

Independent Inquiry into the Care and Treatment of MN

*A report commissioned by
Avon Gloucestershire and Wiltshire
Strategic Health Authority*

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PREFACE

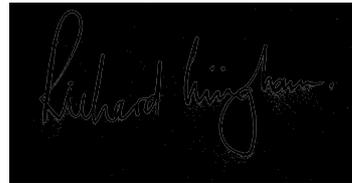
We were commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority to undertake this Inquiry.

We now present our report, having followed the terms of reference and the procedure which was issued to all witnesses and their representatives.



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Chapter 1

Background and Overview

1.1 The Reason for the Inquiry

- 1.1.1 On 17 February 2003 at Bristol Crown Court MN was found guilty of the manslaughter by reason of diminished responsibility of a 79 year old woman on 27 March 2002. The victim of the homicide lived in the village of Winterbourne, a short distance from the home of MN. She was the subject of a prolonged attack and the emotional impact of this killing in such a small community resonated throughout our hearing of the evidence. The families of the victim and MN, along with professionals, managers, providers and commissioners of services, have continued to experience the aftermath of this homicide. For some it has been a very distressing time. The Inquiry Panel offers its sincere condolences to the family of the victim, who gave evidence to the Inquiry and for whom the publication of a Report can never be enough.
- 1.1.2 The Crown Court made MN subject to a Hospital Order under s37 of the Mental Health Act (MHA) with a Home Office restriction under s41 of the Act.
- 1.1.3 After arrest MN had been remanded to HMP Horfield, Bristol, following which he was transferred to Fromeside Medium Secure Unit, also at Bristol, on 18 July 2002 and returned there upon the making of the Hospital Order.
- 1.1.4 The Trust carried out an internal review headed by an independent medically qualified chair. It heard from the health and social services staff and managers responsible for MN's treatment and care. It made a number of recommendations, many of which this Inquiry endorses.

1.2 Setting up the Inquiry

- 1.2.1 In the summer of 2003 Avon Gloucestershire and Wiltshire Strategic Health Authority (AGW SHA) appointed this panel to carry out an Independent Inquiry under Department of Health circular HSG 94(27), which at the time required that an independent inquiry be held where an individual had been in receipt of psychiatric services prior to a homicide.
- 1.2.2 In June 2005 the Department of Health issued new guidance. This replaces paragraphs 33-36 of HSG (94)27 with criteria which require that an independent investigation take place *"when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event"*. We shall see that in this case MN was not subject to Care Programme Approach (CPA) in the six months before the homicide though he was receiving specialist mental health services, but the new guidance also requires that an independent investigation take place *"when it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation"*.
- 1.2.3 The new guidance has not changed the commissioning arrangements for this Inquiry. Under the new guidance it seems likely that an independent investigation would still be required.
- 1.2.4 Terms of Reference were agreed between the Inquiry and AGW SHA and these are at Appendix A of this report.

1.3 The Inquiry Procedure

- 1.3.1 We determined that this Inquiry would adopt the following approach. It would:
- (a) Take into account other homicide inquiry findings locally.

- (b) Draw upon national expertise.
- (c) Use as far as possible a Root Cause Analysis approach.
- (d) Involve local commissioners and providers, and the families of the victim and MN, in the drafting of recommendations for improvement of services.

1.3.2 Anticipating, as it happens correctly, that the Department of Health would, in its new guidance, advise the use of a process called Root Cause analysis (RCA), this Inquiry took advice from the National Patients Safety Agency (NPSA) and analysed its evidence using RCA techniques. The Terms of Reference refer to this intention and we describe the RCA procedure in Chapter 7. We are very grateful to Hazel Crook of the NPSA for her help and advice with this process.

1.3.3 We decided that at the stage of information gathering, in order to ensure fairness and to hear each person's untainted account of events, evidence must be heard from witnesses individually, each person being permitted to have someone of their choice to assist them in the preparation of their written evidence at hearings and to comment on draft findings. The Procedure for the Inquiry as provided to each witness is at Appendix B.

1.3.4 The Inquiry received evidence from a total of fifty-eight witnesses. Fifty gave evidence in writing. Thirty-nine attended hearings to give oral evidence between March 2004 and June 2005. Two of the witnesses were from the local branches of MIND and Rethink. Seven professional witnesses chose not to respond to the request for a written statement and were not called to give oral evidence. A full list of witnesses is included at Appendix C. We are extremely grateful to all who participated in a process which was time-consuming and often stressful.

1.4 The place of this Inquiry, locally and nationally

1.4.1 Coming after two other local homicide inquiries in recent years¹ and the internal audit into the care of MN, it is to the credit of AGW SHA that they were aware from the start of a need to build upon lessons already learnt – or not learnt - from these previous local homicide inquiries, and our Terms of Reference are framed with this in mind.

1.4.2 As we heard witness evidence we found that morale, particularly at senior management level, was low. Energy for addressing yet another set of Inquiry recommendations was lacking. We met with pleas for simplicity. This was especially so where themes from the past repeated themselves. Moreover there was a belief amongst some staff that certain acknowledged weaknesses in service provision were simply not amenable to improvement because national guidance prevented it.

1.4.3 It appeared that some issues arising from this Inquiry might have implications nationally. It was for this reason that, with the support of AGW SHA, we sought national advice and expertise on the CPA and some national recommendations were made part way through the Inquiry process. The account of this process is contained in Chapter 7. We are extremely grateful to the experts and representatives of key mental health organisations who gave of their time to assist in this process and who are named in Chapter 9.

1.4.4 There are two sets of families involved in this Inquiry – those of the victim and those of MN. Unusually they have been in touch with each other, and living in the same local community the homicide will have touched friends of both families. Anger and distress is an inevitability, but we have been impressed by the wish of each family that this Inquiry uncover what happened and why. Most of all everyone - staff and families - hope for constructive recommendations that will bring about change for the better in mental health services. We hope that this Inquiry will satisfy as many of these needs as possible.

1.5 Overview

1.5.1 This report concerns a young man, living at home with his family, who suffered classic symptoms of mental illness in the form of social withdrawal and delusional ideas for up to two years prior to his first admission to psychiatric hospital at age 23 with an acute psychotic episode. Use of s2 MHA to ensure

¹ Report of the Independent Inquiry into the Care and Treatment of RG (2001) Wiltshire Health Authority and Wiltshire Social Services, and Report of the Independent Inquiry into the Care and Treatment of MM (2003) Avon, Gloucestershire & Wiltshire Strategic Health Authority.

his detention for assessment and treatment with anti-psychotic medication was unexceptional given his lack of insight and angry refusal of medication. This was an apparently unremarkable mental illness in terms of how he presented to services. That was confirmed when a Mental Health Review Tribunal (MHRT) decided not to discharge the section and when MN was detained under s3 MHA, the rationale in both cases being the need to treat MN's psychosis with antipsychotic medication.

- 1.5.2 Only after this did MN's care and treatment depart from the norm. For it was at this point that the uncommon diagnosis of schizotypal disorder – generally thought of as a form of personality disorder - was first considered. That diagnosis took root and gradually replaced schizophrenia as the primary diagnosis with the result that MN was no longer treated with anti-psychotic medication. Indeed he remained without medication until the homicide seventeen months later.
- 1.5.3 After five weeks in hospital MN was sent home on extended leave to his family. He remained there, largely withdrawn in his bedroom, believed to be suffering from schizotypal disorder and subject to outpatient appointments with the consultant psychiatrist and visits from a social worker, with which he initially co-operated. After eleven months, by which time he had been discharged from the hospital and from the section 3, he began to miss outpatient appointments and avoid social work visits. His family made efforts to take him to an outpatient appointment but he refused to go with them. It was decided by the psychiatrist and social worker that a referral to the assertive outreach team would be the next move and in March 2002, sixteen months after MN had been allowed home, the social worker called by appointment to see MN in order to discuss this.
- 1.5.4 At no time since his return home had anyone reported that MN was distressed, angry or a risk to other people. Nor did the family raise any concerns on that day. But when the social worker spoke to MN a stream of highly disturbed thinking was suddenly released, including threats to kill the social worker and his family.
- 1.5.5 Returning directly to his office base, the social worker spoke to colleagues and less than three hours after leaving the house he discussed the matter with MN's psychiatrist. They considered the possible use of the MHA, but by then it was too late. MN had already killed, his victim being a stranger to him, an elderly lady in a neighbouring street.
- 1.5.6 Returning to his family after the homicide MN continued to give no indication to them or other acquaintances that he was in an aroused or disturbed state. It was not until four days later that MN was arrested.
- 1.5.7 Much of this report is about diagnosis and risk assessment. For when MN killed, his mental state was not that of someone suffering from schizotypal disorder. He was in the grip of an acute psychotic illness.
- 1.5.8 How, we ask, was it that MN was not receiving medical treatment for this psychotic illness? How did there come to be a change in the diagnosis from psychosis to schizotypal disorder?
- 1.5.9 Our report covers the complex diagnostic area of schizophrenia and schizotypal disorder. We examine how the diagnoses were made and the organisational context in which this took place. We relate how the family felt about what was happening.
- 1.5.10 We make it clear that there were many areas of good practice by individual practitioners including prompt assessment of MN in the community, prompt admission to hospital, good early management of his care and continued involvement of psychiatric services even when MN had missed appointments, until within an hour of the homicide.
- 1.5.11 However, we find that MN could and should have continued to be diagnosed as suffering from a psychotic illness. We locate responsibility in part with the psychiatrists responsible for MN's care, who did not ensure they had the clinical information necessary to make the rarely-used diagnosis of schizotypal disorder bearing in mind the World Health Organisation International Classification of Diseases (ICD-10) advice that the diagnosis is not recommended for general use. In part responsibility lies with the multiple failures of professionals and managers at all levels to operate the Care Programme Approach which should have been able to mitigate the effects of poor practice.

1.5.12 We examine the Care Programme Approach system of care planning and its application nationally, in the Trust, the locality and as it applied to the care of MN. We find that there were gross failings in the implementation of practice guidance, which had been issued sequentially since 1990 by the Department of Health. The impact of CPA on MN's care was virtually nil.

1.5.13 Taken over all, we must conclude that MN did not receive the standard of care he should have been able to expect from international guidance on psychiatric diagnosis and national guidance on CPA and the MHA Code of Practice.

1.6 Predictability, foreseeability and preventability

1.6.1 The victim's family, MN's family, the public and professionals have a legitimate interest in knowing whether this homicide was foreseeable and preventable.

1.6.2 We conclude that it could not have been predicted or foreseen by anyone at any point that MN would, apparently acting on the basis of an undisclosed, undiagnosed delusional belief, at about midday on 27 March 2002 kill Mrs H, a stranger to him.

1.6.3 It could have been predicted that, acting on his expressed delusional belief, MN might attempt to harm the social worker or the social worker's family, but he did not do this. It might also be thought that MN's own family were at risk since they were in the house with him before and after the homicide, but they were not threatened or harmed and did not consider themselves at risk of being so.

1.6.4 This illustrates the difficulty of identifying future victims of homicide. Two hours before the homicide MN reportedly showed no signs of disturbance. Yet an hour before the homicide MN was in an aroused state and voicing delusional ideas about death and killing. At that point it was reasonable to consider the possibility of harm to someone, but it could not be predicted what that would be, whether it would definitely occur, nor when, nor to whom.

1.6.5 The only way that this unpredictable act could have been absolutely prevented would have been by a diagnosis of psychotic disorder and effective treatment with medication so that MN was completely relieved of his paranoid delusional symptoms, and/or detention under the MHA. We do not think any of this was realistically achievable in the half hour available to the social worker before the homicide. The social worker took appropriate action by speaking to the consultant psychiatrist that afternoon, but did not know he was engaged in a race against time.

1.6.6 We make recommendations for urgent reporting procedures where there are specific serious threats, in the hope that when this kind of urgency is confronted in future there can be a quick response. But in MN's case it may still have been difficult to prevent this homicide because the real problem lay further back in the history of MN's care. It was past failures which led to a situation in which MN remained at home for sixteen months, unsupervised and suffering from undiagnosed, untreated schizophrenia.

1.6.7 Our RCA analysis uncovers five fundamental causes amenable to organisational change during the eight months prior to the homicide and on the day itself:

- There was no psychiatric assessment for eight months.
- The full history and facts were not known to the psychiatrists.
- The family were not informed of the symptoms they should report.
- The social worker was not asked to probe for symptoms.
- There was no urgent psychiatric assessment on day of homicide.

1.6.8 These factors both influenced and were influenced by the misdiagnosis of schizotypal disorder. We describe a spiral in which, once it had become established, the diagnosis persisted and interfered with planning for MN's care, reducing perceived risk and causing him to be placed on a low level of supervision, thereby making it less likely that symptoms of psychosis would be detected or reported.

- 1.6.9 Preventability in a public service setting such as this is best seen in terms of raising general standards of protective care.
- 1.6.10 RCA describes preventative functions of an organisation as failsafe procedures or 'barriers' designed to prevent harm to people organisations, and we identify eight such barriers which, if operated properly, could and should have led to a reassessment of the diagnosis, and prevented the harm of MN's deteriorating mental illness, ideally long before the homicide. Failure to operate these 'barriers' effectively were missed opportunities:
- Adherence to CPA procedures of care planning and review.
 - A missed appointments policy.
 - Medical records travelling with the patient.
 - Information on diagnosis and symptoms provided to the family.
 - Allocation of a CPN or social worker specifically to visit and monitor mental health.
 - Procedure for reporting threats of violence to police, psychiatrists and GP.
 - Improved guidance to psychiatrists on the use of 'rare' diagnoses
 - Improved early intervention strategies where diagnosis is uncertain.
- 1.6.11 In short, this particular homicide was not predictable or foreseeable but it may have been preventable through a series of improvements in the service to MN. One improvement in particular could have had the greatest impact. CPA provides the framework within which all mental health care is provided, and if operated properly other aspects of care should fall into place. It is at the very heart of psychiatric care. As a failsafe procedure or barrier CPA is capable of protecting against the occasions when unusual situations arise and routine practice is not enough.
- 1.6.12 Its failure is of such significance that we have examined this in detail in the report, hearing evidence on its operation locally, and consulting on its implementation nationally. We have been reminded by the family of the homicide victim that the public needs to be able to trust mental health services. It seems to us that an effectively operated CPA should be able to provide that confidence in psychiatric services.
- 1.6.13 Please note that, whilst this Inquiry Report needs to be read as whole document, it contains a number of themes. Each chapter is intended to be, if not freestanding, capable of being read separately. This results in some repetition of the history for the purpose of scene setting.
- 1.6.14 In order to respect the confidentiality of the patient's family, carers and all other persons affected by the Inquiry, this Report refers to individuals who gave factual evidence by their initials. Experts are named in full. We refer to service users as patients where they are in hospital, or with reference to the Mental Health Act.

Chapter 2

The History

2.1 Pre-admission history

- 2.1.1 MN was born on 10 May 1977 and was aged 24 when he killed. He grew up in Winterbourne, and was living there when he committed the homicide. He did not know the victim.
- 2.1.2 One of three children, MN lived at home with his mother and younger brother. His older sister lived nearby. MN's parents had separated when he was around 3 or 4 years old and there had reportedly been no contact with his father since that time. MN's mother and two aunts, one of them her twin sister, were key figures in the family. (Referred to as DC and DCr)
- 2.1.3 MN was said by his family to have been a shy, quiet, sensitive, introverted boy who enjoyed rock-climbing, fishing and canoeing until his late teenage years. After leaving school MN attended College, where he completed a mechanic's course and then he had several jobs as a garage mechanic.
- 2.1.4 MN's mother described to us the way she saw her son's behaviour change. She recalled that in 1998 her son suddenly gave up work and withdrew to his bedroom. Some while after that MN's friend had approached her to say he had concerns about MN. MN's mother said she then gave up a few hours of her work *"so I could be home just to watch and listen out for what MN was doing and saying, and that is when I realised he was ill. I did not realise he was ill at the time, but I did get concerned after it went on for months and months.... He used to say he could see dead people anyway, and I did not really take a lot of notice of that at the time. But I was picking up things then once I gave up work. He was tapping his foot, he was always laughing to himself.... He would have a habit of always washing his hands"*. She added that MN did not tell her much *"he would hold everything in, he would not say an awful lot. He was very deep"*. First of all, MN's mother told us, she put his behaviour down to being a teenager. But she also wondered if it had been due to a road traffic accident in 1998 when he had banged his head. A scan was undertaken after the homicide, showing nothing suggestive of brain injury.
- 2.1.5 From 1999 onwards, the family began to feel increasingly worried about his odd behaviour. MN's sister, VN, told the Inquiry that she and MN had always believed in ghosts so she had accepted it when he first said *"I've seen gran" or "I've seen gramps"*, but she became concerned when he said he had seen Hitler, that Scooby Doo was real and that he was king and *"had a wife which was kept in a box either side of him and he had children, but he had to find the key to let them out"*. She noticed that he would laugh out loud and then deny it *"he would say that we were all mad"*. He was not, she told us, a big drinker. She knew he used cannabis but did not attach particular importance to drugs in terms of his illness.
- 2.1.6 DC, MN's aunt recalled an occasion when MN said to her that 'gramps' was there adding *"you should know you've just been talking to him. He is in the corner of the living room"*. On another occasion he pointed at his mother and said *"Look at her, she's got horns. Then in a split second he had gone back to talking normally"*.

2.2 The family takes action

- 2.2.1 Eventually, MN's worried sister VN phoned her Aunt DC telling her that MN had said *"something like... I am not going to be here much longer"*. DC told us *"I said that is it, something has to be done now"*. Knowing that MN took cannabis, DC first of all considered the possibility that drugs were the explanation, so she telephoned to a drugs helpline and it was they who said that it sounded like a mental health problem.
- 2.2.2 So on 23 August 2000 DC, MN's mother and their other sister went to the family GP, explaining that MN had threatened to take his own life the previous day.

2.2.3 An arrangement was made to bring MN into the surgery the following day, and in the morning DC came to pick up both MN and his mother. But MN's mother recalled that her son did not want her to come and so she stayed at home. DC persuaded MN to go by mentioning that if he got a doctor's note he could get some money coming in. On the way back in the car MN told DC he could fly and explained how she too could fly. She said how surprised she was because she had not seen him change so quickly before and "truly believed he could fly". She was so concerned that once home she rang the GP Dr B, who said he was going to refer MN to a psychiatrist because he thought MN was mentally ill.

2.2.4 Dr B noted that he "showed no insight re reason for appoint or family's concerns for him". On 24 August 2000 Dr B wrote an urgent referral letter to Dr M, the consultant psychiatrist for Yate Community Mental Health Team which covered their geographical area, saying "I wonder if you can please organize to see this 23 year old gentleman urgently, either at Yate Health Centre or in his own home. His family first attended yesterday and saw Dr L concerned about his personality and hallucinations. Apparently he has always been rather introverted and somewhat of a loner but he has been worse over the last few years partly possibly related to a RTA two years ago in which he had a mild head injury. Apparently he was in employment until the car accident. He is not signing on as apparently he has said he is king and does not need to sign on. He is very obsessed by spirits and dead people, particularly Hitler and other famous people. His father apparently left home when he was 3 or 4 years old and he is the middle of three children. There is no previous psychiatric history.

An appointment was made for MN to attend the Surgery and as Dr L was away he came and saw me this morning. He did not seem to have any insight into why he was attending or what his family's concerns were. He did talk about Hitler and ouija boards and clearly has some very strange thought processes. He denies hearing voices".

2.3 An outpatient appointment is arranged

2.3.1 An appointment was arranged for MN to see Dr M at Yate Community Mental Health Team (CMHT) on 12 September 2000 and DC described to the Inquiry how the day went. In her words "On the morning of the appointment it was again agreed that I would take MN to Yate and give a handwritten letter to Dr M, merely giving him some background on MN, because I knew that MN was not going to volunteer any information. So I faxed that through and then went to pick MN up for the appointment".

Good practice

The GP made an immediate referral to Dr M, and Dr M arranged an outpatient appointment within two weeks. The family were fully involved. This was a prompt response.

2.4 DC writes to Dr M

2.4.1 DC's handwritten letter to Dr M, with a fax date of 12 September 2000, reads:

"I am writing about my nephew, MN who has an appt today at 9.30 with yourself. Hoping that this information might help.

He thinks he's King and so he doesn't need to work or need money he doesn't claim any Unemployment Benefit or anything, so his mother (my sister) hasn't had any money since about 1998 this has caused problems with the younger son and MN rowing, and his mother telling MN to leave. She only realised during the school holiday just how much MN talks to himself out loud and also laughs out loud, even MN's 4 yr old nephew has noticed MN doing this and asks who are you talking to? What are you laughing at? there is no one there.

MN stays in his Bedroom most of the time and doesn't mix with other people very often, he's always lacked self confidence and when he does see other people he doesn't have conversations just a few words or sentence. He's always been worried about his skin. Also in 1998 MN had a Car Accident but never went to hospital to be checked over (the car went up in the air and flipped over before hitting the ground.)

MN has conversations with people who are dead. These people include his dead Grandfather, his Great Grandfather with other people such as Hitler, Isambard Kingdom Brunel etc.etc. he really believes he knows these people and that they are in the same room.

MN hasn't had a father figure, his parents spilt up when MN was 3yrs. Even when he was much younger at Senior School he said he could see dead people and talk to them. Always employed up until 1998.

Because MN thinks he's king, he doesn't need to Return his library books (he thinks). These have been overdue since 7th May 2000. I have spoken to the library and explained the situation to them and as long as I can get a letter from yourself the Doctor they will stop the fine and as soon as MN feel's he doesn't need these books I can return them. MN will not part with these Books at all, and because he's King he owns the service (library) Hope you can help with the letter, and if so could you please send it to me at the above address.

MN we believe had tried drugs, but as he hasn't any money, we do not believe he's on anything now. I have been told that he tried Angel Dust/(PCP)/phencyclidine. MN thinks he married with children (to the Queen)

Has cartoons and sci fi mixed up with the real world etc etc"

2.4.2 This letter was filed in MN's Yate medical records.

Family actively seeking help for MN

The family was active in seeking help and the provision of information to the GP and Dr M. DC's letter to Dr M contained information intended to assist with the assessment of MN in the expectation that he might not reveal his disturbance in interview.

DC's letter not seen by Dr J

Dr J, the consultant psychiatrist who was later responsible for MN's care and treatment in hospital, told us he had not seen this letter from DC to Dr M and was unaware that MN believed he was married with children, to the Queen.

2.5 MN seen at home by Dr M

2.5.1 When DC arrived to collect MN for the outpatient appointment "*MN was not going to have any of it. There was nothing wrong with him, why should he see somebody, and he just would not go. Then I went home and... my phone was ringing....and it was Dr M..... He said that he was very concerned and could I meet him back at the house at quarter past 3 that afternoon. He would bring a male nurse with him and they would try to assess MN. I rang MN's mother up and she cancelled her afternoon going to work and went to the house...and Dr M and PH arrived as well. I went upstairs and spoke to MN and tried to persuade him to come down...he just laughed"*

2.5.2 MN's mother recalled that Dr M and a CPN, PH, then attempted to visit her son in his bedroom. She told us "*MN was adamant there was nothing wrong with him. When they (Dr M and PH) were leaving they said that he was suffering from mental illness, psychosis and I just could not believe.....it took me weeks and weeks to start to believe he must be really ill..... I have never come across anybody with a mental illness before".*

2.6 Dr M states 'probably schizophrenia'

2.6.1 Dr M recorded that the family had not been able to persuade MN to attend the outpatient appointment on the morning of 12 September 2000. That afternoon he therefore visited MN at home with CPN PH, because he was concerned about the urgent referral and DC's note.

2.6.2 At the house Dr M did not manage to see MN and his assessment of MN's mental state was, he told us, "*conducted while standing on the landing outside his bedroom door in very difficult circumstances. MN clearly indicated, and in very abusive tones, that he wanted nothing to do with us and ordered us to*

leave him alone.....The limited mental state examination was consistent with a provisional diagnosis of paranoid schizophrenia – some of his utterances were odd in that he made reference to dead people and spirits.” Dr M spoke to MN’s Mother and Aunt noting a history of “withdrawal, odd behaviour + thoughts. Talking and laughing to self...pre-occupation with spirits, ability to communicate with the dead. Thinks he is king”. This collateral history was, Dr M said, “in keeping with a psychotic illness with a slow prodrome including isolation and social withdrawal.”

2.6.3 MN was discussed at the Yate CMHT clinical meeting on 14 September 2000. It was decided to await contact from the family and discuss it further at their team meeting on 18 September 2000.

