once the MHSU's consultant psychiatrist was made aware of the MHSU's medication non-compliance he asked the allocated CPN to make contact with the MHSU. This CPN did meet with the MHSU on 5 May 2006. However, he was not able to persuade him to accept any medication. Neither was he able to persuade him to meet with him (the CPN) on a more frequent basis than monthly.

The consultant psychiatrist and CPN were concerned about the MHSU and knew that achieving re-medication was important. Consequently the CPN raised the MHSU's case in supervision and at a team meeting on 17 May. He then met with the consultant psychiatrist on 18 May. The plan was to:

- increase the frequency of visits after his next planned visit on 2 June 2006;
- speak with the MHSU about making contact with his family; and
- achieve re-medication using oral atypical antipsychotic medication if necessary. Ideally depot medication was the preferred option.

Before the professionals involved were able to implement their plan the incident occurred on 24 May, seven days after their meeting.

2.0 TERMS OF REFERENCE

The original terms of reference for this independent investigation, set by the East of England Strategic Health Authority (the EOE SHA), were as follows:

Stage 1

- reviewing the Trust's internal investigation and assessing the adequacy of its findings, recommendations and action plan;
- reviewing the progress that the Trust has made in implementing the action plan; and
- agreeing with the Strategic Health Authority any areas (beyond those listed below) that require further consideration.

Stage 2

- reviewing the care, treatment and services provided to the MHSU by the NHS and the local authority from his first contact with services to the time of his offence;
- compiling a comprehensive chronology of events leading up to the homicide and establishing the circumstances of the incident itself;
- reviewing the appropriateness of the treatment, care and supervision of the MHSU in the light of any identified health and social care needs;
- reviewing the adequacy of risk assessments, including specifically the risk of the MHSU harming himself or others;
- commenting on the adequacy of the communication between the various agencies involved with the MHSU;
- examining the effectiveness of the MHSU's care plan;
- reviewing compliance with local policies, national guidance and statutory obligations;
- considering any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence; [and]
- providing a written report to the Strategic Health Authority that includes measurable and sustainable recommendations.

As stated in the executive summary it was subsequently agreed with the EOE SHA that the following questions would form the framework for this report, as in providing answers to the questions the terms of reference, where appropriate, would automatically be addressed.

- How was the MHSU granted an absolute discharge in 1997?
- Was the MHSU's care and management between May 1999 and December 2003 reasonable in relation to:
    - his transfer from forensic services to adult mental health services; and

        - his plan of care by adult mental health services between January 2000 and December 2003?
    - The MHSU's contacts with primary care services between December 2003 and 25 April 2006.
    - The medical management of the MHSU between January 2004 and April 2006.
    - The re-allocation of a CPN care coordinator for the MHSU following the identification of the need for this in July 2005.
    - The response of Norfolk and Waveney Mental Health Partnership (N&WMHP) NHS Trust when:
        - the practice nurse from the MHSU's GP surgery made contact on 24 April 2006; and
        - following the receipt by the MHSU's consultant psychiatrist of the letter from the GP practice highlighting the MHSU's missed medication.
    - The independent Investigation Team's perspective on the predictability and preventability of the incident.

With regard to the internal investigation undertaken by N&WMHP Trust, feedback to the EOE SHA and N&WMH NHS Foundation Trust about this has been made separately to this report. This ensures that nothing detracts from the primary purpose of this report which is to set out the investigation team's findings in relation to the care and management of the MHSU.

3.0 FAMILY INVOLVEMENT IN THIS INVESTIGATION

Two families were involved in this investigation - the family of the MHSU and the family of Mr Rayner. In addition a number of friends of the MHSU and Mr Rayner also met with the investigation team to help it understand the context of the relationship between Mr Rayner and the MHSU, and also how the MHSU had appeared to his friends in the weeks and months leading to the incident.

The IIT first met with the family of Mr Rayner on 29 August 2007. It met with the family of the MHSU on 30 August 2007 and four other friends of both the MHSU and Mr Rayner on 28 September 2007.

The Lay Chair for the investigation subsequently wrote to the families advising them that he was standing down from the investigation owing to ill health. The author of this report then wrote to the MHSU's family and the son of Mr Rayner on 5 July 2010, advising them that she had been commissioned to bring to the investigation to a conclusion by writing the investigation report.

The author wrote again to the MHSU's family on 28 July with the purpose of arranging to meet with them. This meeting occurred on 15 September.

The author wrote to the family of Mr Rayner on 16 September to advise on the progress of the investigation report and to propose a meeting to feed back to them the findings and recommendations of the investigation.

3.1 Information shared with the IIT by the families and friends

The information shared with the IIT by the MHSU's family, the family of Mr Rayner and joint friends of Mr Rayner and the MHSU highlighted to the IIT the absolute importance of ensuring that specialist mental health services provides opportunity for close family members to have a living relationship with specialist mental health services. All individuals the IIT spoke with were aware that the MHSU's mental stability had deteriorated in the months leading to the incident, and that in the weeks leading to the incident there was increasing concern about him and his behaviour. All of the people in the MHSU's local community believed that the MHSU was under the care of the mental health service and that they would be monitoring him. None of them knew who they could talk to about him.

3.1.1 The MHSU's family

The MHSU's family told the IIT that when their son received his conditional discharge in 1995 and went to live in his new home they had very regular contact with him. This continued for the whole time he lived there. They used to speak most nights and try and visit weekly. The MHSU's parents also used to pay for their son's telephone bill so that they could speak frequently. His mother maintained a diary of her contact with her son, and had done so for a long time. Because of this she was able to recall with accuracy that in the week prior to the incident she and her husband visited the MHSU taking two week's worth of groceries and some money for him, as they often did. His mother cooked lunch. While at his home Customs and Excise visited to check that red diesel was not being used in the domestic cars. During the visit the MHSU's mother recalled that two of his friends arrived, one of whom was Mr Rayner. The MHSU's mother recalled speaking with Mr Rayner and they agreed that if the MHSU became unwell, or there were any problems, they would contact each other. She also recalls that her son looked well.

However, the MHSU's mother began to feel concerned by 21 May as her son did not want to speak with her on the phone which was unusual. However, on 22 May he phoned her to tell her that all was OK. On 23 May he phoned again and told his mum that all was OK. On 24 May she heard nothing from her son and learnt of the death of Mr Rayner while watching the news.

The MHSU's brother told the IIT that he had concerns about his brother in the weeks leading up to the incident. He had spoken to Mr Rayner on the phone and advised him not to confront the MHSU and to call the police if he did anything silly. The MHSU's brother recalled Mr Rayner being unhappy that he suggested calling the police. They did not speak again. In the two weeks prior to the incident the MHSU's brother recalled that he (the MHSU) was saying odd things, paranoid things about people watching him. The brother told the IIT that although he was concerned about this, it was not all that unusual as over the years he would say these things and be absolutely fine the next moment. However, four days prior to the incident he spoke with the MHSU on the phone. He had planned to visit him on his motorbike but as it was raining he decided to call him instead. He recalled that the conversation was not as it usually would be. Notably when he asked the MHSU if he would get him some chain for his bike the MHSU said: "*Can't you get it?"* This was very unusual. Normally the MHSU would have been only too happy to help.

The MHSU's family also told the IIT that once the MHSU had been discharged from the Norvic Clinic they did not feel that they had anyone to contact if they were concerned about their son. They recalled that they may have met with their son's community psychiatric nurse (CPN) (September 1999 – March

2000) but the relationship of strength was with the Norvic Clinic. It was this team that visited the MHSU regularly at home.

The MHSU's family told the IIT and the author of this report that they were not provided with any contact numbers after the MHSU was under the care of general adult services, no one contacted them at any time as far as they can recall and they were never offered a carer's assessment.

This being said, prior to 2006, by and large, the MHSU's family did not feel the need to have contact with the psychiatric services because the MHSU was managing well. However, his brother told the IIT that it would have been useful to know who to call. He recalls that when the MHSU's medications were reduced from fortnightly to three weekly in 2001 a change in his brother's behaviour did occur. He feels that as a family they should have been advised of the change in medication, and they then could have alerted the services to the changes they observed. The brother recalled that when the MHSU's medication was fortnightly his mood was completely stable. However, once three weekly, there was a noticeable deterioration in mental health towards the end of the third week. This was something that was also noticeable to a close friend of the MHSU. The MHSU's brother and the friend assumed that the MHSU's psychiatrist would notice the change. However, his mother felt that the MHSU was very able to present himself as well to the mental health team for the short period of time he was in contact with them.

The MHSU's brother told the IIT that in 2006 he, and his parents, were worried about the MHSU. Following his contact with him on 21 May he, himself, had decided that he would need to speak with someone and was on the verge of contacting the Norvic Clinic when the incident happed. The Norvic Clinic was the only place he knew he could contact.

Anxiety about confidentiality was a hurdle for the MHSU's family in making proactive contact with mental health services. The experience of 1990 had left the family anxious of upsetting the MHSU, or fuelling any paranoia he may have. His mother believed that if she or his father contacted the mental health services, and the MHSU were informed of this, then he would not want to know his family, or it may make him suspicious of them thus increasing their risk factors. The MHSU's brother confirmed that there was a generalised anxiety and that he was anxious for his parents.

The MHSU's brother told the IIT that had anyone from the MHSU's care team in 2006 made proactive contact with him he would have shared his concerns with them. Contact from the mental health service would have been welcome. He would however have wanted an assurance of confidentiality.

3.1.2 Mr Rayner's family

Mr Rayner's family had known the MHSU for approximately five years when the incident occurred. Mr Rayner and the MHSU had become friends in about 2001. His son told the IIT that *"they were all into motorcycles and classic tractors and machines, because a lot of them were retired. The MHSU wasn't working and another chap wasn't working and they spent quite a lot of time with each other going to auto jumbles, going out on their motorbikes and things like that. The MHSU is quite into his machinery, and my dad was a mechanic by trade anyway, so they got together."* Mr Rayner's family also told the IIT that they *"were aware that there was something not quite normal going on, but I don't think a lot of us really knew what was going on".*
His family told the IIT that the local community their father lived in was mutually supportive. People were taken at face value, and Mr Rayner and his circle of friends were inclusive and non-judgmental. Everyone knew that the MHSU had some mental health problems but he fitted in, and they were content to accept the eccentric elements of his personality.

Mr Rayner's family believed that the MHSU's friends felt bad for him because when he had his medication he went very wobbly and he didn't like having it.

Mr Rayner's son told the IIT that people were aware that there had been a incident in the past between the MHSU and his father, but that the community believed that if he was living in the community then he was well enough to do so. What had happened previously was not an impediment to the MHSU being accepted.

Mr Rayner's son also told the IIT that approximately three to four weeks before his father's death, there had been an incident where the MHSU had been aggressive towards his father. Mr Rayner's son recalled his father telling him that the MHSU had been verbally aggressive towards him and had brandished a cutlery knife at him. However, Mr Rayner did not tell him that the MHSU had pinned him up against the wall. He became aware of this after his father's death.

This information highlights that the MHSU was not well at the end of April, even though he appeared so to the CPN who met with him on 5 May 2006.

Mr Rayner's son also told the IIT that he was aware that his father knew the MHSU's parents and that they used to visit the MHSU regularly
And that they would "help him out with money or whatever because he wasn't working." Mr Rayner's son also recalled that his dad *"would go round there and speak to them because he got on quite well with the MHSU's parents."* He also recalled that he advised his dad to take care with the MHSU, but that his father believed he had *"it all in hand."*

The information shared by Mr Rayner, with his son, evidences that the MHSU was not well. Information such as:
"My dad would come back to me with stories of different things he'd (the MHSU) done, like he'd written away to NASA to apply for a job as an astronaut or something similar, and he'd written a letter to the DHSS to say he was cured of his illness and now he was fit to go on to jobseekers' allowance and look for a job – this was about two weeks before the incident. I was getting a bit concerned and I thought he was quite strange."

And:

"The last time I spoke to my dad before he was killed he said that he'd made contact with the MHSU's mother and brother, and he'd said, 'He's really ill, he's not taking his medication. There's something going wrong here, I don't know what it is, you're his parents, there must be something you can do, come down and sort him out.'" Mr Rayner's son recalls his dad telling him that the MHSU's family had advised him to call the police if the MHSU was at all intimidating. He also recalls telling his Dad that: *"I think that's what you're going to have to do."'*

Mr Rayner's son and daughter are confident that people who knew the MHSU in the community were aware that something was wrong; a number of his friends had started to distance themselves from him. However, Mr Rayner was one of the MHSU's constant sources of support. His son feels that:
"it caught everyone by surprise, but everybody knew that something was wrong."

What seems clear to the IIT is that the MHSU received considerable support from Mr Rayner. He visited him regularly, he provided meals for him, he watched out for him. Like the MHSU's family, he was in many respects a friend and an unpaid carer.

Had the general adult mental health service maintained contact with the family and neighbours as directed in the care plan agreed for the MHSU, then the general adult mental health service may have been much more informed than it was about the MHSU.

3.2 Carer's assessments

The Office for National Statistics in 2001 defined an unpaid carer as someone who "looks after, giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age.[1]"

The MHSU's parents were unpaid carers to their son. They visited him weekly, spoke to him on the phone every day, provided him with financial support and supplied him with food parcels. Members of the MHSU's local community who were close to him were aware of the support his parents provided.

It appears that none of the MHSU's care coordinators between 1999 and 2006 were at all aware of the amount of support the MHSU was provided with. Because his care plan was not followed, and there was no assessment of him at home after March 2000, the mental health professionals were:

- never exposed to any of the MHSU's social network;
- never had the opportunity to assess the MHSU's living circumstances; and
- never appreciated that he would spend all of his money on his workshop and tools rather than on necessities such as food.

It is the contention of the IIT that Mr Rayner also met the criteria of a carer for the MHSU. He provided him with meals and visited him approximately three times a week.

Mr Rayner and the MHSU's parents should have been offered a carer's assessment in 2000, and annually thereafter.

The requirement for this was set out in the *"National Service Framework for mental health"* (NSF) (DH 1999).

Standard Six of the NSF says "the CPA care co-ordinator should inform users and carers of the carer's right to request an assessment and ensure co-ordination of users' and carers' assessment plans."

The NSF set out what a carer's plan should include, as follows:

- Information about the mental health needs of the person for whom they are caring, including information about medication and any side-

[1] http://www.bournemouth.gov.uk/Library/PDF/Living/Planning/Research/Census_Factsheets/KS08%20People%20providing%2050+%20hrs%20a%20week%20unpaid%20care%20request%20310304.pdf

effects which can be predicted, and services available to support them.
- Action to meet defined contingencies.
- Information on what to do and who to contact in a crisis.
- What will be provided to meet their own mental and physical health needs, and how it will be provided.
- Action needed to secure advice on income, housing, educational and employment matters.
- Arrangements for short term breaks.
- Arrangements for social support, including access to carers' support groups.
- Information about appeals or complaints procedures.

The *CPA Handbook* (The Care Programme Approach Association 3 February 2001) says in Chapter 6, "*Carer involvement*", that care coordinators to effectively involve carers should:
- be aware of who the main carers are, what their relationship is with the person, and how to contact them;
- communicate with the carer as far as possible;
- consider whether a full carer's assessment is required;
- be aware of the carer's needs;
- make sure the carer knows how to contact the care coordinator;
- include the carer's role in the care plan; and
- consider the need for an individual care plan for the carer.

Neither of these documents differentiates between carers of service users on enhanced or standard CPA.

Between 1999 and February 2002 Norfolk Mental Health Trust did not have an up-to-date CPA policy in place. The IIT reviewed a 2000 CPA policy from another mental health trust which said:
"..the involvement of service users and carers will be seen as a requirement of CPA ... the active involvement of any carer should be encouraged unless their exclusion is specifically requested by the Service User. If significant risk is posed to others by the Service User then consent may be overridden and contact made with the Carer as appropriate."

In the Norfolk Mental Health Trust CPA Policy 2002 it said:
"all individuals who provide regular and substantial care for a person subject to CPA are entitled to:
- an assessment of their social and health needs; and
- a written care plan, agreed with them, that covers their needs as carers, reviewed at least once a year."

The 2002 policy also stated that: "Carers must be given information about the support available to them and how to access it ... Subject to the consent of the service users, or other legal requirements, carers must be given information

about the support provided to the person they care for ... Even if the service user does not want their carers to be involved in the Care Programme Approach it is important for them to know who the care coordinator is, where he or she is based and how to access services in a crisis or outside office hours."

Importantly the Norfolk Mental Health Trust CPA policy in 2002 (page 17) and 2003 (page 16) states:
"... if there is significant risk to the service user or to the carer then contact may be made without the service user's agreement."

3.3 IIT's comment
Because the memory recall of the MHSU's care coordinator between September 1999 and March 2000 was not good, the IIT does not understand why there was no engagement between general adult services and the MHSU's family. Up until September 1999 the MHSU's parents had been in attendance at most of the MHSU's CPA reviews and section 117 after-care meetings. They were very integral to the MHSU's care plan, and care package.

From March 2000, when the MHSU began to attend at the mental health team's community base for his depot injections, it seems as though the then team manager, and senior community psychiatric nurse (CPN-A4) made an assumption that the MHSU had no carer input because he lived independently in his own home. It is the perspective of the IIT that this was a very narrow perspective. Although the MHSU did live in his own home his mother spoke with him daily and his parents continued to provide some financial support to their son as well as visiting regularly until the incident in 2006.

The MHSU's care team from 2000 lost sight of the input the MHSU's family provided to him. This was a consequence of the non-continuation of home visits and the loss of the detailed care plan set out by the forensic service. Having interviewed a range of staff involved with the MHSU between 1999 and 2003 it is also the contention of the IIT that the interpretation of "carer" by staff was a narrow one and confined to tangible and traditional caring activities such as cooking, washing, cleaning, and transportation. The mental health professionals between 1999 – 2003 simply did not see the MHSU as having any needs that would require the support of a "carer". They took the MHSU at face value, and paid no heed to the clear prompt in the CPA care plan of September 1999 that highlighted the importance of maintaining contact with the MHSU's family and friends, i.e. his social network. These were the people most likely to identify an emerging relapse in the MHSU and it was these people who were most likely to be at risk of harm if/when he did relapse.

The report *Safer Services* from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (1999) said:

"Mentally ill homicides were most likely to kill a family member or spouse; the proportion of victims who were strangers was lower than in those without current symptoms of mental illness." (page 7)

It also said:
"In 14% there was a history of previous violence occurring during episodes of psychosis; the majority of these patients were either noncompliant with treatment or out of contact with services at the time of the homicide; just over half were subject to the higher levels of the CPA." (page 8)

It also said in its recommendations (page 12):
"Points of access" to mental health teams should be provided for families who are concerned about a patient's risk."

In this case, the MHSU had already grievously harmed his father in 1990, he had also gone to a local pub with the intent of harming a friend who he felt was making a conspiracy against him. At the time of these acts the MHSU was medication non-compliant.

When he was granted an absolute discharge in 1997, it was foreseeable that should he ever become medication non-compliant again then he would pose a risk to those close to him, that is, close friends and family. The MHSU's family were concerned about their safety should their son ever relapse.

At the very least the general adult psychiatric services should have made sure that the MHSU's family knew:

- who his care coordinator was;
- how to contact his care coordinator if they ever had any concern about his mental health; and
- the numbers to call in a crisis.

Ideally the MHSU's family should:

- have been offered a carer's assessment;
- received a courtesy follow up annually with a revision of their carer's needs offered, if a carer's assessment had been refused initially; and
- have been invited to the MHSU's CPA reviews, as they always had been up until September 1999.

The IIT does not think that the MHSU's family would have accepted a carer's assessment at the time their son was well. However, the IIT does believe that had the MHSU's care coordinators maintained the minimum contact, i.e. an annual follow up, then it is possible, but not probable, that in April or May 2006

a family member may have made contact with the mental health service, or a family member may have provided Mr Rayner with the contact details for the MHSU's care coordinator, or crisis team.

The IIT is more confident that had the mental health services contacted the MHSU's parents and/or brother soon after May 5 2006, information would have been shared that should have resulted in an escalation of the plan of management for the MHSU.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the independent Investigation Team's (IIT's) findings following its investigation. As is often the case when undertaking a retrospective analysis of a service user's care and management by specialist mental health services, the team found that there were aspects of this MHSU's care and management that were good and aspects that could and should have been much improved.

It is important to make clear that in setting out its findings and subsequent conclusions, it has been the responsibility of the IIT to avoid hindsight bias[2]. It has also been responsible for analysing the appropriateness of decisions made or not made, on the basis of the circumstances that were present and the information available to the specialist mental health service at the time (in this case between May 1999 and May 2006).

It is also the responsibility of the IIT to consider what a reasonable group of similarly qualified clinicians would have done in similar circumstances. This is what the National Patient Safety Agency (NPSA) refers to as the "substitution test" in its "*Incident decision tree*".[3]

Before embarking on the presentation of the IIT's findings in relation to the questions set out in the executive summary (page 7) there are a number of aspects of the MHSU's care and management that must be positively acknowledged. These are:

- The overall management of the MHSU by the specialist forensic services, by:
  - at Rampton Hospital;
  - the Norvic Clinic; and
  - the community forensic mental health team (CFMHT).
- The planned stepped handover period between the forensic service and the general adult community mental health service, including a six month period where both services jointly managed the MHSU.

[2] Hindsight bias is the inclination to see events that have occurred as more predictable than they in fact were before they took place. Hindsight bias has been demonstrated experimentally in a variety of settings, including politics, games and medicine. In psychological experiments of hindsight bias, subjects also tend to remember their predictions of future events as having been stronger than they actually were, in those cases where those predictions turn out correct. This inaccurate assessment of reality after it has occurred is also referred to as "creeping determinism".

[3] http://www.msnpsa.nhs.uk/idt2/(jg0xno55baejor55uh1fvi25)/index.aspx

- The management plan for the MHSU at the point of handover between the forensic community service and the general adult community service, which was appropriately detailed and robust.
- The intervention of CPN-A4, on 5 March 2001, when she took action to prevent a locum consultant psychiatrist, who had little knowledge of the MHSU, from taking the MHSU off his depot medication and placing him on oral atypical antipsychotic medication. This CPN recognised the increased risk of relapse such a change would represent for the MHSU. As a result of acting assertively, with the support of TM1, the MHSU remained on his twice weekly injections of Depixol 20mg.
- The recovery team manager, TM2, for the MHSU's CPNs was available to actively support the delivery of a flexible service for the MHSU, including the administration of his depot injections. This individual was able to evidence an intimate knowledge of the MHSU, his interests and his risk relapse indicators. Given the size of the CPN caseloads at the time (in the period 2000 – 2003), the IIT considered it notable that he recalled this service user with such clarity.
- When Staff Grade Psychiatrist PA5 returned temporarily to the MHSU's mental health team on 1 July 2005, for a period of 15 days only, she ensured that that the MHSU was transferred from the staff grade's list to the caseload of the incoming consultant psychiatrist (PA10). The staff grade had always had concerns about the potential risk of medication non-compliance with the MHSU and knew that he required consistency in his follow up from an experienced psychiatrist and not an inexperienced junior doctor.
- When Cons PA10 took over as the MHSU's care coordinator, he recognised at an early stage in his clinical relationship with the MHSU that contact of greater frequency than the established six monthly outpatient appointments was required. Consequently he increased outpatient contact to every two months and requested that the MHSU be allocated a CPN care coordinator so that a balanced care plan could be implemented.
- The primary care service correctly contacted the MHSU's community mental health team as soon as he defaulted on his medication in April 2006. When informed that he no longer had a CPN, the primary care service immediately wrote to the MHSU's consultant psychiatrist alerting him to the situation. This letter was sent on 25 April and received by specialist mental health services on 27 April 2006.

The remainder of this section will focus on the IIT's findings in relation to:

- (4.1 page 32)The circumstances of the MHSU's absolute discharge from section 37/41 of the Mental Health Act(1983) in 1997.

- (4.2 page 40) The reasonableness of the MHSU's care and management between May 1999 and December 2003 in relation to:
  - his transfer from forensic services to adult mental health services (page 40);
  - the conduct of the general psychiatric services September 1999 – December 2003 (page 47);
  - the effectiveness of the MHSU's medication management between January 2000 – December 2003 (page 73); and
  - the decision to discharge the MHSU from the CPN caseload in December 2003 (page 75).
- (4.3 page 86)The MHSU's contacts with primary care services between December 2003 and 25 April 2006.
- (4.4 page 88) The psychiatric management of the MHSU between January 2004 and April 2006 by specialist mental health services.

4.1 The circumstances of the MHSU's absolute discharge from section 37/41 of the Mental Health Act in 1997

In September 1995 the MHSU was given a conditional discharge from section 37/41 of his detention under the Mental Health Act (1983) (MHA). At this time he had been under the care of the Norvic Clinic for three years and three months, having been transferred from Rampton Hospital on 25 June 1992.

The conditions of his conditional discharge as were:

- "That he shall cooperate and comply with medication and medical treatment, including injections, as directed by his responsible medical officer (RMO) and community psychiatric nurse (CPN).
- That he shall attend his RMO and CPN and receive visits from his RMO and CPN as directed by them, their deputies and successors.
- That he shall accept social supervision from his social worker.
- That he shall reside at ... or at such other place as his RMO and Social Worker shall together agree." (Decision Form S75(2) MHRT Rules 1983).

In the two years following his conditional discharge the MHSU was by all accounts a model patient. He complied fully with his treatment, he engaged in work placements, lived independently in his own home, and he was self caring and motivated. Consequently in April 1997 the MHSU applied for a mental health review tribunal (MHRT), to seek absolute discharge from the conditions imposed in 1995 so that he could move on with his life. His clinical team supported his application without reservation.