2.6.4 On 14 September 2000 Dr M wrote a two and a half page letter to Dr B in which he said:

“Thanks for asking me to see this troubled 23 year old, single, unemployed car mechanic. Unfortunately he failed to attend the out patient appointment arranged for him on 12 September and, in view of the worrying symptoms indicated in your letter, I arranged to visit him at home accompanied by PH, CPN, later on the same day.

Presenting Complaint:

The history is of approximately one year of social withdrawal and odd behaviour. Over this period, he has not worked and has been observed to be laughing and talking to himself and has expressed to his family members a variety of odd beliefs. He thinks he is king and, for this reason, he does not require work or money (he has not worked for a year, nor claimed any benefits). He is reported to have conversations with people who are dead, including his grandfather and great grandfather, and others such as Hitler, the engineer Brunel, and others. He is reported to have a fascination with “spirits” and to have many books on the subject of the occult. He has further reported to have a significant history of using illicit drugs, but there are no accurate details available. The use of “angel dust” (PCP) has been specifically mentioned.....

Personal History:

This is limited, to date. From your letter, and from collateral from mother and aunt, we learned of a shy, quiet, sensitive, introverted boy, whose early milestones appeared to have been normal, who followed an unexceptional school career, training in the motor industry and achieving some limited qualification in this area. No history of significant relationships.

Forensic History:

This is denied by mother. However, upon detailed questioning, she revealed that he has in his possession, a number of knives related to his interest in fishing, and that, furthermore, when an adolescent, he had a “pistol”, the whereabouts of this weapon is unknown.....

At interview:

He presented as a neatly attired youth of pallid complexion, average build and slightly below average stature, with some facial acne. His demeanour was very hostile and, at times, threatening. He was verbally abusive to his mother and to ourselves, in a manner consistent with a young man visited by strangers in his house, without warning or invitation. While much of his thought content was, in this regard, understandable and logical, there were a number of clear indications that he is suffering from a psychotic illness. These were exemplified by almost incoherent articulations regarding spirits, dead people, supernatural powers and, also, street drug related themes, indicating perhaps a deep knowledge of such substances as cocaine and cannabis.

It was impossible to ascertain if he was suffering from hallucinations. There was no obvious evidence of this. Nor was there any apparent abnormality of affect or cognition. His insight into his unusual beliefs appeared to be completely absent and his attitude towards receiving help, was entirely hostile. The interview concluded with PH making a clear invitation for MN to discuss his problems at a further date.

In Summary:

This young man is presenting with a history, and mental state examination, consistent with a paranoid psychotic illness, probably schizophrenia, associated with illicit drug use, leading to a year long withdrawal from society. Risk assessment did not reveal any pointers towards self-harm, or overt risk to

others, however, his attitude towards ourselves raised the likelihood that he will not engage with our service voluntarily, and that, furthermore, any forced treatment is likely to be quite violently resisted.

Interim Plan:

- *Await feedback from family, regarding possibility of further CPN/RMO, involuntary involvement.*
- *If this is unsuccessful, MHA Assessment, with Police involvement and Oakwood House downstairs/intensive care bed, to be arranged”.*

- 2.6.5 On the following day DC telephoned Dr M to say that MN did not want CMHT input but that the family was still working on this.

Good practice

There was a swift response by Dr M to the GP referral, an immediate attendance by Dr M at the home after MN had failed an OPA, an appropriate provisional diagnosis of paranoid psychotic illness, probably schizophrenia, a good assessment of anticipated non-compliance and a plan to discuss again. Dr M left DC with the task of persuading MN to co-operate and she felt confident enough to telephone Dr M twice – once the following day, and again a week later with her account of MN’s progress. Together this was excellent practice.

A full assessment letter

Dr M’s assessment letter to Dr B was a full account, although he did not refer to the comments in DC’s letter that MN thought he was married with children to the Queen and had cartoons and science fiction mixed up with the real world. This may not have seemed significant at the time because Dr M had written enough to conclude that MN was probably suffering from a psychotic illness.

2.7 S2 MHA medical recommendation says delusional beliefs

- 2.7.1 On 26 September 2000, nearly a month after referral to the GP, it had become apparent that efforts to encourage MN to co-operate with treatment had been unsuccessful and Dr M spoke to Dr B in order to make arrangements for MN’s assessment under s2 MHA, adding that he thought a police presence would be needed.
- 2.7.2 Dr B asked Approved Social Worker (ASW) JL to make the application and on 4 October 2000 JL liaised with Dr M and Aunt DC and obtained a s135 MHA warrant from Yate Magistrates. This permitted the police to enter his house.
- 2.7.3 On 5 October 2000 MN was made subject to s2 MHA. The Act requires that an application be made by the patient’s nearest relative or a social worker with two doctors providing medical recommendations. Section 2 of the MHA provides authority for a patient’s detention in hospital for 28 days for assessment, which may be followed by treatment.
- 2.7.4 MN’s mother was at first adamant that her son should not be taken from the home. She told us *“I just could not believe he had a mental illness. I just did not want my son being taken away in that way”*. DC explained *“There was a lot going on in [MN’s mother’s] head at the time and she could not take it in, but obviously being the aunty, one step away, it was easy for me to see”*. Dr M spoke to MN’s mother who was the nearest relative under the MHA and who needed to be informed about her right to discharge her son once he was subject to s2. He told her MN was psychotic, probably suffering from schizophrenia. She was very upset and tearful.
- 2.7.5 The application was made by JL who noted *“MN verbally hostile during.....assessment but no physical violence. MN resists accompanying police to ambulance and eventually hand-cuffed”*.
- 2.7.6 The joint medical recommendation was by Dr M and Dr B who together indicated that MN ought to be detained in the interests of his own health and safety but not with a view to the protection of others. Dr M wrote *“MN is acutely unwell, expressing a range of delusional beliefs, totally out of character from his previous character. He is functioning at a reduced level largely confined to his bedroom. He is completely insightful into his mental illness, which needs urgent assessment with a view to treatment”*.

Good MHA assessment

This was good management of the MHA assessment. The medical recommendations were provided by MN's own GP and a psychiatrist who already knew him. There was appropriate involvement of police at MN's home. The family's concerns were taken seriously and MHA papers were correctly completed

2.8 5 October 2000: S2 MHA out-of-area admission to Hillview Lodge, Bath

2.8.1 A lack of intensive care beds meant that MN was not admitted to his local hospital, which was Oakwood House at Blackberry Hill Hospital in Bristol, under the care of Dr M. Instead he was admitted to Balmoral Ward, a locked ward at Hillview Lodge, part of the Royal United Hospital in Bath, under the consultant care of Dr J. Dr J explained to the Inquiry that there were no written protocols or formal agreements for this arrangement. He added that Bath services were happy to have assisted in this way, since more often they had needed to rely on facilities in Bristol in such emergencies.

2.8.2 On 3 and 5 October 2000 Dr M faxed information about MN to Dr J. This consisted of Dr M's assessment letter to Dr B (the referring GP) and the legal s2 MHA admission papers. The medical records themselves were not transferred, and the letter from DC to Dr M describing MN's disturbed behaviour prior to admission remained on file at Yate CMHT, unseen by Dr J.

No transfer of medical records

Dr J told us that the admission from Bristol out-of-area to Hillview Lodge was an unusual arrangement for which there was no policy or procedure, even though both services were within the same NHS Trust. As a consequence Dr M's medical records were not transferred to Dr J. The letter from DC to Dr M sent on 12 September 2000 remained on Dr M's file and was never seen by Dr J who told he us was unaware of MN's belief that because he was king he owned the library and that he was married to the Queen and had children by her. Later on this becomes important, diagnostically. It was the first failure of information flow between the two medical teams.

Local Recommendation 1:

Healthcare records should follow the patient

A lack of intensive care beds

Nationally, it is not uncommon for patients to be admitted out of their area. They may have specialist mental health needs. Local facilities may not exist or be over-stretched. It is of concern that a lack of intensive care beds meant MN had to be admitted to hospital out of area and we make recommendations directed towards prevention and management of such situations.

Local Recommendation 2:

Management of out of area admission

2.9 'Marked psychotic symptoms': first PRN medication

2.9.1 Once in Hillview Lodge MN was nursed in seclusion for five hours and given an injection of neuroleptic medication which necessitated both control and restraint and the assistance of the police. Nursing notes stated "*Concerns re no. of knives owned by MN..... exhibiting marked psychotic symptoms*"

2.9.2 Dr J's Senior House Officer (SHO) noted "*..strong resistance, kicking, punching, kicked S/N on jaw threats ++. C&R used + secluded*". Her notes record two references to apparent delusions: "*saying he is king*" and "*believing he is a king*". The SHO gave her impression as "*Psychosis, given Dr M's view which is schizophrenia; dual diagnosis ..illicit drug use...possibly drug induced psychosis.; possibly affective component. Plan; Acuphase, Droperidol, Lorazepam*".

2.9.3 MN was seen for the first time by Dr J whilst in seclusion and he recorded "*compliant with interventions & appears to be appropriate to be nursed out of seclusion*"

- 2.9.4 MN was moved to the high care area where two nurses observed him at all times, and subsequently moved to the ward, nearly twelve hours after admission, where one nurse was allocated to observe him constantly
- 2.9.5 The same day, 5 October 2000, a Nursing Care Plan was completed by GL, his primary nurse. The Plan had a review date of 8 October 2000 and MN was described as presenting as grandiose and psychotic.
- 2.9.6 Part B of the Plan, entitled '*Assessment of the Potential for Violence*' recorded *"If MN is confronted with medication or about his mental state there is a high risk of violence"*. The '*Risk Assessment Screen*' at Appendix 2 under the heading '*VIOLENCE*' recorded ticks for *"...poor compliance with treatment, psychotic symptoms and irritability, anger, hostility, agitation or suspiciousness"* and *"...presenting as grandiose and psychotic and has become hostile and verbally aggressive toward staff regarding his detention on this ward"*. It stated *"Plan of action:- to monitor changes in behaviour that might end in violence...."*

Appropriate nursing admission procedures

Nursing admission procedures were appropriate and psychiatric assessment was prompt. MN received a speedy physical examination. MN was medicated on three occasions during his stay in hospital. This was the first occasion, and the extent of MN's resistance can be gauged by the need for police support to the nursing staff. At this stage there was general agreement upon a provisional diagnosis of psychosis.

2.10 Verbally aggressive, 'grandiose and psychotic': more PRN medication

- 2.10.1 On 6 October 2000, the day after admission, a drug screen was reported to be positive for cannabis and 'questionable' for cocaine, but a formal report on this sample ten days later was 'negative' for all illicit drugs.
- 2.10.2 MN was, according to the nursing notes, *"very defensive and angry - does not know why he is here. Talking about seeing Dead Souls - admitted to taking cannabis. Refusing medication at first but after a lot of persuasion accepted Droperidol and Lorazepam. Visited by family."*

MN accepts PRN medication

This was the second time MN received PRN medication and the only time he accepted medication voluntarily.

- 2.10.3 The following day, 7 October 2000, MN became very agitated when his family visited but refused PRN medication, which was not pushed because he already seemed sedated.
- 2.10.4 The Nursing Care Plan was reviewed the next day due to his hostile and verbally aggressive mood.
- 2.10.5 MN was verbally aggressive again the following day, 9 October 2000, when he was seen by Dr J who noted *"Has been relatively settled over w/e but when interviewed today became very angry about being here. Wanted to know exactly what had been said. When I explained some of the specifics, he expounded at length about telekinesis; psychokinesis; spirits; and a jumbled speech about molecules and their movement. Very angry towards members of nursing staff - threatening and abusive. CLOPIXOL ACUPHASE prescribed if necessary 150 mg stat."*
- 2.10.6 The Nursing Care Plan of the same day recorded *"presenting as grandiose and psychotic and has become hostile and verbally aggressive toward staff regarding his detention on this ward. MN appears to have no insight this is his first admission and he is neuroleptic naive." Plan of action:- to monitor changes in behaviour that might end in violence....to monitor signs of psychosis...to liaise with med staff about direction his plan of care will take"*.
- 2.10.7 GL also completed documentation concerning risk on 9 October 2000. Under the heading '*Assessment of the Potential for Violence*' he noted in the category '*poor anger control*' *"Yes...became angry at staff & doctor shouting and slamming the telephone down regarding his detention"*.

Dr J and nurses note signs of psychosis

During the first four days of his admission, and despite PRN medication, the medical and nursing records show that MN was very hostile and aggressive, refused hospital food, talked of seeing dead souls, said he was king and revealed disordered thinking about molecules, telekinesis and spirits.

2.11 Isolative with episodes of anger and thought disorder

- 2.11.1 On 10 October 2000 Dr J's SHO noted *"calm when having conversation about every day topics but will suddenly switch at the slightest provocation to denying that sees spirits, Hitler etc. When he starts talking about these subjects he gets angry and aggressive...then will switch quickly back to normal speech when distracted and relaxed."*
- 2.11.2 Nursing notes in the next few days record that MN was settled but isolative. At one point it was noted that there was no sign of psychosis. But on 14 October 2000 MN *"witnessed C&R on a patient and walked in between saying "cut him up with an axe". Told nurse to "fuck off"*.
- 2.11.3 The following day he was again quiet and isolative but *"met nurses gaze from inside his room and ran over to door with angry/suspicious expression on his face."*

A mental state examination should have been undertaken

Notes made by the SHO reveal the low threshold at which MN would respond to provocation with disturbed thoughts and aggressive behaviour, following which he was capable of switching quickly back to normal with no signs of psychosis. The angry episodes during that week should have resulted in a mental state examination and some attempt to understand the underlying reasons for MN's behaviour.

Dr M never knew about the 'axe' incident

Dr M told us he had never known about this incident as he did not receive Dr J's medical records and it was not mentioned in Dr J's discharge summary.

2.12 Aggressive and thought disordered: third and last medication - antipsychotic administered by depot

- 2.12.1 When the next day, 16 October 2000, Dr J saw MN for the third time he *"became immediately aggressive and verbally hostile necessitating use of control and restraint. Whilst being restrained depot given plus PRN..... verbally hostile so decision made to seclude him"*
- 2.12.2 Dr J's medical notes of the same day sum up MN's presentation on the ward at that time: *"has remained relatively settled whilst undisturbed. i.e. when allowed to spend long periods in his room he is not behaviourally disturbed. However, when asked even casual questions he quickly displays thought disorder - both of form and content. Refused Zuclopenthixol depot, denied need for any medication. Therefore after C&R given Zuclopenthixol depot and acuphase, Droperidol, Lorazepam and Procyclidine"*.
- 2.12.3 Dr J was aware, he told us, of the 'axe' incident. *"Through that week he had made statements such as that, that the nursing staff had felt that he was probably isolating himself rather as a way of coping with being on the ward and it was as a result of instances such as that that we gave him the depot medication.."*

Further antipsychotic medication expected in two weeks

Dr J noted that when permitted to remain isolated in his room MN did not show any obvious sign of psychosis, but if asked questions he quickly changed, becoming aggressive and displaying thought disorder. The dose given was not large. It would normally be expected to be repeated after about a fortnight. The medication chart notes that the same dose was written up for administration two weeks later, on 1 November 2000. In fact the subsequent dose was not administered and MN received his last medication on 16 October 2000.

2.13 'Less aggressive' and 'more settled'

- 2.13.1 In the four days following his anti-psychotic medication nurse notes record that MN spent most of his time in his bedroom. A nurse who compiled a report for the MHRT thought the antipsychotic medication had made MN less aggressive and also more able to engage in conversation about his mental state.
- 2.13.2 MN said doctors misunderstood about spirits and on 18 October *"claimed that had not spoken to dead people recently but if mother died today he would be able to see and speak to her straight away."*
- 2.13.3 At one point he refused a scan *"in a slightly aggressive manner"*.
- 2.13.4 Dr J's SHO recorded *"Still convinced about his beliefs in spirits, seeing Hitler as a child and molecules etc. Very fed up about being here..... Seems more fed up and less able to talk about "normal things" than a week ago'.*
- 2.13.5 In his evidence to the Inquiry Dr J said that MN had improved after he had had his depot medication.... *"He had had two previous....longer term Acuphase injections prior to that, which had not had a huge difference one way or the other, but from the middle to late part of October onwards he appeared to be calm, more settled, clearer in his thoughts, able to put many of his odd thoughts in the past..."*

MN calmer following medication

MN became calmer with reduced aggression and an improved ability to talk about symptoms, which he put in the past. This would be consistent with a psychotic illness that was beginning to respond to medication.

2.14 20 October 2000: MHRT does not discharge

- 2.14.1 MN decided to appeal against his detention under s2 MHA and on 20 October 2000 his application was heard by a MHRT, attended by MN, his mother and her sister DCr.
- 2.14.2 Dr J's undated report for the Tribunal stated *"MN has been reported to have been behaving in a strange fashion over the last 12 months. He has become increasingly isolative and has spent prolonged periods in his bedroom.....has expressed beliefs to his family that he has special powers of telekinesis and psycho-kinesis.....He has also expressed the belief that he can have conversations with dead people specifically Hitler, and members of his family (now deceased). He does not have any recognition that these are odd beliefs but believes them to be quite normal and appropriate.....he has kept himself isolated in his room for the vast majority of his stay and has avoided contact with staff and other patients. On direct questioning he is able to be initially appropriate but very quickly becomes defensive about his strange beliefs which pour forth in a stereotyped and frankly disordered fashion.....We initially observed MN in an un-medicated fashion but on Monday 16 October felt that it would be sensible to carry out the rest of his assessment with anti-psychotic medication in his system and therefore forcibly administered Zuclopenthixol Decanoate 200mgs. Once again this required full control and restraint.....I would consider it likely that he is currently suffering from a psychotic illness which has not responded to a simple un-medicated admission. I would consider it will be necessary for MN to stay in hospital to assess the effect of further medication on his state of mind"*.
- 2.14.3 The Social Work report was completed by LMCC who met MN and spoke to his mother for the first time and who wrote *"MN's mother, the nearest relative, stated that MN presents as normal apart from when he talks about spirits or atoms and molecules.....She said that he does have some knives and a pistol with the insides removed but she has never felt threatened by him. Despite this she feels that MN needs to remain in hospital for treatment. My opinion is that he should remain in hospital, if need be, under section until his mental health has improved"*.
- 2.14.4 The Nursing Report by GL stated that MN *"...was exhibiting marked psychotic symptoms such as grandiose delusions believing that he is a king....MN....was medicated. Initially he remained settled on the ward but gradually as the medication began to lose its effect he again became psychotic, talking about spirits, talking to dead people and on one occasion mentioned wanting to put an axe through someone's head. He spends most of his time isolating himself in his bedroom engaging little with staff*

or fellow patients.” It added that the anti-psychotic medication on 16 October 2001 “made him less aggressive and able to engage in conversation about his mental state...”

- 2.14.5 MN’s mother made her own written submission to the Tribunal stating *“most of the time MN appears normal in every way. It is only now and again when he says strange things, which I know are not right and I have concerns. MN is a lovely son. He is not violent in any way, even though he had knives in his bedroom. They were only used for his hobbies: fishing, army cadets, camping. As far as I’m aware, he has never done any harm with them”.*
- 2.14.6 The Tribunal did not discharge him, giving as their reasons that Dr J proposed *“to assess by observation his response to medication...and to carry out tests”.*

MHRT decision typical for a first episode of psychosis

Reports for the Tribunal and the Tribunal Decision were based upon the likelihood that MN was suffering from a psychotic illness requiring treatment with anti-psychotic medication, which the nursing report said had been effective in reducing aggressive behaviour and making MN more able to engage in conversation about his mental state. This would have been a very standard approach with a first episode of psychosis.

Dr M did not see Tribunal documents

Dr M never saw any of the documents provided to the Tribunal or the Tribunal decision because the medical records were not transferred to him.

2.15 ‘A lot of progress’ and ‘no psychosis’

- 2.15.1 In the days following his Tribunal MN continued to isolate himself in his bedroom and was uncommunicative. No aggressive episodes and no psychotic behaviour were recorded. Nursing notes commented *“Isolative as usual only giving one word answers where possible”* and *“Still uncommunicative unless he needs something.... extremely isolative”.*
- 2.15.2 Dr J’s SHO, on 23 October 2000, wrote that he was not very willing to talk but was *“Not challenged today about beliefs and did not talk about them spontaneously”.*
- 2.15.3 Two days later nurse reports noted that he was still isolating himself and it was difficult to assess his mental state due to his reclusive behaviour, adding *“He speaks when spoken to with no evidence of psychosis”.*
- 2.15.4 The day after, on 26 October 2000, nurses again noted *“Remains extremely isolative. No psychotic behaviour observed due to MN’s isolation”*
- 2.15.5 Dr J told the Inquiry that in the period of two weeks after the depot Clopixol MN had made *“a lot of progress”.*

Little evidence of a lot of progress

There was little evidence to support Dr J’s opinion that there had been a lot of progress following the depot anti-psychotic medication. Nursing notes indicate he had been isolative and as a direct consequence of that had not been challenged about his beliefs, and no evidence of psychosis had been observed.

2.16 Detention under s3 MHA on the basis of psychotic illness

- 2.16.1 MN’s s2 was due to expire at midnight on 1 November 2000. On 30 October 2000, Dr J saw him – for the fourth (excluding the MHRT hearing itself) time - in a ward round and noted *“Plan Transfer to Bristol, S2 lapses 2/11/00.....Dr J to speak to Dr M”. The nurse notes added “no expression of thought disorder.....Dr J left ward before decision on medication was made”.*
- 2.16.2 On the morning of 1 November 2000 social services was asked to carry out an urgent MHA assessment. JM, an ASW, made contact with Balmoral Ward staff, establishing that MN had had a ‘tester’ depot earlier in October and the plan was for further treatment with Zuclophenthixol Decanoate.

- 2.16.3 As with s2 MHA, a social worker will usually make the application for s3 and two doctors are required to give medical recommendations. S3 provides authority for detention in hospital for six months for treatment.
- 2.16.4 JM then made contact with the nearest relative, MN's mother, who told us *"it was panic stations that day"*. She told us she had understood that as nearest relative she could object to the s3 and she had felt undecided about it, wondering whether instead she might have MN home. This was confirmed by JM who noted that MN's mother changed her mind during the day. JM first recorded *"Although she doesn't object she wanted to talk to Dr J to make sure that the treatment her son would be given would not have any side effects"*. Later JM spoke to DC who said MN's mother was wondering whether to have MN home. Finally, JM noted *"She is still undecided, she feels that she has a lot of responsibility for her son....eventually said she would not object"*
- 2.16.5 In her evidence to us MN's mother explained her reservations. She said she had not known what to think. She thought the admission had been *"a waste of time"* because she believed they were not currently giving her son any medication. Although she knew he had had medication on 16 October 2000 no-one, she told us, had explained depot medication and she had not realised that it would have had some therapeutic effect for two weeks after that.
- 2.16.6 MN's mother added that she had only agreed to s3 because Dr J had assured her MN would be medicated. Dr J, in his evidence to the Inquiry, disagreed that this had been the basis of her agreement to the s3. We consider the family's views on medication further in Chapter 4.
- 2.16.7 The intention to medicate MN was confirmed by Dr J in his medical recommendation for s3 dated 1 November 2000 where, having seen MN for the fifth time, he stated *"MN displays a change of personality and behaviour and expresses paranoid delusional beliefs. These are characteristic of a psychotic illness which requires antipsychotic medication."* And under Reasons *"MN lacks any insight into his condition and refuses any medication. He has declined any treatment at all on an informal basis"*. Dr J indicated on the form that detention was necessary for MN's own health and safety but not for the protection of others.
- 2.16.8 The second medical recommendation by Dr C, a S12 approved doctor², said *"This young man has psychotic symptoms. He has expressed the view that he is king and has also threatened violence. He has no insight into his illness and will not accept medication."* Reasons: *"He is not willing to accept medication and is not prepared to stay in hospital voluntarily"*. Dr C indicated that detention was necessary for MN's own health and safety and 'with a view to the protection of other persons'.
- 2.16.9 When JM spoke to MN that day *"he said very little, however when questioned about previous drug use, he had pressure of speech and started talking about molecules etc..."*
- 2.16.10 The nursing notes also say *"In his assessment MN showed no sign of mental illness, just some odd ideas regarding the transfer of molecules."*

An unremarkable response to psychotic illness

In the opinion of two doctors MN displayed psychotic symptoms. This was the basis of his detention under s3 MHA. Up to that point it was an unremarkable response to an acute psychotic illness.

Nearest relative agreement to s3 MHA

MN's mother gave evidence that Dr J told her he would prescribe medication for her son, and it had been for this specific reason that she had agreed to the s3. Dr J informed the Inquiry that he disagreed this had been her reason. It would obviously have been helpful if there had been a record of the discussion between them. The social worker's notes do record that MN's mother wished to discuss medication with Dr J in order to ensure treatment would not have any side-effects, and of course Dr J's own medical recommendation stated that s3 was for the purpose of administering antipsychotic

² Approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder under s12 MHA 1983

medication. At the very least the agreement of MN's mother would seem to have been in the expectation that her son would receive medication.

No discussion with Dr M prior to s3

It would have been sensible to discuss assessment under s3 with Dr M, as Dr J had planned to do. Dr M had given one of the medical recommendations under s2 and was expecting to have MN's care transferred back to him at some stage. It would have been good practice if he had provided the second medical recommendation.

2.17 Isolative, relaxed and settled

- 2.17.1 From 1 November until 11 November 2000 medical and nursing notes stated that MN was isolative, relaxed, settled and pleasant on approach. Although there was no spontaneous conversation he responded to questions with *"no overt evidence of psychotic behaviour"*.
- 2.17.2 Dr J told us *"..by the beginning of November he was to all intents and purposes behaving quite normally on the ward.."*

2.18 The decision not to medicate

- 2.18.1 Although in his s3 medical recommendation Dr J expressed an intention to continue with anti-psychotic medication, MN received no more medication, in hospital or at home. Depot zuclopenthixol decanoate, written up for administration on 1 November 2000, was not given.
- 2.18.2 The nursing notes for 2 November stated *'Dr J phoned and will discuss the depot with MN before it is given'* and on 3 November *'Dr J is planning a meeting with staff and MN on Monday (6 November) re medication and future care planning'*. There is no record that MN was seen on that Monday and Dr J told us *"I think I didn't discuss it with MN and that I decided in absentia, as it were, that I would not give him a depot."*
- 2.18.3 However there was an intention to speak to MN's mother and Dr M. The nursing notes for 6 November recorded *'There was a meeting between Dr J and nursing staff this afternoon to discuss future management of MN. Dr J feels that before further treatment options are considered there needs to be a meeting convened with MN's mother and Dr M invited as there seem to be some discrepancies between assessments made prior to admission and his presentation whilst on Balmoral.'*
- 2.18.4 Asked what he understood the discrepancies were Dr J told us he took this to be a reference to the *"differences between how MN was at home and on admission and how he had been whilst on the ward."* He added that MN had been *"..preoccupied with occult features, with a strange book on the occult which his mother brought in, with a video which his mother brought in as well, both of which were being seen as being indicative of mental illness. I read both the book...A Chemical Love Story.... and watched the video...a Swedish art film.....neither of which I felt were....very convincing, certainly not psychologically relevant....we felt there might have been an overreaction to the video and the book.."*
- 2.18.5 Dr J's secretary left a message for Dr M saying there was to be a meeting on 13 December 2000.
- 2.18.6 MN's mother told us that on 6 November 2000 a nurse had said to her *"Dr J wants a word with you soon but he never came."* In fact MN's mother visited MN on 6 November 2000 and asked nursing staff if she could take her son out of hospital for a few hours in a couple of day's time. She described MN as *"normal"*. Nursing staff indicated they would discuss the mother's request with Dr J the following day.
- 2.18.7 Leave accompanied by a family member was duly authorised by Dr J and MN went out shopping with his mother on Wednesday 8 November 2000.
- 2.18.8 When Dr J's SHO saw MN on 10 November 2000 she recorded *"relaxed and calm, went into Bath with mother yesterday. Waiting to go out today. Waiting for Dr J to speak to mother for further plan"*.

2.19 Dr J considers possible diagnosis of schizotypal disorder

- 2.19.1 Dr J told the Inquiry he began to reconsider his approach to diagnosis and treatment of MN just after his detention under s3 MHA, "round about 1st or 2nd November".
- 2.19.2 He said *"The diagnosis (of schizotypal disorder) arose in the context of MN's improvement following on from the Tribunal which was four days after the depot. He had a depot medication on 16 October and four days later was the tribunal and ten or eleven days later after that there was the section 3 assessment, at which point..... it was my clinical impression that MN had a psychotic illness. That was the purpose of the section 3 and that was fine. Having done that, and looking back, reviewing the previous two weeks, during which MN had been considerably improved..... and with....the safety net of being on a section 3 what I did not want to do at that point was to rush straight in and simply continue to medicate..... [MN] had made a lot of progress in the previous two weeks.... the florid positive features of what I categorised as a psychosis initially appeared to have abated and.... in my experience that was surprising given the very small amount of medication that he had had at that point and it was my impression clinically that the aspect..... of his care and treatment that had probably been most helpful to MN was the removal from home, a placement in a calm, secure environment, decreasing arousal, that although it would not be inconsistent with a stress vulnerability model of psychosis it would also fit in with a non psychotic or a brief psychotic presentation"*.
- 2.19.3 Dr J added that he mulled over the idea of schizotypal disorder *"and looked back at MN's presentation and thought actually that is not inconsistent with MN's presentation so far and would explain a number of the features and would also explain what I considered at the time to have been an improvement, predominantly without any antipsychotics although one can obviously discuss that or argue the case on that. So that was the first time that I had thought of the diagnosis"*.
- 2.19.4 In evidence Dr J told us that the improvement in MN to which he had alluded was that MN *"clearly became much less ill. He was, if not a model patient, he was a very quiet and compliant patient"*. His beliefs about being a king and communicating with spirits became something he said had happened in the past. He said he would now claim benefits and went on to do so.
- 2.19.5 Dr J said he had not realised at the time that MN also believed he was married to the Queen and had children, and owned the library so he was not returning library books.

Psychotic illness the most obvious explanation

By this time MN had been in hospital for four weeks. At the outset there had been agreement between all professionals that MN was suffering from a psychotic illness. During the first two weeks PRN medication had calmed him somewhat, though when questioned he would quickly become aggressive and thought disordered. In the subsequent two weeks, following depot Clopixol, MN became reclusive, less aggressive and more able to talk about his mental state with fewer signs of psychosis. Dr J thought MN made a lot of progress in those two weeks though he was still showing sufficient psychotic symptoms to justify s3 on 1 November 2000. The most obvious conclusion from the pattern of the first four weeks in hospital is that MN was suffering from a psychotic illness and that anti-psychotic medication had brought about a lessening of psychotic behaviour and associated aggression.

Schizotypal disorder less common

Yet instead of the obvious diagnosis Dr J began to consider the less common diagnosis of schizotypal disorder. This is thought to be a form of personality disorder that does not usually benefit from treatment with anti-psychotic medication. It is puzzling that when MN had made more progress than expected after medication a decision was made not to medicate.

A clinical turning point

This was a clinical turning point which introduced a largely untested differential diagnosis immediately before MN's discharge on leave and transfer back to Dr M and the care of his family at home. The clinical aspects of this differential diagnosis are considered in more detail in Chapter 5 of this report. Here we identify the following practice and procedural weaknesses:

- Unknowingly, Dr J made his decision to stop medication without having seen important diagnostic information. Since he did not have sight of Dr M's medical records he did not see the letter written

by DC to Dr M mentioning MN's various delusional beliefs including that he was King, owned the library and had children by the Queen – each suggestive of psychosis. He should however have requested the records from Dr M.

- In the absence of pre-admission information from Dr M's medical records Dr J should have taken a full history from the family.
- No meeting was convened with MN's mother, who told us she had understood her son was to receive medication. As the nearest relative she had the legal right to discharge the section (unless barred from doing so by the RMO) and she told the Inquiry she would have exercised that right had she realised there was a change of plan and her son was not going to receive any medication. Good practice should have dictated that she be involved in any discussion of a proposed change to her son's treatment. She or another family member visited the ward almost every day. At the very minimum she should have been told of the revised plan.
- It appears that major diagnostic and treatment decisions were made by Dr J alone. For reasons of professional courtesy as well as good practice Dr J should have shared with Dr M his thinking about a changed diagnosis and treatment plan before MN was given extended home leave.
- All these important loose ends could and should have been tidied up and dealt with by the convening of a prompt CPA meeting as soon as Dr J had begun to re-consider his diagnosis.

2.20 Aunt reports MN laughing incongruously

- 2.20.1 The first mention for some time of behaviour which could be symptomatic of a psychosis came on 11 November 2000, when MN's aunt, DC, reported to nurses that MN had been laughing incongruously whilst out on leave in the town. He also complained that everyone was looking at him when his mother had taken him to the pub on his leave that week.
- 2.20.2 This was followed by nurse entries over the next few days indicating that MN was settled but with poor or minimal interactions.
- 2.20.3 DC told the Inquiry that when they took MN out from the hospital they noticed that *"he would smile but it was not a normal smile. Sometimes he would laugh at nothing"*.
- 2.20.4 Although there is no note of it in the medical records, a nurse recorded that MN was seen briefly on 13 November 2000 by Dr J and the Ward Manager who reported poor interaction. This was the sixth time MN had been seen by Dr J.
- 2.20.5 The s17 leave form lapsed on 15 November 2000.

2.21 In an aroused state on transfer to Caernarfon Ward

- 2.21.1 On 17 November 2000 MN was seen by Dr J's SHO who wrote *"Not eating well as doesn't like the food here....has been out with mother a few times...gone well...relaxed and settled.... Awaiting further plans ?transfer to Caernarfon/Oakwood".*
- 2.21.2 MN was permitted by staff to go out with his aunt for two hours, although this was not authorised by s17 leave, and that afternoon MN agreed to transfer to Caernarfon Ward.
- 2.21.3 MN had been on Balmoral Ward Intensive Care Unit (ICU) for six weeks. According to Dr J, this was not because he needed to be there but because there were no beds on any of the open wards until then.
- 2.21.4 On arrival he initially walked off Caernarfon Ward in an aroused state until a single room was found for him. Nursing staff had not thought him thought disordered, just angry.

2.22 Observed talking to a window

- 2.22.1 The following day nursing notes recorded *"Observed having a 10 min conversation with a window, seen moving the window in different positions while talking to it and laughing loudly....later absconded from the ward at full flight towards the bus-stop, returned three minutes later"*.

- 2.22.2 Dr J told us *"..it was just after he had moved to an open ward, to a different room with different people around him and my explanation, my understanding of that at the time was that it was a reaction to the stress that he was under going from one to the other....it was a limited and discrete episode which was not then repeated at all.."*

Should have been further examination of mental state

It was now a month after MN had received anti-psychotic medication. Any therapeutic effect would have been rapidly diminishing and MN might also have been in a state of arousal brought about by a change of ward. The cause of the incident where MN was observed talking to a window should have been more thoroughly explored to establish whether it was a delusional episode.

Dr M did not know of the episode of talking to a window

This episode was never known to Dr M because the details remained on records at Hillview Lodge.

2.23 Still no plan as to management

- 2.23.1 On 20 November 2000 at a Ward Round Dr J saw MN for the seventh time. He authorised half an hour of unaccompanied s17 leave twice daily and 3 hours of accompanied leave with his family daily.
- 2.23.2 Dr J's SHO noted *"Has reportedly been talking to window and video. No complaints. Still no plan as to management"*.
- 2.23.3 The nursing note of the same ward round stated *"Dr J will phone mother to arrange CPA to arrange a plan of action as she is reluctant to have MN but on medication"*. Nurse DS who wrote this entry gave evidence that she could only vaguely remember MN, but did recall talking to his mother *"quite a bit"*. Although she could not remember making the entry in the notes she told us it *"was meant to convey 'put on medication'. I sometimes used the term 'but' in this manner, particularly if I was in a rush"*.
- 2.23.4 MN's mother told us that Dr J had not talked to her about medication after 1 November 2000 and, although she wanted her son to have a choice between depot and tablets *"I was under the impression he was just going to give MN a depot injection"*.

No care planning

On 20 November 2000 no plan for MN's future care was known to nursing staff, SHO or the family. In the three weeks since detention under s3 there had been no mention in the medical records of diagnosis or medication. The SHO had noted on 10 November 2000 *"Waiting for Dr J to speak to mother for further plan"* but by 20 November 2000 this had not been done and the SHO noted there was *"still no plan as to management"*.

Dr should have discussed diagnosis and treatment with his clinical team and the family

Nursing and medical notes give the impression that Dr J's plan of action was dependent upon further discussion with MN's mother on the subject of medication. But that contradicts Dr J's evidence to the Inquiry that he had already decided not to medicate on the basis of a possible changed diagnosis. It was poor practice that he should have informed no-one of his private view as to diagnosis and medication, leaving his own SHO wondering what was to happen. Although he intended to do so, Dr J did not telephone MN's mother to discuss medication or arrange a CPA meeting.

Dr J should have kept an open mind about diagnosis

In fact there was enough information to keep a very open mind about the continued possibility of psychotic illness. The family had reported to nursing staff that he was laughing incongruously and Dr J was told at the meeting of MN's conversation with a window, both suggestive of psychotic phenomena. Dr J did not make mention of any of this in his discharge summary and Dr M remained unaware that in hospital MN had talked of wanting to put an axe through someone's head and had been seen having a ten minute conversation with a window.

Poor communication with the family over daily s17 leave

The s17 leave form refers to 3 hours of leave daily for MN with his family, but MN's mother told the Inquiry that she had understood he had 2 hours leave. She or her sister DC used to try to take him out most days. They only discovered when they saw the notes afterwards that it had been 3 hours with them and half an hour alone. This suggests poor communication with the family by nursing and medical staff.

2.24 Verbally aggressive

- 2.24.1 On 21 November 2000 Nursing Formative Evaluation notes record *"[MN] not interested in talking to anyone when I spoke to him as allocated nurse denied any problems/worries when asked. Sat in seminar room watching video."* The next entry has been changed with 22 November crossed out and replaced by 21 November. It reads *"Verbally aggressive when asked to move from single room to dormitory. Became very abusive making personal comments and threatening towards myself calling me 'fucking old hag'.....Aunty present in room at the time"*. Both entries were completed by Staff Nurse C.
- 2.24.2 MN's Aunt DC recalls that this incident occurred not on 21 November but on 22 November 2000. She described the occasion to us *"What happened was this, I took fish and chips actually for MN for his lunch and we opened up the smoke room or lounge area and there was smoke billowing out, so he said 'Oh, come on, let's go in my room. You're not supposed to be there really.', so off we went and he was eating his dinner and we were talking..... The next minute, the door just burst open..... they were surprised to see me in the room. Because obviously I should not have been there. They said 'Oh, who are you?' and I explained. Then they ignored that and said to MN 'We've come to move you to a mixed dorm ward'. I could not believe it, because I thought 'Hang on, he's been ill'. His own bedroom at home had been his own world for 18 months or so. Anyway I just left them to it."*
- 2.24.3 DC added *"I think they literally would have picked his stuff up there and then actually and moved him to a mixed dorm, which was across the corridor. Obviously, MN was not going to have any of this and called them names and things like that and then, as she was leaving, she said 'Oh, that's how you feel about it, is it?' She said 'We'll see about that then', and I thought 'Well, that seems an odd thing to say'. And off they went. I think I even said to MN, 'I don't know what they think they're going to do then, [MN] – throw you out?' I think we just had a bit of a laugh and that was it".* DC added that she thought the nurse said they needed the bed for a lady patient.

CPA meeting was held on 22 November 2000

Because the family has, in the context of a complaint against the Trust, disputed the timing of events between 21 November and 23 November we have examined the evidence carefully and in some detail. We have concluded that the aggressive outburst described above occurred on 21 November 2000 and the CPA meeting we shall describe below took place on 22 November 2000. MN went home on 23 November 2000.

2.25 An impromptu CPA meeting

- 2.25.1 The evidence persuades us that it was on Wednesday 22 November 2000 that an unplanned CPA meeting took place, attended by MN, Dr J, Nurse LD, MN's mother and DCr at which it was decided that MN would be given indefinite s17 leave and returned home. He went home the following day.
- 2.25.2 There were many ways in which this CPA meeting was unsatisfactory and we shall describe some of the events of the day in the words of MN's mother and Aunt. However, prior to that we examine the evidence as to the date this meeting actually took place. The family had made a personal diary note at the time that it was on 23 November 2000 and, following investigation of the family's complaint after the homicide, the Trust agreed with them. Our findings below are at odds with this. We have taken some trouble to ensure that we have investigated this thoroughly not only because we have reached a different conclusion to the complaint investigation, but because it had been suggested by MN's family that the completion of dates in records had at best been sloppy, and at worst that there had been concealment. We also simply wished, as far as possible, to present an accurate picture of events in our Inquiry report.

- 2.25.3 In an entry in the medical records signed and dated 22 November 2000 Dr J's SHO noted *"Got very angry yesterday when asked to move into dormitory from single room. Says he didn't want to move into a room w. 'mental patients'. Still claims that there is nothing wrong with him. Remains monosyllabic and not interacting at all. Mother coming in at 12 to take him out for the afternoon.... Awaiting CPA"*. There are no further entries in the medical notes for that day, the CPA meeting itself not having been recorded in the medical notes. However, the CPA Care Plan itself was completed, signed and dated 22 November 2000 by Ward Manager LD and countersigned twice by Dr J. Dr J also completed and signed a s17 leave form dated 22 November 2000 authorising home leave.
- 2.25.4 In order further to clarify the date of the CPA meeting we asked Dr J for his diary records of 22 and 23 November 2000. He was able to assist us with a photocopy of his personal diary entries for the week along with a Trust clinic sheet for the 23 November. This shows, in his own words, *"that I saw patients between 9.30 and 5.00 on 23 November at the Swallows CMHT base which is at Paulton, 12 miles from Bath. The sheet shows that all but one of the patients attended, so the conclusion is that I could not have been at Bath at all on that day"*. We confirm that the clinic sheet shows he saw twelve patients in Paulton and we accept that he would not have been able to attend at Hillview Lodge that day. On 22 November he records that he had cancelled some commitments in the afternoon but saw a patient at Hillview Lodge at 2.30pm. He wrote to the Inquiry; *"I was at RUH from 9-10, and Hillview Lodge from 2.30-3.30. This means that I could have taken part in a CPA for MN any time between 10.30 and 2.30, or 3.30 and 5.00."* We understand that this information had not been seen or requested by the Trust when they investigated the complaint.
- 2.25.5 There were four separate nursing entries dated the 22 November 2000, signed by three different nurses. The Nursing Formative Evaluation (Daily) note completed by Nurse HH recorded *"CPA this am. [MN] will be going on indefinite leave. This afternoon he has been isolating himself socially"*. A nursing Observation Chart signed and dated by Nurse SH recorded that between 2-3pm MN was *"in CPA"* and after 4pm is written *"DISCONTINUE ON EXTENDED LEAVE"*. The last entry in the Nursing Formative Evaluation (Daily) notes written by Nurse W reads *"note; In bed on handover. Appeared asleep on all rounds"*.

A consequence of the poor planning of the CPA meeting

Six different professionals signed entries in records dated 22 November 2000 indicating that the CPA meeting took place that day and MN was still there that night. None of the notes are precisely timed and it is impossible to know exactly when the meeting took place, but Dr J's private diary entries and clinic records confirm that he could only have been at Hillview Lodge on 22 November 2000. We are sufficiently satisfied by the evidence to conclude that the CPA meeting took place on 22 November 2000 and that there was no concealment. It will be seen from the comments of the family below that MN's mother returned to the hospital for her son the following day, 23 November 2000. It should not have been so difficult to establish the date of the CPA meeting. Had the meeting been set up in advance, there would have been a note of it in Dr J's diary, everyone would have known what time it was to take place, MN's mother would have been informed and DC may also have been able to attend. This is an indication of the weakness of the CPA arrangements and the unsatisfactory nature of impromptu arrangements for s17 leave or discharge.

- 2.25.6 MN's mother recalled that she had not been told there was to be a CPA meeting that day. She and MN's Aunt DCr had taken MN into Bath town centre and returned him to the ward at about 2pm. Afterwards they were walking away when she was called back by a nurse to speak to Dr J. DCr had said she couldn't wait because of the need to collect children from school, but they were told it would not take long. MN's mother wrote in her evidence to the Inquiry that they were taken to a room *"where they were waiting for us, they told us MN can come home, this came as a complete shock"*. She added *"I was in the middle of decorating MN's bedroom..... we went back in the evening of 23 November to collect him. We could not take him at the time the doctor wanted us to because we had to go and collect DCr's children from school and there was not room in the car anyway"*. In her oral evidence she told us *"I said 'I will have to come back tomorrow for him'. I said 'We can't take him now. We can't wait'. Then we said 'We'll come back on the night to pick MN up'"*.
- 2.25.7 At that moment it was the practicalities which sprang instantly to her mind. She said that *"as soon as MN was sectioned I changed everything in his bedroom, skirting, the lot – new doorframe"*. His room

was not ready for him to return to. Dr J told us he could not recall being told that MN's room was in the middle of being decorated.

- 2.25.8 Describing her recollections of that day to the Inquiry she told us *"I was beginning to accept that MN was really ill, because they kept saying they were going to treat him"*. She had started learning about the illness, reading up on information leaflets which had been sent through to her. When she was told he could go home she was *"totally stunned and shocked"* and *"did not know what to think. One minute he was ill, the next minute they were sending him home"*.
- 2.25.9 She said she had agreed to s3 on 1 November 2000 because she was told her son would receive medication. Had she known he would not receive medication she would not have agreed to the section; *"In one way I wanted him home, but I could not believe he was being sent home because if I knew at the time, on thethe 1st November...what I knew on the 23rd November, I would not have had him re-sectioned on 1st November because they did nothing with MN at all"*. In his evidence Dr J disagreed that this was the basis of her agreement to the s3. We discuss the family's views on medication further in Chapter 4.
- 2.25.10 MN's mother told us that at the CPA meeting *"I could not get it out of my head that he had not been treated after all that"*. *"That was the idea: compulsory medication if he refused oral medication"*.
- 2.25.11 She did not ask why he had not received more medication and said there was no discussion about what would happen if MN refused to see anybody again. There was no arrangement that anyone would contact her. She was told if he got worse there would be a bed available, but she said that afterwards neither she nor DC were sure who they should contact. They did not know who the Consultant would be – DC thought it could be Dr J, and MN's mother thought Dr M. MN's mother said she knew the s3 was still in existence when he came home but did not understand what s17 leave meant. AB, Advice Worker at Rethink, told us she was *"absolutely"* sure that when DC had spoken to her at the time she had not known what s17 leave was.
- 2.25.12 MN's mother said the CPA meeting lasted about 10 minutes. DC described how it was very awkward because MN was present too *"he felt that all we wanted to do was keep putting him into hospital and now he had this chance of being sent home I did not feel free to say anything..... I felt I would be betraying him"*. They were not given the opportunity to speak to the doctor or nurse alone.
- 2.25.13 On the subject of risk MN's mother said the only worry she had about her son coming home was *"Just that his bedroom was not done up really. I never had no concern. I was never threatened by MN or anything like that. I did not feel threatened"*.
- 2.25.14 Prior to the meeting MN and his mother had been out into Bath and he had been *"his normal self"*. They had been in good spirits on their return. MN's mother told us it was possible Dr J might have believed she would be happy to have her son home because she had told him so on 1 November 2000 at the s3 assessment but, she said, Dr J should also have remembered that she changed her mind on that occasion because he had said he was going to treat him. From the mother's point of view, without treatment there would have been no reason for him to remain in hospital either on 1 November or on 22 November 2000.
- 2.25.15 Going home in the car, DCr told us, she and MN's mother agreed that he should not be coming home, but it did not occur to either of them that they could try to stop it. DCr explained *"I have never been in that situation before so I did not know if it was procedure, that that is what happened, it was a bit of naivety really, because I did not really know"*.
- 2.25.16 Dr J told us that he felt schizotypal disorder was *"a likely diagnosis"* at the time of the CPA meeting but he had not raised it with MN's mother *"because there was the debate, disagreement, about what the diagnosis was, I had been deliberately cautious about even talking about a differential diagnosis at that point"*

No mention of diagnosis or medication at the CPA meeting

There was no mention of diagnosis or medication at the CPA meeting, even though MN's mother had explained her reservations about medication and about having her son home just two days previously at a ward round. Clinical decisions made at the meeting did not take into account the opinion of Dr M, who was expected by Dr J to share the care of MN in the short term and take over his care in the longer term. Nor was there any consultation with, or notification of, MN's GP who might find himself involved with any crisis once MN was at home.

Poor investigation of family support

Like many relatives, MN's mother gave evidence that she found it difficult to express her opinion at meetings in front of her son. In a situation such as this it would have been appropriate to speak to MN's mother alone. In fact, her views should already have been established. There had been no shortage of opportunity to do this since she visited the ward almost every day. Yet there was no record of any attempt to inquire into the family relationships, including that between MN and his mother. She was relied upon to give a dispassionate view of her son's possible return home but she was closest to the situation and least able to acknowledge MN's mental illness. Had a planned CPA meeting been held, the family might have been able to represent their views more clearly. DC, who had been the family spokesperson prior to admission, might also have been able to attend.