The approved social worker who was working with the MHSU in 1997 provided the MHRT with the following information:

"At the Norvic Clinic the MHSU was popular and got on well with staff and other patients. In May 1994 he moved to Highlands, a staffed hostel in the hospital grounds, where he was active in reclaiming the garden, digging, planting vegetables and cutting back hedges. He dealt with his own budgeting, collecting his benefits from the local post office, and did his own shopping, cooking and cleaning.

Although when the MHSU was discharged from the clinic there were some slight misgivings about him moving directly to a totally independent living situation, he has shown that he is well able to manage his affairs and look after himself. His mental state has remained stable and his insight is excellent: he is well aware of the serious nature of his mental illness, and the index offence to which it led him. He accepts that he must continue to comply with the treatment he receives in order to avoid the risk of relapse, and I am confident that he would seek help quickly if his mental state started to shift. Being seen fortnightly, by his CPN, to receive his injection acts as a further safeguard in monitoring his mental health.

For these reasons I would have no objection to the MHSU being granted an absolute discharge."

The MHSU's consultant psychiatrist, herein referred to as Cons PF1, had been the MHSU's consultant psychiatrist since 1993 and included in his report dated 11 June 1997:

- A detailed summary of the MHSU's psychiatric history prior to the attack on his father in 1990. This summary clearly shows that the MHSU always experienced serious relapses when not medicated.
- A summary of the MHSU's progress at the Norvic Clinic, which included;
  - information relating to the steady increase in his leave status with the consent of the Home Office between 1993 and 1997;
  - that the MHSU's behaviour was considered exemplary; and
  - that following his move to Highlands, a rehabilitation hostel within the grounds of the Norvic Clinic, his progress was *"very good".*

Cons PF1 also detailed a summary of the MHSU's progress in the community following his conditional discharge in 1995. This summary included:

- *"His function in the community has been thought to be exemplary. He has made major alterations to the house including adding a*

substantial work garage at the back of the house, where he has major engineering tools."

- *"His function at work has been similarly impressive. He has progressed to working three days a week for a heavy industrial fabricating firm and all reports are very positive about his level of functioning there."*
- *"His mental state has remained very well controlled on his medication, there has been no resistance to medication and he has been entirely co-operative with follow up."*

The final conclusion of Cons PF1 was:

- *"The MHSU is still suffering from a mental illness, namely schizophrenia. The positive and negative features of the illness are well controlled by depot medication and since his return to the community his level of social functioning has been very good indeed.....*
- *Despite that listed above I am now of the opinion that the MHSU is of a mental state which would not make him appropriate to be liable to recall to hospital for treatment for his mental illness. As such I support the application for absolute discharge in this case."*

The role of an MHRT is to:
"provide mentally disordered patients with a safeguard against unjustified detention in hospital or control under guardianship by means of a review of their cases from both the medical and non-medical points of view."[4]

Prior to a hearing:

"The Tribunal panel will have already read the written reports submitted as evidence. It will hear the evidence of the witnesses present on behalf of the Trust (usually the RMO[5] and the social worker) and it will take into account anything that you or your representative has to say. All the parties will be given an opportunity to ask questions."

In this case the information provided to the MHRT did not set out any information about the professionals' view regarding the risk of future medication non-compliance and what the risks of non-compliance were. The solicitor acting for the MHSU told the author that there was 100% support for the MHSU's absolute discharge. When asked if there was any consideration of risk should he become medication non-compliant she could not recall any.

The reports, in the opinion of the IIT, did not represent a balanced professional view of risk versus benefit. Neither did they evidence that there had been sufficient testing of the MHSU's mental health state to support the assertion that his insight was "excellent". The IIT was not able to interview Cons PF1 because of significant health issues, so the IIT has not been able to explore how Cons PF1 understood his duty to his patient and the MHRT at the time, or whether at the tribunal hearing (had he been able to attend) a discussion about the risk of relapse and associated risk would have occurred.

Neither has the IIT been able to interview the consultant psychiatrist to the MHRT.

The IIT did however interview the forensic consultant psychiatrist (FCP-CP) who prepared a report about the MHSU for the Crown Prosecution service in preparation for the case against the MHSU following the death of Mr Rayner.

It is the perspective of FCP-CP that for an absolute discharge to have been granted two years after the conditional discharge was *"dramatically quick*

[4] http://www.courtsni.gov.uk/en-GB/Tribunals/MentalHealthReview/GuideforPatients.htm
[5] Responsible Medical Officer

and most unusual." He told the IIT that an absolute discharge would more usually follow a period of "*6-8 years of stability and with some patients may never be appropriate."* He also told the IIT that in his opinion *"there never would have been grounds for an absolute discharge, because it was the imposed supervisory and consultatory structure which contributed to ensuring"* the MHSU's mental state remained stable. The IIT agrees with this.

The IIT asked the MHSU's social worker what his perspective was. The following is an excerpt from his interview:

*"**Q.** What is your expectation of the length of time a patient would normally be on a conditional discharge?*

A. *How long is a piece of string? With the MHSU it was almost exactly two years between the conditional and the absolute, which I would go no further than say was about average. I've had patients on my books who didn't want to come off their conditional discharge because they wanted the continuing support that only the medium secure unit could provide. I can remember one particular patient who had been on a conditional discharge for six or eight years, and for all I know he may still be, I don't know. What I'm saying is it had to be geared to the patient's needs and their level of confidence, together with our level of confidence that they weren't being over-optimistic. As I say, the MHSU was two years on a conditional and that was right for him.*

Q. *Was that similar with other Norfolk patients, with your knowledge of working in the area?*

A. *It's about average, allowing for the fact that some didn't want to apply for an absolute discharge for perhaps quite a lot longer."*

The IIT also asked:

"Q. *What factors caused you to recommend that the MHSU was suitable for an absolute discharge?*

A. *His ability to cope on his own, basically. Unlike what subsequently happened, we never had any concerns, while he was under our wing, about accepting medication. I think it had been drummed into him right from the word go that if things like that weren't going to happen again, he had to carry on taking the medication, and our understanding at the end was that that message had gone home. The trouble was that four or five years later the memory of that message had got a little bit dim."*

When asked about the objection by the Home Office, the social worker said:

"It sounds awful to say this but I seem to feel I've seen an awful lot of these. It's as if they were churned out as a matter of routine because the Home Office always take the absolute safety point of view and weren't even prepared to entertain any remotest risk. If the Home Office, rather than the tribunal, had been responsible for the ongoing decision-making, the MHSU would probably still have continued on a conditional discharge ad infinitum."

The solicitor who acted for the MHSU told the author that she expected the Home Office to object because there was 100% support from everyone else. She could see how the Home Office could act differently. Its primary responsibility is to public safety and it had to be cautious.

It is the IIT's experience of MHRTs that there is a consistency in the Home Office's response to requests for an absolute discharge from the conditions imposed under the MHA. The most frequent response is 'no'.

The social worker was also asked:
"Q. *Did you expect the tribunal to make an absolute discharge?*
A. *Yes, I think we did. Normally they went along with our recommendations."*

The experience of this social worker is not the same as the IIT's experience of MHRT decisions.

The interview notes with FCP-CP say:

*"In the case of the MHSU, he (*FCP-CP*) found no evidence of a complete recovery. On the contrary, the MHSU had a history, from at least 1985, of a recurring mental health instability and unpredictability. He also had a clear disposition to fail to appreciate the full necessity for, and effect of, his medication. Therefore, this decision cannot be supported due to what was known of his past history, the episodic nature of his condition and the absence of clear signs of enduring improvement in his mental state."*

The interview notes also say:
"The decision was the sole responsibility of the Panel. (That is the MHRT Panel). Its members had a duty to question and challenge the witnesses in depth. The Panel should also provide a detailed and reasoned statement in support of its decision. In particular no weight should be given to the evidence in support of the application given by the MHSU's father, even though he was the victim, because the primary issues for the Tribunal was the state of the MHSU's mental health.

The opposition of the Home Office to the application should have weighed heavily with the Tribunal. It's perspective is one of risk assessment and, in Cons FP1's experience, its evidence is considered and case specific ... the

opposition of the Home Office in 1997 should have been treated as considered and important."

The medical director at the former Norfolk and Waveney Mental Health Partnership NHS (N&WMHP) Trust told the IIT:
"The conditional discharge was in 1995, the absolute discharge was 1997 which, from my outlook of forensic psychiatry, is a very short time period, particularly for an individual with a diagnosis of schizophrenia. We are not talking about an illness that is going to be cured, because he had been unwell since the 1980s ... that strikes me as very short ... The Home Office generally had a policy of we won't look at a submission for absolute discharge unless the person has been conditionally discharged for five years at that time."

The author of this report discussed this whole issue with a firm of solicitors who are members of the MHRT. The recollection of one of its partners was that in 1997 a service user could apply for absolute discharge after one year. One of the main preoccupations of the MHRT, at that time, was there anything in the service user's current state that might suggest there would be reason for recall in the near or more distant future. In the case of this MHSU, it was self evident that in the immediate and foreseeable future that was unlikely. The solicitor also suggested that in the 1990s there was an over-reliance on mental health professionals' usage of the MHA. Now, the situation is very different with the MHRT being much more attuned to the subject of risk and public safety. The IIT, and the solicitor with whom the author spoke, are of the opinion that the MHSU would not have been granted an absolute discharge if the MHRT occurred today. The condition of medication compliance the IIT believes would remain in situ. Then, there was not so much awareness and the impetus was the right of the individual to be managed in the least restrictive environment or circumstances.

To try and clarify further what the balance of responsibility between a service user's clinical team, notably the RMO, and the tribunal panel doctor was at the time the MHSU was given an absolute discharge, an internet search was undertaken which revealed little information about the role of doctors in the MHRT scenario. There was however a useful paper published in the *Psychiatric Bulletin* in 1991, "The role of the doctor in the Mental Health Review Tribunal" by P. Grahame Woolf. (Psych Bulletin (1991) vol 15, no 7, pp407-409, http://pb.rcpsych.org/cgi/reprint/15/7/407)

This article says:

> "Medical member
> The medical member of the panel has a complex role (Finestein, 1988). At his preliminary examination of the patient and study of the case file, if possible at least several days before the hearing, he will check that the patient understands the procedure ... He alerts the President and lay member to the patient's level of comprehension and insight, brings out material factors which do not appear in the reports and ensures that these emerge openly during the hearing. It will be for him to seek to clarify medical evidence as to diagnosis, treatment and future plans, assisting those doctors who may be unfamiliar with the complicated legal jargon of the Act and Rules ... After the hearing the medical member normally takes a vigorous part in the panel discussion, but hospital staff should understand that it is not uncommon for the medical view to have been over ruled in a majority decision."

The same article also says of applications by restricted patients:

> "In cases of applications and automatic references concerning restricted patients (S37/41) convicted of serious offences, the cautious approach of the Home Office and Judge/QC Presidents of Restricted Tribunal Panels is understandable ... In preparation for these hearings in which dangerousness will be a central issue, it is particularly important that the fullest possible reports should be offered, addressing questions of insight into the circumstances of the index offence and future risks to the public. These are some of the cases in which independent psychiatrists, psychologists and social workers may have significant roles, and in which their oral evidence may assist the tribunal to make a just determination. The contributions of all participants would benefit from study of *Risk-taking in Mental Disorder* (Carson, 1990)."

It seems to the IIT on the basis of the case involving this MHSU that there could not have been a balanced consideration of risk. That is, risk to the MHSU and also risk to the public when the absolute discharge was given. The decision for absolute discharge, to the lay person, defies common sense when one looks at the MHSU's past behaviours around medication compliance. It is the perspective of the IIT that without imposed conditions the MHSU would at some stage become vulnerable to medication non-compliance, and that the MHRT should have appreciated this. The IIT does not consider that the decision for absolute discharge was made in the MHSU's best interests. It removed any mandatory treatment options and therefore left him vulnerable to relapse.

4.2 The reasonableness of the MHSU's care and management between May 1999 and December 2003 in relation to;

- **his transfer from forensic services to adult mental health services;**
- **the conduct of the general psychiatric services September 1999 – December 2003;**
- **medical follow up;**
- **medication management; and**
- **the process by which the MHSU was discharged from the CPN caseload to primary care in December 2003.**

4.2.1 The MHSU's transfer from forensic services to adult mental health services

When the MHSU was given his absolute discharge in 1997, it was already known that he would look to be discharged from the forensic service to general adult services. This was acknowledged in the form that recorded the decision of the MHRT. It said:
"We are reassured that instead of an immediate change of care team that his present CPN will continue to visit him for about a year followed by close liaison during the transitional period."

The MHSU remained under the sole care of the forensic service until May 1999.

The first documented evidence of the process of handing over medical responsibility for the MHSU between the forensic and the general adult community service appears in December 1998 in the form of correspondence between the consultant forensic psychiatrist (Cons FP1) and the consultant psychiatrist for adult services covering service users residing in the MHSU's GP practice catchment area, Cons PA1.

In this correspondence Cons FP1 identified that following the MHSU's absolute discharge from the treatment conditions imposed upon him, there was a *"proposal for the MHSU to be transferred to the general psychiatrists, partly at the request of the patient himself."* Cons PF1 informed Cons PA1 that this was not progressed because of illness experienced by the MHSU's previous consultant. Cons FP1 advised Cons PA1 *"if you consider the possibility of transfer to your team a realistic one I would arrange a 117 meeting inviting you and your community psychiatric nurses where a formal transfer can be discussed and agreed."* Cons PF1 also enclosed for Cons PA1 a copy of the medical report prepared for the MHRT in June 1997.

Cons PA1 responded positively to the correspondence from Cons FP1 on 11 December 1998, agreeing to attend a section 117 meeting. He also said: "*If it is considered appropriate by everyone involved (I) will be pleased to take over his future care. "*

The proposed section 117 meeting was organised for 15 March 1999 and Cons PA2, a locum consultant covering for Cons PA1, agreed to attend. On the letter inviting his attendance Cons PA2 wrote: "*I've confirmed for 15/3/99 at 12 noon. Please can you remind me nearer the date to re-read this info."* The IIT presumes that this note was for the attention of the medical secretary. The IIT also notes that the letter to Cons A2, highlighted that the status of the meeting was not now a section 117 meeting. The rationale for not hosting a section 117 meeting was that it would have necessitated the invitation of the MHSU and his family. The forensic service felt a more open discussion could occur between the forensic and the general adult service if it was a professionals-only meeting. The IIT concurs.

In the medical records are detailed notes of the meeting held on 15 March 1999 notated by Cons PA2.

The notes made include:

"*if he refuses medicine or break through in psychosis, loses insight very quickly. Poses risk to himself and others. Forensic team advise to treat early if necessary via Sec 3 (of the MHA) and admit.*
Seriously ill when ill."
and:
"Boundaries with women loose, bordering on inappropriate. Male CPN would be advisable. Female staff visit without problem but would be helpful for male CPN."
and:
"Medication reviewed every three months. He would like to think he does not have schizophrenia or need medication, but accepts need for it as preventative factor."
And:
"*His victims were always known to him and featured in delusional system. Need for staff to check out feelings re. themselves and others as part of assessment. Feels empathy for victims when well."*
and:
"From teams point of view consider supervision register ... handover period to commence after next Sec 117 meeting."

The invitation to an after-care coordination meeting in May was sent to:

- the MHSU;
- the MHSU's parents;
- the MHSU's social worker at the Norvic Clinic;
- Cons FP1;
- the MHSU's GP;
- a representative of NORCI[6];
- two CPNs from the community mental health team (CMHT), including CPN-A1;
- Cons PA1; and
- a local authority social worker.

Of the above invitees,

- a locum consultant psychiatrist (Cons PA3) attended on behalf of Cons PA1;
- both of the invited CPNs from the CMHT attended;
- the MHSU's GP did not attend; and
- the local health authority social worker did not attend.

The documented plan of care in May was:

- *"Fortnightly CPN visits to*
  - *administer IM medication;*
  - *mental state examination;*
  - *guidance re. self monitoring and reporting early signs of relapse/becoming less well;*
  - *advice and support as required;*
  - *monitor the MHSU's relationships with others; and*
  - *refer to risk management plan.*
- *arrange section 117 meetings and CPA meetings as appropriate (with urgency if required);*
- *liaise with significant individuals involved in the MHSU's section 117 after-care;*
- *facilitate multi disciplinary/multi agency working;*
- *provide conduit for communication of information and concerns; and*
- *provide contact point for the MHSU's parents' for advice/information if needed."*

[6] now Meridian East, an organisation in the local area offering supported training employment and placements.

This was a good plan. Furthermore the information gathered from the forensic CPN and approved social worker for the MHSU revealed that it was a plan that was adhered to. At this time there was no active involvement of the general adult service in the day-to-day care management of the MHSU. The next after-care meeting was scheduled for 30 September 1999. This occurred as planned.

The meeting was attended by:

- the general adult services CPN (CPN-A2, who had taken over from CPN-A1);
- the MHSU;
- the forensic consultant psychiatrist;
- the MHSU's approved social worker; and
- the forensic CPN.

The consultant psychiatrist from the general adult service (Cons PA1) who was accepting the MHSU onto his caseload did not attend.

The plan of care as documented on the Care Programme Approach (CPA) documentation tool by the forensic CPN was:

- *"fortnightly visits by CPN from the CMHT;*
- *liaison with local team at their base by forensic CPN;*
- *review by RMO at section 117 meetings;*
- *work placement/college placement;*
- *point of contact / liaison with parents (adult services CPN but until January 2000 also the forensic CPN); and*
- *Cons FP2 to arrange handover with Cons PA1."*

In addition to the care plan the risk assessment and management review form completed by the forensic CPN on 30 September says:
"MHSU to have section 117 c&d (handover) today, to discuss care plans, CPA review and risk review. Current risk management plan still applies, though local psychiatric team will need to plan intervention strategy in the MHSU defaults from follow up. Recommended appropriate follow up and proactive approach with using powers of detention under part III of the Mental Health Act 1983."

The "*current risk plan'* referred to appears to relate to that formulated in 1998. This was entitled "*Discharge risk reduction plan*" and was documented by the MHSU's forensic CPN in preparation for his subsequent transfer to adult mental health services.

This risk reduction plan stated:

- *"regular mental state monitoring;*
- *administer prescribed medication;*
- *observe for signs of planning self harm or harm to others;*

- *report significant changes in mental state to medical staff;*
- *report immediately refusal of medication or default from follow up;*
- *establish sound rapport with the MHSU in order that he feels safe to disclose thoughts, feelings and behaviours; and*
- *assess nature of social relationships to ascertain that the MHSU holds no delusional beliefs about others*."

The full risk assessment complied at this time set out:

- a clear chronology of the MHSU's past risk behaviours that was easy to assimilate;
- the MHSU's criminal history;
- antecedents to the MHSU's risk behaviour;
- the MHSU's usage of weapons;
- the MHSU's attitude towards his risk behaviour, and his emotional control and impulsivity;
- the attributes/characteristics of the MHSU's victims;
- the MHSU's planning of "risk behaviours";
- coping strategies for the MHSU; and
- an evaluation and summary of potential risk factors.

Both documents were completed to a good standard and the risk plan was appropriately robust for the MHSU at the time. The forensic CPN was asked if the information in this document was shared with the community mental health team. He told the IIT that the risk management plan was reviewed just prior to the section 117 review of 31 September 1999 at which the community mental health nurse CPN-A2 was present. The forensic CPN was also able to locate a copy of the 1998 document within the duplicate of the general mental health services file held at the medium secure unit.

In addition to the care plan the risk assessment and management review form completed by the forensic CPN on 30 September (i.e. the same day as the after-care meeting) said:
"MHSU to have section 117 ... (the) local psychiatric team will need to plan intervention strategy if the MHSU defaults from follow up. Recommended appropriate follow up and proactive approach with using powers of detention under part III of the Mental Health Act 1983."

On 1 October 1999, the day after the section 117 meeting, Cons FP1 wrote to Cons PA1. This letter said:
"Further to your letter dated the 11 December 1998 we have had three meetings to formalise the handover of the MHSU's care. It is unfortunate that you were not able to attend the meeting of 30th September 1999.

At the meeting it was agreed that the MHSU remains well and the transfer of CPN care is going according to plan. The MHSU's social worker (Norvic Clinic) will liaise with his counterpart at the local authority. It was also agreed that I should liaise with you and arrange a meeting to formalise transfer of the consultant responsibilities without having to go through another large meeting which is probably distressing to the patient and his family and clinically unnecessary.

I would be grateful if you could arrange to see the MHSU in your out-patient clinic and also kindly ask your secretary to arrange for a meeting involving only the key players to finalise the handover arrangements.

We have revised the MHSU's risk assessment document and were content with the current supervision plans."

There appears to have been no personalised response to the above, but information in the MHSU's clinical records suggests that a section 117 meeting was arranged for 31 January 2000.

A review of the clinical records, by the IIT, revealed that the MHSU had his first outpatient appointment with Cons PA1 on 15 November 1999. The letter from Cons PA1 to the MHSU's GP following this says *"as I have taken over his general psychiatric care I will continue to keep him under my regular outpatient follow-up review".* There is no mention in this letter of the section 117 after-care meeting that was planned for 31 October some two weeks earlier. The letter is copied to Cons FP1.

There is a line under Cons PA1's signature that says: "*Care Programme Approach: He is on minimum tier."* In October 1999 the previous levels of CPA were reduced to two tiers, standard and enhanced.

4.2.1.1 Comment by IIT

The IIT has no criticisms of the forensic service or their conduct of the transfer of the MHSU to general psychiatric services. There was a well formulated plan of care in place for him with which the identified CMHT care coordinators were familiar, and had actively been participating in since 15 March 1999 (CPN-A1) and September 1999 (CPN-A2), some three months prior to the culmination of the transfer process. Because of the way clinical records were stored in the Trust at the time, the IIT was not able to establish what documents Cons PA1 and CPN-A2 had easy access to. However the duplicate file held by the forensic service suggests that all essential CPA, risk assessment and risk management paperwork was available to the general psychiatric service. Furthermore CPN-A2 confirmed to the author of this report that he did have

access to all risk information and that the handover process was comprehensive.

4.2.2 The conduct of the general psychiatric services September 1999 – December 2003

4.2.2.1 Medical management of the MHSU by the general psychiatrists

The information detailed in section 4.2.1 shows that there was positive medical engagement in the process by:

- Cons PA1 in December 1998;
- Locum Consultant PA2 in March 1999
- Locum Consultant PA3 in May 1999

The IIT does not know why Cons PA1 was not able to attend any of the handover meetings with the forensic service.

What is apparent from the general psychiatric records is that it was on the mind of locum consultant PA2 for the MHSU to be managed via the supervision register. It is probable that this individual would have wanted the MHSU to be on enhanced CPA. His documentation was good and he highlighted all of the main issues necessary for the effective clinical management of the MHSU. He was the only consultant psychiatrist to have done so within the general psychiatric service up to and including December 2003.

With regards to continuity of medical care, the MHSU had contact with the following between November 1999 and December 2003:

- Consultant Psychiatrist (Cons) PA1 (15 November 1999)
- Cons PA1 (21 February 2000)
- Cons PA1 (23 August 2000)
- Locum Consultant PA4 (21 February 2001)
- Locum Consultant PA4 (18 April 2001)
- Locum Consultant PA5 (17 October 2001)
- Consultant Psychiatrist (Cons) PA6 (20 March 2002)
- Cons PA7 (5 September 2002)
- Staff Grade Psychiatrist PA5 (17 February 2003)
- Staff Grade Psychiatrist PA5 (4 August 2003)

In four years the MHSU was seen by a total of seven different senior psychiatrists. This was less than ideal for a patient with the MHSU's history. However, what was commendable is the fact that he was always seen by medical staff of consultant or staff grade. The clinic letters to the GP also suggest that all medical staff did try and get to know the MHSU in the short period of time they were in contact with him.

Throughout the four years the MHSU was consistently noted to be well and complying with his treatment. There is however no evidence in any of the medical correspondence, or the notes made in the medical records, that a detailed mental state examination was conducted at any stage. Neither is

there any evidence that the responsible psychiatrist and the MHSU's care coordinator conducted a joint CPA review at any stage. This was largely due to the MHSU being on standard CPA, and being seen as "stable" or "in remission", as of low risk, and as an uncomplicated service user. For such individuals the national and local CPA guidance at the time allowed for a uni-professional CPA review.

There was one occasion in February 2001 when Locum Consultant PA4 (Cons PA4) suggested to the MHSU's GP that as the MHSU was doing so well on *"Depixol 20mg fortnightly, which is close to the limit where he won't need any antipsychotic at all*," he should start oral medication instead. Cons PA4's letter stated:
"*Flupenthixol 1.4mg daily is, in fact, a very low dose but still requires a two weekly visit by the CPN, which could be avoided by the use of oral medication. This man seems very motivated to remain on medication and claims that he never ever had a problem with compliance. Therefore I feel he should be given a chance to have oral medication and I would be grateful if you could prescribe a prescription for Olanzapine 5mg as soon as you receive letter."*
This correspondence highlights perfectly the dangers of lack of continuity in consultant psychiatrist for complex service users. The IIT understands that recruitment was challenging in the Northern Locality and there was little option but to use locum consultants until substantive appointments could be made. In this case, the recommendation of Cons PA4 was challenged by the MHSU's then care coordinator (CPN-A4). Consultant PA4 listened to her counsel and reversed his advice to the MHSU's GP.

The 4 August 2003 was the last medical review of the MHSU before CPN-A4 discharged him from her caseload, thus by default making Staff Grade Psychiatrist PA5, whose caseload the MHSU was on, his care coordinator.

Comment by IIT
In terms of the MHSU's outpatient management, other than the lack of continuity in medical professional, there is little one can find fault with. The MHSU was seen with appropriate frequency and there was regular and reasonably informative correspondence with the MHSU's GP at the time.

What was absent however, was consistent evidence of detailed mental state examination or structured risk assessment at each of the appointments. Furthermore there was no detail in the medical correspondence to the MHSU's GP about what to do if he was at all concerned, or to advise him of what the risk management plan for the MHSU was if he relapsed. Whilst this may not have been the common standard of practice in 1999, by 2002 and 2003 the IIT asserts that more detailed and structured correspondence should have been produced by the medical staff responsible for the MHSU.

4.2.2.2 Nursing management of the MHSU May 1999 – December 2003 within the MHSU's community mental health team

It is clear that there was good CPN engagement with the handover process from the forensic team between May 1999 and January 2000. Not only is the attendance of the general psychiatry CPNs noted at the after-care review meetings of May and September 1999, but the general adult CPN progress notes for the MHSU clearly show regular home visits to meet with him between May 1999 and January 2000 by CPN-A1 and CPN-A2.

From January 2000 the general adult community mental health team took over complete responsibility for the MHSU. Although the quality of documentation by CPN-A2 was not of the quality one would expect, the progress notes evidence regular fortnightly home visits with no apparent concerns.

The CPN records show that over this period:

- the MHSU "*was settled and living his life";*
- "*very settled, nil to report*";

There was a joint visit with the general adult community CPN and the forensic CPN on 22 November 1999. The records again note that the MHSU was settled and pleasant.

On 3 January 2000 the MHSU was visited again by the forensic CPN and a full assessment record was made. The record confirmed the well health of the MHSU. The forensic CPN also noted that:
"*He expressed insight into the security that the medication offers in preserving his mental well being and this his present lifestyle. He appreciates the relatively low dose required to achieve this causes minimal undesirable effects, compared to previous treatment doses when he was actively psychotic."*
The forensic CPN also noted that he would see the MHSU again in "*approximately 4/52"* for the section 117 meeting.

There is no nursing record in the CPN progress notes of the section 117 meeting. Furthermore a thorough search by the Trust has not revealed any paperwork relating to this section 117 meeting. A subsequent discussion with CPN-A2 revealed that at the time the section 117 was due he himself had taken leave to attend to an important family matter, this may have been a reason why it did not go ahead as planned. CPN-A2 also suggested that at the time responsibility for section 117 was a local authority responsibility and he himself was not all that familiar with the process having only addressed it from an inpatient perspective up until that point in his career. CPN-A2 also

told the author of this report that at the time he was not clear about the role of the care coordinator. This was his first community mental health nurse post. CPN-A2 advised that he experienced little in the way of induction at the time.

Between the forensic CPN's visit and CPN-A2 leaving the CMHT in March 2000, the MHSU's home visits continued and were unremarkable.

On 23 March 2000, the MHSU was asked to attend at the CMHT base for his depot injection, to which he agreed. The IIT understands that there was no CPN available to be care coordinator for the MHSU in the immediate period following the departure of CPN-A2. This situation continued until early July 2000 when the MHSU was allocated a new CPN, CPN-A3. CPN-A3 was female and completely new to community mental health nursing.

It is notable that 13 March 2000 was the last home visit the MHSU ever had before being discharged off the CPN caseload in December 2003. All further contact with the MHSU was at the depot clinic. Initially this was on a fortnightly basis and from April 2002, when the frequency of his depot injections was reduced, three weekly.

The nursing records over this period are largely unremarkable with the consistent theme being the MHSU's good state of health and willingness to continue with his medication. Furthermore, the nursing records, although brief, as one might expect from a depot clinic, do show that the CPNs were aware:

- of the MHSU's financial issues;
- his college course;
- the various examinations he took, and how he felt about these; and
- projects he was working on in his workshop.

There were some particularly notable entries that are worth referring to here i) because of the incident that subsequently occurred and ii) because they are relevant to the IIT's commentary on the MHSU's care plans and risk assessments.

- 17 July 2000: The MHSU was introduced to his new care coordinator, CPN-A3. This individual found the MHSU to be over familiar with her, a consequence of which was a decision for the MHSU to attend at the CMHT base for his subsequent appointments.

- 27 September 2000: This was the second time the MHSU had contact with CPN-A3. This nursing record noted that the MHSU was reporting some side effects of his medication, but was not willing to take procyclidine. CPN-A3 noted that she advised him that she would arrange a meeting to review this. It was also noted that CPN-A3 again experienced some over familiar behaviour from the MHSU. The records show that this was discussed with the team manager and also CPN-A4. Consequently the next time the MHSU attended for his depot he was seen by the team manager and CPN-A4. It is notable that when told why CPN-A3 would not be seeing him again he told CPN-A4 *"that he was not aware he had over stepped the mark".* CPN-A4 also arranged for the MHSU's previous forensic CPN to meet with him at home to discuss boundary issues. (The IIT has not identified any information that suggests that this occurred).
- 31 January 2001: The MHSU was noted to be in *"full remission of his illness".*
- 28 February 2001: The MHSU was seen by CPN-A5. He informed this individual that Cons PA4 the week previously had suggested a change from depot medication to oral medication. CPN-A5 wisely told the MHSU that he needed to discuss this with CPN-A4 (the MHSU's care coordinator) when she returned.
- 14 March 2001: CPN-A4 met with the MHSU when he attended for his depot. Her records evidence a long discussion with him about his medication. The outcome of this was noted as: "*The MHSU wishes to stay on his depot injection which has suited him and kept him well for so long. The MHSU is fully aware of his rights re. acceptance of medication and was readily agreeable when I reminded him that his past relapses were due to non-compliance with oral meds."*
- 2 January 2002: CPN-A4 noted that a CPA review was completed and that there were no problems to record.
- 27 March 2002: CPN-A5 noted that the MHSU reported seeing Cons PA6 the week previously and that he suggested reducing his depot to three weekly. CPN-A5 suggested that the MHSU kept his appointment with CPN-A4 in two weeks' time and discussed it with her then. As it transpired the MHSU was seen by CPN-A6 at his next appointment (10 April 2002), and the nursing record shows that his medications had already been changed to three weekly.
- 3 July 2002: The MHSU was introduced to CPN-A7 who was to become his new care coordinator. This was a male CPN. However, on 24 July following a discussion with CPN-A4 the MHSU was noted to prefer to have ongoing contact with CPN-A4 rather than proceed

with a change of CPN. The MHSU was noted to be well with no evidence of psychotic symptoms.

- 25 September 2002: The MHSU had been admitted to hospital two weeks prior to this appointment, with a severe asthma attack, for four days. The MHSU was noted to be reliable with his medication but worried about the increase in prescription costs. CPN-A4 suggested he consider pre-payment methods and gave him information on how to proceed. CPN-A4 also noted that a new risk assessment was completed and that his care plan was re-evaluated. CPN-A4 also noted that the care plan would be reviewed in six months.

- 20 November 2003: CPN-A4 discussed with the MHSU the possibility of him attending at his GP surgery to receive his depot injections as of January 2004. The CPN records note that the MHSU was keen to reduce his contact with mental health services "*due to the perceived stigma that exists".* The CPN records also noted that she would write to the MHSU's GP.

- The final CPN record of 2003 said the MHSU "*remains well. No problems to record. Will now discharge him to GP practice – see letter to GP and Practice Nurse. Depot given as per chart."*

The MHSU's documented plan of care and his risk assessments are presented below.

4.2.2.3 The MHSU's documented plan of care January 2000 – December 2003

The first care plan for the MHSU, generated by the general adult community mental health team, was written by CPN-A2 on 30 September 1999 after the section 117 after-care meeting. It was of an unacceptable standard and did not contain any of the essential information required to ensure that when there was a change in CPN that a robust plan of care was maintained. When compared to the plan noted in the CPA review/section 117 after-care record written on the same day, one would have thought the CPN's care plan was about a different service user. CPN-A2, more than any other who had contact with the MHSU within the context of general psychiatric services, was the best placed to ensure that the plan of care agreed on 30 September 1999 was continued. The lapse in documentation standards was, in the opinion of the IIT, pivotal in a subsequent lack of awareness among staff regarding the need for an ongoing plan of care that included home visits and also a lack of risk awareness.

When CPN-A3 was allocated to the MHSU in July 2003, she told the IIT that she experienced an unsatisfactory handover of care to her by CPN-A4, a senior CPN. Her recollection is that she was introduced to the MHSU in the kitchen at the team base. There was no detailed history handed over to her, and no indication of the MHSU's risks. However, on taking over as the MHSU's care coordinator she did review his case file, including the medical records.

It was not however, as a result of her review of his records that a revised care plan was created. It was because of the inappropriate behaviour of the MHSU towards her.

The plan of care for the MHSU, documented by CPN-A3, was:

- *"for depot medication to be administered fortnightly:- to invite the MHSU to attend team base.(Not to be visited at home by female. History of inappropriate behaviour[7]);*
- *review mental health at each appointment;*
- *liaise with other agencies."*

It did not constitute an appropriate plan of care for the MHSU. It showed no cognisance of his detailed history or any element that had been agreed in September 1999. There was no recognition of the value of some home visits for the MHSU or of the need to assess the quality of his social relationships.

The plan of care was subsequently periodically evaluated on a six monthly basis. This in itself was good practice. Because the MHSU was on standard CPA the reviews were conducted on a uni-professional basis. In 2000 uni-professional reviews for persons on standard CPA were considered acceptable even if more than one professional was involved in their care.

Evaluations occurred on:

- 27 September 2000;
- 6 December 2000;
- 4 July 2001;
- 2 January 2002; and
- 25 September 2002.

The evaluations were undertaken by CPN-A3 (x1) and CPN-A4 (x4).
The September evaluation with CPN-A3 highlights that the MHSU was inappropriate with her for the second time. Consequently the plan stated that he was not to be seen by a female on his own. Following this incident CPN-A3 stepped down as the MHSU's care coordinator and CPN-A4 took over. The plan of care was confirmed by CPN-A4 and the then team manager, TM1.

[7] Note this issue has already been discussed in section 4.2.2 page X of this report.

There was no consideration of the care plan requirements for the MHSU as determined by the forensic services the previous September.

As with the records made throughout the MHSU's attendance at the depot clinic, the care plan evaluations noted that the MHSU was:

- mentally stable;
- there were no problems; and
- the MHSU was socially active and busy with casual employment and college studies.

Although brief they did suggest that CPN-A4 was able to elicit information about how his life was progressing, in the short period of time afforded in a busy depot clinic.

The update of 4 January 2002 provided more specific information about the MHSU's significant past history than previous care plans had done. It said:

Care Programme Community	
Key worker: CPN-A4 **Telephone: -** **Alternative contact No: -**	**Date:** *4 July 2001* **CPA Tier:** *Standard* **Section 117 supervision register: -**
Significant Factors from Past History: *Forensic services. History of paranoid schizophrenia. Violence towards others and self at times of relapse.* *Absolute discharge from above 1997.*	
Aims of After Care Programme *To maintain in the community at optimum level of functioning*	
Components of Care Programme 1. *Attends CMHT base for depot injection and monitoring of mental state;* 2. *Attends OP reviews with locum consultant; and* 3. *Attends work placement and city placement via NORCI services.*	
Agreement for After Care [This section was left blank]	

However, it does not highlight:

- the MHSU's past chronic non-compliance with oral medication;
- that all of the MHSU's past relapses were associated with medication non-compliance, and that relapse occurred quite quickly when unmedicated;
- that his violence had been towards people known to him; or
- that he could be inappropriate towards women and often had no to little awareness of his inappropriate behaviour

Neither does the care plan say what the plan was if the MHSU displayed any signs of psychosis, or became disengaged from his treatment plan in any way. Furthermore, even with the revised design of care plan, the space allocated for "Agreement for After Care" is left blank. A review of the MHSU's records, even at this stage, would have provided the opportunity for a reconsideration of the features of his care plan that appeared to have been forgotten in 2000.

The plan of care documented on 13 March 2003, did go some way to addressing these issues. This plan stated:

- *"MHSU to continue to attend team base for his depot injections every 3/52;*
- *CMHN[8] to monitor and evaluate mental health and advise on medication and maintain awareness of boundaries;*
- *MHSU continues to maintain independent therapeutic activities;*
- *For MHSU to be able to discuss any problems that might arise;*
- *MHSU to attend Cons PA2's O/P clinic for regular reviews;*
- *MHSU to be seen at the base; and*
- *Home visits only if necessary, by 2 members of staff – one of whom must be male."*

CPN-A4 also wrote:
"MHSU is not always aware of boundaries and acceptable behaviour around women. Sometimes needs reminding. Risk unchanged since last screening."

Comment by IIT
The IIT is at a loss to understand how the detailed plan of care agreed with the forensic service was forgotten about so quickly once CPN-A2 had left the general adult CMHT in March 2000. Up until his departure home visits were reliably performed, although the IIT does not have confidence in the quality of the home visits as the documentation around those visits was sparse. However, at interview CPN-A2 told the IIT that he could not recall there being any problems with the MHSU at all. This the IIT has elected to take at face value, as the MHSU had been stable in the community since 1995.

[8] CMHN is a community mental health nurse. This is the same as a community psychiatric nurse (CPN), but a more modern expression.

Furthermore CPN-A2 was being interviewed 10 years after his contacts with the MHSU, and one would not expect him to particularly remember his home visits to the MHSU.

The IIT is particularly critical of the lack of consideration given to the plan of care for the MHSU after his inappropriate behaviour with CPN-A3.
To have taken the position that the MHSU would only be seen at the team base from that point onwards was to manage his care for the convenience of the mental health team, and not in the best interests of the service user. Although the MHSU could be inappropriate in his behaviour towards females, there was information available from other mental health nurses that said that these boundary issues could be managed effectively by restating and reinforcing the boundaries.

The IIT accepts that a male worker for the MHSU would have been preferable. However, it is not always possible to provide a same sex worker for a service user. Consequently TM1, and whoever was involved in the allocation of care coordinators should have explored:

- joint working;
- TM1 or TM2 undertaking the home visits for the MHSU; or
- enlisting the support of a male colleague from another team.

The lack of consideration of these options and the immediate cessation of any consideration of home visits as a core component of the MHSU's care plan, meant that the mental health team never had the opportunity to carry out an essential component of his care management. In particular these were:

- The assessment of the quality of his social relationships and that he was not harbouring any delusional beliefs about friends and family.
- The assessment of his living conditions and home environment.

The IIT also notes that TM1 did not give due consideration to the appropriateness of allocating an inexperienced CPN such as CPN-A3 to this MHSU.

The issues that appear to have contributed to the lack of attention to detail in the MHSU's care plans were:

- The culture in the mental health team had not evolved to one where a team leader and the consultant psychiatrists worked together effectively as a team.
- The lack of involvement of Cons PA1 in the transfer of care process. At significant times his role was being covered by locum consultant psychiatrists who did not stay with the general adult community mental health team for any length of time.
- There was no effective handover process between outgoing and incoming care coordinators. Although TM1 asserts that there was an operational policy in place during his period as team leader, it is the

contention of the IIT that because of the consistent lack of effective care coordinator to care coordinator handover it could not have been an effective policy, or it was not properly enforced by the team manager. Furthermore the 1994 CPA policy in use was not updated until 2002. This was a corporate and not a local responsibility.

- No one saw the MHSU as a problem – he was medication compliant, easy to work with, and turned up for his appointments on time. He was self sufficient, and had good quality recovery on his medication. Given the average caseload for CPNs at the time, providing he was taking his medication he would not have ranked highly on anyone's radar.
- The team manager could only attend one in three team meetings at best. There were three consultants attached to the MHSU's mental health team and all three had their team meetings on the same day, at the same time, in different locations.
- TM1 was not as involved in the handover process for the MHSU as he should have been, given the level of concern about the MHSU should he ever relapse. The IIT accepts that TM1 did attend a multi-disciplinary meeting about the MHSU in March 1999, however it asserts that TM1 should have made clear his expectation of an invitation to subsequent CPA and section 117 meetings during the handover process.
- The appointment of a female care coordinator was unavoidable owing to the chronic shortage of male CPNs. It was for this reason that CPN-A3 was instructed to meet with the MHSU at the CMHT base until she got to know him.
- The lack of structured case management review by TM1 and TM2. TM1 does not accept that he provided insufficient case management to his staff. The IIT agrees that TM1 had a reputation for being approachable and of providing regular supervision to his staff. However the picture is patchier in relation to TM2. Except in relation to the specific management of the MHSU, the IIT can only see a lack of case management review. He was the highest risk profile service user on the community team's caseload, however, the robust management plan agreed with the forensic service was not adhered to. This can only have prevailed with a lack of effective case supervision.
- The lack of effective clinical and management supervision.
- The MHSU was on standard CPA which meant that there was no requirement for any multidisciplinary team (MDT) working in relation to his case management. The CPNs were doing the depots, and the consultant psychiatrists were meeting with the MHSU on a six

monthly basis at outpatient appointments. There was no requirement under the CPA guidelines published in 1999 for more. Furthermore all of the standards detailed in the "*National Service Framework for mental health*" (DH, 1999) about CPA related to the care of service users on enhanced CPA.

- The lack of consistency with which his full documented history was accessed owing to the separation of the medical and nursing notes at the time.

4.2.2.4 Risk assessments conducted January 2000 – December 2003

The conduct of an effective risk assessment is a core element of CPA and also effective care management. For this MHSU there was a "*Summary of risks*" form that was completed by CPN-A3 and CPN-A4 between 28 July 2000 and January 2001.

The style of the form was "tick box". There was no space provided for any qualitative information. The form was completed as follows:

Date and Time	**28 July 2000**				**4 July 2001**				**Jan 2nd 2002**			
Type and Level of Risk	Low	Mod	High	High & ↑	Low	Mod	High	High & ↑	Low	Mod	High	High & ↑
Suicide	✓				✓				✓			
Deliberate SH	✓				✓				✓			
Harm to others		✓				✓			✓			
Self neglect									na			
Harm by others	✓								✓			
Absconding									na			
Moving and Handling									na			
Other (say what)									na			
Assessors initials												

The information collected by the IIT from the friends and family of the MHSU between 1999 and 2006 suggests that these risk assessments were accurate. It was however less than ideal that the style of form did not promote a better quality of documentation. The design of this form did not lead the CPNs through an effective risk assessment process. It did not require:

- any description of identified risk issues, the antecedents to risk behaviours or the consequences of the identified risk behaviours;
- any risk containment/relapse prevention plan; or
- any crisis management plan if relapse of the service user's mental illness were to occur, or if features identified as having been antecedent to previous risk behaviours were to materialise.

The Trust did change the design of paperwork in January 2002. However, some of the problems associated with the pre-2002 paperwork design remained. Specifically there was no requirement for staff to document a risk management or crisis management plan. This was not in step with the expected standard of practice at the time. In 2002 had a mental health professional undertaken a risk assessment, then he/she would be expected to have in place a risk management plan for any risks identified, and that should have included what to do in an emergency or crisis. This expectation was reflected in the Trust's CPA policy at the time.

The last risk assessment undertaken with the MHSU, before he was discharged from the CPN caseload, was on 25 September 2002.
The form is replicated below, (the IIT's comments are in grey).

Preliminary Risk Screening Form completed September 2002

a) Risk of Suicide? consider		**Past Risk ✓ Current Risk ☐**
Previous attempted suicide?	✓	All risk elements are in the past. The last 6 years have been risk free.
History of deliberate self harm?		
Recent adverse life events?		
Suicide/attempted suicide of relative/friend?		
Suicidal ideas/evidence of planning?	✓	
Feelings of hopelessness/ helplessness?		
Impulsive behaviour	✓	
Hospital admission/discharge?		
b) Risk of self-harm? consider		**Past Risk ✓ Current Risk ☐**
History of accidental/DSH	✓	All risk elements are in the past. The last 6 years has been risk free.
Evidence of, or intention to self harm?		
Stress factors/hazards in current situation?		
c) Risk of Self Neglect?		**Past Risk ✓ Current Risk ☐**
History of self neglect		No risk in six years but forensic history with poor insight when unwell. **It is unfortunate that more information about this was not recorded as it was a critical component of the MHSU's relapse behaviour and associated lack of insight when unwell.**
Past/current financial/housing problems		
Difficulty in maintaining physical health		
Difficulty in maintaining daily life		
Social/ geographical isolation		
Poor engagement with services		
Denies problems perceives by others	✓	
d) Risks to physical health?		**Past Risk ☐ Current Risk ✓**

Illnesses or physical health problems	✓	Severe asthma can manage medication but has acute episodes. **No information about the side effects from his depot was recorded here. Testimony from friends and family revealed that Parkinsonian side-effects were a persistent problem for the MHSU.**
Side effects of prescribed medication		
Effects of smoking/sexual health issues?		
Mobility/moving and handling issues?		
a) Risk of Violence and Aggression		**Past Risk ✓ Current Risk ☐**
History violence/aggression/offending	✓	All past risks, none in last six years, but forensic history with index crime of serious assault. **This section should have been completed more fully for the form to have been of clinical use to another member of the mental health team. Although the MHSU had been stable for six years his risk of harm to others would be manifest if unmedicated. In 1990 he threatened to kill a co-worker and made a crossbow with the express intent of doing so. He attacked his father with a knife. He also attacked a member of staff in Rampton Hospital. When paranoid he was a suspicious and dangerous character to those near to him.**
Impulsive behaviour	✓	
Feelings of intense frustration	✓	
Active symptoms of psychosis	✖	
Previous use of weapons	✓	
Talking about/planning harm to others	✓	
Specific risks to mental health workers/carers	✓	
Specific risks to other service users	✖	
Risk Screening Cont..		
b) Risk of Exploitation or abuse		**Past Risk ☐ Current Risk ☐**
c) Risk to Children		**Past Risk ☐ Current Risk ☐**

The rear of the form asked for further information about a service user's risk history. In this section of the form CPN-A4 wrote:

"*Known to behave inappropriately around women – struggles at times with boundaries but responds to advice. Can make some members of staff uncomfortable as he invades their personal space*. "

Under the heading warning signs she wrote:
"*Talking of suspicion of others. Not taking or accepting medication. No indications of current risk*."

Under Supportive factors the following are notated:
✓ *engagement with care and treatment plan*
✓ *support from family and friends*
✓*coping strategies*
✓ *insight into mental health problems*

The sources of information for the risk assessment were noted as the service user and the clinical records.

The final question detailed on the risk screening form was, "Any immediate action to manage risk?" CPN-A4 wrote: "*None needed currently, but maintain awareness of possible inappropriate behaviour with women*".

Comment by IIT

Although CPN-A4 had undertaken a risk assessment the risk tool contained insufficient detail for another professional to have an appropriate understanding and insight into the MHSU's risk issues and behaviours. However, two significant issues were noted:

- the MHSU's inability to maintain appropriate boundaries with women from time to time; and
- not taking or accepting medication.

There should have been a relapse prevention plan for the MHSU and also a crisis management plan. In the early stages of the handover process between the forensic and the general psychiatric service, the locum consultant covering for Cons PA1 wrote in the medical notes:

"*If he refuses medicine or break through in psychosis, loses insight very quickly. Poses risk to himself and others. Forensic team advise to treat early if necessary via Sec 3 (of the MHA) and admit.*
Seriously ill when ill."

It would have been prudent for relapse prevention and crisis management plans to have been formulated by CPN-A4, and in 2002 this was the expected standard of practice. However, at this stage there was no expectation that an advance directive would be formulated with a service user setting out their wishes during a relapse period. The NICE guidance "*Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care*" was not published until December 2002.

There were no further risk assessments documented for the MHSU between September 2002 and his discharge from the CPN caseload in December 2003. Even though the MHSU remained stable, there should have been a full risk assessment undertaken before CPN-A4 discharged him from her caseload. Furthermore, this and the accompanying risk management and crisis intervention plan should have been copied to the MHSU's GP.

The IIT's analysis of the MHSU's discharge from the CPN caseload and transfer to primary care services for the administration of his depot injections is addressed in section 4.2.4 of this report page 75 – 87.

4.2.2.5 Section 117 after-care

Of particular concern to the IIT was the sudden cessation of the s. 117 after-care meetings for the MHSU. A review of his clinical records revealed that these were held regularly between 1994 and September 1999 as the list below (in reverse chronological order) depicts.

Section 117: After-care review meeting 30/9/99
Section 117: After-care review meeting 17/05/99

Section 117: After-care review meeting 10/11/98
Section 117: After-care review meeting 11/08/98
Section 117: After-care review meeting 09/03/98
Section 117: After-care review meeting 26/11/97
Section 117: After-care review meeting 09/07/97
Section 117: After-care review meeting 01/10/96
Section 117: After-care review meeting 14/05/96
Section 117: After-care review meeting 14/12/95
Section 117: After-care review meeting 30/10/95
Section 117: After-care review meeting 25/09/95
Section 117: After-care review meeting 05/06/95
Section 117: After-care review meeting 27/06/94
Section 117: After-care co-ordination meeting 13/06/94

Health Service Circular/Local Authority Circular HSC 2000/003: LAC (2000)3, "*After-care under the Mental Health Act 1983: Section 117 after-care services*" says:

"Section 117 of the MHA places a duty on health and social services authorities to provide after-care services for certain patients discharged from detention under the Act."
and:
"After-care provision under section 117 does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under section 117 should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted."

In the case of the MHSU, he was self supporting in the community. He managed his own financial affairs, he worked part-time, he had developed a good social network, he had interests and hobbies. He was on incapacity benefit, but other than that he required no support from social services. He was then someone who one could have considered discharging from s. 117 after-care.