2.26 The CPA Care Plan

- 2.26.1 A CPA Care Plan form recorded that the CPA meeting took place on 22 November 2000 and was attended by Dr J, MN's mother and Nurse LD. This was the eighth occasion MN had been seen by Dr J.
- 2.26.2 The form was completed by LD and signed twice by Dr J, indicating he was both the RMO and the Care Co-ordinator, stating in his latter capacity that the Care Plan had been agreed and explained to the user and carer. Despite this the form says elsewhere that the Care Co-ordinator is yet to be allocated and specifies "*community nurses*" as the agency.
- 2.26.3 The form indicated that of three possible 'levels' of CPA; minimal/complex/multidisciplinary, MN was subject to the multidisciplinary level of CPA.
- 2.26.4 A tick indicated that MN was subject to s117.
- 2.26.5 Follow up was to be "*arranged via Dr J who will see MN on 1/12/00..... CPN to be allocated – visit & support whilst on leave.... TO BE ALLOCATED BY CMHT YATE*".
- 2.26.6 In the section headed '*If User declines service/fails to attend for treatment or meet other commitments...Action to be taken*' was written "*Consultant to be notified...by GP, CPN, family*". There was no 'what to do in a crisis' contingency plan included on the form.
- 2.26.7 'Carer comment' was given as "*Mum does not see much change in MN since admission*".
- 2.26.8 A s17 leave form was signed by Dr J authorising "*indefinite*" leave to MN's home address, the authority to lapse on 1 December 2000.
- 2.26.9 LD told us that once the form had been completed she would have handed it to her ward administrator whose task it was to copy it to all those people named in the circulation list on the form. They were the GP, Consultant, User, Relative and CPN. At this stage it was not expected that a social worker would be involved and so the CPA form was not sent to social services and LMcC never saw the form. MN's mother said she received a copy on 30 November 2000. SL, Locality Co-ordinator Yate CMHT, told us she had not received a copy and indeed did not see the CPA form until after the homicide. This is despite the fact that we have been able to see a faxed copy of the CPA form dated 28 November from LD to SL with a note reading "*copy of CPA as promised*" and LD confirmed the handwriting was that of her ward administrator. SL thought that the form would probably have been picked up by the Yate CMHT secretaries and been passed straight to Dr M because of his previous involvement with MN.

Unfortunately, Dr M does not recall seeing the form either, telling us he had not seen it until after the homicide.

- 2.26.10 The CPA form was not sent to anyone responsible for administering the CPA register at Hillview Lodge or in South Gloucestershire and MN's name was never entered onto any CPA register.
- 2.26.11 Although it is not dated a handwritten note from Dr M's secretary to Dr M asks him to contact DC. It appears that it was written after the CPA meeting and it reads "family not happy that Dr J is discharging MN (he may be going home tomorrow). There was a meeting with Dr J's team about this. Think it sounded like a CPA type meeting".

CPA care plan inadequately explained to carer

Although Dr J signed to say that the Care Plan had been agreed and explained to the user and carer, this was meaningless given that there had been no explanation of diagnosis or treatment, MN's mother told us she did not understand what s17 leave meant and there was no explanation of what was expected from the family.

CPA care plan did not record diagnosis or treatment

No mention was made of diagnosis or medication on the CPA form because it had not been discussed. Neither Dr M nor MN or his family knew what the diagnosis was when MN left hospital. Our recommendations refer to the importance of recording diagnosis and treatment on the CPA form unless there is a clinical reason not to do so.

Local Recommendation 3:

Recording of diagnosis and treatment in CPA care plans

Failure to involve Yate CMHT resulted in breakdown of arrangements

This was a key point in MN's care. Dr J believed he had set up arrangements for MN to be seen by a CPN, but there was no discussion with Yate CMHT prior to the meeting. The CPN service later refused to visit MN because of concerns for their personal safety, and there was no allocation of a Care Co-ordinator by the CMHT.

S117 aftercare needs not assessed

Although MN was subject to s117 MHA aftercare arrangements while on s17 leave, no social worker was present at the CPA meeting to assess his s117 needs. Indeed this was not even considered and the form was not sent to social services. The matter of aftercare should have been addressed before MN went home on extended s17 leave. We recommend a review and audit of the Trust s117 policy jointly with social services.

Local Recommendation 4:

Ensuring s117 aftercare planning takes place

CPA Care Plan information not used

- Dr M and SL do not recall seeing the form even though it was faxed to Yate CMHT
- MN's name was not entered onto any manual or computer database of individuals subject to CPA. Our recommendations deal with the need to ensure that there is a CPA register fully operational throughout the Trust. This is discussed further in Chapter 6.

Local Recommendation 5:

Ensuring a functioning Trustwide CPA register

2.27 A Nursing Care Plan

- 2.27.1 The next day preparation took place for MN to leave hospital that evening. Entirely separately from the CPA care plan, a Nursing Care Plan was completed, signed and dated 23 November 2000 by Nurse SH. It stated

"MN has been placed on section 3 from 1/11/00 and section 17 leave with extended Leave agreed by Dr J and MN's mother..."

Aim of care/goal:

For MN to return to the ward when MN and family feel support necessary.....To recommence medication regime when returns to the ward

Interventions/Plan of action:-

For primary nurse:-

- 1) To offer support to family members and MN when requested.*
- 2) For primary Nurse to liaise with Dr J to commence further care when MN returns to the ward.*
- 3) To encourage MN if he returns to the ward to take medication and offer support in the importance of taking medication required".*

No connection between CPA and nursing care plan

This nursing care plan did not seem to fit with the CPA plan in that it referred to future support for MN and his family being offered by nursing staff, with recommencement of medication upon return to the ward. There is no record anywhere else of an intention to resume medication and neither MN nor the family ever did return to the ward. Nursing care plans should be consistent with CPA plans and we recommend that the Trust address this point.

Local Recommendation 6:

Consistency of nursing and CPA care plans

2.28 Referral to Yate CMHT

- 2.28.1 LD told us that during the day on 23 November 2000 she first telephoned SL, Locality Co-ordinator Yate CMHT, then faxed to her a handwritten referral letter. The faxed letter is on file signed by LD, dated 23/11/00 and timed at 15.01. It reads

"Dear [SL]...Please find enclosed a risk assessment form re: the above named young man. I understand that Dr M does know MN even though he has no previous psychiatric history. This letter is by way of referral to the CPN service.

MN is on section 17 leave from hospital due for review on 1/12/00. He has been on an open ward since 17/11/00 being deemed settled enough to leave high care. He has been isolating himself from co-patients and has superficial contact with staff. He does not feel there is anything wrong with him and did not want to be in hospital (although he has made no effort to abscond on an open ward). He has only had one verbally hostile outburst which was precipitated by a request to move from a single room to a dormitory. This did not appear to be due to mental illness and he quickly calmed down.

At present MN is not taking medication a) because the efficacy was minimal, b) it was always a physical confrontation to enforce medication & c) he would not agree to take it in the community".

- 2.28.2 The risk assessment documentation faxed with the letter had been completed by GL on 5 and 9 October 2000.
- 2.28.3 Having sent the referral LD signed an entry in the Nursing Significant Events notes dated 23 November 2000 stating *"Following CPA yesterday MN is going on extended leave today. I have faxed a CPN referral to the team in Yate..... re: MN today. Mother is coming for him tonight at 7pm".*
- 2.28.4 The next entry in the nursing notes by SH dated 23 November 2000 states *"Confirmed that MN CPN referral has been sent to Yate and they know that he is going on extended leave from 23/11/00 at 7pm".*
- 2.28.5 The final entry in the Nursing Formative Evaluation notes signed and dated 23 November 2000 by Nurse MG states *"MN has commenced leave in the company of mother – GP to be informed tomorrow."*

Referral to Yate CMHT lacked important information

The nursing referral to Yate CMHT made no mention of diagnosis because Dr J had not shared his thoughts on the subject with nursing staff. The risk assessments sent to Yate were out-of-date, having been written soon after admission. The referral did not mention the important information that within a week prior to home leave MN had been seen having a ten-minute conversation with a window, nor that he had been reported by DC as laughing incongruously and believing people were looking at him whilst they were out. Nor did the referral include the CPA form, medical notes, MHRT reports or any other documentation.

Medical notes were not transferred to Dr M

MN's return home on leave was a key point when information exchange was crucial. However, just as Dr J had not seen Dr M's medical notes when MN was admitted, Dr M did not see Dr J's medical notes when MN went home. In consequence neither psychiatrist possessed all the available information, though neither of them realised this. We repeat our Local Recommendation 1, that medical records should follow the patient so that the consultant psychiatrist responsible for a patient's care has possession of the full medical record.

2.29 23 November 2000: MN returns home on s17 leave

- 2.29.1 MN's mother recalled that on 23 November 2000 when he came home MN went straight upstairs to his bedroom. There was nothing in the room because it had just been decorated. He put the door back on its hinges and stayed there.
- 2.29.2 DC was troubled and she took action. She told us *"I thought it was wrong that we did not know MN's diagnosis when he came home"*. She tried to speak to Dr J, getting only his secretary who, went away to speak to Dr J and rang back to say that the diagnosis was *"possible schizotypal disorder"*. This was the first time they had heard that. She telephoned and wrote to Dr M, telephoned LMcC, MIND, SANE and Rethink.
- 2.29.3 We heard evidence from AB, Senior Advice Worker with the National Advice Service of Rethink³, who advised DC on the telephone in October and November 2000. With the consent of DC, we were able to look at AB's notes made at the time. They recorded DC as saying that on 22 November 2000 Dr J had without prior notice said MN's mother could take MN home with *"No medication. No aftercare plan. Family shocked"*. DC had been told MN was suffering from schizotypal disorder, which AB described to us as a *"controversial diagnosis"*. She had provided DC with advice about getting a second medical opinion.
- 2.29.4 Attempting to find an explanation for MN's sudden return home, his mother and DC began to wonder whether it had been because his bed had been needed the day before the CPA meeting and he had refused to move to a dormitory. But they had also been reassured that a bed was available for MN. DC explained how confusing that was at the time *"none of us could make head or tail of what was happening. We knew there was a bed available for MN but we did not know if MN was going to need the bed, what sort of things we should have looked out for or whatever. I was puzzled. "If they sent MN home because they needed his bed, how could they say there was a bed available for him?", so just none of it made sense really"*.

2.30 Yate CMHT 'surprised' at referral

- 2.30.1 SL, Locality Co-ordinator at Yate CMHT, told us she was surprised when she got the referral from LD because this was not the usual way that referrals were made. They would expect to be involved in the decision-making before a patient went on extended leave since it would not always be appropriate for a CPN to be allocated. She was also concerned, she told us, because the risk assessment had been done on admission and her view was that one should have been carried out prior to s17 home leave.

2.31 Dr M says MN deserves trial of antipsychotic medication

- 2.31.1 On 27 November 2000 MN was discussed at a Yate CMHT meeting, following which Dr M wrote to Dr J:

³ Rethink was at that time known as the National Schizophrenia Fellowship

"I felt I should write as a matter of urgent priority.....I would be happy to attend a ward review of MN following his trial s17 leave provided that I am given sufficient notice.....There is very great concern about the notion of the Yate CMHT re-assuming responsibility for this patient if he remains untreated, given the florid nature of his initial presentation when assessed at home. His proposed CPN – PH who conducted the initial assessment with myself, shares my view that MN deserves an adequate trial of antipsychotic medication."

2.32 Dr J informs family diagnosis is 'possible schizotypal disorder'

- 2.32.1 On 29 November 2000 Dr M faxed a further letter to Dr J enclosing a letter he had received that day from DC. In it DC referred to Dr J's *"decision on sending MN home, the suddenness of this decision and especially without a care planI have spoken to Dr J's secretary, to find out what is wrong with MN, she rang me back with the Diagnosis Possible Schizotypal DisorderI do not think it's acceptable that Dr J let MN home in the way he did. I was even more concerned when he mentioned he would let MN home and see if he gets worse, and if so, he would have him back in hospital.....this was the opposite of what you wanted to do in the beginning, as you wanted to get MN now before he got worse....I do not feel MN will get better on his own...."*. She described the *"suddenly arranged meeting on Wednesday"* when MN was asked *"do you have any intentions of doing harm to others?"* to which he replied *"No"*. DC wrote that the family couldn't believe their ears. *"What else did he expect when MN thinks there is nothing wrong with him. What is happening now/next?"*
- 2.32.2 On the day of receipt, Dr M sent a copy of this letter to Dr J with a covering note *'I am not sure how to respond. Is MN being reviewed on Caernarfon Ward this week?'*

The family should not have been told of the diagnosis by Dr J's secretary

There is no justification for the way the family learned of MN's diagnosis. DC should not have needed to telephone Dr J to find out, since it should have been discussed at the CPA meeting. DC should not have been told by Dr J's secretary.

Dr M should not have learnt of the diagnosis from DC

It also appears that this was the first Dr M knew of the diagnosis of Schizotypal Disorder. He had already voiced his dissatisfaction strongly in a letter to Dr J saying he did not wish to take over care of MN until he had been treated with antipsychotic medication.

DC's letter

Within days of going home on s17 leave the decision was questioned by Dr M, the CPN PH and DC, all of whom had been involved in MN's admission to hospital. DC was right to say in her letter that the arrangements for MN's return home were unacceptable.

2.33 Extension of s17 home leave

- 2.33.1 The CPA form and LD's letter of referral to Yate CMHT referred to Dr J's plan to see MN for a review on 1 December 2000, which was when the s17 leave authorisation lapsed.
- 2.33.2 In fact MN was not seen on that day. Instead LD telephoned MN's mother. She noted *"Spoke to mother who feels that MN is better than before going to hospital – that he does still note dates etc. in his diary but on the whole was positive. I informed her that Dr J would be in touch re out pt appt and then hand over to Dr M. Dr J will extend sec 17 to cover this."*
- 2.33.3 s17 leave at home was extended to 5 December 2000.

Dr J should have reviewed MN as planned

Although at the CPA meeting Dr J had properly arranged to see MN a week after he had gone home in order to decide whether to extend his s17 leave, he did not do so. He should have seen him and it was not satisfactory to rely upon the reported opinions of MN's mother, who he knew was ambivalent about MN's mental health.

- 2.33.4 On 4 December 2000 s17 leave was again extended to 8 December 2000, when LD made a note that Dr J would see MN at Hillview and also *"try to get Dr M to visit"*. That was followed up by Dr J's secretary, who left a message for Dr M saying the meeting was to be on 13 December 2000.
- 2.33.5 s17 leave was extended again on 8 December until 11 December 2000.

2.34 Social Services make contact with Dr J

- 2.34.1 Taking the initiative, KB from social services wrote a letter to Dr J on 8 December 2000 asking what social work input would be required:

"my team has not yet been contacted regarding any social work in-put that might be necessary.....it would be helpful if we could be clear about what services MN might require...I would be grateful if you could let me know when you will be holding a CPA or s117 meeting..."

2.35 Dr J and Dr M hold first review meeting

- 2.35.1 On 13 December 2000, three weeks after going home on s17 leave, MN was seen for the first time at a meeting attended by MN, his mother, DC, Dr J and Dr M. There was no social worker in attendance despite KB's letter of 8 December 2000, and nothing to indicate that this was a CPA meeting. The meeting was held at Hillview Lodge.
- 2.35.2 Dr J signed a further s17 leave form extending it at the home address until reviewed on 17 January 2001. There is no medical or nursing note of this meeting. The main record is contained in a letter sent by Dr M to Dr J later that day.

2.36 Dr M says 'psychotic illness, probably schizophrenia'

- 2.36.1 In a letter to Dr J on 13 December 2000, Dr M wrote:

"MN remains under your Responsible Medical Officer care under s3 MHA and on s17 leave at home. We had an interesting meeting, attended by MN, his mother, and his aunt, DC. MN presented in a subdued fashion but was fairly deferential and co-operative, certainly in comparison with my two previous contacts with him. He continued to deny adamantly that he has any problems. When I put it to him that I remained concerned that he is unwell, he became a little more aroused only. His mother offered the view that her son had improved since hospital admission but there appeared little objective evidence for this. DC's views were non-committal in the meeting but when I interviewed her in the hospital car park, she said that MN had been keeping a diary in his bedroom which contained odd dates, and had acquired a knife which sounds like a hunting knife which he keeps with this diary. She also commented that MN's brother J has reported at least one episode when MN was laughing to himself in his bedroom. Towards the end of the meeting, MN volunteered that he had arranged a job working as an order picker in a local factory, which he hopes to start immediately.

- *Our conclusion was that there remain very clear concerns that M is suffering from a psychotic illness, probably schizophrenia, mainly characterised by a paranoid delusional system, but which is not currently accessible to interview.*
- *He will be reviewed on 17/1/01 on Balmoral ward in a re-run of today's meeting where further action will be considered with a likely recommendation that he be re-admitted to the ward for active pharmacological treatment if there are further concerns about his mental state .*
- *That home visiting by our CPN Team, or other personnel, is not to be undertaken in view of MN's previous hostile reaction to home interventions and taking into account his wider risk assessment including his possession of a knife.*
- *That he remains under your RMO care pro tem, with ongoing attempts to transfer his care to Oakwood House Ward, bed permitting.*

I trust this letter is helpful in summing up our meeting today. Thank you again for your continuing support and input in this difficult case"

Review meeting sets out plan of action

This letter describing the review meeting sets out a clear plan of action against which MN's future care could be measured. *"Very clear concerns"* that MN was suffering from psychotic illness were linked with plans to re-admit MN to Balmoral Ward for medication if there were further concerns about his mental state.

Should have been a CPA review with care co-ordinator appointed

This should have been a CPA meeting with the attendance of a social worker, the appointment of a care co-ordinator and a CPA care plan and risk assessment drawn up, but there was no mention of CPA and no mention of a care co-ordinator. It was made very clear that home visiting by CPNs or other personnel was not to be undertaken for reasons of staff safety, but no mention was made of possible risk to MN's family or others. MN was deprived of a care co-ordinator whose task is described by the Department of Health as *'maintaining close and regular contact'* with patients and involving *'consultation with carers'*:⁴ In practice this meant that no professional was appointed specifically to monitor MN's mental state and risk at home or to consult with the family. Alternative strategies for home visiting should have been considered including visiting in pairs, with a reassessment of risk later. Under no circumstances should a service user be deprived of a care co-ordinator under CPA.

Local Recommendation 7:

Ensuring a care co-ordinator is always appointed

Family not provided with guidance on symptoms

In the absence of a care co-ordinator family members were relied upon to detect deterioration and report symptoms that could indicate a psychotic illness. But in order to do this they needed to know what to look for. None of the evidence suggests they were given any guidance on this. We return to this important point later in the Report.

2.37 Dr J notes 'schizotypal disorder'

- 2.37.1 Dr J next discussed MN at a ward round on 18 December 2000 and his SHO noted *"Remains reasonably well at home. Has started new job. 17/1/00 – OPA Blackberry Hill... diagnosis Schizotypal disorder. To stay on extended leave at home"*.
- 2.37.2 At the ward round on 22 December 2000 Dr J's SHO wrote *"Seems to be improving. On Sec 17 leave at home for another 6/52"*

Dr J's diagnosis of schizotypal disorder becoming more certain

Despite Dr M's continued view that MN was probably suffering from a psychosis, Dr J's diagnosis of *"possible schizotypal disorder"*, as given to the family on the telephone, had become *"schizotypal disorder"* by 18 December 2000. Four days after that Dr J thought MN was improving, but it is not clear where the information for this came from. There is no evidence that there had been any contact with the family between 13 December and 22 December so this could only have been a continued reliance upon information obtained at the meeting on 13 December 2000.

2.38 A social worker is allocated

- 2.38.1 In the New Year, on 3 January 2001, social services once more took the initiative. This time JB wrote to Dr M, who had sent social services a copy of his letter reporting on the review meeting of 13 December 2000. JB asked *"Would you like a SW to attend the next review on 17/1/01? If not, will need to be involved in s117 so can you let me have dates of any meetings"*.
- 2.38.2 When he received JB's letter the following day, Dr M left a handwritten note on it saying *"I left message to say 'yes' but SW should arrange this with [MN] directly"*.
- 2.38.3 On the same day, 4 January 2001, DC telephoned social services and spoke to LMcC who wrote in the social services notes that she was *"Very confused about MN's situation, he is now at home but family"*

⁴ From *Building Bridges*. See full quote at paragraph 6.2.12 of this report.

have had no contact from the hospital – unsure whether he has been discharged & can't get in touch with Responsible Medical Officer Dr J – advised she ring hospital & I would contact Specialist Registrar re allocation”.

- 2.38.4 JB, LMcC's supervisor, dealt with the matter immediately, completing a social services referral form stating *“Requires s117 aftercare currently at Hillview Bath”* and allocating the case to LMcC. She left LMcC a handwritten note saying *“I have told (Dr M) that you are the allocated worker. He thinks you should a) inform the ward about MN's mother's concerns about [MN's] mental health b) inform the ward that you will be attending the meeting on 17/1/01..”*
- 2.38.5 LMcC noted the following day *“Allocated to me – CPA at Cedar House 17/1/01...Will attend”*.

Clinical responsibility not clear to family or social services

Lines of communication were unclear. Social services had initially written to Dr J asking what social work input was required but seemingly had no reply and no social worker had been invited to the review meeting. Unsurprisingly, after Dr M had, as a matter of good practice, copied his letter of the review meeting to social services, their response was to get in touch with Dr M rather than Dr J. DC remained confused about the situation. Having already written to Dr M and been unable to get in touch with Dr J, she then wrote to social services who advised her to ring Dr J. It was most unsatisfactory that neither social services nor the family knew who had the authority to make decisions concerning MN's care, and whether he was still an in-patient or had been discharged.

Dr M states home visiting not to be undertaken for safety reasons

Dr M did nevertheless make a crucial decision. Despite his own letter of 13 December which had stated *“home visiting by our CPN Team, or other personnel, is not to be undertaken in view of MN's previous hostile reaction to home interventions and taking into account his wider risk assessment including his possession of a knife”*, he asked social services to make contact with MN directly and accepted social services' allocation of a social worker to MN. Social services, who had received Dr M's letter, seemed content to make the allocation.

2.39 Dr J and Dr M hold second review meeting

- 2.39.1 On 17 January 2001 a review meeting was held at Cedar House, Blackberry Hill Hospital. Dr M, Dr J, LMcC, MN, MN's mother and DC attended.

- 2.39.2 Dr J's note in the medical records stated

“MN did not get job prior to Christmas, but is drawing benefit. Plans to enrol on an NVQ III Mechanics. Atmosphere at home better. ‘I don't think he is ill or anything.’ Concerned about writing numbers on calendar. Mother plays this down. No major concerns. Much more (animated) than previously.

Plan

- (1) SW to meet with MN re NVQ*
- (2) Mother to see Dr M in clinic*
- (3) 6/52 Section 17”*

- 2.39.3 LMcC's notes indicate he was under the impression this was a CPA meeting, though that was not mentioned anywhere else. He wrote;

“CPA. MN more talkative and open but still not talking about his illness, denying anything was wrong insisting he is keeping active meeting friends. Mum and aunt still feel he's not completely well. Decision – MN to meet myself & Dr M at Yate HC within two weeks & to be available for family. S17 to be extended & not discharge. Aunt advised she would contact Dr M later”.

- 2.39.4 DC did indeed contact Dr M the next day with a faxed letter dated 15 January 2001 addressed to them both and enclosing a copy of MN's diary, adding *“Please DO NOT show these details to MN”*.
- 2.39.5 Together, and without MN's knowledge or consent, MN's mother and DC had persuaded MN to leave the house, taken his diary from its secret location and photocopied it.

2.40 MN's diary

- 2.40.1 We have seen MN's photocopied diary, which consisted of ten pages. Four of them were similar to a calendar, covered with a series of numbers. Six of them had one or two columns of brief phrases or words - about thirty per column, for example monk, priest, exorcist, sacrificial, fifth element, immortal fighters, ninja, boxing, wizard, devil, demon, witch, satan worship, crack cocaine, crypt of light, nut meg, flint, vampire, pcp angel dust, microdot, CD, vinyl, MD, lattice, MDMA, alcohol, solar solex system, jesus, snake bite, dynamite, gadget, poltergeist, M18 machine gun, diamond, quartz.

2.41 Dr M says clear clinical grounds for psychotic illness

- 2.41.1 As was his style, Dr M wrote a letter to Dr J as a record of the review meeting, making reference to MN's confidential diary entries, which he had by then received and assumed Dr J had also received, though Dr J told us he could recall having seen only part of the diary. If there had been only one consultant psychiatrist this would not, of course, have been an issue. Dr M wrote:

"Some days prior to the meeting, a highly confidential document had been faxed to both yourself and myself from DC which is a photocopy of pages of a diary which MN is apparently keeping in his bedroom. MN is totally unaware that this document has been copied to us. It consists of 10 pages. Lists of numbers occur, some of them surrounded by boxes, and some of them by the words weeks and days, apparently representing some form of calendriatal system. The numbers appears to be uncomprehensible. Pages 5 to 10 are covered with lists of words, which have a spiritual and occult theme, and there are also references to illicit drugs. They are consistent with a schizotypal or schizophrenic illness.... MN more animated and friendly, and a little hostile....very anxious to present himself as a normal young man...continued to deny adamantly any mental health problems....His mother corroborated the impression of further improvement. Mother comments that there has been no further evidence of MN talking or laughing to himself in his bedroom. His aunt, DC, also contributed to this positive view of things. Close questioning by yourself and myself of MN did not elicit any untoward symptoms."

- 2.41.2 Dr J could not recall whether he had seen the section of MN's diary containing words rather than numbers, but he told the Inquiry *"..at the time with the diagnosis I was working at.... I would have considered these to be consistent with the magical thinking..."*

- 2.41.3 The letter also mentioned a confidential discussion without the family present:

"Concluded that this is a most difficult and unusual case. There are clear clinical grounds for believing that MN continues to suffer from a psychotic illness, probably Schizophrenia. However his outright and adamant denial of symptoms, and in parallel his mother's support of this view makes it very difficult to help MN at this stage. It was felt unanimously that to bring MN back into hospital and compel him to take medication would be highly counterproductive, and would militate against any future good therapeutic relationships with him and his family. It was unanimously concluded that the risk assessment of this case did not point towards need for such action at this stage."

Dr J's last contact with MN

The review meeting of 17 January 2001 was the last time Dr J saw MN. Although Dr J remained RMO, Dr M now took over seeing MN at his outpatient clinic, indicating the progress of a handover of care. From this point Dr J's decisions as RMO were based on others' reports of his patient's progress.

Should have been a CPA review

Again no CPA documentation was completed and nothing in the contemporaneous clinical notes indicated it was a CPA meeting. Only the social worker referred to it as such. It should have been a CPA meeting if the Trust's operational policies had been followed. We examine CPA in more detail in Chapter 6.

Dr J and Dr M's different views on diagnosis

The 17 January 2001 review was an important one. Just as Dr J was bowing out of involvement with MN's care, evidence seemed to be mounting that MN was improving at home without medication, appearing to confirm Dr J's view that schizotypal disorder was the correct diagnosis. In his evidence to

the Inquiry Dr J confirmed that this was his recollection at the time. He said *"things were very positive"* in December and January. Whilst Dr M still thought the diagnosis was probably schizophrenia he was struggling to find the evidence for this as MN adamantly denied symptoms and his mother appeared to support him in this. Action taken by DC in faxing to Dr M MN's photocopied diary, telling him it was kept with a hunting knife, was not diagnostically decisive as Dr M thought it could be consistent with either a schizotypal or schizophrenia illness. This was the first time Dr M had mentioned the possibility that MN's symptoms might be consistent with schizotypal disorder.

2.42 Meeting between Dr M and family

- 2.42.1 On 31 January 2001 Dr M saw MN's family without MN. MN's mother said *"Nothing came of that meeting actually"*. She recalled that there had been talk of re-sectioning MN and she expressed her view in this way; *"I think the reason why they did not re-section MN was because the way he was last time..... because there had to be a police escort to hospital. MN had something against doctors and nurses. He was adamant there was nothing wrong with him."*

Good practice to meet with the family

Despite the view of MN's mother that the family meeting with Dr M was of limited value, it was an example of good practice. Dr M demonstrated his wish to listen to the family and his commitment to the care of MN. By this time Dr M, rather than Dr J, was taking the lead role in the ongoing care of MN and acted alone in seeing the family.

Last meeting with the family

We note that this was the last time Dr M saw any member of the family. He spoke once to DC on the telephone in October 2001. He had no further communication with MN's mother.

2.43 Dr M says schizophrenia or schizotypal disorder

- 2.43.1 Once more Dr M wrote to Dr J reporting on the meeting. He said

"The meeting was arranged following discussion between myself and DC... and was an attempt on my part to try to understand more clearly what has been happening with MN while on leave, and to try to seek more background information.....from the family....."

- *As previously volunteered all family have noted a marked fall off in MN's level of functioning over the last year to 18 months with a retreat to his bedroom and a reduction in his range of social activity*
- *His use of street drugs remains unclear*
- *It is likely that he used cannabis and Ecstasy regularly prior to his "breakdown". His current use is impossible to gauge, but he may be smoking some cannabis.*

.....there was wide confirmation of the view that [MN] had improved a little since his Balmoral admission. This improvement is in the form of leaving his bedroom to watch television...and to leave the house intermittently to visit friends.... Furthermore there has been less evident laughter coming from his bedroom..."

.....With the possible exception of (LN), who remains very ambivalent, the family members see MN as "ill". They also believe that he has some element of insight into this...

.....The family acknowledge the very difficult ethical issues which we as professionals face. They are aware.....that the diagnosis is likely to be either schizophrenia or a schizotypal disorder. They are aware that it is unusual for patients suffering from schizophrenia to so successfully conceal their symptoms as MN apparently does, but they also know that untreated schizophrenia may deteriorate....

...Family agree with plan to forge a "therapeutic relationship with local CMHT".

MN 'improved a little'

The family reported that MN had improved a little since his Balmoral admission in that he was more sociable and there was less laughter from his bedroom, but they still thought he was "ill". His presentation was markedly similar to that before he was admitted.

2.44 Social worker speaks to DC

- 2.44.1 Early in February 2001 LMcC obtained an application form for MN to obtain Disability Living Allowance and spoke to DC. There was no mention in his notes of any conversation about MN. Because of an unexpected and urgent work commitment, LMcC was unable to attend MN's outpatient appointment on 12 February 2001.

2.45 MN brought to outpatient clinic by DC

- 2.45.1 On 12 February 2001 MN was brought by DC to Dr M's outpatient clinic and seen alone. There was no recorded discussion with DC. As usual, Dr M's medical note was contained in a letter to Dr J and reported: *"My meeting with MN was brief but reasonably positive in that he presented in a friendly and reasonably relaxed fashion. He denied any symptoms... He promised to come and see me again on Monday 26 February....when I hope to be joined by LMcC."*

2.46 MN at outpatient clinic with LMcC

- 2.46.1 At the outpatient clinic on 26 February 2001 Dr M recorded in the Yate medical notes *"No change to mental state. Well-presented, pleasant and friendly, though defensive and not willing to expand upon themes..."*
- 2.46.2 LMcC recorded in his social work notes *"MN still not psychotic but not unwell (sic) – agreed to meet him re Benefits & NVQ in car maintenance on 27/2/01"*

Handover to Dr M

The process of handover from Dr J to Dr M can clearly be seen. MN was discussed initially in Dr J's ward rounds without Dr M, next at the first review meeting in Dr J's clinic with Dr M present, and then in the second review meeting in Dr M's clinic with Dr J present. All subsequent appointments were in Dr M's outpatient clinic without Dr J's participation. Once arrangements for seeing MN transferred to Dr M's clinic, MN and/or his family were seen quite frequently. Between 17 January and 26 February 2001 Dr M held four such meetings.

No sign of mental illness

At the two outpatients appointments in February 2001 MN gave no indication of mental illness and there would have been no reason for Dr M to conclude that MN was still suffering from a psychosis, or any cause to recommend to Dr J that MN's leave be rescinded.

2.47 First social work home visit

- 2.47.1 On 27 February 2001 LMcC made his first home visit to MN. There is no record of any conversation with the family. LMcC went alone and made this entry in his notes *"Presented as OK – short monosyllabic answers, but quite relaxed relatively speaking. Filled in DLA form – MN insisting he had no disability & insisted he had not mentioned speaking to his dead grandfather. MN will contact Soundwell..."*
- 2.47.2 LMcC followed this up with a telephone call to MN on 13 March 2001 when MN made the *"Same brief answers....Has contacted Soundwell, they are looking for a garage placement for him"*.

2.48 Social Services' 'Assessment of Need and Care Plan'

- 2.48.1 The following day MN was allocated to LMcC under social services' own Care Management procedure, and on 15 March 2001 a form entitled *'Adult care – Assessment of Need and Care Plan'* was completed by LMcC and authorised by his line manager KB. This stated:

"MN was compulsorily medicated on two occasions, which he found very unpleasant.....was released on s17 leave in January 2001 and has stayed home. He is subject to s17 aftercare. MN's care is taking place within the CPA.....MN denies any ongoing psychosis...we have been looking at the prospect of him doing NVQ level 3..."

Assessed needs: *Garage mechanic courses – LMcC; Ongoing monitoring of mental state within CPA process – 3 monthly – Dr M.*

Risk Assessment: *"..when first assessment under the MHA...there was a concern that MN had a knife and that there was a potential for violence. Despite these concerns they proved groundless.....MN's mother said she does not feel threatened by MN".*

View of carer: *"MN's mother expressed concerns about her son's presentation before his admission to hospital. Since his return home MN's mother feels that he is much better"*

Outcome summary: *"To support MN in the community. To seek to help him return to either employment or training."*

- 2.48.2 According to the form it was copied to the Service User on 19 March 2001. LMcC told the Inquiry that it was not copied to NHS colleagues though he acknowledged that it should have been. At the time there was not a sense of urgency and they were, he said, "...overwhelmed with paperwork".

LMcC's observations consistent with those of Dr M

MN did not show any signs of psychosis and his mother said he was much better. This is the last recorded mention of the family's views until, seven months later, in October 2001 when contact is made with them after MN had missed appointments.

Social work role was to help with work and training

The tasks identified for the social worker were to give MN support, in particular with work or retraining.

Separate health and social services care planning systems

The Care Management Plan should have been sent to Dr M. The existence of two separate care planning systems was unsatisfactory at the time. We heard this has since changed.

2.49 19 March 2001: MN discharged from s3

- 2.49.1 On 19 March 2001 Dr J was reminded by the Trust's administrative staff that MN's s3 would expire on 30 April 2001. MN was discharged by Dr J from s3 and from hospital on 19 March 2001, and two days later LMcC received a telephone message from DC about the expiry of the s3, to which he responded but had no reply.
- 2.49.2 Asked about her understanding of the expiry of the section and how things stood after that, MN's mother said *"I did not really understand it, I just thought they knew what they were doing".* At home MN was *"just what I would class as his normal self. He was the same lad. I did not see a deterioration in him. I did not see him any better."*

Should have been a CPA review upon discharge from S3 MHA

The decision to discharge the s3 and the hospital admission was made summarily by Dr J, who had not seen MN since mid-January 2001, and without reference to Dr M who was by now supervising MN medically. There should have been a CPA review to include both psychiatrists and the family at this point. However, there was little in Dr M's records of recent interviews with MN to justify a continuation of the liability to detention under the MHA. With schizotypal disorder looking increasingly like an agreed diagnosis, it is also debatable whether s3 on the grounds of mental illness could have been justified much longer, though there is no record that this was ever discussed at the time.

Local Recommendation 8:

CPA review upon change in legal status under the MHA

2.50 Review meeting with Dr M and LMcC

- 2.50.1 On 29 March 2001 MN was seen in Dr M's outpatient clinic. This was a joint assessment with LMcC, who had taken MN to the clinic, and who noted that he was *"doing OK.... Agreed to ring him in a couple of weeks re course"*.
- 2.50.2 Dr M wrote in evidence to the Inquiry that he understood LMcC's *"main role was to build a therapeutic relationship with MN focussing on work and training issues."*

2.51 Dr M says increasingly likely to be schizotypal disorder

- 2.51.1 Dr M summed up his assessment in a letter dated 30 March 2001 to MN's GP, Dr B. He wrote:

"Apart from a phone call from MN's aunt to the effect that MN was still circling dates on a calendar at home in an odd fashion, there were no other pointers towards a deterioration in his mental state from the collateral histories....He looked more relaxed than at previous interviews, and although somewhat defensive....he did, on this occasion volunteer some spontaneous conversation....He also describes some social activity, visiting friends....out on his bike. His section 3 has elapsed, and there are no current grounds for detention. It looks increasingly likely that this young man is suffering from schizotypal disorder. Whilst his inner thoughts remain inaccessible to professionals, his current presentation and level of activity has to be seen as a positive improvement. We are going to see him again in three months time in the clinic and LMcC is going to telephone in a few weeks to enquire about progress with the NVQ course".

- 2.51.2 To Dr J, who ceased to have any responsibility for MN upon the discharge of s3, Dr M wrote

"Just a note to thank you most sincerely for your input with this difficult and unusual case".

Dr M's view shifting further in the direction of schizotypal disorder

There were no overt symptoms of psychosis and MN seemed to be engaging in some social activity, so the circling of dates on a calendar in an odd fashion was not considered diagnostically significant. Dr M stated that MN's inner thoughts remained inaccessible to professionals. However, this appears to have been very similar to his presentation at home in the year or so before admission to hospital. It would not exclude the possibility that when aroused he might again reveal disordered psychotic thinking, but there was apparently nothing disturbing MN's equilibrium. Indeed he appeared relaxed.

Should have been a CPA review before reducing outpatient appointments

With a definite diagnosis of schizotypal disorder it might have been reasonable to arrange the next outpatient appointment for three months time. But the possibility of a psychosis had not been ruled out and a three month gap for a patient suffering untreated schizophrenia would have been a long time.

2.52 Two more social work home visits

- 2.52.1 LMcC made home visits to MN on 24 April and 15 June 2001, noting *"Little communication"* and that MN was still interested in the car course.

MN tolerating social work visits

In his evidence to the Inquiry LMcC said it seemed to him that MN *"felt that he had to put up with me calling to visit him and he knew that if he did not do that..... then maybe he will be brought back to hospital, so he tolerated me"*.

2.53 June 2001: last outpatient appointment

- 2.53.1 On 21 June 2001 Dr M saw MN at an outpatient appointment and recorded in the Yate medical notes that this was a routine appointment and that MN *"Looks fit and well. On no meds"*. MN appears to have attended the appointment on his own, since Dr M wrote on the same day: *"I have not had any recent contact from his family ... he continues to express a willingness to come and see me ..."*

Last contact with a doctor

This proved to be the last occasion MN was seen by any doctor prior to the homicide.

Contact with the family

Dr M reported that he had not had any recent contact with the family. In fact he had last seen DC and MN's mother in January 2001, and had spoken to DC on the telephone in March 2001. During the year prior to the homicide he was to have one further conversation with a member of the family, this being a telephone discussion with DC in October 2001.

2.54 Dr M says most likely to be schizotypal disorder

2.54.1 Expressing his opinion in a letter, this time to LMcC and copied to the GP, Dr M wrote

"I have not had any recent contact from his family. MN tells me that he saw you a few days ago. Perhaps we could discuss your findings in due course. I thought he looked very well today....tells me he has been doing quite a lot of cycling..... Today's conversation was superficial and defensive as ever..... I pushed him quite hard today to open up to me about his private thoughts. He denied any untoward beliefs and thoughts, as ever. He continues to express a willingness to come and see me in the clinic and I have given him an appointment for October. I think the diagnosis continues to be most likely a schizotypal disorder. If the current stalemate continues, I will have to give thought to either discharging him or giving him longer gaps between interviews."

Dr M considers discharging MN from his care

Dr M, aware of MN's defensive and superficial conversation, pushed him to open up about his private thoughts, but without success. There had been no recent contact from the family and no reason to alter his increasingly settled impression that MN suffered from schizotypal disorder. This letter was not seen by the family, who gave evidence that they had not known that Dr M had given consideration to discharging him from his care.

2.55 July 2001: last social work contact

2.55.1 LMcC saw MN on 18 July 2001 and again noted "Little communication".

Last contact with any professional

This was the last time LMcC, or indeed any professional, saw MN until the day of the homicide. In those eight months the family was relied upon for information.

2.56 4 October 2001: First missed outpatient appointment

2.56.1 On 4 October 2001 MN failed to attend an outpatient appointment with Dr M. This was the first time he had missed an appointment and a new one was made for 23 October 2001. Dr M advised the social worker and GP accordingly.

2.57 MN not at home for social work visit

2.57.1 On 10 October 2001 LMcC wrote to Dr M saying that MN was out when he arrived to see him that day. He spoke to MN's mother who

"reports that he still keeps to himself in his room. She is quite sure he is writing out 'significant dates' etc., in a folder which he keeps locked in a brief case under his bed. She says he laughs to himself regularly but will deny this irritably when asked about it. MN also taps his right foot constantly when downstairs. He had not started the car maintenance classes that he discussed with me earlier this year."

2.57.2 LMcC told MN's mother he would write to MN in another two weeks.

Never any explanation for MN laughing to himself

There is no mention in the medical or social work notes of any explanation for MN laughing to himself. It was important to attempt to establish whether this was connected with delusional thoughts or a response

to auditory or other hallucinations. This should have been investigated long ago when MN was in hospital.

2.58 23 October 2001: Second missed outpatient appointment

- 2.58.1 MN missed the re-arranged outpatient appointment on 23 October 2001. The following day Dr M wrote to the family GP, Dr B, with a copy of his letter to LMcC, saying *'MN has now missed two consecutive appointments with me in the clinic at Yate having, as you know, been a regular attender up until recently. This leaves me with something of a dilemma, because, although no therapeutic transaction was taking place in his appointments, at least I was able to keep an eye on him. I have decided to write a brief letter to his aunt, DC, who was closely involved in his initial presentation, asking her to give me a ring, by way of keeping the channels of communication open with the family. I will let you know of any further developments.'*
- 2.58.2 He wrote to DC asking her to telephone him. Two days later he wrote to Dr H, consultant psychiatrist at Hillview Lodge, explaining that no discharge summary had ever been received.

2.59 'Agitated' behaviour

- 2.59.1 Responding to his letter, DC telephoned Dr M on 29 October 2001 and he noted:

"[DC] not so close to MN's mum of late. Feels she has her 'head in the sand' re MN. Reports an incident where MN 'became agitated' in a supermarket when in the wrong queue. No details apparently raised his voice. I asked DC to encourage MN's mother to ring me. She will do this".

- 2.59.2 Following this up on 31 October 2001, Dr M arranged a further appointment for MN on 15 January 2002, making a note, presumably for his secretary, saying *"Note: Ring MN's mother to REMIND HER of this appointment"*. There is nothing to indicate whether or not this was done and no record of any further contact between Dr M and the family.

An indication of possible deterioration

Family accounts of MN's agitated behaviour were the first in a long while. Along with MN's missed appointments they were an indication of possible deterioration in MN's mental health. Dr M took prompt action arranging further appointments, making contact with the GP, the social worker and with MN's aunt. Interestingly, Dr M wrote not to MN's mother but to DC. She had been the one to initiate contact in the past but she was not the nearest relative and MN did not live with her.

No clear channels of communication established with the family

DC's response emphasised that she and MN's mother did not always have the same knowledge of what was happening at home, or share the same views of MN's mental health. Dr M's action in reminding MN's mother of the next appointment and asking DC to speak to her, suggested he was sensitive to the MN family dynamics, their possible impact upon the care of MN at home and the information reaching professionals. However, it would have been better if this had been addressed explicitly at previous meetings so that it was known precisely who would do what, including ensure MN's attendance at appointments. There was the danger of reliance upon DC when in fact she was not part of the immediate family.

2.60 Dr J's late discharge summary is received

- 2.60.1 On 31 October 2001 Dr H wrote to Dr M saying he had looked through the notes and could not find a discharge summary. He had therefore asked Dr J to deal with the request since he was the RMO involved at the time.
- 2.60.2 21 November 2001 Dr J wrote a two-page discharge summary addressed to Dr M, outlining the pre and post admission history. In the first 48 hours of admission when in an aroused state MN *"spoke at length about 'tele-kinesis, psycho-kinesis, spirits' and also spoke in what was apparently a thought disordered fashion, about molecules and their movement..... one could engage him in bland conversations about every day topics....but when questioned about any abnormal beliefs his manner became much more agitated, his speech faster, slurred and full of references to spirits and other abnormal beliefs"*.

- 2.60.3 After Zuclopenthixol depot 200mgs stat as well as Zuclopenthixol Acetate 150mgs stat he became, over the following few days, *“significantly more settled. On the 2 November 2000 he was placed under s3 MHA and his mental state observed on Balmoral Ward over the following three weeks. Despite not having any further medication his behaviour became significantly calmer and his thoughts increasingly rational. When asked about the abnormal beliefs that he had expressed previously, he acknowledged that these were things he had thought as a child, but not since and he no longer spoke in a thought disordered fashion when aroused. There was only one episode of anger during his stay, subsequent to the beginning of November, and that was when he became angry when asked to move from a single room into a dormitory. This is only frank psychotic symptoms and it became more likely that the diagnosis was on of schizotypal disorder rather than frank schizophrenia”.*
- 2.60.4 Dr J added *“During his time on the ward his family, especially his mother was very ambivalent about his treatment. Clearly they wanted the best for him and felt that he needed treatment. At the same time they did not want him to have psychotropic medication by depot, which might have extra-pyramidal side effects. He had leave at home which proved successful, and was therefore provisionally discharged in much improved fashion on 22 November. I had phone contact with his mother on 4 December and she described him as being significantly more settled and when I reviewed him on the ward on 18 December he had been coping reasonably well at home, his thoughts had become much more normal and we therefore agreed to extended leave. He was reviewed at Blackberry Hill Hospital on 17 January 2001 with Dr M and his family and following further review by Dr M he was subsequently discharged from section on 19 March 2001.”*

Discharge summary was written a year late and omitted important information

This discharge from hospital summary should have been written upon discharge from s3 on 19 March 2001. This was poor practice. Moreover, it omits to mention incidents involving MN saying he wanted to put an axe through someone’s head, laughing incongruously, saying others were looking at him, and talking to a window. These incidents remained unknown to Dr M. We make recommendations for a review of discharge summaries.

Local Recommendation 9:

Review of discharge summaries

2.61 7 December 2001: Third missed outpatient appointment

- 2.61.1 On 7 December 2001 Yate CMHT sent a letter to MN confirming the date of his next appointment as 15 January 2002.
- 2.61.2 On 9 January 2002, six days before the appointment, a letter was sent to MN re-scheduling it to 14 January 2002.
- 2.61.3 MN did not attend his third outpatient appointment.

Good communication with the family over missed appointments

Although the appointment was rescheduled to 14 January, it appears from Dr M’s letter below that the appointment was on 15 January 2002. Whichever was correct it does not appear that this caused confusion since DC understood when the appointment was to be and telephoned Dr M when she could not persuade MN to leave the house with her.

2.62 Dr M asks social worker to see MN

- 2.62.1 Dr M wrote to LMcC on 15 January 2002 saying that MN did not attend his outpatient appointment that morning, and that there had been a telephone call from DC who had explained that:

“MN had absented himself from his mother’s house at the expected time of pick-up, so it looks as if he has deliberately avoided this appointment. [DC] reported that things are unchanged regarding MN’s reported mental health problems. He continues to isolate himself in his bedroom for much of the time. He now apparently keeps a locked file in his bedroom so that his jottings are not accessible to his mother. He generally avoided contact with the family over the Christmas period. Apparently he has

failed to fill in forms for his Benefits, which I presume include Disability Living Allowance. I think this might provide an opportunity for you to see him and simultaneously monitor his mental health. I wonder whether you would be happy to get in touch with him with a view to this? In conversation with [DC], she fully understood our continuing dilemma in being unable to offer a more assertive role at this stage. I will leave an open appointment for MN at this stage."

MN actively avoiding appointments

If there had been any doubt about it before, it now became apparent that MN was deliberately avoiding contact with professionals. MN told us this was because he did not wish to be readmitted to hospital.

Changing the basis of social work involvement

LMcC's role had previously been to help MN obtain employment. When Dr M asked LMcC to monitor MN's mental health this changed the basis of the social work involvement. It expected the social worker to assume a more pivotal role in the care of MN and some thought should have been given to (i) the information on diagnosis LMcC required for this task, and (ii) an assessment of potential risks involved to LMcC, bearing in mind that if MN's mental health had deteriorated there might have been a re-emergence of the concerns over risk which had led to the CPN service declining to take him on and Dr M stating that no home visits were to be made.

Potential for misunderstanding

DC described MN's mental health as unchanged but it is not clear whether she and Dr M understood this to mean the same thing. Was MN well or unwell? More information was needed.