The issue for the IIT is not so much that he ceased to be under s. 117 after-care following his discharge from the forensic service, but that there is no evidence that an appropriate discharge meeting was convened. Apart from the simple notation of "discontinued" on a copy of the September 1999 CPA document by CPN-A2, there is nothing. Furthermore, at interview CPN-A2 and the then team manager gave the impression of being nonplussed by the lack of section 117 follow up. CPN-A2 was adamant that other CPA and section

117 meetings had occurred, but was unable to say when, or produce any documents to support this assertion.

A number of interviewees in managerial positions alluded to the lack of effective systems and processes for section 117 and also the lack of effective management across the Northern Locality in general. This however appears not to have been recognised until 2005, after the publication of an initial investigation report into a homicide by Richard King in 2004. This was some four years after the MHSU was transferred to the care of Cons PA1. Further exploration with the Trust revealed that in 2000 there were a number of registers for persons being cared for under the MHA and also on section 117.

The IIT surmises that because the MHSU was no longer subject to any conditions imposed by the MHA, having achieved an absolute discharge, there was no automatic trigger for his section 117 status to be registered. Furthermore it was the understanding of CPN-A2 that section 117 after-care was the responsibility of social care not healthcare. This also contributed to the lack of awareness of the need for the care coordinator to ensure that the section 117 meetings continued until such time as the MHSU was discharged from section 117. This was a significant weakness in the systems and processes operating in the Trust at the time. It was not within the scope of this investigation to robustly analyse the clinical governance systems and processes in situ in the Trust in 1999 and the early 2000's. However for many trusts, clinical governance remained in its infancy across the NHS in the late 1990s and early 2000s. Today, one would expect Norfolk and Waveney Mental Health NHS Foundation Trust to have robust governance systems in place, so that it is fully aware of those localities and teams that are underperforming and non-compliant with national and local policy. The Trust has assured the IIT that it now has robust systems. Core elements of these are presented in chapter 5 of this report.

4.2.2.6 The Care Programme Approach (CPA)

Section 4.2.2.3 (page 52) dealt specifically with the content of the MHSU's care plans. This section focuses specifically on the overall compliance with the CPA during this MHSU's contact with his CMHT between January 2000 and December 2003.

The key to the effective care planning and case management for the MHSU was the application of CPA. In 2000, as has already been stated, there were two tiers to the CPA, the "standard" tier and the "enhanced" tier.

Standard CPA applied to service users who:

- Required the support or intervention of one agency, or discipline, or required low key support from more than one agency or discipline.
- Were able to self manage their mental health problem.
- Had an active informal support network.
- Posed little danger to themselves or others.
- Were more likely to maintain an appropriate contact with the services.

Enhanced CPA applied to service users who:

- Had multiple care needs, including housing employment etc, requiring interagency co-ordination.
- Were only willing to cooperate with one professional or agency but had multiple care needs.
- Were in contact with a number of agencies possibly including the criminal justice system.
- Were more likely to require more frequent intensive intervention perhaps with medication management.
- Were more likely to have mental health problems co-existing with other problems such as substance misuse.
- Were more likely to be at risk of harming themselves or others.
- Were more likely to disengage with services on a regular basis.

The determinant factor regarding the level of CPA a service user was to be placed on was to be influenced by the assessment of their risks. If a service user represented a significant risk to themselves or others, then the right level of CPA was the enhanced level. It was also considered that because the principles of CPA and s. 117 after-care were the same, then s. 117 would become a discrete sub-section of the CPA process.

Reflecting on these criteria, that were applied in 2000, the IIT can understand why the MHSU was placed on the standard CPA tier. He:

- was self supporting;
- was integrated into his local community;

- required no support from health or social services;
- was medication compliant, so posed no risk to himself or others; and
- was transferred into the CMHT on standard CPA.

However, what was predictable for this MHSU was, should a time arise where he was medication non-compliant he would in all probability relapse into:

- self neglect;
- withdrawal from his support network, or his support network would withdraw from him; and
- he would become a significant risk to himself and others.

The "*National Service Framework for mental health*" (DH, 1999), page 53 is explicit in the level of CPA a service user should be placed on:
*"*Standard CPA is for individuals who require the support or intervention of one agency or discipline, who pose no danger to themselves or to others, and who will not be at high risk if they lose contact with services*."*

On this basis there is no doubt that the MHSU should have been on enhanced CPA. However, the IIT can understand how the community mental health team (CMHT) came to place him on standard CPA. The MHSU was transferred to their care on standard CPA and he did, as shown above, meet many of the then criteria for standard CPA. What was unhelpful for staff was that the Trust's CPA policy, implemented in 1994, remained in situ in 2000 and 2001.

Although the MHSU was transferred into general psychiatric services on standard CPA, it is the contention of the IIT that the CMHT did not give sufficient thought to the level of CPA the MHSU required, to ensure that the same level of contact and team-based review of the MHSU that had occurred in the forensic service was sustained within a busy general community service. Significant factors were that:

- within the forensic service there was greater capacity to maintain close contact with the MHSU; and
- the MHSU's CMHT did not have the same capacity as the forensic team. Importantly the caseloads for individual CPNs were much higher – at least three times the size. This left less time for a CPN to spend with each service user. Consequently the MHSU's CMHT was not in the position to provide the same level of service to the MHSU as the forensic team. It should have considered this and how best to ensure that the service provided to the MHSU was safe.

Placing the MHSU on enhanced CPA would have assured a multi-disciplinary team (MDT) approach to the MHSU's care plan (CPA) reviews. Enhanced CPA however may not have influenced the day-to-day care plan management

for the MHSU, or the quality of the care plans recorded. The "*National Service Framework for mental health*" (NSFMH) (DH, 1999) page 53 said:
"The written care plan should be drawn up by the named care co-ordinator, with the involvement of the service user, and where appropriate their carer. It should include explicit contingency arrangements so that the service user or their carer can contact specialist services if they need to. A copy should be given to the service user and his or her GP."

Enhanced CPA may have influenced the care planning for the MHSU if the following NSFMH guidance (p53) was followed:
*"*The written care plan for individuals on an enhanced CPA should include:

- arrangements for mental health care including medication;
- an assessment of the nature of any risk posed;
- arrangements for the management of this risk to the service user and to others carers and the wider public, including the circumstances in which defined contingency action should be taken;
- arrangements for physical health care: how and what will be provided - usually by the GP, but also by social services when help with meals and personal hygiene may be offered;
- action needed to secure accommodation, appropriate to the service user's needs;
- arrangements to provide domestic support;
- action needed for employment, education or training or another occupation;
- arrangements needed for an adequate income;
- action to provide for cultural and faith needs;
- arrangements to promote independence and sustain social contact, including;
- therapeutic leisure activity; and
- date of next planned review."

However the IIT is not confident that at the time the MHSU's CMHT was following this guidance. Consequently even had the MHSU been placed on enhanced CPA, it is questionable whether it would have made any material difference to the content of his care plan or risk assessment. The only material change it would have made was to the way in which the MHSU was discharged from the CPN caseload to the GP surgery for his depot injections. This process would have had to have been accomplished with a proper CPA discharge meeting.

The practical impact of this MHSU being left on standard CPA within the CMHT was:

- A lack of annual team based review. The MHSU was being monitored by psychiatrists and also a CPN. However there were no joint assessments and the CPNs did not attend the six monthly outpatient appointments with the MHSU, as far as the IIT is aware.
- The lack of a relapse prevention plan, and crisis management plan. However as intimated above, whether such a plan would have been of the robustness required the IIT considers to be doubtful.

4.2.2.6.1 Why the Care Programme Approach was not followed as well as it should have been between 2000 – 2003 with respect to the MHSU's care plans and his risk assessments

There were four care coordinators appointed to the MHSU between May 1999 and September 2000. This was far from ideal and will have contributed to the loss of important information when the MHSU's care was transferred between professionals.
There were a range of contributory factors to this:

- The Northern Locality was more difficult to staff than other areas of the Trust. It had a reputation as not being as forward thinking as other areas of the Trust.
- There was a lack of understanding amongst staff about CPA, even though it had been implemented in the Trust in 1994. When asked about the allocation of standard or enhanced status for service users, Cons PA1 told the IIT that he thought there was confusion about that. He said: "*There probably was some confusion about whether you regard complexity or just the number of people involved as to what should be going on*." The then team manager also noted the number of professionals involved in the delivery of care as one of the criteria used to determine whether a person needed to be on enhanced or standard CPA.
- Not one interviewee who had contact with the MHSU between January 2000 and December 2003, or was in a team leadership capacity, was able to tell the IIT the frequency with which a service user on standard CPA should be reviewed, or that from October 1999 the individual assessment of need was what should have determined review frequency.
- There was a reported lack of engagement among some of the medical staff in CPA, and also a preference for assigning standard CPA to service users in care of the nursing staff because it required less paperwork. This was highlighted by the Commission for Health Improvement report published in December 2002 following a visit to Norfolk Mental Health Trust in April 2002. This report said:

"The National Care Programme Approach has not been wholeheartedly welcomed within the Trust and insufficient progress has been made. The process for CPA is not effective. Staff are concerned about the cumbersome and time-consuming paperwork which is not unified across the Trust and a number of staff do not understand it ... There needs to be better staff education, more rigorous compliance checks, especially for care coordinators."

Furthermore the then medical director told the IIT that he

"… discovered that some consultants were going along to medical records or whatever and saying, 'do not put my name down as care coordinator: I am not the care coordinator.' When I had discussions with them it was, 'I'm not in a position to discharge all the duties' etc. 'But you are the only person involved in this case, they are only on standard CPA.' A memo was issued so no longer would any member of medical staff go along and ask for their name to be removed as care coordinator. It wasn't just consultant medical staff. I have a recollection that some clinical psychologists had also taken the same view."

Although this MHSU was on standard CPA at the time he was transferred to the CMHT, the findings of the then Commission for Health Improvement, and the comments of the then medical director, clearly identified that there were cultural problems with CPA.

- With regard to the CPA care plan, the then medical director was able to tell the IIT that:

  "The situation we then had was that people on standard CPA, if they were only seeing a member of medical staff, that member of medical staff was the care coordinator. Of course, the care plan could well be the letter to the general practitioner. I did check this out with a medical director elsewhere in the region from an adult mental health background, who said the approach we were taking was the right one."

  For nursing staff there was a clearly designed care plan template that met with most of the national good practice standards at the time. The only omission was the lack of prompt for the notation of a crisis management or relapse prevention plan.

- There was no effective handover between the care coordinator CPN-A2 and CPN-A3 who were appointed to the MHSU. The IIT was informed that when CPN-A3 was allocated to the MHSU, CPN-A2 had already left the team. CPN-A3 was a new member to the team

and was allocated her caseload by one of the senior team members, CPN-A4.

CPN-A4 told the IIT that at the time she was handed over to by CPN-A2: *"I think it would have been a bit of verbal communication handover and discussion, but I can't remember ... it's such a long time ago that it could have been different."*

When CPN-A3 was asked about the allocation of the MHSU to her she said that the way in which he was handed over to her was unusual, *"but I'd just come to the job, and the chap that was in the job previously had only been seconded, so he had a caseload and I inherited his cases*".

CPN-A3 told the IIT that when she first met the MHSU she *"was in the kitchen at the mental health team base and he put his arms around her, bear hugged and lifted me off the floor"*. She was with CPN-A4 at the time who had introduced her to the MHSU: "*This is CPN-A3, she's going to be your CPN*."

CPN-A3 also told the IIT that with some other service users she was *"handed their notes and there was a file I was told `these are the people you are taking over'". Others I was taken to their homes by whoever I was taking over the care from. There was another chap with paranoid schizophrenia I had on my caseload and I was taken by his nurse to go and meet him at home, was introduced and got a much better handover of care and got more history about his family background*."

These excerpts reveal inconsistency in practice within the MHSU's CMHT and a lack of established approach to the handover of care between an outgoing and incoming care coordinator. This inconsistency can only have arisen from a lack of effective leadership of the team and the absence of an effective operational policy. This lack of effective operational policy suggests a overall lack of effective management within the Northern Locality at the time.

- With regard to CPA training, there does not appear to have been much investment in this prior to 2003. The nursing director appointed in 2003 told the IIT that in 2003:

  "CPA had just been reviewed by my predecessor, so the training (workshops) we commissioned were around integration and CPA, and we worked with social services for that.". The IIT asked her about training availability prior to 2003. She said:

"There would have been some training. Before I took over, the training was led by HR, and the only bits for clinical staff would have come out of the School of Nursing, and some of the medical training always had Friday sessions. The medics always had Friday afternoons to do their training, and when I was quality manager I persuaded the medical director to let nurses come to that if they wanted to. It was very much more geared towards admin, and we shifted it."

The IIT asked:
"Q. *So prior to 2003 there was very little training around care coordination and key worker roles."*
The director of nursing answered:
"Very little. One individual was in charge of medical education, and unless she managed to get money from outside, then we would put on something, but a lot of the emphasis I can remember, that was all picked up through the training school. "

CPN-A4 was asked the following:

"Q: *Were you aware of any training for risk assessment or CPA training at that time within the Trust?*
A. *There's always risk assessment training at regular intervals. I don't have any memory of specific CPA training."*

A review of the training records for CPNs revealed that neither CPN-A2, CPN-A3 nor CPN-A4 attended any CPA training between 1998 and 2003. Neither had CPN-A2 or CPN-A3 attended any type of risk assessment and management training over this period. The IIT's interview with TM3 (team manager from 2006 – date) confirmed that there was no care coordinator training available in the Trust until the summer of 2006.

- Clinical supervision was not as effective as it could have been. Although TM1 is confident that he delivered supervision requirements in line with the Trust's policies when a team manager and also as locality manager, supervision records for staff when TM2 was in post could not be located for at least one member of staff involved in the care and treatment of the MHSU. In spite of the assertions of TM1 and TM2, no supervision records for CPN-A3 or CPN-A4 could be located prior to 2006.

4.2.2.6.2 The root causes to the lack of effective care planning and risk contingency planning for the MHSU January 2000 – December 2003

It is difficult to say precisely what these root causes were, as a detailed analysis of what more senior management were doing in relation to their

management and quality monitoring responsibilities in the late 1990s and very early 2000s was not possible within the constraints of this investigation. A significant factor will have been that clinical governance remained embryonic within the NHS and it is well recognised that CPA presented a challenge to many mental health providers. What is clear from the information the IIT gleaned was that significant contributory factors were:

- Although there were clear care planning and risk assessment documentation tools, neither prompted the recording of a relapse prevention or crisis management plan for a service user.
- There was no CPA training provided to any of the CPNs acting as care coordinator for the MHSU between 1998 and 2003.
- The MHSU's community mental health team did not operate on a MDT basis. That is there were the consultants, and then there were the nurses and social workers. There was no team approach.
- Clinical and managerial leadership by the respective team leaders was not effective.

4.2.3 The effectiveness of the MHSU's medication management between January 2000 to December 2003

The IIT has no concerns about the MHSU's medication management between January 2000 and prior to his discharge off the CPN caseload in December 2003.

The treatment of choice for service users suffering from paranoid schizophrenia is antipsychotic medication. From February 1993 until 20 March 2002, the MHSU was prescribed flupentixol 20 mgs fortnightly to be administered by injection (commonly called depot medication). On 20 March 2002, at his own request the MHSU's depot medication injection frequency was reduced to three-weekly, still at a dose of 20 mgs. This remained his prescribed medication up until the index offence. He continued to maintain stability in his mental health state on this dosage, turning up reliably for his injections with CPN-A4. The fact that his mental state remained stable means that the frequency and dosage was right for him.

The rationale for maintaining the MHSU on depot medication was because of his long history of non-compliance with oral medications prior to his attack on this father in 1990. In the 1980s the MHSU had been treated with oral medication and his many relapses into psychosis were attributable to medication non-compliance. Depot medication was a way of assuring that the medication administered did enter into the MHSU's system. It was in his best interests.

In spite of the IIT's previous comments about the lack of robustness in the MHSU's care plans and risk assessment it was recognised by CPN-A4, who had most contact with the MHSU, that maintenance of his medication was critical to the stability of his mental health. Consequently when, on 20 March 2002, a locum consultant psychiatrist unfamiliar with the MHSU wrote to his GP suggesting that he could be changed to a newer atypical antipsychotic via oral administration, CPN-A4 wrote to the locum advising against such a change and highlighting the risks of doing so. Consequently the locum wrote again to the GP to reverse the plan.

The management of side effects

There is little reference in the medical or CPN records about any side effects the MHSU experienced as a result of his medication. This is in stark contrast to the recall of his family and friends who told the IIT that he was consistently troubled by Parkinsonian-type side effects. His limbs would be very shaky and he would not be himself for approximately one week after having his depot injection.

There is one reference in the medical correspondence where the MHSU told a consultant psychiatrist in March 2002 that the injection "*pulled him down physically",* making him somewhat tired. At this time the MHSU was very keen to reduce the frequency of his medication to three weekly.

There is one other reference to the MHSU's experience of side effects in the CPN records, made by CPN-A2, where she stated the MHSU refused any medication to assist with his Parkinsonian type side effects.

At interview Cons PA2 and Staff Grade Psychiatrist A1 told the IIT that the MHSU minimised any side effects he may have had. Cons PA10 also told the IIT that there was no validation of the side effects the MHSU reported to him.

Comment by IIT
Given the openness with which the MHSU talked about the side effects of his medication with his friends, the IIT suggests that there may have been a lack of exploration with the MHSU about his experience of side effects at his outpatient appointments and when he attended at the depot clinic.

A service user's experience of medication side effects is a known trigger for medication non-compliance and it was considered best practice from 2002, following the publication of the National Institute for Clinical Excellence guidance on the management of schizophrenia, for side effects to have been proactively managed.

Given the passage of time between the MHSU's clinical contacts and the interviews undertaken for this investigation it is possible that staff did discuss side effects with the MHSU, but did not make any documentary record of this. The IIT hopes that the mental health professionals will better appreciate the value of good quality clinical records as a consequence of this investigation.

4.2.4 The decision to discharge the MHSU from the CPN caseload in December 2003

On 21 November 2003 CPN-A4 wrote to the MHSU's GP asking if he would be agreeable to the MHSU attending the surgery for future depot injections. In her letter she told the GP that: "*He (the MHSU) is well maintained on small doses of Depixol 20mg every three weeks and has been stable for some 3-4 years, simply coming to the base for his injection. His mental state has not been of concern for some 5-6 years despite his forensic history and he is wholly reliable and compliant, never missing an appointment in that time."*
CPN-A4 told the GP that if the MHSU attending at the GP was acceptable, that she would give him his last depot injection on 11 December and then direct him to the surgery for the next appointment due in the first week of January 2004.
She also said: "*If I do not hear from you I will assume this arrangement can go ahead. I am very keen to `normalise' things for the MHSU as he feels there is still great stigma attached to being part of mental health services."*
CPN-A4's next letter to the GP is dated 16 December, it says "*as previously arranged I have discharged this patient from our active caseload".*

The way this transfer of responsibility for the administration of depot medication was conducted was unsatisfactory and did not comply with what was intended to occur as detailed in the "*Mental health policy implementation guide: community mental health teams*" (DH 2002). Pages 9 -16 of this guidance say:

- "weekly team meetings should include the consultant psychiatrist where actions are agreed and changes in treatment discussed by the whole team";
- "close and effective links needed with Primary care where they prescribe or administer" medication;
- "CMHT and PHCT staff should be fully involved in discharge planning";
- "discharge letters need to be comprehensive and indicate current treatment and procedures for re-referral" and;
- "relapse signatures and risk assessment/management information should be provided where available".

Although the plan for the MHSU to receive his depot injections was discussed at the CMHT meeting on 26 November 2003, at which Cons PA7, TM2 and CPN-A4 were present, the meeting notes do not evidence any reasonable depth of discussion about this. The notes merely say "*depot being organised with GP by CPN-A4 and TM2".* Cons PA7 told the author of this report that it would have been very unusual for him not to have recommended that the transfer of responsibility for the administration of the depot injection be

undertaken within the CPA process, and more robustly than that which was proposed in CPN-A4's letter to the MHSU's GP.

In her letter of 16 December 2003 CPN-A4 said: "*It would be appropriate to mention that the MHSU has a long forensic history, and whilst he has been stable for some number of years, he would relapse without his medication."* However this was insufficient information to have provided to a primary care service where the professionals were not mental health trained, especially with the well-recorded risks associated with medication non-compliance.

In addition to the inadequacies in process and information exchange, CPN-A4 copied her initial letter to Cons PA7, whereas Staff Grade Psychiatrist PA5 was the psychiatrist who had seen the MHSU at outpatients in August and February 2003. Cons PA7 had only seen the MHSU once in September 2002 when he transferred medical case management to Staff Grade PA5[9].

The subsequent correspondence of 16 December 2003 should have been copied to Cons PA7 and Staff Grade PA5. Furthermore the decision to discharge the MHSU from the CPN caseload should have been discussed with Staff Grade PA5, as a matter of courtesy at the very least.

The IIT considers that the GP surgery was left exposed with regards to the ongoing medicines management of the MHSU. Furthermore the practice nurses were also left exposed, as nowhere in the correspondence to the GP was he advised of the fact that the MHSU could from time to time be inappropriate with female staff. This represented a lapse in CPN-A4's duty of care to her primary care colleagues.

4.2.4.1 How was CPN-A4 able to discharge the MHSU as she did?

CPN-A4 told the IIT that she did discuss the transfer of the MHSU to the GP practice, for his depot injections, in her management supervision session with TM2. She advised that a record of this was made and that she did sign it. TM2 confirmed that he did discuss this with CPN-A4. The IIT asked for copies of her supervision records but no records could be found.

When asked whether a CPA review was organised at the time of the MHSU's transfer to primary care for his depot medication, CPN-A4 said: *"No. I believe it was between the usual planned reviews and they were very informal and would usually be myself and the MHSU."* She also told the IIT that she *"didn't believe that they had a formal set up for standard patients at that time."* The

[9] Note: Staff Grade PA5 had also met the MHSU in her capacity as locum consultant psychiatrist in October 2001.

IIT has reviewed the Trust's CPA policies for 2002 and 2003 and the guidance provided to staff does not differentiate between standard and enhanced service users at the point of care transfer. However, the discharge of the MHSU would not have constituted a transfer of care within the common interpretation of the Trust's CPA policy in 2003. Transfers of care were generally considered to be occasions where a service user was moving out of the geographical area and therefore required transfer to another mental health team within Norfolk or in another county.

The 2003 CPA policy did include a section entitled "*End of contact with specialist mental health services*" but this would not have been seen as relevant to the MHSU, as he was remaining in contact with specialist mental health services during his six monthly outpatient appointments.

The 2003 CPA policy did not address the situation for this MHSU, that is the intra-team transfer of care coordinator. This however was not uncommon. Many CPA policies did not and do not state that the standards required of an out of team transfer also relate to intra-team care coordinator transfers. The author of this report has come across ineffective transfer of information, when there is a change of care coordinator within the same team, during a number of mental health homicide investigations.

The IIT also asked CPN-A4 what plan was put in place if the MHSU were to miss any of his medications. She responded: "*I don't believe there was a written plan. The fact he was discharged from the active caseload would have simply meant that we knew his name, everybody was very aware that we would have highlighted that, and arranged for probably the team manager or a named nurse to see him. It never arose."* It is the contention of the IIT that CPN-A4 genuinely did expect that staff would remember the MHSU and if the GP surgery asked for help then it would be forthcoming and quickly. However, her knowledge of the MHSU, and her seniority within the CMHT, means that she should have appreciated the need for a crisis management plan for this MHSU, especially as the 2003 and the 2002 CPA policies highlighted it as a good practice element for service users on standard CPA.

The IIT asked CPN-A3 what she would do if discharging someone from her caseload in 2003. She told the IIT that if she wanted to discharge someone from her caseload she would "*discuss it with them (the consultant psychiatrist if involved) within the arena of the team meeting, or if it was just me and the consultant involved in the care, I might just have a one-to-one meeting with the consultant. If it was just me I'd discuss it with the GP. It depended who was involved in the care. Then a discharge meeting would be arranged."*

Although CPN-A4 did not arrange a CPA discharge meeting, in 2003 there was no requirement in the Trust's CPA policy for such a meeting for a service user on standard CPA.

The interview with Staff Grade PA5 revealed that her experience for service users on standard CPA was that "*sometimes the CPNs discharged the patients without discussing them in the team meeting and without discussing them with the consultant".* She advised the IIT that she had brought this issue up at a locality meeting with the locality manager and TM2 and the other consultants attached to the MHSU's community mental health team. She told the IIT that "*at least there should be a CPA programme or 117 meeting, or at least informal discussion with the clinician; because I felt that it's very difficult for me sometimes to come to the clinic and find a letter in the notes about the CPN discharging a patient to the GP".* Staff Grade PA5 also told the IIT that her point was accepted but not actioned.

The IIT asked this doctor if she felt that Cons PA7 had accepted the responsibility for the transfer. Her response suggested that Cons PA7 had no objections to the transfer of the responsibility for administering the MHSU's depot injection to the GP practice per se. However, there is no evidence to suggest that Cons PA7 held any responsibility for the operational aspects of the transfer of responsibility.

What is clear to the IIT is that the decision to transfer the responsibility for the administration of depot injections to the GP surgery was not made in a vacuum. CPN-A4 did not simply do it unilaterally. She did liaise with her manager, and she did table the proposal for discussion at the team meeting involving Cons PA7. It is unfortunate that the minutes of the team meeting do not contain any detail about the discussion held amongst team members about the proposal. What is clear is that TM2 did not ensure that there was an effective process for handing over care coordination responsibility for the MHSU to Staff Grade PA5 who was on annual leave at the time the decision was made.