Should have been a CPA review and risk assessment

Rather than leave an *"open appointment"* for MN and ask LMcC to inquire further into MN's mental state, a CPA review meeting should have been held involving Dr M, DC, MN's mother and LMcC. In-patient and out-patient medical records should have been brought together and a comprehensive risk assessment undertaken before deciding upon a course of action. Although Dr M thought it most likely that the diagnosis was schizotypal disorder, his opinion never reached the level of certainty, leaving untreated psychotic illness as a real alternative possibility. We recommend that the Trust review its ICPA Policy, to ensure that where there is a differential diagnosis risk is assessed on the basis of each diagnosis.

Local Recommendation 10:

Assessing and recording risk.

2.63 Referral to Assertive Outreach Team discussed

- 2.63.1 In fact LMcC did not immediately visit MN. In evidence to the Inquiry, LMcC said that he discussed MN with his supervisor who suggested *'we were not getting anywhere and that assertive outreach have a smaller caseload.....they can do a lot more chasing people up.....figuring out where they are, and they can spend a lot longer seeing them.'*
- 2.63.2 LMcC considered that referral to the Assertive Outreach Team (AOT) might be the best way forward and on 4 March 2002 he noted *"in view of our failed efforts to keep contact with MN, I discussed referral to Assertive Outreach Team....Dr M agreed"*.
- 2.63.3 On 14 March 2002 LMcC therefore telephoned AOT and left a message saying that he wished to discuss a possible referral. The next day he noted *"AO Team will send referral form"*.
- 2.63.4 On 25 March 2002, having received the referral forms, LMcC telephoned MN arranging to see him at home on the morning of 27 March 2002. He planned to see Dr M in the afternoon of the same day.

Social work suggestion of referral to Assertive Outreach Team

Referral to the Assertive Outreach Team was an appropriate course of action but it should not have been left to LMcC and his supervisor to think of this. By now LMcC was handling communications at the request of Dr M although he had had no direct contact with MN or his family for five months. In effect, he was making a request for the transfer of Dr M's patient to another health team on the basis of information which Dr M had recently heard on the phone from MN's aunt.

2.63.5 The events of 27 March 2002, the day of the homicide are covered in Chapter 3.

Chapter 3

The day of the homicide

3.1 A summary

- 3.1.1 Following such an apparently random and extreme act of violence it is natural and inevitable that both family and professionals should find themselves re-living the day of the homicide again and again in an attempt to understand what happened, why, and what might have been done differently that may have prevented the tragedy.
- 3.1.2 We wished to hear all the accounts fully and fairly. For this reason we quote extensively from those involved in these sad events as they unfolded.
- 3.1.3 However, before that detailed examination we describe briefly what happened on 27 March 2002, the day of the homicide.
- 3.1.4 At 11.00am LMcC visited MN at home, intending to discuss with him referral to the Assertive Outreach Team, prior to meeting with Dr M that afternoon. Initially he found MN to be unresponsive as before, but in response to more probing questions MN abruptly became very disturbed, ultimately issuing threats to “*butcher*” LMcC and his family. After leaving the house LMcC returned to his office, discussed the situation with colleagues, and at 2.00pm spoke to Dr M at a meeting they were both expecting to attend. It was decided that an immediate assessment under the MHA was not necessary and that LMcC would speak first of all to the family, but in any event MN had by this time already committed the homicide.
- 3.1.5 A few minutes after LMcC had left the house MN also left. It does not appear that he made any attempt to find LMcC or act upon his threats towards him. Unknown to the family or anyone else, he walked around the corner and into the open house of Mrs H, whom it seems he did not know, who had been gardening and had her front door open. She was in the kitchen when MN killed her. She died from multiple stab wounds.
- 3.1.6 When MN returned home some hours later that afternoon the family noticed nothing untoward about his behaviour; nor did others including JB, a friend of MN’s, who saw him later. DC did not mention any concerns when LMcC spoke to her on the telephone the following day. They all remained unaware of MN’s role in the killing until his arrest four days later.
- 3.1.7 It was LMcC who telephoned the police on Good Friday, 29 March 2002. By this time he had heard about the killing, realised MN lived near the victim and made a connection with the threatening content of MN’s speech. The police took evidence from LMcC over the course of 29 and 30 March and arrested MN on 31 March 2002.

3.2 The events of 27 March 2002 and the following few days

- 3.2.1 The most contemporaneous account of 27 March 2002 is that given by LMcC in his letter to Dr M dated 28 March 2002.
- 3.2.2 With hindsight, the family has wondered whether LMcC had by this time already heard about the homicide, since it had been on the local radio. LMcC told the Inquiry that he had not known about it then but was responding to an agreement with Dr M that he would set out in writing what had happened the previous day.

3.2.3 LMcC wrote:

'As agreed at the ward round I am writing to document details of my visit to MN on 27.3.02. As you know we discussed referring him to the Access Team as we have both had difficulties in meeting with him. I decided to try one more visit before completing the Access Team referral form.

Initially at interview MN was the same giving brief answers to questions. I put it to him that there was concern that he was mentally unwell and that in the past his conversation with me had been bizarre referring to atoms and chemicals, which I could not follow. On previous occasions when I raised this he flatly denied any of it. On this occasion, he came out with a stream of incoherent explanations on a 'Death Row Shop' in Sheffield which sold items for butchering people. Some of the items sold, he explained, would give immortal life or death. He spoke like this for some minutes; he was animated, drew shapes on the carpet and grew increasingly agitated. I took the opportunity to join some relatives who were leaving the family home at that point. MN followed me out and was increasingly hostile sensing, I think, my discomfort. Outside his front door he adopted a very hostile pose and told me that both my family and myself would be butchered.

As agreed I will ring his family to find out how they are currently feeling about him and you said you would speak to a colleague about MN's presentation.'

3.2.4 In his statement for the criminal proceedings LMcC described events thus:

'I started off by asking general questions of M such as how he was and what had he been doing etc. I asked him about a car mechanic course that we had both discussed at Soundwell College (it was felt this course would assist him in his treatment) but he told me that none of the placements on the course were close enough for him to get to. M's response to my questions was the usual denial that he had any problems at all. So therefore I put it to him directly that there were genuine concerns about his mental health. He asked what I meant by this and I reminded him that the last time we talked we had a very bizarre conversation about Atoms and Chemicals.

It was as if I pressed the 'play button' in M and his psychosis started coming out. He said words to the effect of 'so you don't believe me' and then followed a stream of animated, incoherent ramblings about a number of subjects including a Death Row shop in Sheffield which sold items for killing people, pills or tablets that would kill you or if you knew the right sequence would make you immortal, he mentioned that other shops like this existed in other countries. People like the Mafia, Ku Klux Klan and the Nazis could get equipment from these shops to kill those people. The people working on Death Row could get this equipment free.

In the middle of this I asked him if he was finding this on an Internet Site but he said no he wasn't.

Throughout the conversation M was questioning me about whether I believe him or not and as the conversation went on I felt he was becoming more agitated and aggressive toward me. I felt that he might strike me so I decided to leave the premises, I was getting scared.

The time would now be 11.15 am and his Aunt, DC and one of the males left the premises and I used this as an excuse to leave so I followed them out the front door. M came out after me and closed the door at this point he was still saying his psychotic ramblings and during the middle of this I heard him say to me 'You and your family are going to be butchered'. I felt threatened by this.

I walked off and got into my car. M had gone back into the house but I then saw him come out again whilst putting his jacket on. The way I remember it when he saw me in my car he once again returned inside and closed the door. I then drove off.....

Later that afternoon I spoke with MN's Psychiatrist he said he would discuss MN's case with another colleague and I would speak with DC.

On Thursday 28 March 2002 I rang DC and asked if there was anything unusual about MN's behaviour.

She felt he was the same as ever and reminded me he still kept his writings and jottings in a steel briefcase which he kept in his bedroom with the keys.'

- 3.2.5 We established that at the time there was no Trust policy or procedure for the management of outpatient non attendance or failure to keep home visit arrangements. Nor was there a Trust policy for lone working. There was, however, a South Gloucestershire Social Services policy 'Preventing Violence' dated September 1999 which, under the heading 'Working away from the office', gave detailed guidance on visiting users' own homes, including risk assessment. LMcC explained that he had followed ASW training and procedure for safe home visiting. In response to our Inquiry questions regarding the arrangements for visits where risk might be present LMcC said in his written statement:

'Our practice in relation to visiting when we are concerned about risk depends on the level of risk. In extreme cases, such as high risk Mental Health Act Assessments we will attend with the Police. If the risk is less we will request the person to attend at our offices so that other colleagues are available if needed. If there is some concern we will visit in twos. We also can arrange to inform colleagues about a visit and advise that if we are not back by a set time that they seek to make contact with us at the home address. With MN on 27 March 2002 I had no reason to expect any threat to myself so I did not make any arrangements with colleagues about this visit.

At present all Approved Social Workers have their own mobile phones. At the time we shared phones which we only used for Mental Health Act assessments. At present we can therefore be contacted directly or contact colleagues or Police if there are concerns. If I had had a mobile phone I would have had the option of phoning a colleague or Dr M directly for advice.'

No threat expected

LMcC was clear in his evidence to the Inquiry that he had no reason to expect any threat to himself when he visited MN on the day of the homicide. In particular, he pointed out that he did not know MN possessed a collection of knives. We refer again to this later.

No mobile telephone

LMcC was not issued with a mobile telephone for routine social work visits. We consider it essential that all community mental health professionals carry mobile telephones and we are pleased to hear that South Gloucestershire ASW's now do so.

- 3.2.6 In his written statement LMcC went on to describe the significance which he and Dr M attached to MN's behaviour as reported at the team meeting in the afternoon on 27 March 2002:

'When I spoke to Dr M in the afternoon I explained that I had visited M that morning. I explained the bizarre nature of his speech and his threat to me. It is difficult to recall in detail how our discussion went. I seem to remember that Dr M was not under any sense that M was an immediate risk to himself or anyone else. We agreed that he would discuss M's presentation with a colleague and that I would contact the family to see if there was any indication from them that things had been different for M recently. I also agreed to put my concerns in writing.'

- 3.2.7 At Bristol Crown Court on 17 February 2003 the Prosecution's Opening Facts, undisputed by the Defence and accepted by the Court, described the events of 27 to 31 March 2002 in these terms:

"As to the facts of the case, on 27 March last year, at or shortly before midday, the defendant MN stabbed to death a 79 year old housewife called RH in the kitchen of her home in Winterbourne.

He used the knife that is on your Lordship's desk in the brown envelope. The knife, as you can see, is resting in a home-made sheath and is a very large knife indeed. It was a savage and brutal attack, at least 42 stab wounds were later found on her body. It was also an attack without any motive at all. Nothing was taken from the house other than her car which was used to get away from the scene and abandoned later the same day not far away.....

.....At about 11 am on the 27th, LMcC went to see MN at his home... by appointment. There they talked for a little while and the defendant refused to acknowledge that there was anything wrong with him, which was par for the course. Otherwise the beginning of their conversation was normal. But as the conversation developed, LMcC reminded him that he had talked of atoms and molecules on a previous occasion, and this instantly triggered something in the defendant. He immediately became irrational and at times incoherent. He talked of death shops in Sheffield, the Ku Klux Klan and pills that would kill you if you took them in the right sequence.

His behaviour was so frightening that LMcC quite understandably began to get scared. It was now about 11.15 and he chose his moment and made to leave. The defendant was still incoherent and rambling on, but in the middle of these ramblings he said to LMcC these words: "You and your family are going to be butchered".

The defendant, who is invariably described as a "loner" by those who know him, then left the house shortly after 11.15 and he took that knife, which your Lordship has, in a home-made sheath with him.....

After hearing from LMcC on the Sunday, that is 31 March, the defendant was arrested at his home..... He had a recent cut to his hand which had obviously bled at some stage.....there was a very careful search of the house, especially his bedroom, and what was discovered in his bedroom proved beyond any doubt whatsoever that the defendant killed RH.....

It would appear likely that almost as soon as LMcC had left [his home], the defendant, in that emotionally aroused state observed by LMcC, became more unstable, armed himself with a knife and left the house..... RH was almost certainly in the front garden, weeding, hence the rubber gloves. The defendant would appear to have seen her and would appear to have gone into the house, either with her consent or followed her into the house without her knowing.

One of the features of the defendant's illness is that he has no insight into it at all. I make it clear to your Lordship and to the public that there is no doubt that he is genuinely ill and there is no question here of him malingering or exaggerating his symptoms.

That lack of insight appears to be the case up until the present day. He is quite sure there is nothing wrong with him and he remains fairly adamant at least that he had nothing to do with the killing, but has been persuaded by the evidence and by members of his family that he patently did do the act."

3.3 The family's recollections of that day

3.3.1 The day was unremarkable as far as the family was concerned. When LMcC arrived to see MN several members of the family were already present. MN's mother, her ex-husband's second cousin CP (now deceased), DC and her son J, were discussing an imminent family holiday. There had been no concerns about MN's health. He had been to cash his money that morning. DC remembered that he had come downstairs when she arrived and, since her son and MN had not seen each other for some time, there had been laughter. "We were saying "oh my gosh, you look so much alike" and everything and MN was smiling and my son was laughing and everything; and then MN went upstairs. That was only a few minutes. My son stayed in the kitchen with us and MN went back upstairs, like he always did really".

3.3.2 The family remained in the kitchen whilst MN and LMcC sat in the living room, about a couple of metres away with the doorway open but more or less out of earshot. As she was leaving with her son, DC said goodbye to MN but he did not reply, having his head in his hands, which she had briefly thought was strange, but she did not think he was agitated or upset. We quote from MN's mother who described what happened immediately after that; "MN came out into the kitchen and LMcC stood there and looked at me and I said, "This house is hectic". It is a madhouse in our house. He left and I could see when MN shut the door he was like all agitated. He did not know what to do. He was pacing backwards and forwards. I said, "[MN], you all right?" He said "What?" He said, "Oh, all about molecules and things". I looked and he was still sort of edgy, pacing about, and I said "Well what did he say then, [MN]?" He said - he mumbled. I do not know exactly what he said and I could not tell the police neither.

I said it was either 'he does not have to see him again' or 'he will not be seeing him again'. I did not know which it was. At the time I am thinking, 'Oh my God, I hope he hasn't dismissed MN'."

3.3.3 MN then went straight upstairs, back down, out of the house, around the corner and killed Mrs H. He returned home that afternoon at around 3pm.

3.3.4 The following day at about 2pm LMcC telephoned DC on her mobile. She was in the supermarket at the time and recalls that LMcC told her about his conversation with MN the previous day in which MN had mentioned a Death Row shop and drawn things on the carpet, and saying he had thought MN was going to "thump" or "hit" him. DC had thought the conversation "bizarre" and "weird", wondering why he had rung her. She did not think he had mentioned a meeting with Dr M.

3.4 Health and social services responses on 27 March 2002

3.4.1 The Inquiry has read the Multi-Disciplinary Homicide Audit, completed by the Trust, and heard evidence from the professionals and family involved.

3.4.2 The findings of that Audit, which were reported in February 2003, highlighted two particular issues regarding LMcC's actions after MN's disturbed utterances and threats during the home visit on 27 March.

'.....LMcC had previously asked M about his mental state when he saw him at home, M had denied experiencing any symptoms and remained calm during these conversations. There was no reason for LMcC to predict M's very different response to questioning about this area when he saw him on the 27 March.....'

.....M's relatives were present in the N's home at the time when he threatened LMcC. However LMcC did not take this opportunity to discuss MN's threats with them, or to obtain their feedback about M's recent behaviour.'

3.4.3 As one of the 'Lessons Learned' the Audit concluded:

'.....When a patient makes a specific threat to a named individual staff should take very prompt action, in particular if this is the first occurrence of this type of behaviour. It is good practice to inform relatives/carers and consult with them as early as possible following a serious incident of this type.'

3.4.4 In its recommendations the Audit specified:

'.....Clear guidance on staff actions and responsibilities following a threat of violence made by a patient in the community should be included in Trust Risk Assessment and Management training programmes.'

LMcC's action consistent with training

LMcC has pointed out to the Inquiry that he was not given an opportunity to comment upon the finding of the Multidisciplinary Audit that he had not spoken to MN's family about the threats to him before leaving the house. He states that his response was in line with the training he received, which advised him to remove himself from a situation in which he believed he was going to be imminently assaulted. We accept this and refer to it again in the commentary at paragraph 3.12.8 where we make recommendations concerning action that should be taken.

3.5 Victim's and patient's families' concerns

3.5.1 In their written and oral evidence to the Inquiry, members of the victim's family has expressed in the strongest terms their view that health and social services had failed to monitor MN from July 2001 onwards, and that the response to his threats to butcher LMcC and his family should have been immediate. The family of MN also thought that LMcC, knowing that MN had a collection of knives, should have swiftly called the Police and not left MN 'agitated and upset'.

- 3.5.2 Our Inquiry has attempted to keep in mind their concerns, and the associated deeply distressed feelings, as we have taken evidence from staff and in examining related operational policies and practice guidance. In particular, we have considered:-
- The extent to which LMcC had been briefed and updated as part of his joint work with Dr M to respond to the behaviour of MN;
 - Any operational guidance and associated training that would have been expected to influence their judgement and actions.
- 3.5.3 In doing so we have remained aware that the events have also been personally traumatic for all the staff who were directly involved. We are also aware that in LMcC's case, the killing happened after a period of prolonged work pressure and at a time of extremely distressing family illness. Whilst sympathetic to the nexus of human feelings so clearly experienced by victims, carers and staff members, we have tried to weigh dispassionately any evidence which might show whether or not the professionals concerned responded appropriately in the circumstances.

3.6 Briefing and updating

- 3.6.1 LMcC's first contact with MN was as the Approved Social Worker reporting to the MHRT on 20 October 2000. In his written statement he described himself as *'familiar with the background'* when on 4 January 2001 MN's Aunt contacted him *'as he had been discharged home and she was confused about the situation.'* By agreement with his supervisor, he became the allocated worker from social services, attending most of the joint meetings involving the psychiatrists, MN and family members between 21 January 2001 and 29 March 2001. Thereafter, he saw MN on his own in April, June and July 2001 and, after direct contact was lost, he and Dr M advised each other by letter of their contacts with family members until 15 January 2002. They also spoke informally about MN when they met at weekly meetings of the Community Mental Health Team, though there was no planned discussion within the team.
- 3.6.2 Chapter 6 will later examine CPA as it did and did not impact upon MN's care. We have already noted that aftercare planning was informal and did not follow CPA national policy guidance and the Trust's own CPA procedure. In consequence, LMcC did not receive copies of the discharge CPA form. He completed social services' care management documentation, but it was not copied to Dr M. Thus the paperwork of each agency was not a mutual briefing tool. However, Dr M and LMcC clearly kept each other informed of significant contacts with MN and with his carers after direct contact with the patient himself ceased, from July 2001 until 27 March 2002.

Good communication between Dr M and LMcC

Although the arrangements for ongoing contact with MN failed to follow formal procedure and there was little discussion within the Yate CMHT, we have seen no evidence to suggest any impediment to communication between the psychiatrist and social worker. On the contrary, the content of the letters, which represented the principle records as well as means of communication, suggest a good degree of mutual understanding and shared views of MN's circumstances within the previously described limitations of the information which was provided when he was discharged on s17 leave from hospital on 23 November 2000 and later from s3 on 19 March 2001.

3.7 Designation of official roles in relation to MN

- 3.7.1 Both the Trust's CPA procedures and social services' Care Management process expected that a named person would be appointed as the primary contact with the patient, his carers and other related services such as GP, housing agencies etc. In practice no-one was appointed as care co-ordinator under the CPA procedure, and LMcC told us he did not consider himself the case manager under Care Management since he did not have overall responsibility. He described himself as the allocated social worker.
- 3.7.2 SL, the Locality Co-ordinator responsible for case allocation in Yate CMHT, told us in her statement: *'There is written evidence of several meetings involving members of MN's family and Dr M. There is no written evidence of a professional's meeting where joint concerns could have been raised and solid plans put in place.'*

Dr M decided on 3-monthly outpatient appointments for MN, a decision which was not known to the Team. My knowledge of this Team suggests that members of the Team would have questioned such a lengthy gap between appointments.

Liaison between Dr M and CMHT members was patchy. MN was seen in June 2001, then did not attend his appointment in October 2001. To the best of my knowledge there was no discussion following this event within the Community Mental Health Team.'

- 3.7.3 This is consistent with LMcC's evidence that: *'My understanding is that Dr M was responsible for the overall care of M's mental health. I saw my role as seeking to engage with M, monitor his mental health and help him develop a constructive routine that would enhance his mental wellbeing.'* Also *'The overall responsibility for how we managed and overall decisions we take about MN were Dr M's'.*
- 3.7.4 His understanding is echoed in Dr M's evidence: *'Over the following months MN attended outpatient appointments at my clinic at Yate, some jointly attended by LMcC.....whose main role was to build a therapeutic relationship with MN focussing on work and training issues.'*
- 3.7.5 In terms of LMcC's part in eliciting the nature of MN's thoughts, Dr M told us that his *'role in relation to managing MN was under the heading of trying to engage rather than challenge or assess his mental state in detail'.*
- 3.7.6 All of the evidence suggests that this mutual understanding of roles, and arrangements for communicating progress, continued up to the killing as described by Dr M: *'During the period between October 2001 and MN's arrest, LMcC and I discussed him on a regular basis at our Team Meetings and acknowledged both our limitations in respect of his decision to default from follow-up, and our belief that the family would alert us in the event of a significant deterioration in his health.'*

3.8 Social Services' case recording

- 3.8.1 As social services' allocated worker for Care Management, LMcC completed the documentation for social services allocation, recording and work supervision procedures. His running records, although brief, logged all his contacts and attempted contacts with MN and his carers. However, we concur with the view expressed by the Multidisciplinary Homicide Audit, which assessed the social service case file against the national standards set by the Social Services Audit Tool (2001), and found: *'The file failed to meet many of the relevant quality standards.'*

LMcC and Dr M shared information with each other despite very poor record keeping

It has been important to determine in what ways the acknowledged deficiencies in completing the Trust's CPA records, combined with Dr M's complete absence of medical notes other than follow up letters, and LMcC's scanty record keeping, may have contributed to the events of March 2002. We have, however, seen no evidence that Dr M and LMcC did not understand each other's roles or, more crucially, that either was unaware of the most recent information relating to MN, which would have influenced their actions in the months leading up to the killing.

3.9 Understanding MN's mental state

- 3.9.1 We have noted that at the end of November 2001 Dr M had received Dr J's belated discharge summary which, referring to MN's presentation in hospital, described his reactions as *'bland response to everyday topics....but when questioned about any abnormal beliefs, his manner became much more agitated.....'* His summary reiterated that *'it became more likely that the diagnosis was one of schizotypal disorder rather than 'frank schizophrenia'.*
- 3.9.2 Dr M described the understanding on which he and LMcC were working thus:

'I believe, most if not all of the management of his case turned on his diagnosis. He came in for an assessment which was prolonged, and he went from section 2 to section 3, but the diagnosis was revised, initially by his inpatient consultant and subsequently by myself, in favour of a diagnosis that did not have clear implication in terms of treatment. In a young man for whom engagement was a problem,

which in turn led to the need for a management plan that was sufficiently sensitive to respond to deterioration, but also one that he would agree with, a more formalised intensive care ICPA approach was considered. It was rejected because of the revised diagnosis on the one hand, and because of the impracticality and unworkability given his personality style, on the other hand. Right up until the day of the murder he was under active consideration by myself and LMcC, the two professionals involved. We continued to discuss him, as LMcC's letter of 28 March shows, in terms of referral to assertive outreach. I believe we were continuing to grapple with the problem of how to assess and monitor him, but we did not see him and had never seen him as potentially dangerous. His risk assessments had shown no previous violence, no evidence of specific victims, threats, command hallucinations, his drug usage was an historic one. So we were reassured – wrongly as it turns out – that his case could be managed in the way I managed it, which was essentially watching and waiting for any sign of deterioration.'

Impression of little change

By the second half of January 2002, Dr M and LMcC were both under the impression that in the previous three months MN's behaviour had remained strange but not overtly disordered, and that he continued to avoid contact with the treatment and care offered. His family had not made recent requests for advice or support, and in response to Dr M's and LMcC's enquiries had described little if any change from the situation that from their perspective had prevailed after discharge from hospital, over a year previously.