The above being said, the IIT would have expected a CPN of CPN-A4's experience to have ensured that:

- "Appropriate services have been set up with the receiving team/service to meet the service user's needs.
- Sufficient information has been made available to appropriate professionals in the receiving team/service," as stated in the Norfolk and Waveney Mental Health Partnership NHS Trust's 2003 CPA policy.

It is the opinion of the IIT that the minimum information requirements were met, but that the depth of information required to ensure the safety of the MHSU, his family and the staff at his GP surgery was not communicated.

4.2.4.2 Overall comment by IIT

The information gathered via interview, the CHI report (2002), the Richard King report (2005) and a review of the report of the "*Northern Locality – organisational development approach*" (February 2006) leads the IIT to be confident in its belief that at the time the MHSU was discharged from the CPN caseload:

- Local management structures within the Northern Locality and consequently the MHSU's community mental health team were not as effective as they should have been.
- CPA training for care coordinators had not been delivered and care coordinators did not have a complete understanding of their role.
- The thrust of the then CPA policy for the Trust was around the management of enhanced CPA service users. Furthermore the policy was not written in an accessible style. It was heavily narrative and its focus was split between providing up-to-date clinical guidance and an historical overview of CPA. It lacked clarity on the clinical standards expected of its staff.
- The guidance provided for staff on risk assessment, within the CPA policy, was woolly and unlikely to result in risk assessments of good standard. Furthermore it limited the requirement for contingency and crisis intervention plans to those service users on enhanced CPA.
- Supervision of staff, although in place, was more geared towards caseload management at the time and not clinical practice. At the time this MHSU was discharged there was a drive to reduce CPN caseloads and to discharge to primary care those service users who did not need the input of specialist mental health services. This was a national initiative and represented a massive change for community mental health services. However the "*Mental health policy implementation guide: community mental health teams" (DH 2002)* is explicit around what was expected when service users were transferred or discharged from a CMHT.
  The key elements of this guidance relevant to the MHSU's discharge were:
  - "discharge letters need to be comprehensive and indicate current treatment and procedures for re-referral; and
  - relapse signatures and risk assessment/management information should be provided where available." (page 16).

  It was the responsibility of TM2 to ensure that the guidance was adhered to. He did not.

- Corporately there was either insufficient monitoring, or an inadequate process for monitoring, compliance with national policy standards at the time.
- Staff understanding of and engagement with CPA, and other national standards as a “whole team activity” was lacking.

The whole system has changed in the Trust and today a service user would not be discharged from a CPN caseload in the way the MHSU was. There is however opportunity for reflective learning for CPN-A4. The IIT highlights the sentence in her letter to the GP, that said if she did not hear from him she would assume that the transfer of responsibility for depot injections was acceptable. A CPN should never assume understanding and acceptance on the basis of a non-response. Effective practice requires that one checks out that all is OK. CPN-A4 should have ensured that she had a conversation with the GP before discharging the MHSU.

In relation to the above, the IIT does also need to comment on the memory recall of Cons PA7, the supervising consultant for Staff Grade PA5. He told the IIT that had he seen the letter of 16 December he would have been concerned. He said: *“I am pretty sure and it is my practice to expect something a bit more joined up around that, we did have CPAs. Even if it was standard, he was under some sort of CPA process. I don’t know why it wasn’t sent to me because the first one was, and I don’t know how that happened ... It would have triggered me thinking can we go through the things I’ve just talked about: how do we know he’ll be alright, what if something goes wrong, how will we know, at what point should we detain him if he stops. All of these things so it’s pretty spelt out.”* The IIT does not doubt Cons PA7’s integrity, and appreciates that the passage of time will have affected the clarity of his memory recall about the precise nature of the discussion at the team meeting of 23 November 2003. The IIT accepts that on the balance of probabilities Cons PA7 is more likely than not to have highlighted the need for a robust handover process between the CMHT and the MHSU’s GP surgery. A more robust follow up of the actions agreed and subsequently taken during the weekly multi-disciplinary team meetings may have alerted him to the fact that this is not what happened.

Finally, the IIT spoke with the MHSU’s GP about how the transfer of depot responsibility occurred. His recollection was completely different to all of the staff involved from specialist mental health services. He told the IIT that: “*It was done in person at a meeting like this, with Consultant Psychiatrist PA7 and two of his mental health nurses around the table. It was put to us, and I think the reason given was that the MHSU did not like the stigma of mental health nurses visiting him, do you think we could take this on as a responsibility. On the face of it, it seemed OK to me.”*

The IIT is confident that the MHSU was discussed with his GP, in a meeting such as described above. However, the balance of information does not support the GP's memory recall that it was a proactive meeting convened specifically for this purpose. It is much more likely that it occurred in one of the regular monthly meetings CPA7 and CPN-A4 held with the GP practice. This in itself was good practice, however the meeting would not have facilitated the depth of discussion required around this MHSU in relation to the responsibilities the GP surgery were accepting and the risks of which they needed to be aware.

4.2.4.3 The appropriateness of transferring the MHSU to the GP surgery for his depot injections at all

The "*Mental health policy implementation guide: community mental health teams*" (DH, 2002) said:

"Patients should be discharged back to primary care promptly when they are recovered. This is essential to protect capacity for new referrals."

Without a doubt this MHSU was stable, and had been stable since 1997 when he was given an absolute discharge from conditions imposed under the MHA. During his period of contact with the community mental health team (1999 – 2003), bar two episodes of over familiarity with CPN-A3, his conduct had been exemplary. He was a service user who had good quality recovery, was self sufficient and was well integrated into his community. Technically, there was no logical reason why primary care services could not take over the responsibility for administering his depot injection on a three weekly basis.

There was however a range of opinion expressed by interviewees about the appropriateness of this action for <u>this</u> MHSU.

The following represent the range of positive and negative perspectives.

Responses supporting the decision made:

- *"When I looked at it my initial reaction was, ... what on earth are we doing handing across someone with such a history. That could be around stereotyping service users, and that would imply that you could never have a stable life ... I would be happy that he was cared for in primary care ... knowing he'd had six years of being very well maintained ... It's considered best practice where possible to let service users be cared for in the least restrictive areas that are beneficial to their treatment."* (Director of Nursing 2003)

- The MHSU *"had not had a hiccup, had not had a relapse, had not had an admission, for I don't know how many years prior to that. How long do you go on stigmatising him? ... He really wanted to be discharged and treated like anybody else and go to his GP for his medication. That wasn't an unreasonable request."* (TM2)
- *"It was about encouraging people to have better control of their lives and independence as opposed to remaining dependent on mental health services if they didn't need to be ... I felt as comfortable about that as I felt with any other patient we considered and successfully transferred at the time … he would be continually followed up by the psychiatrist so he was still part of the service. Looking at his risk assessment at the time with us, the fact he was compliant, I had no problems in doing that whatsoever."* (CPN-A4)
- *"The reason we were given was that the MHSU wanted to feel a normal person in the community, and I think the idea of having mental health nurses visiting him and giving him injections was not, to his mind, normal. It was much more normal if he were to attend a GP practice because that is what normal people do."* (MHSU's GP)
- *"My view would be the MHSU had been well and was concordant for a number of years. My view professionally and morally would be at what point would he be enabled to be well."* (Interim CMHT Team Manager end 2005)

Responses that were cautious about the decision:

- *"It was unusual in this particular case ... what's unusual in this case is the past history of violence and aggression. The other patients that are having depot (at a GP practice) don't have that history."*
- *"Because he was mentally stable at the time it is very difficult to argue that he would need a CPN, but from my point of view I would say that this patient has a very risky past. Although he is stable it would be more helpful if he could even have one contact with a CPN every three weeks just to give him his depot and see how he was doing, because his outpatient appointments were very scarce every six months and you would never know what would happen in the space of six months."* (Staff Grade Psychiatrist PA5)
- *"From the Royal College of Nursing's point of view, when it was first mooted that depot injections would come over to primary care, this was always one of the concerns we had. It is not merely giving an injection, it is a whole lot more than that, and these girls didn't have the skills to do that really."* (RCN rep for the GP practice nurses) (Note: there were many similar comments about the capability for the practice nurses to effectively monitor the MHSU's mental health state.)

- *"He had a lifetime illness, he needed lifetime treatment. Under those circumstances that I was working with him I would have kept the MHSU within my caseload."* (Forensic CPN to the MHSU up to January 2000, in response to a question asking whether he ever foresaw a time when the MHSU could be discharged from the CMHT caseload).
- *"I would say somebody with that history, where it is so significant when this person stops their medication, to only have a consultant psychiatrist every six months and then every two months is just not enough for me."* (TM3 (in post March 2006)
- The locality manager at the time, previously TM1, told the IIT that had he been aware of the plan he would have opposed the discharge of the MHSU off the CPN caseload, simply because of the MHSU's past history and his belief that such a service user required more regular contact with specialist mental health services.

Because of the range of responses and because professionals interviewed will have been affected by what subsequently happened, the author of this report determined that the issue needed to be tested with a range of professionals outside of Norfolk and unconnected with the investigation, thereby invoking the principles of the National Patient Safety Agency's substitution test.

In a chapter entitled "The incident decision tree: guidelines for action following patient safety incidents" from *Advances in patient safety: From research to implementation, vol 4: programs, tools, and products* (Agency for Healthcare Research and Quality, February 2005), authors Sandra Meadows, Karen Baker and Jeremy Butler say:

"If protocols were not in place or proved ineffective, the substitution test helps to assess how a peer would have been likely to deal with the situation. James Reason advises:

"Substitute the individual concerned, for someone else coming from the same domain of activity and possessing comparable qualifications and experience. Then ask the question 'In the light of how events unfolded and were perceived by those involved in real time, is it likely that this new individual would have behaved any differently?""

Eleven mental health professionals (three consultant psychiatrists, one professor in forensic psychiatry, one mental health commissioner, one assistant director of nursing, and senior mental health practitioners) were given the contextual overview of the MHSU but were not told what subsequently happened. They were asked to give their response to the following statement and to answer questions such as Q2 below.

Statement: "It seems to me that given the length of stability in the MHSU to enable him to receive his depot at the GP surgery was in itself OK. However, in view of previous forensic history, one might have expected:

I. The CPN to meet with the practice nurses who would be giving it and ensure that they understood when they needed to get in touch with the CMHT.
II. The CMHT to have an alert attached to the MHSU's name so if the GP surgery got in touch there was a rapid response and assessment of the MHSU at home, or in outpatients."

Q 2: "Would this have been reasonable? Or is it that anyone with a severe and enduring mental illness (paranoid schizophrenia in this case), and a significant forensic history should never be discharged from a CMHT caseload even after a long period of stability?"

Eight professionals responded to the email. All agreed with part ii of the statement and seven agreed with part i. The person who dissented was a consultant psychiatrist who considered it the GP's responsibility to make sure that his practice nurses were well informed, providing that the GP was given sufficiently good information to start with.

With regard to the question of discharge from the CMHT caseload the range of responses were as follows:

- *"I agree with your view on this so long as the GP was fully informed of the history. The standard must be whether the right thing was done, rather than who was doing it. The absolute discharge by a tribunal would also tend to support the decision to move the case to GP care."* (Two same type responses – i) A professor in forensic psychiatry and ii) a consultant psychiatrist in general psychiatric services)

- *"I think that it would be wrong to keep someone who is well and compliant on a CMHT case load if they are agreeable to being managed by the GP and primary care and there is an agreed fast track route back into secondary care if there are any concerns."* (Experienced mental health nurse, with CMHT management experience, now an assistant director of nursing*)*

- *"People can and should be discharged from secondary services <u>IF</u> risk assessment and care planning is in place to ensure that there is clear outline to all parties (including the user of the service), who has responsibility for what and what will happen if any of the relapse indicators are noted. All parties should be made aware of the potential risk - risk of danger to others if not medicated should be highlighted."* (Experienced mental health occupational therapist who has held care coordination responsibility. Now the lead for risk and safety in her mental health trust)

- *"They should have had a care planning meeting before transfer and transmitted such info to the GP at least, then up to him to let practice nurses know the score."* (Consultant psychiatrist assertive outreach)
- *"The GP should have been aware of his history."* (Experienced CMHN and now commissioner of mental health services)
- *"There is an argument about if there are no issues or matters of concern at home why should services intrude, but in order to say this is the case, services would need to factor into the care plan home visits to ensure home situation is OK. (When I ran a depot clinic in my CPN days, 20 years ago!, given that you only see someone for a very short period of time, I did home visits to check on the situation at a frequency depending on the patients individual circumstances, at the time this was seen as good practice).*
  "A possibly un-written bonus of his receiving his depot at a depot clinic is that this is where he is likely to receive monitoring during administration from a team who do little else. Therefore they have a weather eye on his mental state and are well versed in responding to signs of relapse however the time allocated to patients at these clinics can be very short." (Experienced CPN and team manager, most recently CPA and risk assessment lead for his mental health trust)

On the basis of applying the substitution test, it seems clear that the issue was not so much the discharge from the CPN's case load to the GP practice for depot injections but, more the way in which it was executed. Had there been:

- a discharge CPA meeting;
- a clear presentation of the MHSU's history and risk vulnerability; and
- a clear and robust risk management and crisis intervention plan agreed between CPN-A4, Cons PA7, Staff Grade PA5 and the GP,

then the transfer from the CPN to the GP practice for the purposes of depot injection would have been effected safely and be above criticism.

Furthermore, had the monthly meetings between the GPs at the surgery and Cons PA7 continued after his departure from the CMHT, there would have been regular opportunity for the GPs to raise any concerns they might have had about the MHSU. It was a requirement of the "*Mental health policy implementation guide: community mental health teams*" (DH, 2002) that such meetings occurred and TM2 and the locality manager should have ensured that there was provision for their continuation once Cons PA7 left to take a post elsewhere. These meetings should not have been reliant on the efforts and energy of one consultant.

4.3 The MHSU's contacts with primary care services December 2003 – 25 April 2006

The contacts between the MHSU and the practice nurses at the GP surgery were largely unremarkable. It is clear to the IIT from speaking with the practice nurses that they saw their job as administering the MHSU's depot injections, and having light conversations. None of them considered themselves to have the capability to monitor his mental health state. Clearly if there was "*something very odd"* then they would raise it with the GP. The perspective of the practice nurses is, in the opinion of the IIT, perfectly reasonable. Their view of their role in the process was supported by the mental health professionals interviewed by the IIT.

A number of the practice nurses told the IIT that they did not feel entirely comfortable around the MHSU and some of this was linked to his tendency towards over-familiarity. However the practice nurses were able to manage him in this respect. It did not pose a big problem to them.

The practice nurses told the IIT that they did not attend the meetings between the GPs and the consultant psychiatrist; this was simply something that did not happen. However they did have contact with the mental health primary care liaison nurse. The MHSU, however, was not someone who the practice nurses would have discussed with the mental health primary care liaison nurse as they considered the MHSU to already be in receipt of specialist mental health services via either a CPN or a consultant psychiatrist. All of the practice nurses the IIT spoke with believed the MHSU to have a CPN.

With regard to the two occasions the MHSU defaulted on his medication by turning up late, the practice nurses were not particularly aware of this at the time as he had changed his appointments by contacting the receptionists at the surgery. It was not seen therefore as "not turning up". He had rearranged his appointments and attended in line with this. It was and is not unusual for patients to change appointment times, and in January 2006 there was no system for flagging up to the nurses patients who had changed their depot injection date, or other "essential" appointments where a change in date could have negative consequences for a patient. The practice nurses told the IIT that they did not appreciate at all the significance of him extending the periods of time between his injections. They emphasised that they did not see him as medication non-compliant because he was coming for his medication.

The practice nurses recalled that there was one occasion where he did try and refuse his depot early in January 2006 but the practice nurse on duty appropriately remonstrated with him, and insisted that he speak with the GP, as it was the GP who wanted him to have his injection. This practice nurse recalls the MHSU not being happy about the position she took. However, he did see the GP and as a result he did have his medication. Neither this nurse

nor the GP perceived there to be a more serious problem because the MHSU did take his medication on this occasion.

On 21 April the MHSU did not turn up for his medication at all. The practice nurses on duty tried to contact him at home on a number of occasions to ask him to come in for it. When their attempts at contact were unsuccessful, they contacted the mental health team on 25 April 2005. They were told by the person they spoke to that the MHSU no longer had a CPN and they would need to re-refer the MHSU. The practice nurse, not knowing what else to do, wrote to the MHSU's consultant psychiatrist (Cons PA10) highlighting that the MHSU had missed his depot injection. This letter was received by Cons PA10 on 26 April 2006.

The practice nurse on duty on 21 April 2006 also ensured that the GP was advised.

4.3.1 Comment by the IIT

There can be no criticism levelled at the practice nurses regarding their contact with the MHSU between January 2004 and January 2006. Furthermore it does not seem reasonable to have expected them to realise the significance of the MHSU increasing the time span between his depot injections between 27 January 2006 and 21 April 2006. As soon as the MHSU defaulted from attending for his medication the practice manager and practice nurses responded appropriately. They tried to contact and re-engage the MHSU on 24 and 25 April, when this was not successful they contacted the mental health team as instructed in CPN-A4's correspondence of 16 December 2003.

Some might suggest that the GP practice should have had more robust systems and processes in place, to pick up on those patients who were not complying with the time frames in which medicines should be administered. The IIT agrees with this. If a GP practice is administering antipsychotic medications and other medications where the time differential is important, then its systems should be sensitive enough to allow any deviation from the planned administration times to be raised as an alert with the responsible GP and/or practice nurse. The GP surgery for the MHSU has already changed its systems and processes in this respect so that the chances of another patient extending time periods of medicine administration has been reduced to its lowest level. The GP surgery had implemented this prior to this investigation.

4.4 The psychiatric management of the MHSU between January 2004 and May 2006 by specialist mental health services

Following the MHSU's discharge from the CPN caseload on 11 December 2003, the plan was for him to attend outpatient appointments with his nominated care coordinator on a six monthly basis. The IIT notes that the MHSU's initial appointment was made with Cons PA7. However this appointment was cancelled by the specialist mental health service and rescheduled a month later on 23 February 2004 with PA5 (the staff grade).

As a consequence of this meeting Cons PA5 wrote to the MHSU's GP. Her letter said: "*He has remained stable since last seen ... He didn't seem to agree that it is the medication that is keeping him well, but says he will carry on because we have advised him to. I also emphasised to him that it is better to have an injection every three weeks than to be ill and he tended to agree with me on this."* Overall Cons PA5 found the MHSU to be well and there was a good rapport between them.

The MHSU was next seen in the staff grade clinic on 9 August but by a locum staff grade psychiatrist, Staff Grade PA8. He was again noted to be well denying "*any paranoid delusions, perceptual abnormalities and self harm or harm to others ideations"* The locum felt that the MHSU "*remained stable".*

On 15 February 2005 the MHSU was again seen in the staff grade clinic by locum staff grade psychiatrist PA9. The letter to the GP following this appointment shows that PA9 did read through the MHSU's notes: "*I understand he has had a long period of stability for the last six years where he has remained well and complied with his medication."* The plan was to continue with his medication and to be reviewed again in six months.

On 18 July the MHSU was again to have been seen in the staff grade clinic, however because Staff Grade PA5 was leaving the team she had wisely asked for the MHSU's case to be transferred to the consultant clinic. Consequently on 18 July 2005 the MHSU was assessed by the newly appointed consultant, Cons PA10.

This consultant undertook a thorough review of the MHSU's clinical records. As a consequence of this, and particularly in light of the MHSU's past forensic history and his history of ill-health associated with medication non-compliance, he referred the MHSU's case to TM2 for reinstatement of a CPN care coordinator. In his letter to the GP following this appointment he indicated that this would occur in the "*near future".* Cons PA10 also arranged for a further outpatient appointment in two months' time.

As planned, Cons PA10 met with the MHSU in outpatients on 16 September 2005. At this appointment a nurse care coordinator had not been allocated. The MHSU, however, was noted to be well.

The next outpatient appointment was on 14 November 2005. Cons PA10 noted the MHSU to be well at this appointment, and that "*we are waiting for TM2 to allocate a care coordinator from the CMHT".* A subsequent outpatient appointment was booked for 30 January 2006.

On 30 January 2006 the situation remained unchanged, and Cons PA10 again noted "*he has been referred to the CMHT to be allocated a (new) care coordinator".* Further medical review was booked for 10 April 2006.

In the MHSU's medical records there is a file note dated 1 February 2006. It says "*history of non-compliance needs care coordinator who is male".* Subsequent correspondence from CPN-A8 (a male CPN) to CPA10 on 7 March 2006 shows that CPN-A8 had been asked to make contact with the MHSU with a view to becoming his care coordinator. This CPN told PA10 that: "*whilst he was pleased to hear from me as he remember me from NORCI ... he did not want to see me. He said things were going really well and he feels he did not need to see me, as he is currently very well. I said if he changes his mind he could either contact me at Base C or via yourself."*

Cons PA10, when he saw the MHSU at his outpatient appointment on 10 April, negotiated with the MHSU to engage with CPN-A8. He agreed with the MHSU that if he met regularly with CPN-A8 then he would not have to come to the outpatients clinic so often. Consequently a further outpatient appointment was not made at this stage. Cons PA10 advised the MHSU's GP that CPN-A8 "*will take over the role as care coordinator and will arrange another medical review and CPA meeting in due course".*

On 27 April, Cons PA10 received a letter from one of the practice nurses at the MHSU's GP surgery. The letter was written on 25 April. The letter stated the MHSU "*was one week late for his last Depixol 20mg injection and has not attended for the most recent injection dose on 21 April 2006. We are finding it increasingly difficult to contact the MHSU and encourage his compliance with his 3 weekly Depixol injections. We have contacted Base C and understand that he does not have a community mental health nurse at the moment."*

The records of CPN-A8 confirm that Consultant PA10 contacted him on 28 April and asked him to contact the MHSU, which he did. CPN-A8 told the IIT that the MHSU advised that he would go to the surgery to have his depot injection. However, when CPN-A8 contacted the surgery on Monday 2 May to find out if had attended he was advised that the MHSU had not. CPN-A8 then contacted the MHSU again and asked him why he had not attended for his

medication. The MHSU told CPN-A8 that he had not had his medication because when he went that morning "*they were busy".* The CPN'S records said: "*He then said he would go again tomorrow morning and have his depot as he has to pick up his inhaler."* CPN-A8 then contacted the surgery to advise them to expect the MHSU the following day. He also booked the MHSU an appointment to meet with him on 5 May 2006.

On 4 May the practice nurse from the MHSU's GP surgery contacted CPN-A8 and told him that the MHSU had again not attended for his depot and that he had told the practice staff that he did not want it.

CPN-A8 noted that he contacted Cons PA10 about this who advised he "*monitor the MHSU's mental health state for any signs of deterioration".* (At this time the MHSU was two weeks behind his medication schedule.)

CPN-A8 met with the MHSU as planned and wrote to Cons PA10 the same day. He advised Cons PA10, in his letter, that the MHSU had confirmed that he no longer wished to have his depot injection. The reasons given by the MHSU were cited as:

- shaking in his legs and jerking in his arms;
- since not taking his medication he was not so tired;
- he was losing weight;
- he had lost his coffee addiction; and
- he found it difficult when working to explain why he had to go for an injection. (The CPN noted that "*this may relate to the MHSU telling me he has requested and is going on to Jobseeker's Allowance with the intention of finding work and coming off benefits*".

CPN-A8 also wrote: "*When I asked him what would happen if became ill again, he said he would become paranoid which he currently was not. I asked him what he would do if he became paranoid he said he would contact the surgery. I asked him what would happen if his paranoia became so severe that he thought it was real or normal thought. He said his friends would notice him acting differently and alert the authorities ... I discussed with the MHSU what would happen if he became ill and he said he would go back to the surgery and restart his depot. I also discussed with him the possibility of an alternative to his depot injection which would be going onto one of the newer anti psychotics .. .he said he would give it some thought."* This letter was copied to Cons PA10, the practice nurse and to TM3.

Following the formulation of this letter, CPN-A8 met with Cons PA10 on his return from annual leave, 18 May 2006. It was agreed between them that CPN-A8 should again try and persuade the MHSU to see him fortnightly and also to try and see him at his home. Making contact with the MHSU's family

and friends was also discussed. The date of the next planned meeting with the MHSU was 2 June.

The incident subsequently occurred on 24 May2006.

4.4.1 Comment by IIT

The period 11 December 2003 to July 2005 was unremarkable. However the IIT has a number of concerns about what happened between July 2005 and 24 May2006 (the date of the incident). These are:

- Why did it take almost seven months to allocate a CPN care coordinator to the MHSU?
- Given the MHSU's risk history and well-documented risk factors, when the MHSU declined medication on 5 May 2006 (his last medication was on 31 March 2006), why was there not more assertive follow up of him including:
  - a CPA meeting with TM3 and Cons PA10;
  - a more persistent approach to trying to achieve more frequent contact with the MHSU rather than the four weekly contact he agreed to; and
  - consideration of, and assessment under the MHA if the MHSU did not accept the home visit, and/or medication?
- Why did not CPN-A8 contact the MHSU's family soon after his assessment on 5 May to:
  - establish if they knew how to contact the mental health service, and if they felt safe to do so;
  - alert the MHSU's parents that he may be becoming unwell; and
  - to enable a more complete assessment of the MHSU?
- By 18 May the MHSU was four weeks behind his medication schedule. Why did CPN-A8 and Cons PA10 agree not to seek contact with the MHSU in advance of 2 June?
- What was TM3 doing over this period of time and to what extent, did he discharge his team leader duties in respect of the case management of the MHSU?
- Why did not CPN-A4 communicate with CPN-A8 about her understanding of the risks associated with the MHSU when unmedicated?

The analysis of the above concerns is presented in the remainder of this section.

4.4.2 Why did it take almost seven months to allocate a CPN care coordinator to the MHSU?

The actions of Cons PA10

The first written evidence of Consultant PA10 seeking a CPN care coordinator for the MHSU was on 18 July 2005, when the correspondence emerging from his outpatient appointment was copied to the then team leader, TM2. The letter is quite clear.

The usual process for requesting and allocating a care coordinator was via the mental health team meeting and/or a direct request to the team manager. All interviews confirmed this as the common understanding and expectation. A review of the team meeting minutes between July 2005 and February 2006 revealed that the first time the issue of a care coordinator for the MHSU was discussed was on 16 November 2005. There was another discussion on 30 January 2006 at the weekly team meeting. Cons PA10 has confirmed to the IIT that the usual process was to discuss the case at the weekly team meeting and that "*was the usual procedure of how cases were allocated".*" He also told the IIT that "*in this particular case it took a different route"*.

Cons PA10 told the IIT that because of the particular circumstances of the MHSU, that is, that he was having his depot at the GP surgery and receiving medical follow up at the psychiatric outpatients clinic on a six monthly basis, Cons PA10 thought it was more appropriate to discuss the referral with the manager of the CMHT. He told the IIT that "*we talked about the contact with the MHSU after my outpatient appointment. He (TM2) knew the MHSU from the forensic services and he was fully aware about his risk history. He recognised that if there was at some point a relapse it could be quite dramatic because his behaviour, (i.e.) what he had displayed in the past had been quite dramatic. We discussed the thing and he agreed for an allocation of a care coordinator."*

The IIT asked the consultant why the discussion took place outside of the usual team meeting. His response was:

"*Because I thought it was more appropriate. Given the circumstances, there were no significant changes (*in the MHSU)." Because of this Cons PA10 was uncertain as to whether he could justify his request for the reinstatement of CPN input for the MHSU. However, Cons PA10 also felt that his *"clinical assessment tells me that we should increase the contact and the level of the resources".* Cons PA10 told the IIT that the date he had the conversation with TM2 was 20 July 2005, two days after the MHSU's outpatient appointment. Cons PA10 told the IIT that there was no urgency for the allocation of a CPN at the time and that he was satisfied that it would occur in "*due course".* This he still believes was acceptable given the stability in the mental health of the service user. Cons PA10 told the IIT that he had waited to dictate his letter to the GP until after he had spoken with TM2 about the appointment of a CPN

care coordinator, and had his agreement to this. Cons PA10 confirmed to the IIT that he was fully aware that until such time as a CPN care coordinator could be allocated, he remained the care coordinator for the MHSU.

When a CPN care coordinator had not been allocated by November 2005 Cons PA10 took his request for a CPN care coordinator to the weekly multi-disciplinary team meeting of 16 November 2005. The notes of this meeting say "*Consultant Psychiatrist PA10 has requested CMHN[10] and TM2 was planning to liaise with CPN-A8 as the MHSU should have a male care coordinator, although very stable the MHSU has a worrying past mental health history".*

Cons PA10 told the IIT that it was his understanding following this meeting that CPN-A8 was to be allocated as the MHSU's care coordinator. TM2 however was not at the meeting; he had been on sick leave since 11 November following serious ill health. It was known that he was unlikely to be returning to work for a number of months. The IIT notes that there was no acknowledgement of this in the team minutes in relation to the progression of the allocation of a CPN care coordinator for the MHSU.[11]

Five weeks later on 28 December 2005 the team minutes state that the MHSU had been allocated to CPN-A8 with CPN-A4 to liaise. However, it appears that although the allocation was made, CPN-A8 was not present at the meeting and as far as the IIT can ascertain he was not advised of this decision. The IIT has not been able to establish why not, however the lack of team leadership may have been an influencing factor. The minutes taken of the meeting do not identify the "chair" or the most senior nurse present.

At this stage, it was five months since Cons PA10's first request for a care coordinator. However, he advised the IIT that over this period there was no change in the circumstance of the MHSU. He remained well and medication compliant. He was not therefore overly concerned about the delay in CPN allocation. The IIT is satisfied that Cons PA10 had assessed the MHSU at an outpatient appointment on 30 January and had determined that the MHSU's psychosocial circumstances had not changed, and that at the time there was no evidence of risk to self or others and that he was the same as he had been for many years.

The team minutes of 1 February 2006 also identify that the MHSU required a care coordinator. Cons PA10 was not at this meeting, however he

[10] Community mental health nurse
[11] There were nine team members present at the team meeting on 16 November, including two medical staff. The minutes were taken by CPN-A4.

subsequently discussed the matter with the new team manager (TM3) around 2 or 3 March 2006 and told him that TM2 was intending to allocate CPN-A8 as the MHSU's care coordinator. TM3 agreed to the plan and asked Cons PA10 to liaise with CPN-A8. Cons PA10 told the IIT that he did this the same day, and provided CPN-A8 with information about the risk history of the MHSU.

It is clear to the IIT that although Cons PA10 wanted a CPN care coordinator for the MHSU, he did not think there was any urgency for this at the time the request was made. He was content for the allocation to occur in the fullness of time. This, the IIT agrees, was not an unreasonable position to take. There were no immediate risks that suggested that Cons PA10's request needed to be treated on an urgent basis. The IIT also agrees that when, in November 2005, Cons PA10 determined it was time to step in and take his request formally to the weekly multi-disciplinary team meeting, this was the correct thing to do. The IIT however, does suggest that at this juncture Cons PA10, as the MHSU's care coordinator, should have more proactively ensured that his request for a CPN care coordinator was addressed promptly. The IIT accepts that the MHSU remained well at this time and that the community mental health team was under considerable pressure given the recent ill health of the team manager TM2, and that these factors did make some contribution to the further delays in delivering Cons PA10's request.

The actions of TM2

At the time Cons PA10 made his initial request to TM2 the prevailing national standard as detailed in the "*NHS Plan*" (DH, 2000) for GP non-urgent referrals was three months. Mental health services were expected to comply with this. Because of this standard, and that the MHSU was already in the mental health system, the IIT believes one could reasonably have expected the MHSU to have been allocated his CPN care coordinator by TM2 within this time frame.

TM2 told the IIT that he considered the conversation he had with consultant PA10 to have been an informal one. However, this is not supported by the recollections of Cons PA10, the note Cons PA10 made of the discussion, or the content of Cons PA10's letter to the MHSU's GP which was copied to TM2.

During interview TM2 was quite dismissive of the conversation he had had with Cons PA10 in July 2005. Furthermore, he did not consider there to have been a delay in the allocation of a care coordinator through August and September. If one accepts that the request was "non-urgent" which the IIT does accept, then allocation of a CPN care coordinator towards the end of October 2005 would have been reasonable.

Because TM2 was on sick leave as of 11 November 2005 he did not become aware of Cons PA10's action of bringing his request to the weekly multi-disciplinary team meeting on 25 November 2005. However, every outpatient letter to the GP from July 2005 was copied to TM2 and in each it was unequivocally stated that Cons PA10 was waiting for the allocation of a CPN care coordinator for the MHSU. It is the contention of the IIT that TM2 should have seen and acted on this correspondence as the team manager. The IIT believes that TM2 should have advised Cons PA10 to bring his request formally to the first multi-disciplinary team meeting after discussing the issue with him in July 2005.

4.4.2.1 Conclusion by IIT

The formal process for allocating a care coordinator to the MHSU was only commenced in November 2005 when Cons PA10 took his request to the weekly multi-disciplinary team meeting. Because of:

- the gap in team leadership, owing to the sickness of TM2;
- a poorly attended team meeting in December 2005; and
- Cons PA10 being on annual leave, and then not attending the multi-disciplinary team meetings on 30 January or 1 February 2006, one of which was a "nursing" meeting,

the issue was not proactively addressed until Cons PA10 spoke with TM3 on either 2 or 3 March 2006. The issue was then immediately addressed and CPN-A8 allocated as the CPN for the MHSU. The plan was for a handover period to allow CPN-A8 to build a rapport with the MHSU before taking over the care coordination responsibilities.

The IIT suggests that prior to March 2006, Cons PA10 could have been less patient with the managers for the community mental health team, and insisted at an earlier point than March 2006 that the CPN he had requested materialised.

The IIT also suggests that TM2 should have ensured that Cons PA10 was reassured that he could bring his request to the next multidisciplinary team meeting after their discussion in July 2005. This would have resulted in the request being made in August 2005 and allocation of a CPN care coordinator by the end of December 2005, eight to nine weeks before it actually occurred.

Had this happened, CPN-A8 would have had a much better chance of building a rapport with the MHSU before he became medication non-compliant and potentially building a rapport with the MHSU's family.

4.4.3 When the MHSU refused his medication on 21 April and then again on 5 May 2006, and made it clear he was not going to accept any further

depot injections (his last medication was on 31 March 2006), why was there not more assertive follow up of him after 5 May 2006, including:

- **a CPA meeting with CPN-A8, TM3 and Cons PA10;**
- **attendance at the MHSU's home by CPN-A8 and Cons PA10, with a view to conducting a joint assessment; and**
- **consideration of an assessment under the Mental Health Act (MHA)?**

The reason why none of the above occurred was initially unclear to the IIT, however, following the initial interviews with Cons PA10 and CPN-A8, it understood the following.

- Both Cons PA10 and CPN-A8 were very concerned that the MHSU had stopped his antipsychotic injections. The consultant told the IIT that at the time he thought *"we are in trouble, we need to review the situation, we need to assess, we need to take an action, and that was my priority"*. This was why he asked CPN-A8 to make contact with the GP surgery and also the MHSU, with a view to ensuring that the MHSU received his medication, and to conduct an assessment of him, and inform Cons PA10 of the outcome of his contact with the MHSU.
- The MHSU initially gave very plausible reasons why he did not attend at his GP surgery on 21 April for his medication. For example he told CPN-A8 that he thought the practice nurses were on strike. As it happened there had been a nurses' strike reported in the press at the time. Cons PA10 told the IIT "*at that time I thought it could have been a misunderstanding. Obviously in retrospect I doubt it very much now."* This was a reasonable perspective based on the information available at the time.
- It was not until 5 May that it was crystal clear that the MHSU was not going to accept further antipsychotic medication by injection. Cons PA10 did not learn of this until 18 May 2006 when he met with CPN-A8 on his return from annual leave. CPN-A8 had written to Cons PA10 on 5 May, and this letter arrived in Cons PA10's office on 8 May by which time he was on annual leave.
- Cons PA 10 told the IIT that: *"On 18 May 2006 I discussed with CPN-A8 the management plan for the MHSU and I advised to explore with him the possibility of more frequent contact, for instance every two weeks."* He also advised that CPN-A8 needed to plan to make contact with the MHSU's family. CPN-A8 and Cons PA10 also discussed the usage of the MHA. However at the time the MHSU was, to Cons PA10's knowledge, not displaying any signs of psychopathology. Consequently in his professional opinion it was not appropriate to pursue an MHA assessment at that time.

- On 5 May, the MHSU had provided a coherent explanation as to why he did not want to continue with his depot medication. This was due to the side effects he had been experiencing. At no time did the MHSU indicate that he wanted to stop the medication for other reasons or because of a lack of awareness that the medication kept him well. CPN-A8 has told the IIT that he did explore the medication issues with the MHSU and the risks of not taking medication. He felt, at the time, the MHSU made appropriate and reasoned responses. There were no signs of psychosis that he could detect at the time. The MHSU articulated well and responded to all questions in a reasonable and reasoned manner.

4.4.3.1 Comment by IIT

On 18 May the MHSU was four weeks behind his medication schedule, having last accepted his depot injection on 31 March. He had himself stepped out his medication intervals in January and February 2006 to four weekly as far as the IIT can establish. On this reduced dose he had managed to present well to the health professionals he came into contact with. It was not known to any health professional that the MHSU was causing concern in his local community.

The date of 18 May was 13 days after his assessment by CPN-A8. Consequently neither CPN-A8 nor Cons PA10 knew whether the MHSU had deteriorated or not over the 13 day time period.

The next planned CPN contact with the MHSU was to be 2 June, 15 days into the future. This meant that the MHSU would not have been assessed by any mental health professional for 27 days, by which time he would have been six weeks behind his medication schedule, and to all intents and purposes medication free.

In view of the MHSU's risk history of:

- rapid relapse when unmedicated; and
- his known risk of harm to others when in relapse and showing signs of psychopathology,

the IIT considers it to have constituted a significant error of judgment in both CPN-A8 and Cons PA10 to not have made more assertive efforts to achieve face-to-face contact with the MHSU between 5 May 2006 and 24 May 2006. The IIT accepts that Cons PA10 was on annual leave between 8 and 18 May. However, there were other psychiatrists, and a team leader (TM3), who could have provided direction and advice to CPN-A8 during this period. The MHSU's non-engagement with the recommended treatment plan (i.e. fortnightly meetings with the CPN and recommencement of depot medication or oral anti-psychotic medication) could also have been discussed at the team

meetings in the week commencing 8 May, or in a meeting with the team manager at a time soon after the 5 May assessment.

When Cons PA10 returned to work he was updated on the situation with the MHSU by CPN-A8. Although he recognised that the situation was far less than ideal, and he was aware that the MHSU was at risk of relapse, he did not act assertively enough to achieve the assessment necessary to enable him and CPN-A8 to have a reasonable perspective about the MHSU's mental state. He should have made more stringent efforts to achieve a face-to-face assessment with the MHSU such as attending at the MHSU's home with CPN-A8 to try and conduct a mental state examination. In light of the incident that occurred, Cons PA10 agrees with this. At the time he feels that he gave too much consideration to the wishes of the MHSU, and not enough consideration to what he believed was in the MHSU's best interests.

It is important to note that had Cons PA10 been more proactive and attended at the MHSU's home to try and achieve a face-to-face assessment with him, this strategy would not have been without risk. The MHSU had sixteen years previously gone absent without leave and lived rough, "under the radar" of mental health services. The risk of disengagement was a significant factor that influenced the decision of the mental health professionals to go with the MHSU's wishes. The IIT can understand this.

Nevertheless, in the light of what subsequently occurred, it would have been more prudent to have made more determined efforts to achieve face-to-face contact and thus to gain an opportunity to assess the MHSU. This would have provided the opportunity for signs of psychopathology in the MHSU to be identified, if present. In turn, this would have provided the opportunity for an assessment of the MHSU under the MHA with a view to admission to hospital and compulsory treatment. The decision made by the mental health professionals meant that these potential opportunities were lost.

4.4.3.2 Additional analysis of factors underpinning the decisions made by Cons PA10 and CPN-A8

Because of the nature of the incident, the IIT wanted to be sure that it fully understood the basis upon which the mental health professionals based their decisions in relation to the MHSU after 5 May 2006.

Understanding of the MHSU's risks

The IIT is satisfied that Cons PA10 did appreciate the significance of the MHSU's past risk history. He told the IIT that:

"On previous occasions the relapses have been quite dramatic and florid and my understanding is that there was a significant number of admissions – I can't remember the figure – previous to 1990. I can't remember if it was eight or nine admissions, something like that; ... In general the relapses, I wouldn't say it was days, and besides the documentation from there is not telling me exactly what was the length because I don't think that even the people there knew exactly when he was or wasn't taking oral medication. But they knew there was poor compliance and they knew that there was a link between discontinuation of medication and relapse."

As to reflecting on why he did not assert himself more in terms of achieving a face-to-face assessment, Cons PA10 had told the IIT that
"on 10 April, that this man turned down the offer of a joint meeting, so I never saw him with him [CPN-A8]."
On 5 May 2006 the MHSU reiterated his intolerance for a home visit to CPN-A8 insisting that his meetings with CPN-A8 were held at the community mental health team base. Cons PA10 felt, and feels, that one does have to accept to a large extent the wishes of an individual service user where there are no restrictions or conditions imposed regarding their life in the community. The circumstances in which one presses more firmly to persuade a service user to comply with the wishes of the professional are not prescribed, they are a matter for each clinician to judge based on their knowledge of the service user and the prevailing circumstances at the time.

The IIT highlighted to Cons PA10 that there was no notation of the MHSU refusing a joint appointment or assessment with Cons PA10 and CPN-A8, in his letter to the MHSU's GP. The records only note that the MHSU has agreed to see CPN-A8 and that Cons PA10 will arrange another appointment with him in "*due course".* Cons PA10 accepted that it would have been better to have made a more complete record of the exchange of information between him and the MHSU on 10 April 2006. Cons PA10 emphasised that on this day there were no signs of psychopathology in the MHSU.

Medication compliance

With respect to medication, Cons PA10 told the IIT that he *"discussed the importance of the compliance with medication from the first day I met this service user, and the importance and the nature of the mental illness, the importance of the medication and the dramatic impact that it could have in self-harming behaviour, or behaviour hurting others, with the implications. It was a process of trying to increase awareness, to keep the awareness fresh."*

Although Cons PA10 was very concerned by the MHSU's decision not to take his medication from 21 April 2006, he told the IIT that the MHSU, like many service users, had the human right to choose not to take his medication. The IIT can only concur with this. When the MHSU was awarded an absolute discharge in 1997 from the conditions imposed on him in 1995, it gave him the right to be self governing as most people are. This meant that his freedom in the community was no longer contingent on his compliance with medication. It also meant that mental health services had no automatic right to insist that he took his medication or to forcibly treat him. The only way this could have been achieved was via the powers provided under the MHA. The exercise of these powers had to meet set criteria.

Usage of the Mental Health Act (MHA)

Consequently the IIT asked Cons PA10 whether he had considered using the power of the MHA to enable the assessment of and treatment of the MHSU. Cons PA10 told the IIT that he had considered the MHA. He also told the IIT that he *"discussed those things with CPN-A8 and there were no grounds to call for a Mental Health Act assessment".*

The IIT asked him to explain what "*would have constituted grounds to call for a Mental Health Act assessment?"*

Cons PA10 replied that he believed that there are a range of triggers for considering the use of the MHA, including medication non-compliance. However, he said signs of psychopathology are also a key indicator for considering use of the MHA. If a service user had a known risk history, was medication non-compliant, able to logically explain why he/she was not taking medication any more, able to logically articulate the potential risks associated with a lack of medication and what measures he/she would take if becoming unwell, and there were no signs of psychopathology, Cons PA10 advised that he would not consider assessment using the powers of the MHA. However, where such a service user displayed the smallest degree of psychopathology then he would not hesitate to assess using the MHA.

In the case of this MHSU, Cons PA10 detected no signs of psychopathology when he assessed him on 10 April 2006. Furthermore no signs of psychopathology were detected by CPN-A8 on 5 May 2006. Consequently on 18 May 2006 he and CPN-A8 concluded that there were insufficient grounds for conducting an assessment of the MHSU using the MHA.

4.4.3.3 Comment by IIT – the actions of Cons PA10

The *Mental Health Act Manual 9th edition,* written by Richard Jones and published by Sweet & Maxwell (2004), addresses the complexities of using the power of the MHA with the medication non-compliant patient where relapse into acute mental illness is predictable without medication.
This manual says:

"It is suggested that the following approach should be taken by those involved in the assessment of a `revolving door` patient who has ceased to take medication for his mental disorder:

- a withdrawal from medication is a significant but not a determining factor in the assessment;
- the role of the professionals involved in the assessment is to assess the patient's response to the withdrawal and to identify the reasons for his decision to cease taking medication; and
- although it would not be possible to determine that the provision of either s.2(2)a or 3(2)a are satisfied solely on the ground that the patient has ceased to take medication, an evaluation of the patient's history, and in particular, of his reaction to withdrawal from medication in the past, could lead to a decision that the `nature' of his mental disorder justifies an application being made in respect of him." (page 37)

Furthermore the manual says:
"The Legal and Ethical Special Interest Group of the Mental Health Act Commission suggests that the following factors should be present if a patient is to be detained on the ground of the `nature' of his or her mental disorder.
"At the very least there would need to be reliable evidence
(a) that the patient's symptoms are merely being controlled by the residual effect of the medication which he or she has recently ceased taking;
(b) that he or she therefore continues to suffer from mental disorder;
(c) that the natural course of that disorder is that relapse inevitably follows the discontinuation of medication;
(d) that his or her health or safety, or other persons' safety, are significantly at risk when the manifestations of his or her disorder are not controlled; and
(e) that these risks justify depriving him or her of the general right to liberty, including his or her freedom to refuse medical advice and treatment.
In addition, it is probably the case that there must be some evidence that the patient's mental health has begun to deteriorate. That is there must be some evidence of an abnormality of mental functioning which enables a doctor to reach an opinion on evidence rather than pure conjecture that the familiar chain of events is once more in motion. (Taken from "The threshold for admission and the relapsing patient", Mental Health Act Commission discussion paper, June 1988, paras 6,7)."

The MHSU whose care and treatment was the subject of this investigation met all of the criteria detailed in “The threshold for admission and the relapsing patient” as quoted in *The Mental Health Act Manual* (2004).

However, neither Cons PA10, nor CPN-A8 was aware that the MHSU had been showing signs of mental health deterioration. This fact was only known to the MHSU’s friends, and suspected by his family. On the basis of assessments conducted by Cons PA10 and CPN-A8 on 10 April and 5 May respectively, there were no signs of psychopathology present at all.

The IIT does not suggest in any way that the MHSU’s family and friends should have made contact with mental health services. By all accounts although the MHSU’s behaviour had become more bizarre it was not such that there was “alarm”. Furthermore the loss of the component of the robust care plan for the MHSU set out in September 1999, which required ongoing family contact meant that neither family nor friends knew who to contact if they were concerned about the MHSU’s mental health. No relationship with mental health services existed.

This situation was not caused by any act or omission by Cons PA10 or CPN-A8. It is a situation they inherited. Cons PA10 did not make contact with the MHSU’s family in 2005 because the MHSU did not want this. At the time, respecting the MHSU’s wishes was entirely appropriate. The MHSU had been living successfully in the community for six years and had a good level of recovery on his medication.

Nevertheless, in view of the risk the MHSU posed to his own and others’ safety when mentally unwell, both Cons PA10 and CPN-A8 should have agreed a contingency plan for what was to happen if the MHSU did not engage with them to the degree necessary for them to monitor the impact of him being off medication on his mental health.

This contingency plan should have been discussed and agreed before Cons PA10 went on annual leave on 8 May 2006. CPN-A8 had only known of the MHSU since March 2006, and his first communications with him only occurred after he refused his medication on 21 April, when Cons PA10 asked him on 27 April to make contact with the MHSU and the GP surgery. The IIT considers therefore that Cons PA10 should have taken the responsibility for ensuring that a reasonable plan was in place during his absence for this potentially very high risk patient.

A reasonable contingency plan might have included:

- discussion of the situation and the risks associated with it with the community mental health team leader (TM3);
- discussion of the situation with the consultant psychiatrist providing medical cover during Cons PA10's absence (initiated by Cons PA10 prior to going on annual leave, and then followed up by CPN-A8 after his meeting with the MHSU on 5 May);
- regular attempts at telephone contact with the MHSU;
- contact with the MHSU's family at the earliest opportunity. (The contact number for the MHSU's mother was available on the Identification Sheet of the MHSU's records. However, this document was not available to CPN-A8 at the time);
- achieving clarity from the GP surgery about the MHSU's behaviours around his medications in the preceding six months;
- consideration and conduct of a home visit by CPN-A8 and a colleague, preferably a staff grade doctor or more senior; and
- usage of the MHA if there emerged any evidence supporting deterioration of the MHSU's mental health;
- consideration of the use of section 135 of the MHA to enable the mental health professionals to enter the home of the MHSU should he not voluntarily allow this[12].

The lack of a well formulated contingency plan, and the decision of Cons PA10 and CPN-A8 not to progress a home visit to meet with the MHSU, meant that they could not assess the MHSU's response to the stopping of his medication. Neither could they detect any emerging deterioration in his mental state. Consequently the IIT considers that the plan of action promoted by Cons PA10 was flawed, and removed any opportunity that may have presented itself to have averted the incident that occurred. In making this judgment the IIT does acknowledge that at the time Cons PA10 believed he was doing the right thing by respecting fully the MHSU's wishes regarding frequency of contact.

4.4.3.4 Comment by IIT – the actions of CPN-A8

[12] It is the perspective of the IIT that prudent general mental health professionals may have considered organising a section 135 prior to attending at the MHSU's home, and attending at his home with all professionals required for the conduct of a MHA 'standing by', including the police. This would have enabled a door step challenge to have been attempted with seamless progression to a MHA if required. This would have minimised the predictable risk of the MHSU 'going underground'.

At the time the MHSU was a patient of general mental health services in Norfolk the Northern Locality operated in a traditional consultant led way. "*New ways of working*" (DH, 2004) was not to become established until the mid to late 2000's where a greater emphasis was placed on shared responsibility for clinical decision making between the mental health professionals engaged in a service user's care and management.

However, CPN-A8 was an experienced CPN and consequently the IIT was interested in a number of key aspects of CPN-A8's contacts with the MHSU. These were:

- his understanding of the MHSU's risk factors when unmedicated;
- to what extent he explored the MHSU's ability to self determine whether he was paranoid or not;
- whether he considered his nursing management to have been appropriately assertive; and
- if he was satisfied with his communications about the care management with Cons PA10.

CPN-A8 told the IIT that when he was asked to become CPN to the MHSU he did access his medical records to familiarise himself with the MHSU's history. The IIT asked him "*how comfortable he felt that he had the whole picture*"? CPN-A8 said: "*As far as the notes went and the people I spoke to I felt I had the whole picture".*

CPN-A8 told the IIT that during the initial period of contact he had with the MHSU, which was telephone contact only, that he did not have a high level of concern for the MHSU "*because he was still OK, so it was probably about 6/10*[13] *at that time".* At this time CPN-A8 recalls there was no firm concern about medication compliance and the MHSU. The MHSU was articulating that he would attend at the GP surgery for his medications.