3.10 The actions of Dr M and LMcC in 2002

- 3.10.1 By January 2002 LMcC had been unsuccessful in his attempts to see MN since July 2001. His direct last contact with the family had been on 10 October 2001 after which he reported to Dr M MN's mother's description of his withdrawn, pre-occupied and irritable behaviour. This was later confirmed by Dr M's subsequent note, after the failed outpatient appointment of 23 October 2001, that MN was described by his aunt as *'irritable and agitated'*. As a result, Dr M arranged the next outpatient appointment for 15 January, which he requested the family to make sure MN attended.
- 3.10.2 Dr M's evidence confirmed that at the time he saw this measured pace of response to the family's reports as appropriate. It also reflected the view expressed to MN's aunt, and contained in his letter to LMcC following the next failed outpatient appointment on 15 January 2002, that there was *'a continuing dilemma in being unable to offer a more assertive role at this stage. I will leave an open appointment for MN at this stage.'*
- 3.10.3 In his oral evidence LMcC described the situation thus: *'.....we were not being presented with a great crisis. MN is either keeping on it or he is better than he used to be. He is not causing a fuss, he is not frightening anyone.'* He also commented *'On reflection it is clear that there is some disordered thinking going on.....he is still unwell but he is holding it together. It is just the difficulty of what we do with him. What do you do with someone who is unwell but not presenting any management issues, in effect not presenting you with any chance to help him or work with him?'*
- 3.10.4 In this context, during LMcC's next supervision session with his senior colleague, the suggestion arose that MN might be better served by the assertive outreach team. When we asked if this might have been initiated sooner, LMcC responded *'at the time that MN started to avoid us I personally had a lot of other work to do as well, so unfortunately it is just that somebody drops down your priority list and again it's the same issue, that he is not a concern, he is not doing anything to frighten us, we are not hearing the family on the phone every week saying we are really frightened; would you please talk to us and tell us what is happening.....By January 2002 we are not thinking this man is a risk, we are just thinking we cannot get in touch with this guy.'*
- 3.10.5 The note of the supervision session conducted by JB on 14 February 2002 records: *'MN is avoiding all contact with Dr M and L(McC). Discussed referral to Assertive Outreach Team. L(McC) to discuss it with SC (Assertive Outreach Team leader)*
- 3.10.6 LMcC discussed this with Dr M on 4 March 2002 and ten days later spoke to the Assertive Outreach Team, who sent a referral form that he took with him to explain to MN on 27 March 2002.

On basis of what was known at the time a non-urgent approach was not unreasonable

In Chapters 5 and 6 we shall conclude that when MN began to miss appointments Dr M should have re-assessed the possibility that MN could have been suffering from untreated schizophrenia. A full CPA review should have been held, with the family, Dr M, LMcC, CMHT CPN's and GP invited. This might have resulted in earlier referral to the assertive outreach team or even a psychiatric assessment at home. A more rigorous Trust 'missed appointments policy' was undoubtedly needed and we refer to this below under paragraph 3.11.4. However, we cannot know whether a quicker or more in-depth investigation would have revealed any new symptomology, or made any difference to the outcome. On the basis of what was known at the time, the decision making process between Dr M's letter of 15 January and 4 March 2002 reflected the not unreasonable, non-urgent view which, in the absence of any contrary indications from patient, family or GP, psychiatrist and social worker took of MN's condition and needs. Without any obvious emergency, the pace of referrals from acute services to long term assertive and rehabilitative mental health services will commonly follow such a measured, evaluative course.

3.11 LMcC's preparedness for the home visit on 27 March 2002

- 3.11.1 LMcC briefly noted that he spoke to MN on Monday 25 March 2002 arranging the visit for Wednesday 27. In the light of the CMHT's concerns at the time of MN's discharge from hospital in November 2000, we asked if there were any triggers that would have caused LMcC to think he should not be visiting MN alone. He considered, however, that the CMHT's views had related back to the circumstances of the s2 removal in October 2000, almost 1 ½ years previously, and that all subsequent contacts during 2001 had raised no such concerns. Dr M and he had discussed the fact that he was seeing MN alone and there was an established pattern at CMHT meetings for alerting CPNs and social workers to the advisability of visiting in twos. *'That was not the case with MN. He was not making a fuss or telling me not to visit.'*
- 3.11.2 LMcC added, in his evidence to the Inquiry, that he did not know, and had not been told by any family member, that MN had a collection of knives. He cited his entry in his Assessment of Need dated 15 March 2001 that there had been a concern that MN had 'a knife', but that it was a small fishing knife and MN's mother did not feel threatened by this. Dr M told us *'we did not see him and had never seen him as potentially dangerous'*.
- 3.11.3 This perception of low risk prior to the home visit was in such stark contrast to the disturbed MN revealed later the same day that we have examined it in more detail in subsequent chapters. We conclude that the memory of MN's aggressive behaviour, originally linked to his psychotic thinking, seemed to fade with the change in diagnosis to schizotypal disorder.
- 3.11.4 Had there been a CPA review and structured risk assessment before LMcC visited MN, LMcC might have been reminded that
- MN had been telling the clinical team not to visit, by means of missed appointments for eight months. This might have indicated a deterioration in mental health and MN could have been as disturbed as he had been when Dr M originally visited him at home.
 - A diagnosis of schizophrenia had not been excluded.
 - There was evidence that MN had a number of knives. Dr M's letter back to Dr B, MN's GP, before assessment under s2 stated *"Mother said MN had knives in his possession"*. That letter had been sent to Dr J and upon MN's admission to hospital a nurse referred to concerns about the *"no. of knives owned by MN"* and, despite his evidence to the Inquiry, LMcC wrote in his social work report for the MHRT that he had spoken to MN's mother who said *"he does have some knives and a pistol with the insides removed but she has never felt threatened by him"*. Added to this, on 13 December 2000 Dr M wrote to Dr J saying that DC had told him MN had recently acquired a hunting knife which he kept with his diary. The social services department received a copy of that letter.
 - Despite the comment of Dr M above, MN had been seen as potentially dangerous upon his admission and during assessment under the MHA when it was said he had *"threatened violence"*.

CPA review and risk assessment may have helped preparation for home visit

We cannot know what difference, if any, a CPA review and structured risk assessment would have made to LMcC's preparedness for the home visit on 27 March 2002, but he might have been alerted to the possibility of finding MN suffering from untreated schizophrenia. MN had not been seen by a professional for eight months and his mental state was unknown. It is also possible that a CPA review would have resulted in attendance at the home by a CPN rather than an ASW – or indeed both. With two professionals it might have been easier to obtain information from the family and manage any unexpected situation.

LMcC could have been at risk himself

By undertaking this home visit by himself, possibly expecting to find MN alone in the house, LMcC could have placed himself at risk. We do not overlook the fact that threats were made to his life and, had he walked away from MN's house rather than getting into his car, his safety might have been in serious doubt.

LMcC's actions consistent with procedure on safe home visiting

We conclude that, as far as procedures were concerned, LMcC had complied with his department's requirements as to safety of home visiting. He had in 2001 attended training courses on 'Risk Assessment and Risk Management' and on 'Staying Safe – Responding to Aggressive Service Users'. We have examined the procedure on visiting in situations of potential risk contained in South Gloucestershire Social Services' Policy *Preventing Violence* dated September 1999, and find that his arrangements for the home visit were consistent with such training and that policy.

Need for improvement to Trust and social services' policies

We have seen the Trust ICPA Policy which, since the homicide, has an Outpatient Non-Attendance and Failure of Patients to Keep to Home Visit Arrangements Policy included within it referring to the need for consideration of staff safety when visiting patients at home after missed appointments. We recommend that the policy state in clear terms that there must be a CPA review and risk assessment before a home visit is made by a CPN or social worker to a patient who has missed appointments, not been assessed for some time and whose mental state is unknown. Social services' *Preventing Violence* policy and the Trust's lone worker policy should link with the ICPA Policy and make specific reference to the need for such CPA review and risk assessment.

Local Recommendation 11:

Home visits following missed appointments

3.12 LMcC's judgement in response to MN's violent threats

- 3.12.1 In his written statement LMcC described his assessment thus: *'As part of my Approved Social Work training I did a study on risk assessment and management within the Mental Health Act assessment setting. A key element of risk assessment is that the best predictor of future violence is past violence. MN had indeed been physically aggressive when detained under section and when forcibly medicated. There was as far as I was aware no indication that MN had any history of using a weapon against others or wounding. I had no indication from previous history that he would do so. I would therefore have only been expecting M at worst to be aggressive in terms of punching me and not attempting to attack me with a weapon.'*

Another element of risk assessment and management was the danger to a person threatened with violence by a patient. In the case of my visit on 27 March 2002 I was that person. MN made a thinly veiled threat against me. My conclusion was that I should get out of the situation as soon as possible.'

- 3.12.2 This is consistent with his statement to the Police: *'Throughout the conversation MN was questioning me about whether I believe him or not and as the conversation went on I felt he was becoming more agitated and aggressive toward me. I felt that he might strike me so I decided to leave the premise. I was getting scared.'*

The time would now be 11.15 am and his aunt, DC and one of the males left the premises and I used this as an excuse to leave so I followed them out the front door.'

MN came out after me and closed the door, at this point he was still saying his psychotic ramblings and during the middle of this I heard him say to me 'You and your family are going to be butchered'. I felt threatened by this.'

3.12.3 When asked who was actually at risk at that moment, LMCC responded: *'The impression that I had was that M was very agitated, very angry. I do not actually recall these things that I have said in the statement, but what it says here is that M is saying "you don't believe me". The impression that I had was that he is very agitated and very hostile and I am going to get a punch if I stay in this room any longer. That is the impression that I had.'*

3.12.4 We also asked about the immediacy of these threats and whether, if he had a mobile phone at the time, he would have phoned for assistance. He responded: *'Possibly, yes. I felt alarmed, I felt threatened, I felt that I needed to get out of the way and that is what I did. I suppose that I have spent a lot of time thinking "what if" or "I should have done this, I should have done that". Maybe, if I had not already known that I was meeting Dr M at two o'clock that day, I would have thought that I have got to get on to this straightaway. I have to get in touch with Dr M right away. But I knew that I was going to see him, it was a previous arrangement. I was going to run this past him and see what he says, see what we do. I think M's threat was not I am going to butcher you and your family, it is you are going to be butchered. So it was not going to pick up a knife and come after you today, but it was just a very unpleasant general threat.'*

I think I said somewhere that part of risk assessment and management is if a person says I am going to get you, or you are the one who is going to be got, then that is the person you need to get away from them.'

3.12.5 We also questioned if he had considered the possible risks to MN's family members in the next room. LMCC responded that only MN's mother was present, his aunt and other visitors having left. He thought *'I can actually get out of here without saying "MN you are scaring me, I am going"'*.

3.12.6 LMCC told us that after he heard of the killing he thought of several male clients known to him *'and I did not even think of MN as possible.'* It was not until a colleague asked if he had considered MN that he made the association that it had *'happened on the same day. It was just around the corner. It is right in the vicinity. I think that reflecting on the content of MN's speech at that point, that was really quite bizarre that stuff.'* After discussion with his team manager on 29 March 2002 they agreed that he should inform the Police of his concerns.

3.12.7 In his statement, Dr M summarised his view thus *'With the benefit of hindsight I believe that MN had a remarkable capacity to conceal his psychotic symptoms from professionals and carers alike which he displayed throughout the period following his discharge from hospital. I also believe that following his hospital admission, his determination to evade both medication and re-admission was a strong motivation for him. He managed to successfully present himself to me and to LMCC for assessment and other appointments in a manner which left little leeway for more assertive intervention. I do not believe that significant violence of the kind which occurred on the day of the incident could have been predicted given the information available to me and my team.'*

3.12.8 In his oral evidence, referring to the situation which faced LMCC on the home visit in March 2002, PMcK said *"Whether you are a nurse or a social worker, the level of aggression and violence that we deal with now was not part of the contract – it was not part of the job.....We are dealing with something we are not keeping pace with in the sense of how we prepare and support staff. It is an incredibly frightening place sometimes to work in...whether in a ward or whether you go into somebody's home. I do not think people have kept pace, both nationally and locally, with just how different and how difficult it is any more."*

LMCC's actions based upon perceived personal threat

All of LMCC's evidence, at the time and to the Inquiry, has consistently reiterated that he interpreted MN's threats as personal to himself and his family, that he should defuse the situation by stopping the interview and then leave MN's home immediately. His action is consistent with the standard practice of withdrawing in the face of overt threats in order to defuse a situation of conflict.

Appropriate response

In view of the open configuration of the house, it would not have been possible to speak to MN's mother immediately without MN becoming aware of the discussion. LMcC was not issued with a mobile telephone and had no means of making an urgent call. He clearly saw the need to inform Dr M and did so as soon as they met that afternoon. Dr M's response was, appropriately, to suggest that the family should be asked if they had seen anything unusual in MN's behaviour. When LMcC telephoned DC the next day, she reported nothing untoward. None of the parties to these discussions and enquiries, that is, carers, social worker or psychiatrist, were at that time aware that the killing had taken place. To that extent their experience and views of MN's condition appeared much the same as before, save for the disturbed and threatening reaction when LMcC had asked him about his thoughts. At the time, both Dr M and LMcC considered that they might be facing the need for another MHA assessment in the manner of October 2000.

Threats of specific serious violence should be reported immediately

Even after he knew of the killing, LMcC did not immediately think of MN as a possible perpetrator. Nevertheless, and bearing in mind what appears in paragraph 3.4.4 above, we consider that in situations where a patient makes a threat of specific serious violence, in the manner described in LMcC's evidence, those threats should be reported immediately to the police and/or the patient's psychiatrist and general practitioner. All mental health professionals should have a mobile telephone so that this can be done very quickly if necessary. In this way contemporary evidence is immediately shared so that decisions may be made jointly by the responsible agencies on the action to be taken. In MN's case it might still not have been possible to act quickly enough to prevent the killing of Mrs H, which no-one could predict would occur within half an hour of LMcC's visit. But at the very least this would have ensured that the police might have been able to make an immediate connection between the victim and her near neighbour as a person who had a history of mental illness and had made a recent threat to kill.

Local Recommendation 12:

Responding quickly when threats of serious violence are made

3.13 MN suffering from paranoid schizophrenia

- 3.13.1 Following MN's arrest on 31 March 2002 Dr OB, duty psychiatrist, was asked to attend the police station, and he says of this in his statement to the police later: *"I found MN to be having bizarre paranoid delusions. It is ... my opinion that MN suffers from paranoid schizophrenia"*.
- 3.13.2 That diagnosis was confirmed in psychiatric reports prepared for the criminal proceedings for the purpose of conviction and sentencing. Dr L saw MN in Fromeside on 30 October 2002 and states in his subsequent report *"In my opinion, there is very good evidence that MN suffers from a severe mental illness, namely paranoid schizophrenia"*. Dr RT interviewed MN on 3 February 2003 and in his associated report states *"His clinical team have made a firm diagnosis of paranoid schizophrenia"* and his own opinion, *"He appears to have a mental illness, which is schizophrenia"*. Dr E in his report dated 14 February 2003 states *"MN is suffering from a mental illness, namely schizophrenia, within the meaning of the MHA 1983"*.

Chapter 4

MN and his family

4.1 Reasons to be concerned

- 4.1.1 We have asked ourselves how it was that MN could remain suffering from a psychotic illness whilst untreated at home, untreated for part of the time in hospital and untreated for over a year after his return home.
- 4.1.2 With the advantage of hindsight it is possible to see from the history that MN's mental illness remained covert for most of the time, while at home and in hospital. When withdrawn in his bedroom, both at home and in hospital, he was able to conceal many of his symptoms, even when unmedicated.
- 4.1.3 We conclude in this Chapter that following MN's admission there was a spiral of withdrawal and concealment of symptoms, which prompted a gradual revision of the diagnosis and treatment plan, that led to his further withdrawal and concealment of symptoms. This eventually resulted in MN's return home without medication and his discharge from s3 MHA on the basis of a working diagnosis of schizotypal disorder. Thus his situation as someone with a severe but untreated mental illness, as in the year preceding his admission, was reinstated by degrees.
- 4.1.4 MN's clinical treatment and diagnosis is considered elsewhere in this report. Here our focus is upon the family's place in this picture.
- 4.1.5 Whilst reading this Chapter it is worth bearing in mind the comment made to us by MN's sister, VN, who described how different MN was after he had been treated in Fromeside Secure Unit: *"He is completely different. You can hold a conversation with him. He will laugh at the jokes.... MN is now the MN he was when he was a little boy....just totally different."*
- 4.1.6 We add a note here that we have heard from both the victim's family and the family of MN. Unsurprisingly, the emotions revealed have been considerable. Unusually, after the criminal proceedings MN's family asked the police if they could write a letter to or even meet with the victim's family. The family of the victim agreed and a meeting took place, mediated by a policewoman and attended by two detectives, at a local hotel. Summing up her feelings about the meeting, DC told us that it was *"very good for both families. Hard."*

4.2 Family recollections of MN's mental illness

- 4.2.1 We were interested to establish what the family thought of MN's behaviour before, during and after he was admitted to hospital, so we asked members of the family for their recollections. Of course we take into account that after the homicide the family will inevitably have re-lived that period in their minds, searching for signs of what subsequently happened. That might have influenced their memories of MN. However, what emerges below is of a young man who was, from the family's point of view, the same a year before his admission as he was a year after.
- 4.2.2 Prior to admission he was withdrawn in his bedroom most of the time, saying he could see and communicate with dead people, believing he could fly, talking and laughing to himself, tapping his foot very quickly, washing his hands frequently, thinking he was king and therefore not claiming benefits, believing that as king he owned the library and therefore not returning library books and believing he was married with children to the Queen. Giving evidence MN's mother also remembered that MN had thought something was going to happen to him on the day of the eclipse in August 1999, though that information does not seem to have emerged previously.
- 4.2.3 MN's sister told us that he came out of his room to eat and have a drink, but quickly returned there. He did not talk much. The symptoms were not accompanied by aggression and for a long while they were tolerated by the family, who did not realise he was ill.

4.3 'Normal'

- 4.3.1 It is impossible to read through the notes of the time and the Inquiry evidence without being struck by the number of occasions on which MN is described as "normal" or even slightly 'improved'.
- 4.3.2 MN's mother wrote to the Tribunal on 20 October 2000 *"most of the time MN appears normal in every way"* and she repeated that her son was 'normal' to nurses on 6 November 2000. CPA documentation on the day that s17 home leave was authorised stated *"Mum does not see much change in MN since admission"*. MN's mother confirmed to us that on the day of his return home he *"was just his normal self"*. In January 2002, following MN's third missed outpatient appointment, Dr M wrote that DC had told him that morning *"things are unchanged regarding MN's reported mental health problems"*.
- 4.3.3 A week after returning home, when nurse LD spoke to MN's mother, she recorded *"Spoke to mother who feels that MN is better than before going to hospital"*. Two weeks after that, following a review, Dr M wrote that MN's mother *"offered the view that her son had improved since hospital admission"*. Dr J noted on 17 January 2001 that MN's mother had told him *"I don't think he is ill or anything"* and Dr M, referring to the same review, wrote *"His aunt (DC) also contributed to this positive view of things"*. Two months later in March 2001, LMcC wrote in his Assessment of Need *"Since his return home MN's mother feels that he is much better"*.
- 4.3.4. On the face of it these appear to be optimistic remarks. And Dr J told us that he had relied on this contemporaneous evidence of improvement which he noted had taken place in the absence of medication.
- 4.3.5. But how did it come about that such positive comments could be made when it now appears most likely that MN was suffering from a psychotic illness throughout that time? In an attempt to find an explanation, albeit a retrospective one, we asked the family for their recollections.
- 4.3.6. MN's mother told us that when her son arrived in hospital *"he was the same as what he was at home. It was just that in hospital he was a bit more edgy... because he did not want to be medicated"*.
- 4.3.7 MN's aunt DCr noticed that he seemed to become *"a bit cautious of us"* after he had been admitted. She thought this was because she, DC and MN's mother had been involved with his admission to hospital. But he was essentially *"no different"*. She too used the word 'normal' to describe MN and she tried to explain what the family meant by this; *"The MN we all knew...the MN that has grown up. To me he was just a normal child apart from his beliefs and his strange sayings... He was the MN who we had got to know, I suppose. Obviously, he was different, because he was ill, but, because it had been a gradual slow process of him getting from being like a sane person, if you like, we did not really take much notice. He was just like an everyday person, but, obviously, he was not.. He was his normal self"*.
- 4.3.8 DCr recalled that when they took MN out for lunch in Bath *"he was really laughing to himself. I felt quite embarrassed really"*. But, she added that they had *"got used to MN being like that"*. One of the curiosities of his behaviour was that *"you would be talking like we would be talking and then all of a sudden he would say something strange and then within seconds he is talking normal again"*. She recalled that there was no change in MN upon his return home from hospital: *"he was no different to me, he still had his strange beliefs and strange sayings.... I have never known anybody with a schizophrenic illness or a schizoid or whatever. It was all new to us. We did not really know what was the matter with him. We just knew he had some sort of problem"*.
- 4.3.9 VN, MN's sister confirmed *"There was no change in him from the day that he went into hospital to the day that he came home to the day of the crime. ...he was still quiet, he was still laughing, he was still talking to himself"*.
- 4.3.10 Describing MN in March 2001 when the s3 MHA was discharged, MN's mother again referred to her son as *"his normal self. He was the same lad. I did not see a deterioration in him. I did not see him any better.... once he came home he was just the same as he always had been"*

- 4.3.11 Asked whether during 2001 there had been any notable change, his mother replied *"No.... laughing, tapping his foot, thought he could fly – things like this. He remained the same person and that did not change.... It was the obvious signs before he went into hospital". She repeated "There was no change in him. That is what I cannot understand. He just stayed the same. All the symptoms were still there, but then again I would not know what to really look for if he got worse. Apart from what happened, what else does schizophrenia do?" She added "I was used to it. I am sure if he was doing something different I would have picked up on it or if he did get better I am sure I would have noticed that, and there was no change".*
- 4.3.12 Asked by the Inquiry panel if she experienced her son getting better or worse at any time – before, during or after admission - she repeated *"...he was the same person as when he was at home". Emphasising the point she stressed he was "To me, just his normal self.... he stayed the same from the day he was – before he went in to be sectioned, he remained the same person right up to the day of the crime.... and that is why I cannot understand and still believe that he has done it...he was in the kitchen with us on the morning and everything.... nothing". The homicide had been "an absolute shock".*
- 4.3.13 She added that she had *"never spoken to MN about his illness".* No-one in the family had discussed MN's thoughts and beliefs with him in such a way as to *"spark"* a reaction like the one to LMcC on the day of the homicide.
- 4.3.14 When MN returned home on the evening of the homicide he was, his mother told us, *"his normal self".*

MN the same before, during and after hospital admission

When MN's mother used the term 'normal' to the MHRT and to nursing staff she told us she meant it to mean that MN was unchanged, his usual self with all his symptoms before, during and after hospital admission. That is consistent with the situation as we now know it. MN had been suffering from schizophrenia throughout that time. We find the description given by MN's mother of her son's slow mental decline a natural explanation for her gradual acceptance of MN as he was.

Explaining accounts of improvement

The contemporaneous family comments of improvement, relied upon by Dr J, may have had several explanations (i) MN's mental state and mood may have fluctuated, particularly according to whether he was under stress and in or out of hospital (ii) He may sometimes have been more able to conceal his delusional thinking, and (iii) there may have been misunderstandings and miscommunications with the family over reporting of MN's mental state. All of these may have been explanations. There was certainly a need for more assessment of the situation with less reliance upon vague descriptions such as 'improvement'.

4.4 'A step away'

- 4.4.1 Whilst MN's mother clearly struggled to understand the illness that had taken over her son's life, on the other hand DC was, as she put it herself *"a step away"* from the situation, and this allowed her to see it more clearly than her sister. In her own words *"[MN's mother] had seen a gradual change in MN over quite a long period of time, so we could see MN was ill and I think this is where we get confused a bit. [MN's mother] still sees him as the same, but I suppose it was the ill MN....she had got used to this gradual decline and so therefore MN had become normal, where we all could see MN on a semi-regular basis and we would say to ourselves, "No, he's still not right".*
- 4.4.2 MN's sister VN confirmed her mother's difficulty. She said *"Mum did not pick up on it....I did not know what was wrong with him at the time, but I just knew that what he was saying was eccentric....It took her a long time to accept the fact that he was ill".* Eventually VN rang her aunt, DC, saying *"Look, he's gone mad, he needs help, Mum doesn't want to believe it, what can we do?"*
- 4.4.3 Although MN's mother did speak to the clinical team and told us she felt able to contact them if necessary *"I would have just phoned them up. Dr M it would have been",* in practice she rarely instigated such conversations. On repeated occasions DC was the one to take the initiative, express dissatisfaction and bring symptoms to the attention of nurses and doctors.