The IIT asked CPN-A8 about his assessment of the MHSU on 5 May. He told the IIT that the appointment was scheduled to last for one hour, but that the MHSU wanted to leave after 30 minutes. CPN-A8 managed to extend this by 10 minutes which meant that the face-to-face contact lasted for 40 minutes in total. CPN-A8 did well to extend the time of this meeting.

[13] This rating scale was a scale applied retrospectively and represents the CPN's perspective at interview.

CPN-A8 recalled that the MHSU arrived for the appointment very smartly dressed. The MHSU, as CPN-A8 recalls, told him immediately that "*a judge has given me an absolute discharge and a social worker, (the forensic social worker) has told me that I don't have to do anything I don't want to do, and I am not having a depot injection".* CPN-A8 told the IIT that as that was the MHSU's "*opening gambit*" he had to try and build it up from there. CPN-A8 told the IIT that he did try and speak with the MHSU about his medication and "*how it kept him well and what would happen if he became unwell".* CPN-A8 recalled how the MHSU had answers to everything he said and asked, including that if he became so paranoid that he was unable to act for himself then his friends would call for assistance.

From the interview the IIT conducted with CPN-A8 it is clear that CPN-A8:

- Was aware of the need for assertive follow up of the MHSU. However he was also aware that if he pressed too hard the MHSU was likely to disengage completely, that was the impression he had during his 40-minute assessment. CPN-A8 did not want to be in a situation where the MHSU refused contact with himself and Cons PA10. This concern was and remains understandable with this MHSU.
- Did encourage the MHSU to take medication reminding him that it was the medication that kept him well.
- Tried to achieve a frequency of visits on a fortnightly basis but the MHSU would only accept monthly. CPN-A8 offered a number of suggestions about where and how he and the MHSU could meet. The MHSU rejected all suggestions.
- When it was clear that the MHSU was not going to accept depot medication, suggested alternative medications to the MHSU. CPN-A8 was aware that oral medication was not a long term solution but he was also aware that oral medication was better than no medication if he could persuade the MHSU to accept it.
- Gave the MHSU a number of contact cards with his (CPN-A8's) details. The idea was that the MHSU would distribute these to his friends. At the time CPN-A8 gave the MHSU these cards he was not at all confident that the MHSU would distribute them to his friends and family. However, he felt he had to do something even if he was "scraping the barrel" of opportunity.

With regard to the MHSU's risk status CPN-A8 was able to tell the IIT that he believed that:

- the MHSU had been unmedicated for approximately four weeks when he met with him on 5 May;
- that unmedicated that the MHSU "*would become paranoid, also he would be acting strangely"* and*;*
- that he felt reasonably informed about the MHSU from his reading of the medical records and his conversations with Cons PA10.

CPN-A8 confirmed to the IIT that he was aware that disengagement from services and medication non-compliance were relapse indicators for the MHSU. However CPN-A8 did not perceive the MHSU to be "refusing" medication. He considered him to be pondering the suggestion of oral atypical anti-psychotics as an alternative to the depot which he was refusing. With regard to disengagement, CPN-A8 did not see the MHSU as disengaging at that point although he did think disengagement was a risk. However, at that the time the MHSU had agreed to continue contact with himself and also Cons PA10. The contact however was on a less frequent basis than he (CPN-A8) would have preferred.

The author of the report has discussed CPN-A8's beliefs with him at length and CPN-A8 can now appreciate that the MHSU had disengaged from the treatment that would keep him well, whatever platitudes he gave. CPN-A8 has consistently reported being very concerned about the situation and the IIT and the author of this report believe that he was.

CPN-A8 also told the IIT that when he asked the MHSU about how he might behave if in relapse, the MHSU said:
"He would start thinking people were talking to him and things would happen and he would hear voices, and that people were after him and planes would be talking to him. He said that's what would happen if he became ill." CPN-A8 considered this to evidence a good insight by the MHSU. Cons PA10 agreed with this, he also confirmed that between July 2005 and April 2006 the MHSU expressed good insight.

The IIT asked CPN-A8 how quickly he thought the MHSU needed medicating. He responded:
"I would have said certainly within no more than a few weeks because I felt he needed something. Although he wasn't showing any signs of psychosis or thought disorder, I thought this is not good. If it's maintained him for this length of time we need to try and get him back on line with something." His thinking was influenced by his belief that the MHSU would still have some residue from his injections in his bloodstream. CPN-A8 sought advice about the likely residue in the MHSU's bloodstream from the chief pharmacist at Hellesdon Hospital. At the time this advice was sought CPN-A8 was not aware of the

increased time period the MHSU had instigated in relation to the depot injections administered to him in January and February 2006. He only became aware that the MHSU had stepped out his injection periods to four weekly in January and February after the incident.

Because of information elicited from the MHSU's friends about his attitude to his medication, the IIT was interested to know whether the MHSU had revealed to CPN-A8 his belief that if he was off medication he would be more attractive to an employer. CPN-A8 was certain that the MHSU did not link his ability to seek Jobseeker's Allowance with being off his medication.
It was CPN-A8's recollection that the MHSU told him that he was *"going to go on Jobseekers allowance because I've been at work, I can go back to work and I want to be a useful member of society. I don't want to keep claiming benefits, it's not fair on society me keep claiming benefits when I feel I can work. I'm going to tax my motorbike because it's going to be cheaper to run my motorbike in the summer than a car, so that's going to be a good idea."* It was the perspective of CPN-A8 that the MHSU *"was saying all the normal things that you would expect of someone who had recovered".* By this CPN-A8 meant that the MHSU was making sense, had reintegrated successfully into a community, had friends, looked after himself, etc.

Following this meeting with the MHSU, CPN-A8 recalled that he needed to make prompt contact with Cons PA10, TM3 and the MHSU's GP. He did this via a letter. When asked what his expectation was regarding a response to his letter CPN-A8 said: *"I would have liked to have thought they could have contacted me and may be said what other medication are we going to give him, so that would give me a chance to then try and contact him again."* Although CPN-A8 did not know that Cons PA10 was on annual leave when the letter arrived in his office, the IIT considers that CPN-A8 could have been more assertive in chasing up a response if he believed more action was required. He was a seasoned CPN. The IIT does. however, accept that this CPN was working across a number of community mental health teams, and was at the time having to prioritise which team meetings he attended as he could not attend them all. Furthermore when he met with the MHSU there were no signs of mental health deterioration although CPN-A8 was aware that this would occur if they could not achieve re-medication of him. It is important to remember that at this juncture the MHSU was only two weeks off medication, and the CPN's belief that residual build-up would sustain him for a longer period than this would have dampened his risk concern and his perception of any need to escalate the management plan at this stage.

CPN-A8 advised the IIT that he did speak with his team manager (TM3) during supervision subsequent to 5 May, telling him that he "*wasn't happy with this and I think we ought to keep an eye on it".* TM3 it seems did agree with

CPN-A8 and it was agreed that CPN-A8 would meet with Cons PA10 and discuss the management of the MHSU which they did on 18 May 2010.

CPN-A8's original statement to the Trust's internal investigation about this meeting was:
"On Thursday 18 May in the afternoon I had a meeting with PA10 at Base C regarding the MHSU. I told Consultant PA10 the outcome of the session with the MHSU including my suggestion of an oral atypical antipsychotic medication, and agreed that I would try to persuade the MHSU to see me every two weeks, preferably at home, and to make contact with his friends so that I could introduce myself and give contact details. Consultant Psychiatrist PA10 said that tablets were a good way to go if he would not have his depot injection."

The interview record with CPN-A8 suggests that consideration was given to a more assertive approach at this meeting. However, CPN-A8 told the IIT that:

"I felt that if you were too assertive you'd lose him. You had to have an amount of assertion but if it was too much he was going to say, 'Bye bye, I don't want to see you anymore'."

When asked about the potential for using the MHA he said:
"At that stage he was not certifiable under the Mental Health Act. Both Consultant PA10 and I had seen him and he was showing no signs of being sectionable under the Mental Health Act."

The IIT is confident that on 5 May, when the MHSU was last assessed by CPN-A8 he may have not been assessed as '"sectionable", however, the facts of the matter are that he never had the degree or quality of assessment to properly determine this. On 18 May 2006, CPN-A8 had no knowledge of the MHSU's mental state, he only had knowledge of it 13 days previously.

CPN-A8 told the IIT that he would consider a MHA assessment if a service user was *"showing signs of deterioration"*. However, *"If they just stopped (*their medication) *and carried on okay, no. But if they stopped and there were obviously signs of behaviours that were untoward to them or anybody else, then yes. It would all depend on how they reacted after they'd done it."*

This response reflects the advice provided in the Mental Health Act Manual (2004), excepting reference to risk and diagnosis.

What CPN-A8 was unaware of, was that the MHSU could lawfully have been assessed under the MHA without there being signs of mental health deterioration because of his diagnosis, history of relapse and the associated risks of relapse. However, what the author of this report has learnt is that it

would not be usual for mental health professionals in general adult psychiatry to use compulsory detention without there being some sign of psychopathology.

The IIT also asked CPN-A8, "*given that his* (the MHSU's) *offending behaviour was normally against people that were in his circle of friends and family, did you not consider that ... contacting the family was an option at that time?"* CPN-A8 responded: "*At the time I wasn't sure if he was seeing his family. I know he had some friends I could contact, but it wasn't until afterwards that I found out he was seeing his family."* CPN-A8 advised the IIT that he planned to contact the MHSU's family after his planned meeting with the MHSU on 2 June 2006.

The IIT accepts that contact with the MHSU's family was in the mind of CPN-A8. However, given the situation of the MHSU only agreeing to monthly contacts and that he was at this stage four weeks without medication (behind his medication schedule), it is the opinion of the IIT that making contact with the MHSU's family should have been a higher priority for CPN-A8 regardless of whether the MHSU was in contact with them or not. CPN-A8 and Cons PA10 had a duty of care to the MHSU's family given the previous attack on his father during his last unmedicated period in 1990.

Non-contact with the MHSU's family meant that there was a loss of opportunity for them to share with the CPN any concerns about the MHSU. However, the IIT cannot be completely certain that the MHSU's family would have shared any concern about the MHSU. Much would have depended on who the CPN had contacted and when.

CPN-A8 advised the IIT that he did look for contact details for the MHSU's family in the records held at the community mental health team base. However, there were no contact details in these. Subsequent to the incident when all of the available clinical records were collated, the contact details were found. The lack of availability of this information to CPN-A8 highlights the importance of the criteria in the national risk management standards of "one patient, one set of records". This had been a Clinical Negligence Scheme for Trusts risk management standard since 1995. CPN-A8 told the author of this report that the current situation is that all medical and mental health nursing records are stored together in one case notes folder.

4.4.3.5 The IIT's comments regarding the team manager

TM3 was asked to take over the team manager role for the MHSU's CMHT on 6 February 2006 by the Trust's director of clinical services (DCS). Prior to this he had been the manager for the primary care service and responsible to TM2. He had been in this role since 2004. TM3 told the IIT that:
"initially she (the DCS) asked me if I would do both primary care, the assessment and brief intervention, and recovery, and I said no, it was too big. I said I wouldn't be able to do either job well, so I suggested one of the nurses who I was working with in primary care who I felt had potential and was interested ... so we met up and agreed that."

TM3 told the IIT that from the start he had some concerns about the quality of work delivered by some of the staff in the recovery team, and two members went on sick leave quite quickly. Consequently he had:

"to grab hold of that (those) caseload(s) and start to re-allocate it, and as I was going through it and looking at the actual CPA documentation and the order of it, what was there and what wasn't and what had been reviewed and what wasn't, I was starting to get a little concerned about the actual quality of that, and some of it I think was related to that they hadn't had, from what they told me, any regular management supervision previously."

TM3 also told the IIT that the minutes taken at the weekly team meetings, prior to his arrival, were not used as living documents to track that actions agreed had been activated or completed. The minute document was he said *"an event"* in itself. They were filed after the meetings and not referred to again. Once he became aware of this the system changed and a feedback loop was instigated. This was achieved in 2006.

With regard to the MHSU, the first time TM3 became aware of him was in the first week of March following his return from annual leave, when Cons PA10 came to him and told him that he had been waiting for a CPN care coordinator since July 2005, and that he believed that the MHSU needed one and closer follow up in view of his "*significant mental health history*". TM3 agreed that CPN-A8 would be appropriate as he had some space on his caseload. TM3 at this time did not know anything about the MHSU's history.

TM3 recalled that he was at the team meeting on 17 May when the MHSU was discussed. At interview he said:

"Yes, CPN-A4 was there, I was there, Consultant Psychiatrist PA10 was there. `Client discussion. MHSU raised by Consultant Psychiatrist PA10. Has stopped his depot. CPN-A8 is talking to patient about atypical anti-psychotic

medication.' Consultant Psychiatrist PA10 then talked to CPN-A8 about the discussed options."

The IIT asked TM3

"Q. *So at that particular time there was no concern expressed that he'd stopped his depot and that, given his history, it was quite risky.*

A. *There was concern that he'd stopped his depot, but based on what CPN-A8 was saying from his assessment of the MHSU on 5 May, CPN-A8 was saying that he'd done a thorough assessment of the MHSU and that no symptoms whatsoever. But it wasn't raised either by CPN-A8 at that time or Consultant Psychiatrist PA10 at that meeting that we really must do something now."*

TM3 told the IIT that at the time he was not aware that the two notable risk relapse indicators for the MHSU were (i) if he disengaged from services and (ii) if he stopped his medication. His knowledge about the MHSU was what CPN-A8 told him at his supervision meetings.

The IIT asked TM3 whether on 17 May CPN-A4, who had been aware of the risk factors associated with the MHSU when unmedicated, contributed to the discussion. TM3 could not recall, which in fairness was reasonable given the IIT meeting occurred some two and a half years after the meeting. However what TM3 did say was:
"If you'd worked with a client for a long period of time and you knew their history very well and you remembered it, and they came back because there were concerns raised, and you'd been the person who'd discharged them and said `These are the risk factors and this is why it's important', then I would expect that clinician to raise the alarm bells and say: `We really need to take this very seriously and we need to get on with this now because these are the issues'."
He also told the IIT that during the meeting on 17 May he stressed to CPN-A8 that he and Cons PA10 must meet, and decide what they were going to do with the MHSU. He also recalls at the supervision meeting he had with CPN-A8 on 9 May where he specifically asked him:
"Are you sure you've checked him out thoroughly, that there's nothing there?" He said `No, he's not psychotic, he's not this, he's not that.' I said "Okay".

TM3 did put faith in the clinical judgment of CPN-A8 and PA10, which was not unreasonable. However, the IIT believes that he should be been more enquiring. CPN-A8's clinical record did not evidence a structured assessment of the MHSU's mental state, nor is there any part of CPN-A8's clinical record that sets out clearly the risk history of the MHSU and the potential consequences of a relapse. It is the contention of the IIT that TM3 should have ensured that CPN-A8 talked him through these factors. The IIT accepts

that because, from TM3's perspective, neither CPN-A8 nor Cons PA10 were articulating great concern that the triggers to prompt a team manager to be more inquisitive were not there.

With regard to contact with the MHSU's family, TM3 told the IIT, CPN-A8 *"said that was his plan but because the MHSU was a little bit guarded he felt he needed to take things slightly measured, otherwise he might just say, `Go away.'"*

Finally with regard to usage of the MHA, TM3 said:
"I think through the supervision I had with CPN-A8 I do recall saying, `He's stopped his depot, is there any concern?' and he said: `Look, he's presenting ever-so-well. There's no signs, no symptoms', and I said: `Well, when you see Consultant Psychiatrist PA10 you need to go through all the options.'"
The IIT considers that this was not unreasonable direction. CPN-A8 was a very experienced CPN, he had by his own recollection read through the MHSU's case file and therefore it was reasonable for TM3 to expect him to know what "all the options" were.

TM3 did express to the IIT that, once he had read the records about the MHSU, he was disappointed that CPN-A8 and Cons PA10 did not act more assertively about the MHSU's medication, and take a more assertive approach altogether. It is the observation of the IIT that TM3 could have sought an update from CPN-A8 on Monday 22 May, and have encouraged a more assertive approach, if he had felt the plan agreed on 18 May insufficient.

4.4.3.6 Overall comment by IIT regarding the MHSU's management between 27 April and 24 May 2010

The immediate clinical management of the MHSU following the alert raised by primary care services on 26 April 2006 was reasonable. However after 5 May 2006 the clinical management of the MHSU was not as assertive as it should have been. There was sufficient information in the medical records to inform CPN-A8 and Cons PA10 that if the MHSU were to relapse then he was likely to pose a serious risk of harm to someone known to him. Furthermore the records made clear that without medication he tended to relapse quickly. Consequently there was a level of certainty that he would become mentally unwell if unmedicated. Consequently a management plan should have been formulated with a clear escalation pathway. The recommended period of contact with the MHSU ideally should have been weekly, rather than fortnightly, engaging the crisis team if necessary. However, the IIT accepts that the mental health professionals had a challenging situation with a service user who might disengage completely if they pushed too hard for the optimal

management plan. Finally, contact with the MHSU's family should have been a greater priority.

Because of the lack of an appropriately assertive management plan, the IIT believes that there was the potential to have prevented the death of Mr Rayner on 24 May 2006. However preventability is by no means certain. Even with a more comprehensive management plan for the MHSU, and a more assertive approach by Cons PA10, CPN-A8 and the CMHT to ensure more frequent assessment of the MHSU's mental state, avoidance of the incident was not guaranteed, even if the MHSU had been assessed under the MHA prior to the date of the incident. This is because one cannot assume that compulsory treatment in hospital would have been an outcome of such an assessment. The treatment plan, based on the principle of least restriction, may not have required hospital admission.

Members of the IIT feel strongly that had Cons PA10 and CPN-A8 have been more assertive it trying to achieve further face-to-face assessments with the MHSU after the 5 May 2006, and if he did not agree to meet with them, then they should have moved forward with an MHA assessment to ensure that an assessment of the MHSU's mental state occurred. Unfortunately no such assertion was demonstrated by the mental health professionals involved.

The author of this report has discussed what the reasonable body of mental health professionals working in general adult psychiatry would have done in similar type circumstances. All spoken with agreed that there should have been greater effort to achieve face-to-face assessments of the service user between the 5 and 24 May 2006. Not all feel that if these efforts were unsuccessful that they would have progressed to a MHA without any evidence of psychopathology. All professionals approached working in assertive outreach or crisis services would have taken this action. It appears therefore that there may be a lack of appreciation of the flexibility the MHA offers to effect an assessment of mental state, in high risk situations, where service user is not willing to accommodate this voluntarily.

The IIT considers the most significant factors contributing to the lack of effective management of the MHSU between 5 May 2006 and 24 May 2006 to have been:

- The insufficient emphasis placed on the past levels of dangerousness presented by the MHSU when unmedicated, and an unrealistic expectation of the residual effect of his antipsychotic medication, coupled with an over-emphasis on the preceding years of stability whilst medicated.
- The lack of appreciation and weight attached to the MHSU's history of lack of insight about his illness especially when unwell. Although right up to May 2006, the MHSU evidenced insight regarding what

might happen to him when off medication, there is a range of information in his clinical records prior to July 2005 that suggests the MHSU may never have accepted that he had a serious mental health disorder, the control of which was dependent on medication.

- The lack of assertive action taken by CPN-A8 when he received no response to his 5 May 2006 correspondence to Cons PA10.
- The accommodation of the MHSU's wishes in relation to the frequency of contacts with the mental health service after 5 May 2005. This accommodation was misplaced and was not in the MHSU's best interest.
- The absence of a clearly formulated and documented clinical management and crisis plan for the MHSU which set out what should happen in circumstances such as his refusal to take his depot antipsychotic medication on 21 April 2006.
- The non-contact with the MHSU's family between March 2000 and December 2003 and then again from 21 April 2006.
- The lack of an effective approach to the conduct of team meetings in the CMHT which made it difficult for mental health professionals to attend all those relevant to them. There were three different team meetings – one each for the three consultants.

5.0 Improvements made by Norfolk and Waveney Mental Health Partnership NHS Trust (now Norfolk and Waveney Mental Health NHS Foundation Trust) since May 2006

This investigation, coupled with information already available to N&WMHP NHS Trust underlined pervasive and endemic problems within the Northern Locality. These problems were such that rapid change was not appropriate. The Trust recognised that it needed a process of progress and sustainable change that that would result in a complete re-engineering of the locality.

The key changes have been brought about as a result of this are as follows:

- The implementation of functional teams and New Ways of Working including a locality wide recovery service, a well established Primary Care Team, and significant practice and cultural changes in workforce at the Hellesdon Dementia Unit.
- Annual reports highlighting service improvements and objectives for each service area.
- Succession planning, talent management and clear deputising arrangements across the locality.
- Robust governance systems including referral processes, risk management systems, clear documentation relating to team meetings and case discussions.
- The establishment of modern and effective clinical leadership, cumulating in the appointment of the current lead clinician, an appointment that followed a robust competency based appointments process
- The identification and appointment of a substantive locality manager
- The consistent application of Trust Policy

Some examples of the manifestations of the changes brought about can be found by analysing some data.

The Trust has also conducted a further management review of the North Locality which showed that the North Locality is currently performing in a way that is unremarkable in comparison with other localities. This represents considerable improvement in performance.

Another area of significant change within the trust is in relation to section 117 after-care. Since 2006 a single system for section 117 after-care has been implemented in the Trust. The current Section 117C Policy was published April 2009 and new Section 117C paperwork was introduced on 1st

September 2009. All new Section 117 after-care cases after this date used this paperwork.

The Trust has audited compliance with this new policy. The audit sample comprised cases where a Section 117C meeting had been held between 1st July 09 and 16 December 2009. Therefore the audit consisted of cases using both the old and new paperwork. The audit reported the findings for seven localities (North, South, City, West, Great Yarmouth, Waveney and Forensic). The total number of individual service user case records included in the audit was 247.

The audit revealed that:

- 182 out of 201 (91%) of s117 review meetings were conducted on a six monthly basis;
- Where a service user eligible for s117 after-care had been discharged from hospital in 195 out of 228 cases (85%) the service users care coordinator had already set the date for the s117 after-care meeting. Further more in 71% the care coordinator had informed the Mental Health Act administrator of the date.
- There was 100% compliance with the completion of the s117 paperwork;
- That compliance with the standard requiring the invitation of those present at the initial s117 meeting to subsequent meetings ranged from 82% to 97% depending on the professional involved. Greatest compliance was associated with the invitation to the service users responsible clinical and least compliance related to invitations extended to the social services representative.
- Overall there was good compliance with the standard that before the end of a s117 meeting the date and time of the next meeting should be agreed and recorded.

In addition to the audit of compliance with measurable performance standards the audit revealed that the MHA administrator contacted all care coordinators with service users on s117 after-care to remind them of the need for a six monthly review. If at this time it becomes apparent that there has been a change in care coordinator of which the MHA administrator was unaware he/she then takes all the necessary actions required to ensure full policy compliance.

The Trust has completely reversed situation the IIT found where there was no systematic approach to s117 after-care.

The Trust has also implemented an auditable standard for practice supervision. This was implemented in July 2010. The policy standards are robust and the Trust is committed to auditing compliance with its policy. The

IIT considers that the Trust will need to provide evidence of the audit and its results to the EOE SHA within 12 months of policy implementation, therefore by July 2011.

In addition to the far ranging improvements the Trust reports having made to its services since 2006 the Trust's response to the IIT's recommendations has been positive with the Trust providing to the IIT an action implementation plan in November 2010. This is very good practice and evidences the Trust commitment to continual quality improvement and excellence in practice. In Its action implementation plan the Trust highlighted the specific actions it has committed to that will ensure the recommendations are implemented in full.

These actions include:

- The further review and modification of its clinical risk assessment training programme to ensure that the complex issues of insight is included.
- A re-review of the recently ratified CPA policy to ensure that the principles of the IIT's recommendation relating to CPA have been addressed. In particular the standard that the quality of information recorded for CPA and risk assessment is sufficient for the range of staff engaged in the care and management of a service user to obtain a grounded appreciation of historical and contemporary risk issues, in particular early warning signs of relapse, and the core elements of an effective and safe care management plan.
- Awareness raising for Consultant psychiatrist's of the need to produce Mental Health Review Tribunal reports that meet the current expected standards.

It is not possible to do justice to the far reaching changes implemented in the Trust and in particular the Northern Locality in this report. However, the IIT is satisfied that the current executive management team and the chief executive of the Trust are committed to continual improvements in the care and service provided to its service users. It is the responsibility of this management team and the external bodies responsible for monitoring the Trust's performance in the future to ensure that its commitment to continual audit and monitoring continues on a Trust wide basis.

6.0 CONCLUSIONS

The death of Mr Rayner, and the manner of his death, has deeply affected his family, the local community in which he lived, his friends, the family of the MHSU, and the MHSU himself. At the time of the incident the MHSU had been without medication since 24 April 2006, having previously attended for this on 31 March 2006. Unmedicated his relapse was predictable. That he might harm someone if he remained unmedicated was also predictable. Sixteen years prior to the attack on Mr Rayner, the MHSU had attacked his father who sustained a near fatal injury. He had also, in the same time period, attended at a public house near to his home at the time with the intent to cause harm to a person he knew. These incidents occurred in 1990 the last time the MHSU had been without medication.

It is the contention of the IIT there were a number of lost opportunities in the care and management of the MHSU. Had different actions been taken at these points the death of Mr Rayner on 24 May 2006 may not have occurred. The most significant lost opportunities, in the opinion of the IIT were:

- The decision to grant the MHSU an absolute discharge from the Mental Health Act (1983) in 1997. This meant that the previous condition of medication compliance was removed.
- That the care plan devised for the MHSU by the forensic service was not continued as intended 'when his care was fully transferred to general adult mental health services from the forensic service in January 2000.
- The absence of a documented risk management and crisis intervention plan for the MHSU.
- The lack of an appropriately assertive plan of action when the community mental health team became aware that the MHSU was going to remain medication non-compliant (May 2006).
- That the clinical team in May 2006 gave too much weight to the MHSU's wishes and insufficient weight to his past risk history when unmedicated. This meant that the clinicians were insufficiently assertive in their efforts to achieve a face-to-face assessment with him after 5 and 18 May respectively. Consequently there was no opportunity for them to determine whether or not he displayed any psychopathology.

It is absolutely clear to the IIT that had the MHSU not been allowed to extend the time gaps between his medication doses between January 2006 and 31 March 2006, and be without medication from 21 April through to the 24 May this incident may not have occurred. The primary care service cannot be criticised for not alerting specialist mental health services about the increased

time period between depot administrations January to March 2006. The primary care service did what was asked of it. When the MHSU did not attend for his medication, and was non-contactable, primary care team members promptly contacted the MHSU's community mental health team (CMHT).

With regard to the MHSU's absolute discharge from section 37/41 of the Mental Health Act decision made by the Mental Health Act Review Tribunal was premature. However, the decision was made eight and a half years prior to the incident. Although the actions required of the community mental health team (CMHT) would have been clear cut had the MHSU remained subject to a conditional discharge, there were sufficient risk indicators available to the CMHT in the weeks leading to the incident for there to have been a more assertive approach once the MHSU was known to be unmedicated and not engaging in the recommended treatment plan for him.

Components of a more assertive approach should have been:

- proactive contact with the MHSU's parents to find out if they had any concerns about their son;
- attendance of Cons PA10 and the MHSU's CPN, CPN-A8, at the home of the MHSU to conduct a face-to-face assessment as soon as possible after their meeting on 18 May, ideally on the same day;
- a direct request from the mental health professionals that the MHSU accept immediate re-medication to prevent relapse and the clear risk to the MHSU of his loss of liberty and the lifestyle he had attained; and
- organisation of a mental health assessment under the Mental Health Act if the MHSU did not make himself voluntarily available for this when requested to do so.

Overall conclusion

It is the overall conclusion of the IIT that the death of Mr Rayner on 24 May, may not have occurred had the decisions and actions of the clinical team been different between 5 and 24 May. However preventability of his death is by no means certain.

Absolute avoidability of this was dependent on the MHSU being treated in hospital either on a voluntary or a detained basis prior to this date.
There is however no guarantee that had the MHSU's mental state been assessed at any time between 5 and 24 May 2006, that a hospital admission would have been the outcome of this.

The variables that would have impacted on the conduct of any assessment of the MHSU's mental state and its outcome were:

- He may have gone “underground” if pressed to make himself available for a mental health examination. Had this occurred the MHSU would have been ‘invisible’ to mental health services.
- He may, if more assertively approached, have made himself available to Cons PA10 and CPN-A8, and presented appropriately, displayed no signs of psychopathology, and agreed to more frequent contact with his mental health professionals.
- Any decision that the MHSU required an assessment of his mental state under the auspices of the Mental Health Act, would have had to have been supported and arranged by an Approved Social Worker, who had, and has, the responsibility for ensuring that the law is complied with. Except in the most urgent cases it is considered good practice to plan a Mental Health Act assessment so that professionals known to the service user are present. The planning of an assessment therefore can take a number of days.
- The presentation of the MHSU at the time of his assessment. The outcome of a MHA assessment cannot be predetermined. There are defined criteria that have to be met before an individual can be detained in hospital against their will. Although the MHSU had a serious risk history, he had been stable on a relatively low dose of medication in the community for 16 years, and it is possible that had he been assessed under the MHA (1983) he may not have met the criteria for compulsory detention in hospital.

Although the IIT considers it unlikely that the MHSU would not have displayed any signs of psychopathology at all during a detailed mental state examination his family believes that he had the capability to deliver a convincing performance of well health.

Cons PA10 and CPN-A8 recognise that they should have been more assertive with the MHSU, and should have insisted on meeting with him on a frequent basis to monitor his mental state. However, Cons PA10 does not accept that an assessment under the Mental Health Act should have been a core component of the MHSU’s risk management plan if he did not agree voluntarily to an assessment of his mental state. For Cons PA10 signs of psychopathology would have had to have been present to warrant such an assessment.

The IIT do not agree with this at all. The MHSU’s past history of violence with intent to cause harm ,when unmedicated, meant it was imperative that assessment of the MHSU’s mental state occurred on a frequency to enable early identification of signs of psychopathology after it became clear that he did not want to re-engage with medication on 5 May 2006.

It is the strongly held view of the IIT that had the MHSU not agreed to the necessary assessments, had they been promoted, then the criteria necessary for the conduct of an assessment under the MHA (1983) would have been met, with there being a possibility that a hospital admission would be required as a consequence, thus justifying the full assessment process.

However, what the IIT wish to make very clear is that it cannot say what the outcome of any such assessment would have been in terms of compulsory treatment for the MHSU. What it can say is that by not following up the MHSU more assertively including making strident effort to conduct an assessment of the MHSU's mental state, there were lost opportunities for changing the subsequent course of events. Whether more assertive efforts would have precipitated an equally tragic outcome, or have avoided tragedy altogether cannot be speculated upon.

7.0 RECOMMENDATIONS

The IIT has seven recommendations for Norfolk and Waveney Mental Health NHS Foundation Trust.

Recommendation 1: The Trust must ensure that all of its clinical staff engaged in the assessment of, and care planning for, service users have a comprehensive understanding of the concept of insight.

"Insight" could be described as:

- Awareness and acceptance that one is suffering from a mental illness.
- Awareness that certain experiences, beliefs and perceptions may not be real and are a component of the illness.
- Acknowledgment and acceptance of the medical implications of the mental illness and one's experience of it.
- Acceptance of treatment as the means to enable one to be in recovery from mental illness and to live as healthy a life as possible.

In the case of this MHSU, staff determined that he had insight because he took his medication. However, this MHSU did not associate his wellness or quality of life with this. He never accepted that he had a mental illness, even though he could and would articulate what mental health professionals wanted to hear. Consequently he lacked insight.

Mental health practitioners should be able to explore and differentiate the degree of insight and limitations to insight in a service user with whom they have a therapeutic relationship.

The IIT suggests that the concept of insight could be addressed within existing training workshops on risk assessment. Determination of a service user's insight is a core element of an effective risk assessment, relapse prevention plan and crisis intervention plan.

Recommendation 2: All mental health practitioners, including medical staff, must understand the thresholds for assessment under the Mental Health Act (MHA) and the thresholds for the compulsory detention of an individual under the MHA.

The case involving this MHSU showed that the clinical staff involved in his care and management, once he was medication non-compliant, did not have the level of understanding of the MHA one expects. Consequently the MHSU was not assessed under the MHA when he should have been.

To ensure that staff have the best opportunity for gaining the depth of knowledge required in their day to day work, especially in the community scenario, the IIT suggests that:

- The current MHA training includes a range of case scenarios.
- Attendees are required to feed back to their colleagues and the workshop facilitator about how they would manage each case scenario in relation to the MHA and assessment under the MHA. This will enable gaps in knowledge and understanding to be identified and addressed.

In addition to the above the Trust is encouraged to consider whether there are other competency assessment criteria that could be utilised to test the knowledge and understanding of its staff about the MHA, and the circumstances in which one can justifiably conduct an assessment.

In addition to the above the IIT recommends that as a minimum all clinical supervisors and team managers are required to attend MHA training so that they can discharge their supervision duties effectively in this respect.

Ideally all staff acting as care coordinators should have a working knowledge of the MHA and understand the range of thresholds that enable assessment under the Act to take place.

The Trust is encouraged to ensure that a component of its CPA and/or risk assessment training is dedicated to thresholds for assessment under the MHA.

Recommendation 3: Norfolk and Waveney Mental Health NHS Foundation Trust must ensure that its medical staff, when providing reports to a mental health review tribunal (MHRT), follow the guidance for such reports as set out by the MHRT.

In the case of this MHSU, the reports submitted to the MHRT in 1997 unanimously supported the MHSU's application for an absolute discharge. In no report was the fact that the MHSU's mental stability depended entirely on his depot medication highlighted. There is no evidence that any of the clinicians gave any consideration to the risk management question of medication non-compliance which, even at the time, had a realistic potential to occur.

The current guidance on MHRT reports is clear and detailed and can be found at the following website address: http://www.mhrt.org.uk/

The document is entitled "*Guidance for the preparation of medical reports for the MHRT."* (www.mhrt.org.uk/Documents/GuidanceForHealthcareSocialCare/Guidance4PreparationMedicalReports.pdf).

Other useful documents are:

- *"Changes to the mental health review tribunal from November 2008"* (www.mhrt.org.uk/Documents/ChangesTotheMHRTfromNov08.pdf); and
- *"Social circumstances report by social workers for mental health review tribunals"* (DH, 2002).

The IIT recommends that the Medical Director for the Trust and all clinical directors reporting to this director, implement an assurance framework so that the Trust can be assured that when required its medical consultants and other MHPs are producing reports for the MHRT of a sufficiently good standard. These must set out all material information a MHRT requires to properly consider the ongoing restrictions imposed upon a service user.

Recommendation 4: Norfolk and Waveney Mental Health NHS Foundation Trust needs to ensure that the care management and risk management plans developed by its staff contain a sufficient quality of information to minimise the loss of organisational memory over time about long term service users with a significant risk history.

In the case of this MHSU, at no time during his contact with general adult psychiatric services (1999 – 2006), was an informative care plan or risk management plan devised for him. The core elements of the effective plan of care agreed between forensic and general psychiatric services were not repeated within the general psychiatric care plans, or medical management plans. These omissions left the MHPs vulnerable and also left the MHSU vulnerable to inappropriate management during a relapse, which is what happened.

The IIT appreciates that achieving a good quality of documentation is challenging. However it recommends the following which it believes will enable the Trust to provide assurance that it is doing all that it can to deliver good quality documentation:

- The Trust must review its existing documentation tools to check that they are guiding its mental health practitioners, including medical staff, through a robust documentation process. For example in 2002 the risk assessment tool in use did not require the documentation of a risk management or crisis management plan. It should have.
- The audit of an individual's clinical records should form an integral component of management and clinical supervision. Supervisors must be required to assess quality against core criteria and to maintain a record of their assessment as a core component of the supervisory meeting.
- The Trust is encouraged to implement peer review as a core component of its approach to documentation audit. It is a powerful reflective practice tool and makes much more tangible for staff the importance of good standards of record keeping.
- The Trust's documentation audit tools must incorporate an assessment of the quality of record keeping. Many audit tools are quantitative in their approach looking for evidence of identified information. However often the quality of the information recorded is not assessed. It is important that qualitative information is also gathered.
-

Recommendation 5: Norfolk and Waveney Mental Health NHS Foundation Trust must have a robust system for the registration and tracking of all service users on section 117 after-care regardless of their MHA status.

When this MHSU was transferred from forensic to psychiatric services, the then Norfolk Mental Health Trust did not have in place an effective tracking system for service users on section 117 after-care but who were not under the MHA. Consequently when general psychiatric services took over the care and management of the MHSU there was no trigger mechanism to ensure that his s. 117 after-care meetings continued.

Recommendation 6: When primary care services, or another agency, contacts the Trust about a patient currently in receipt of mental health services, the Trust must satisfy itself that the operational policies for all inpatient and community services set out what should happen.

The IIT expects that all inpatient and community teams should be able to evidence their compliance with their operational policies in how they respond to primary care services, or other agencies, when they phone with concerns about existing service users.

In the case of this MHSU, when primary care team members made contact with the CMHT they were told he did not have a care coordinator and he was closed to the team. This was incorrect and unacceptable. Measures must be taken to ensure that this does not happen again.

At minimum it is the expectation of the IIT that when primary care services make contact regarding existing service users,

- a check is made on the electronic information system by the person receiving to call to determine:
  - the consultant psychiatrist for the service user; and
  - the CPN or care coordinator for the service user.

It must be the responsibility of the individual taking the call to ensure that the information communicated by the primary care service is passed on to the care coordinator or consultant psychiatrist. Where there is no care coordinator, or any doubt at all in the mind of the person receiving the call then the team manager must be informed.

Recommendation 7: Norfolk and Waveney Mental Health NHS Foundation Trust must satisfy itself that its mental health practitioners are complying with all current standards applicable to the involvement of, and support for, families and carers.

In addition the IIT suggests that the Trust adds a section to its website, under carers, entitled "What I can expect?". The Trust may also want to consider relabeling its current "Carer" tab to "Families and Carers" to maximise accessibility of the information.

This investigation highlights the central importance of family involvement in the delivery of a safe and effective mental health service. The role of the family in the MHSU's management plan was overlooked completely by the general adult mental health service to its, Mr Rayner's, the MHSU's and his family's cost.

It is essential that the Trust is able to demonstrate how it ensures that all of its community mental health practitioners acting as care coordinators make sure that the views and opinions of families and carers are sought and utilised, to enable the best possible package of care to be delivered to a service user.

This engagement of families does not usually infringe the confidentiality owed to a service user. Engagement of the family at some level can more often than not be achieved without breaching client confidentiality.

APPENDIX 1
SUMMARY OF THE MHSU'S CONTACTS WITH MENTAL HEALTH SERVICES 1995 – May 2006. The detail of his care and treatment is contained within Section four of this report pages 30 - 114

Date	Contact
Between 1985 and April 1989 the MHSU had six admissions under specialist mental health services. The main risks for the MHSU during this period of his contact with mental health services were identified as harm to self and non-compliance with medication which precipitated a relapse of his mental illness.	
7 May - 28 May 1985	The MHSU's first admission to hospital
24 June - 17 July 1985	The MHSU's second admission to hospital
July 1985 – 14 November 1986	MHSU managed with community follow up
14 November 1986 – 6 January 1987	The MHSU's third admission to hospital.
23 January 1987 – 9 March 1987	The MHSU's fourth admission to hospital.
26 April 1988 – 1 June 1988	The MHSU's fifth admission to hospital.
14 January 1989 – 16 March 1989	The MHSU's sixth admission to hospital.
25 July 1990	On this seventh admission the MHSU had allegedly visited a local pub and fired two arrows in to the dart board from a homemade crossbow. It was alleged that he had made the crossbow in order to protect himself from two men. The MHSU subsequently absconded from the inpatient unit and was discharged in his absence on 2 August 1990.
2 August 1990 and 28 September 1990	The MHSU was not in contact with mental health services and was predominantly living rough. During this period an incident did occur which resulted in an assessment of the MHSU under the MHA (1983) but he was assessed as not detainable.
	The MHSU attacked his father with a knife, having previously attacked a friend by ramming his car with his own.
8 November 1990	The MHSU was transferred from Norwich Prison to a special hospital.

Date	Contact
November 1990 – September 1995	The MHSU was resident at Rampton Hospital and then the Norvic Clinic. In 1995 her was awarded a conditional discharge from section 37/41 of the MHA.
September 1995 – 31 January 2000	The MHSU was managed by the forensic community psychiatric services before being discharged to general mental health services in January 2000. The most notable year in this period was 1997 when the MHSU was awarded an absolute discharge from section 37/41 of the MHA.
January 2000 – July 2000	The MHSU's plan of care was followed as agreed with forensic services. He received his depot injection at home or at the CMHT base.
July 2000	The MHSU attended at the CMHT base for his depot injections and received no further home visits after this date.
17 July and 27 September 2000	The MHSU was reportedly over familiar with a female member of the CMHT. Consequently his care coordinator was changed.
11 October 200 – 11 December 2003	The MHSU had a regular care coordinator, CPN-A4. During this period he reliably attended for his depot injections and there were no concerns about him.
Mid December 2003	The MHSU was discharged from the CMHT caseload to primary care services, where he would continue to receive his medication. His outpatient appointments with a Consultant Psychiatrist were to continue every six months.

Date	Contact
January 2004 – April 2006	The MHSU attended reliably for his outpatient appointments and also for his depot injections. No problems were noted by, or reported to health professionals.
21 April 2006	The MHSU did not attend for his depot injection. In the three months preceding this, it transpired that he had extended the time period between his injections on two occasions by one week. Primary care services notified specialist mental health services of his non attendance on 25 April when they had been unsuccessful at making contact with the MHSU themselves.
2 May 2006	CPN-A8 contacted the MHSU's GP surgery to discuss the events and the MHSU with the practice nurses. CPN-A8 also made telephone contact with the MHSU.
4 May 2006	CPN-A8 received a message from the MHSU's GP surgery advising that he had again not attended for his medication. Consequently contact was made by CPN-A8 with the MHSU and an appointment made for the following day.
5 May 2006	The MHSU attended at the CMHT base to meet with CPN-A8. At this meeting the MHSU made it clear that he did not want any more depot injections and that he would think about oral medication. He also told CPN-A8 that he would agree to monthly contact but not more frequently than this.

Date	Contact
18 May 2006	CPN-A8 meets with Consultant Psychiatrist PA10, who had been on annual leave between 8 and 17 May. CPN-A8 and Consultant Psychiatrist PA10 agree that they needed to try and persuade the MHSU to meet with them fortnightly rather than monthly, ideally at home. They also agreed that they needed to make contact with the MHSU's family and that CPNM-A8 would discuss this with the MHSU at their next planned meeting on 2 June 2006. The importance of recommencing medication for the MHSU was also discussed.
24 May 2006	The index offence occurred.

APPENDIX 2: NORFOLK AND WAVENEY MENTAL HEALTH PARTNERSHIP NHS TRUST

Norfolk and Waveney Mental Health Partnership NHS Trust was established in 2003. From 1994 to 2003 it was known as Norfolk Mental Health Trust. It provides a specialist mental health service to approximately 800,000 people across all age ranges in central and east Norfolk, and the Waveney area of Suffolk. In addition to general mental health services, the Trust provides forensic services to the whole of Norfolk and social care services to people of working age.

When the MHSU first came into contact with the specialist mental health services in Norfolk there were none of the following:

- crisis resolution and home treatment teams;
- assertive outreach teams;
- integration with social services;
- service user and carer involvement;
- early intervention services;
- partnership with voluntary organisations; and
- primary care workers.

Many of these services were not operational nationally until the early 2000s through to 2004. Service user and carer involvement did not really come to the fore until it was made a standard, in the *"National Service Framework for mental health"* (DH, 1999).

Organisationally the Trust did have a core purpose which was to "improve the mental health of people in Norfolk and Waveney, and to promote positive mental health and a positive understanding of mental health issues".

It was, and remains, a Trust committed to the core values of:

- respect;
- accessibility;
- individuality;
- maximising independence;
- safety;
- valuing staff;
- achieving excellence;
- learning from mistakes;
- efficiency and effectiveness;
- professionalism;
- fairness; and
- openness.

During the time period the MHSU was receiving care and treatment from the general adult mental health service, the Trust did experience a number of challenges that highlighted deficiencies in its attainment of its core values.

One of these challenges was the publication of the Richard King homicide investigation report in 2005 that drew attention to the Northern Locality; the other was an internal review of the Northern Locality which confirmed that it was a locality that was underperforming in relation to Trust targets and the modernisation programme. The internal review also highlighted inconsistencies in:

- CPA practice;
- the quality of documentation;
- clinical and management supervision; and
- team leadership.

The findings of the internal review confirmed privately held views of a number of consultant psychiatrists who had taken posts in the Northern Locality but who had moved on to more forward-thinking areas of the Trust quite quickly afterwards.

The problems identified in the Northern Locality did impact on the quality of service afforded the MHSU, who is the subject of this investigation.

APPENDIX 3: INVESTIGATION METHODOLOGY

The investigation methodology was as follows:

- Critical appraisal of the MHSU's clinical records and the identification of areas that the IIT needed to explore.
- Document analysis.
- Face-to-face interviews.

The investigation tools utilised were:

- Triangulation of interview questions.
- Investigative interviewing.
- Affinity mapping and qualitative content analysis of the interview data.

The primary sources of information used to underpin the findings of this investigation were:

- The MHSU's mental health records (forensic and general adult).
- The internal investigation report, and interview data gathered by Norfolk and Waveney Mental Health Partnership NHS Trust.
- Interviews with:
  - three of the psychiatrists who had treated the MHSU;
  - a range of senior managers at Norfolk and Waveney Mental Health NHS Foundation Trust, including the past and current medical director, the previous director of nursing, and previous chief executive officer;
  - four general adult community mental health nurses;
  - the MHSU's forensic community mental health nurse at the Norvic Clinic in 1999;
  - the MHSU's forensic social worker at the Norvic clinic;
  - all three team leaders of the MHSU's community mental health team between 1999 and 2006;
  - the family of the MHSU;
  - the son and daughter of Mr Rayner;
  - friends and neighbours of Mr Rayner and the MHSU; and
  - the consultant forensic psychiatrist who provided the pre-sentencing opinion and assessment of the MHSU.
- Norfolk Mental Health Trust CPA policies 2002 and 2003.
- The Mental Health Review Tribunal decision forms relating to the MHSU's conditional and absolute discharge.
- The Mental Health Act Commission discussion paper "*The threshold for admission and the relapsing patient*".
- Report of the Northern Locality Review, February 2006.
- Various written evidence from interviewees.

In addition to the core information the investigation team:

- accessed a range of policies and procedures from other mental health trusts;
- studied relevant academic papers;
- entered into correspondence with the Ministry of Justice regarding the absolute discharge of the MHSU; and
- entered into correspondence with the Tribunals Service for mental health.

APPENDIX 4: GLOSSARY

The Care Programme Approach (CPA)[14]

CPA is the framework for good practice in the delivery of mental health services. In early 2008 the *"Refocusing the Care Programme Approach policy and positive practice"* document was published[15]. This made changes to the existing Care Programme Approach.

One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, its principles and values do. CPA still aims to ensure that services will work closely together to meet identified needs and provide support to MHSUs in recovery. If a MHSU has a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When the needs have been identified and agreed, a plan for how to meet them will be drawn up and a care coordinator will be appointed. The MHSU and his/her views will be central throughout the care and recovery process.

There are four elements to the Care Programme Approach:

- Assessment – this is how the MHSU's health and social care needs are identified.
- Care coordinator – someone is appointed to oversee the production and delivery of a MHSU's care plan, keep in contact, and ensure good communication between all those involved in care.
- Care plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of the care and support.
- Evaluation and review – the care plan will be regularly reviewed with the MHSU to ensure that the intended outcomes are being achieved and if not that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as "enhanced CPA".

[14] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php

[15] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

Mental Health Act
Summary of the Mental Health Act 1983 with inclusion of appropriate 2007 revisions[16]

1. The main purpose of the Mental Health Act 1983 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.

2. Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies.

3. In certain circumstances, people who have been detained in hospital for treatment can be discharged on to a Community Treatment Order (CTO) by their responsible clinician, the senior professional in charge of their case. This means they are free to leave hospital and continue their treatment in the community, subject to the possibility of being recalled to hospital if necessary. This is also known as Supervised Community Treatment (SCT).

4. Part 2 also sets out the procedures for making an application for someone to be received into guardianship under the Act.

5. Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order, on the basis of two medical recommendations, for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a guardianship order. A restriction order may be imposed at the same time as a hospital order to place restrictions on the movement and discharge of a patient for the protection of the public; all movement is then subject to the agreement of the Secretary of State for Justice. This part of the Act also

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

contains powers to transfer prisoners to hospital for treatment of a mental disorder.

Most patients who are detained in hospital under the Act can be given treatment for their mental disorder without their consent. Some types of treatment have to be approved first by an independent doctor - a Second Opinion Appointed Doctor (SOAD). Unless it is an emergency, patients who have the capacity to consent cannot be given electro-convulsive therapy (ECT) unless they agree. SOADs must also approve certain types of treatment given to SCT patients. With very limited exceptions, SCT patients cannot be treated against their wishes unless they have been recalled to hospital.

6. Most patients who are detained, or on SCT or guardianship, have the right to apply to a Tribunal for their discharge. The Tribunal is an independent, judicial body. Part 5 of the Act sets out when patients, and sometimes their nearest relatives can apply. Most detained patients and all SCT patients can also ask the managers of the relevant hospital to discharge them. Patients' responsible clinicians must also keep the appropriateness of continued compulsory measures under review.

7. In England, the Care Quality Commission is responsible for monitoring the way the Act is used and protecting the interests of patients. It sends Mental Health Act Commissioners to visit hospitals and talk to patients about their care and treatment. It also appoints SOADs.

Mental Health Review Tribunal

The First–tier Tribunal (Mental Health) hears applications and references for people detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007). Their Tribunal judiciary and members are appointed by the Lord Chancellor. Their jurisdiction covers the whole of England. The Tribunal sits within the Health, Education and Social Care Chamber of the First Tier Tribunal. The Chamber President is currently His Honour Judge Phillip Sycamore who is based in Manchester. The Deputy Chamber President responsible for the Mental Health Tribunal is currently Judge Mark Hinchliffe who is based in Manchester. Judge John Wright is the current Principal Judge who is based in Preston.

Risk assessment

Risk assessment and risk management should be part of the routine care provided to a MHSU. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However the general principles of risk assessment and risk management rely on undertaking an assessment and identifying aspects of an individual's behaviour and lifestyle

that might pose a risk to self, or to others, and to the qualification of that risk where possible. Once risks are identified it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

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