- 4.4.4 The differences of view between MN's mother and his aunts are suggested in the findings of the Multidisciplinary Homicide Audit in these terms: *'During the admission Dr J had contact with MN's mother LN and with two of his aunts. He found that MN's aunts were both concerned about their nephew's mental state, they felt he had changed in his functioning and personality, and were keen for him to receive energetic treatment in hospital, including the administration of medication against his wishes if necessary. Dr J found that MN's mother was much more ambivalent about her son's illness. She tended to minimise the problems he had shown prior to his admission'*

Dr J reassured by views of MN's mother

Dr J told the Inquiry he felt reassured by the more cautious views of MN's mother, as she seemed to confirm his opinion that MN might not be suffering from a mental illness.

4.5 Carer and communicator

- 4.5.1 The roles of carer and communicator were rather separate in this family. Although MN's mother was the carer it was DC who took on most of the responsibility for communicating concerns to the outside world. Their respective roles should have been clarified by the clinical team. There were crucial moments when the carer was also expected to be the communicator and vice versa, resulting in misunderstandings that could have had an impact upon the progress of MN's care and treatment.
- 4.5.2 Most particularly, at the impromptu CPA meeting MN's carer, his mother, was also relied upon to be the communicator. Later on when MN missed appointments Dr M telephoned DC because she was the communicator, but she could not provide carer information on MN's mental state because by that time she was not in such frequent contact with the family. She had her own family commitments and told us she withdrew when LMcC became involved, believing she could hand responsibility for overseeing the situation to him.
- 4.5.3 To add to the confusion MN's mother and DC told us they had not understood what was meant by being a 'carer' in the formal sense that the word is used in CPA. Nor did they understand they had been classed as 'carers' and were entitled to a carers' assessment.

The family roles of carer and communicator needed to be established by staff

It should have been made clear within the clinical team, to MN's mother and to DC who was going to be responsible for which aspects of care and communication. It should have been clarified at CPA and review meetings. This was especially important because the family was being relied upon to refer should there be any deterioration. Someone within the family needed to know what to look for, when to communicate it and to whom. The professionals involved might have imagined DC was doing this, but she thought LMcC was doing it, whereas in fact it was MN's mother who was left with the roles of both carer and communicator. And she, with a mother's natural doubts about her son's mental disorder, was probably the one least able to see the situation objectively.

Local Recommendation 13:

Making a commitment to carers

4.6 Nursing responses to the family

- 4.6.1 During most of the time he was on Balmoral Ward MN was noted to be settled and isolative. Nursing notes made frequent mention of MN's mother or aunt visiting the ward, sometimes with a food parcel, sometimes asking if MN could go out shopping. Once s17 leave had been authorised, there was a record that he had gone out of hospital and with whom. On only four occasions were there any notes of a conversation with the family concerning MN's mental state:
- On the day of admission nursing notes briefly recorded that mother had no concerns about the number of knives owned by MN.
 - On 6 November 2000 nursing notes record that when MN's mother visited she thought her son was 'normal'.
 - Nursing notes of 11 November 2000 stated DC reported to ward staff that MN had been laughing incongruously whilst out on leave and complaining that everyone was looking at him.

- Notes made following a ward round on 19 November recorded that MN's mother was reluctant to have MN home "*but (sic) on medication*".

- 4.6.2 Given the family's daily visits, it is surprising so little was recorded though, judging by the comments of MN's mother and DC, there was some communication. DC recalled that when MN was first admitted to Balmoral Ward she was told that nurse DW was MN's keyworker and she remembered meeting him. Describing Balmoral and Caernarfon Wards MN's mother told us they had a different feel to them: "*You get to know the staff.... He had been four weeks in that ward, Balmoral, and then he moved into Caernarfon and there were different staff so we did not know them.... Sometimes we would approach the staff but they could not really say a lot to us. But I did not really approach the staff*".
- 4.6.3 DCr, who often visited with MN's mother, recalled that it was difficult to speak to staff because "*we did not want MN to see that we were talking about him behind his back.....on a few occasions we asked if there was any progress with MN and the nurses did not seem to know anything*". MN was, she told us, always in his room when they arrived, apart from one occasion when they were surprised to find him alone in the TV room.
- 4.6.4 The relationship between family and ward staff on Caernarfon Ward was soured by a request upon MN's arrival that he sleep in a dormitory and the further attempt to move him to a dormitory the day before the CPA meeting. In the opinion of the family his refusal to be moved had resulted directly in a decision the following day that he should return home. This serious assertion was investigated by the Trust in the course of responding to a complaint from the family, and we refer to the outcome later in this Chapter.

Poor nursing records of contact with the family

Nurses recorded very little contact with the family even though they visited the ward most days. It appears that nurses acceded to MN's wish to remain 'isolative' in his room where, with his family visiting and bringing in food, he was able to conceal his psychotic symptoms from ward staff. This was not good nursing practice and did not assist accurate diagnosis.

4.7 Medical responses to the family in hospital

- 4.7.1 Medical notes made no mention of any conversation at all with the family whilst MN was in hospital. MN's mother was not asked for a family history and there is no record of any enquiry into the family background. Dr J did not see or indeed ask to see Dr M's outpatient records. He told the Inquiry he knew nothing of the information Dr M had received from the family including the letter from DC to Dr M. Dr J's Tribunal report contained no information about MN's presentation at home or his family background.
- 4.7.2 However, there clearly were occasions when Dr J and the family spoke. Asked how often that was, MN's mother told us she had one meeting with Dr J in connection with the Tribunal and another when MN was assessed under s3 MHA. Other than that "*it was hard to catch hold of Dr J actually. But once or twice I did manage to speak to him even if we caught him coming out of the ward as we were going home*". DCr confirmed this. She was often with MN's mother when they were visiting MN on the ward and had been present at the Tribunal and the CPA meeting.
- 4.7.3 DC told us she did not meet Dr J at all during the period MN was in hospital, though he rang her when the s3 assessment needed to be organised and she then got in touch with MN's mother.
- 4.7.4 The MHA Code of Practice states that longer periods of s17 leave "*should be properly planned, if possible well in advance.....there should be detailed consultation with any appropriate relatives....(especially where the patient is to reside with them)*".⁵ But there was no discussion about long-term home leave with any members of the family until the unplanned CPA meeting on 22 November 2000, and even then there was no mention of diagnosis or treatment plan.

⁵ Mental Health Act Code of Practice paragraph 20.5

- 4.7.5 After MN had returned home DC tried to speak to Dr J about diagnosis, but it was his secretary who rang her back with the diagnosis *"possible schizotypal disorder"*. She did not think it unusual that she had received this information from his secretary because she *"could never see Dr J"*.
- 4.7.6 With considerable honesty Dr J was able to say to the Inquiry *"If I look back on my involvement with MN's care on the ward, probably the thing that I feel was the worst aspect of MN's care was my communication with the family."*
- 4.7.7 He had realised after the CPA meeting that he *"had not treated MN in the way that Dr M had recommended, or that the family had hoped for. So at that point the family.....felt very let down....on MN's behalf that MN was not receiving active treatment."*
- 4.7.8 He went on *"Although I explained the reasons why I did not want MN to receive active treatment at that time,....in retrospect I did not do it well – and as a result of that Dr M, who had been involved from the start and had explained that he wanted to treat MN actively, understandably became a good doctor and myself as somebody who was taking a much more cautious view or liberal view....became very much the bad doctor. So I think the family felt that they could not talk to me personally....it was certainly not a good situation."*
- 4.7.9. It was, Dr J thought, DC who had really lost faith in him. His impression was that MN's mother had, at the time, *"accepted my viewpoint much more, but in retrospect I guess that is because it accorded more with her view of MN's problems."*

A family history should have been taken from the family

Dr J should have ensured that a family history was taken from a member of the family, especially since he did not have Dr M's community medical records. At the minimum he should have requested that his SHO discuss MN with members of his family who were visiting daily, and record that in the medical notes. He should certainly have ensured that MN's mother, with whom MN was to reside, was fully involved in detailed consultation about long term home leave well in advance of the CPA meeting, as recommended in the MHA Code of Practice. We make a recommendation about history taking at Local Recommendation 13.

4.8 Family understanding of MN's medication and diagnosis

- 4.8.1 Dr J described to us his discussions with MN's mother on the subject of medication. He recalled that MN refused medication from the moment of his arrival on the ward (not quite true: he accepted PRN the day after admission) and so he realised that if he was going to give him medication it would have to be a long-acting medication of a typical type (a depot). He said he explained this to MN's mother and, since she had already spoken to National Schizophrenia Fellowship (now Rethink) and Saneline, she was *"if not knowledgeable, at least aware of the potential side effects of typical neuroleptics and therefore was not coming to it entirely fresh...so it was in that light that she said....if we can get by without giving him those sorts of medications I would very much like that."*
- 4.8.2 Explaining the impact of that discussion on his treatment plans, Dr J told us *"I am not sure, but I do not think I have ever based a treatment decision like that solely on the request of a parent or loved one, but certainly that was an influence, there was a desire to try and engage the family as much as MN in any treatment plan that we had. At that point as well, we were trying to observe MN's progress or otherwise without medication anyway, and so the things came together at that time."*
- 4.8.3 We note there is no evidence that MN's mother did ever speak to Rethink. It was DC who made this contact.
- 4.8.4 Dr J's account also contrasts with that given to us by MN's mother, whose understanding of MN's medication, even whilst he was receiving it, does not seem to have been clear. She described to the Inquiry how she regularly asked her son whether he had been given medication that day, even though he was still receiving the benefit of the depot Clopixol. This was not, she said, explained to her at the time, and she had not realised its effects were long-lasting.

- 4.8.5 Although MN's mother was told by a nurse that Dr J wished to speak to her about medication, she recalls that he did not do so and MN's mother described to us how this felt; *"they just kept saying they were going to treat him but nothing happened. I would go and say to MN have you been treated, have you had any medication? No. The last time was the 6th November and one of the staff approached me and said Dr J wants a word with you soon, and he never came. I cannot recall meeting him. It was about medicating I think"*.
- 4.8.6 On 20 November 2000, two days before the CPA meeting, a nurse noted *"Dr J will phone mother to arrange CPA to arrange a plan of action as she is reluctant to have MN but on medication"*. This is a confusing sentence and we asked its author, Nurse DS, to tell us what she had meant by *"but on medication"*. She informed the Inquiry that she had intended to convey that MN's mother was *"reluctant to have MN put on medication"*.
- 4.8.7 However, MN's mother told us she did not at any stage say she did not want her son to be medicated. She had asked that he be given a choice of tablets or depot injection: *"I did not really want him to have depot injections because of the side effects....all I wanted was for [Dr J] to give MN the choice"*. This is confirmed by JM, the social worker who saw MN's mother prior to the making of the s3 treatment order. JM wrote that before agreeing to the s3 MN's mother *"wanted to talk to Dr J to make sure that the treatment her son would be given would not have any side effects."*
- 4.8.8 MN's mother agrees she did not ask any questions about medication or diagnosis at the CPA meeting. Nor did she say she did not want her son home. She accepted that it might have seemed to those present that she was fully in agreement with the plan. But privately she disagreed. It was simply difficult, she told us, to express her views in front of her son.
- 4.8.9 AB, of Rethink, put it to us very simply: *"to be honest, if someone who is not used to dealing with professionals is told by a doctor "You can take your relative home" you tend to say "Yes, of course"*.
- 4.8.10 MN's mother, trusting of the professionals with whom she had contact, said to us there was no point at which she doubted the care given to MN: *"No. I just had faith and trust in all of them"*.

Dr J should have discussed medication with the family and noted their views

We do not think there is any evidence to conclude, as the Multi Disciplinary Homicide Audit did, that MN's mother was 'very resistant' to her son having treatment with anti-psychotic medication. However, the evidence we have seen does suggest some confusion over who thought what on the subject. This was not surprising since MN's mother was at times ambivalent about her son's mental illness, and Dr J's plan not to medicate was connected with the changed diagnosis, itself a complicated matter which was not discussed with the patient or revealed to the family until later. It would have been helpful if Dr J had made a clear note in the medical records on the subject, both when the s3 was made and at the CPA meeting. At Local Recommendation 3 we recommend that diagnosis and treatment is recorded in CPA care plans.

- 4.8.12 We wondered what the family had thought of the medical disagreements on diagnosis. DC endeavoured to understand the professional relationship between the two psychiatrists, coming to the view that *"Dr M probably felt it was schizophrenia but did not like to go against Dr J's diagnosis – ethics and all that.... I just think because you had MN under Dr J – but obviously Dr M was still quite closely involved. I think it was a bit of an awkward situation"*. She recalled asking Dr M *"if you had him and MN was being looked after, would you medicate him?"* and he said *"Yes."* She added *"I know later on Dr M agreed with the schizotypal thing, but.... I think there was just a doubt somewhere in his mind"*.
- 4.8.13 Privately, DC said, she had thought all along it was schizophrenia because 'Rethink' had sent her information about the illness that seemed to fit MN. They also said that schizotypal disorder was a diagnosis that should not really be used.
- 4.8.14 In an effort to ensure the right diagnosis was being made, DC and MN's mother went to some lengths to photocopy MN's diary, coaxing MN out of his bedroom on the pretext of an errand to the local shop. DC explained they did it because *"we knew he was writing things down and if it was going to help anybody"*

make a good diagnosis or whatever we wanted to give them all the information.” It was after this that MN began to lock things away, guessing, so DC thought, that someone had found his diary.

- 4.8.15 Neither MN's mother nor DC were able to explain to us the difference between schizophrenia and schizotypal disorder, and did not recall having had this explained to them at the time. Following the homicide, and in response to a complaint from the family, there was a meeting in January 2003 at which DC remembered Dr J mentioning *“the differences between the three things, I think: schizoid, schizophrenia and schizotypal disorder. I think he tried to explain, but even today I do not really understand what the main difference is, other than Dr J said that schizotypal did not respond to medication.”*
- 4.8.16 When DC made contact with Rethink in November 2000 she was given the names of two psychiatrists in Birmingham who might provide a second opinion on MN's diagnosis. Or in this case it would of course have been a third opinion, perhaps best described as an independent opinion. AB, of Rethink thought it would have been difficult to arrange this without the co-operation of MN, which had seemed unlikely at the time.

Communication with the family was poor

It is of concern that the family remained so ill-informed on matters of medication, s17 leave and diagnosis. We conclude that communication with the family fell below an acceptable standard, including the Trust's own CPA standards which expected participation by carers.

DC's determination to be heard

We think DC in particular deserves considerable credit for her determination to bring her concerns to the attention of those responsible for MN's care. As the spokesperson for the family her voice should have been heard, not after MN's return home, but before.

4.9 Social work contact with the family

- 4.9.1 During the time MN was in hospital the most comprehensive recorded contact with the family came not from within the hospital but from outside it.
- 4.9.2 As an Approved Social Worker, LMcC met with MN's mother on 17 October 2000 in order to prepare a social circumstances report for the MHRT on 20 October 2000, and he recorded her views in his report. On 1 November 2000 social worker JM sought out MN's mother, who as the nearest relative was entitled to object to her son's detention under s3 MHA.
- 4.9.3 Asked how she got on with LMcC, MN's mother told us *“I did not really have a lot to say to him to be honest”*. LMcC confirmed this, telling the Inquiry that it was DC who was the more involved; *“She would ring up, ask questions and try to find out what was happening.... MN's mother was concerned about her son but..... not really engaged.... I do not think that she ever actually asked what was happening. She did not try to find out what I was doing”*.
- 4.9.4 LMcC did speak to MN's mother on 10 October 2001 when MN had, apparently deliberately, been out when LMcC arrived by appointment to see him at home. Moreover he immediately wrote to Dr M explaining the detail of that conversation. This was good practice.
- 4.9.5 On the day of the homicide when LMcC visited MN at home there was no conversation with the family either before or after the social worker spoke to MN, though we bear in mind that it would have been very difficult in practical terms to talk about MN in his presence.
- 4.9.6 For most of time the social worker's role was that of supporting MN and helping him obtain employment. It changed only when Dr M asked LMcC to monitor MN's mental health. At no point was there an expectation that LMcC would use the family as informants, and there had been no discussion about confidentiality.

4.10 MN at home again

- 4.10.1 The MHA Code of Practice states *"It is essential that any appropriate relatives and friends, especially where the patient is residing with them whilst on leave.....should have easy access to the patient's rmo if they feel consideration should be given to the return of the patient to hospital before his or her leave is due to end".*⁶
- 4.10.2 Reflecting upon 2001, DC said that she had taken MN to one or two of the outpatient appointments and they had had a few meetings with LMcC, Dr J and Dr M, and *"lots of words and things were being said, but my thoughts were, 'But nobody's doing nothing'.... We wanted MN to be in hospital to be treated but it just did not happen".* DC explained that expressing dissatisfaction at meetings was a problem because MN was present, and it was difficult to say things in front of him. She was limited to raising her eyebrows and pulling faces in an attempt to convey her opinions. DC recalled that on one occasion in the car park MN *"told us – me in particular – to keep my mouth shut and not say anything, because I think he felt, "They're going to take me back into hospital".*
- 4.10.3 MN's mother and sister said MN spent most of his time at home by himself in his bedroom, often appearing to be asleep. VN said she did not speak to him because *"I would not dare.... He still did not believe he was ill.... we were just doing his head in by keep asking him questions. I thought that I would just keep the peace and not bother to ask him anything."* She asked her mother *"What happens now?....Is he going to be re-sectioned and go back in?"* and her answer was that she did not know. DC told us she did not think it was appropriate for her to go to the GP about MN because she did not think she would have been able to discuss anything with him for reasons of confidentiality.
- 4.10.4 Nor did DC think the family could influence the course of events through Dr M. Her understanding of the situation following a telephone discussion with Dr M in October 2001, illustrates the continuing confusion of the situation *"I think what it was – because MN was under Dr J and Dr J done the diagnosis – I think Dr M did not want to go against that in some ways.....It would not have made any difference I do not think, if I said, "Actually, I think he should be in hospital and have medication". Like I said, it was all confusing, because they were saying one thing but doing another it seemed to me".*

Clinical responsibility was not made clear to the family

It is of concern that a year after MN's return home, when Dr J had long ago ceased to have any involvement with MN's care, it was still unclear to the family that Dr M had taken over complete responsibility for MN. This should have been explained to them earlier in 2001 and certainly by the time of his discharge from s3 in March 2001.

The family felt powerless to influence MN's readmission to hospital

It is also evident that the family did not, despite Dr M's efforts, understand his reasons for not admitting MN to hospital again. Even in retrospect they did not think they could have had any influence on the situation.

4.11 Before and after

- 4.11.1 With the advantage of hindsight we think it probable that MN was suffering from schizophrenia when he was admitted to Hillview Lodge and during the sixteen months he was at home. His mental state may have improved somewhat after his return to his family, but we take seriously the comments of MN's mother, aunt DC, aunt DCr and MN's sister, who together knew him better than anyone else, that MN was much the same at the time of the homicide as he had been before hospital admission. Indeed for the last eight months there was no other evidence of his mental state because MN had been at home without medication and without seeing any professional for the whole of that period.
- 4.11.2 But why, if his mental state was the same, was he not readmitted to hospital? Prior to admission his symptoms had resulted in the family's approach to the GP, the GP's referral to Dr M and an admission to hospital under s2 MHA. Why, if the symptoms were the same, was that process not repeated?
- 4.11.3 We conclude that there were differences in the situation before and after.

⁶ MHA Code of Practice paragraph 20.12

- 4.11.4 Firstly, having been once compulsorily admitted to hospital, the family believed MN wished to avoid that again, and he had sufficient insight to conceal his most disturbed symptoms. In the view of Dr M, who had tried very hard to elicit symptoms from him, MN's capacity to conceal symptoms was unusual. MN also, according to DC, had enough insight to attempt to prevent DC revealing information about him at an appointment with the doctor.
- 4.11.5 Secondly, and paradoxically, the diagnosis of schizotypal disorder itself may have discouraged reporting of symptoms. For the family had already done the most anyone could do with a mentally ill family member – triggered a MHA assessment resulting in compulsory admission to hospital. Before his admission to Hillview Lodge they had reported all the symptoms they observed, including a range of delusional ideas. But the only consequence was that MN had been assessed, pronounced not to be suffering from a mental illness and sent home to them untreated. What more were they to do?
- 4.11.6 We think they were placed in a very difficult position. In order to trigger a recall to hospital or another MHA assessment the family was being asked to look for deterioration, but what exactly did this mean? Looked at from their point of view, there would be no point in repeating the same catalogue of symptoms, since this had had no impact on his treatment at all. For them, the threshold was now in effect higher. The family was put in the invidious position of needing to find something worse about MN's behaviour before any further action could be taken.
- 4.11.7 But there was nothing worse. MN was in the words of his mother *"just normal"*, by which she meant he was still *"laughing, tapping his foot, thought he could fly – things like this. He remained the same person and that did not change.... It was the obvious signs before he went into hospital.... He just stayed the same. All the symptoms were still there"*. By the beginning of 2002 the family had reported that he hid himself away in his room, made strange jottings, laughed to himself, tapped his foot and failed to fill in forms for his Benefits - some of the same symptoms he had had before his admission. The admission had been, MN's mother felt, *"a waste of time"*. After a flurry of concern about possible psychosis, the diagnosis had settled down into something seemingly benign. With schizotypal disorder there was less risk, less to worry about and no treatment for it anyway. The family had reported their concerns but really had no alternative other than to live with MN as he was. Perhaps it is not surprising that MN's mother said she'd become *"used to it"*.

4.12 Risk

- 4.12.1 Our retrospective examination of risk reveals very different understandings of the risk MN represented.
- 4.12.2 At no time did MN's mother suggest that MN was a risk to others. MN had from an early age, we heard, enjoyed outdoor activities such as camping and fishing. It was these activities which, according to his mother, resulted in a collection of about five or six knives. Indeed she said she had bought one or two knives for him herself. VN, MN's sister, said that three of the knives were a set which had belonged to his grandfather. They were curved, the largest having a blade about twelve inches in length. He kept them in his wardrobe, lined up along the back, stood up lengthwise. On the day of his admission to hospital MN's mother told nurses that she had *"no concerns"* about the knives. She repeated this to the social worker LMcC who wrote in his tribunal report *"... he does have some knives and a pistol with the insides removed but she has never felt threatened by him"*. DC told us *"so far as I know he never threatened anyone. He used to just get them out. I think actually my sister-in-law and her son was up in the bedroom a few weeks before [the homicide] and they were just looking at them. They were quite ornate, some of them"*.
- 4.12.3 VN, MN's sister, confirmed that she had never felt threatened by her brother, nor was she worried about any aggression towards others, being content to visit the house with her baby.
- 4.12.4 Dr J emphasised that no-one had suggested MN had violent thoughts or fantasies or had acted out any violent behaviour.
- 4.12.5 Echoing that, Dr M gave evidence that *"we did not see him and had never seen him as potentially dangerous. His risk assessments had shown no previous violence, no evidence of specific victims, threats, command hallucinations, his drug usage was an historic one"*.

- 4.12.6 Everything during the year of his return home suggested a low-key response to a young man who was thought to be unusual but not mentally ill and not dangerous.
- 4.12.7 Yet we remind ourselves that this contrasted hugely with the accounts of MN upon his admission to Balmoral Ward. Then he was thought to be psychotic, in itself associated with uncertainty and potential risk, a police presence was needed, he had knives at home, he was nursed in seclusion, control and restraint were used to administer medication, he was threatening and abusive towards staff. The nursing care plan stated *"If MN is confronted with medication or about his mental state there is a high risk of violence"*. The nursing risk assessment three days after admission (the only formal written risk assessment ever undertaken) gives ticks under the heading *"VIOLENCE"* to *"poor compliance with treatment, psychotic symptoms and irritability, anger, hostility, agitation or suspiciousness"* and *"grandiose and psychotic and has become hostile and verbally aggressive toward staff....Plan of action:- to monitor changes in behaviour that might end in violence"*. Later on the ward he said of another patient *"Cut him up with an axe"* and talked about wanting to put an axe through someone's head. One of the medical recommendations for s3 reads *"This young man has psychotic symptoms..... he has also threatened violence"*. Less than a month after MN had returned home Dr M wrote *"home visiting by our CPN Team, or other personnel, is not to be undertaken in view of MN's previous hostile reaction to home interventions and taking into account his wider risk assessment including his possession of a knife"*. Within three weeks of MN's return home Dr M wrote that DC had told him MN had acquired another knife, which sounded like a hunting knife, which he kept with his diary.
- 4.12.8 Why did the memory of this level of aggression and risk seem to fade? With the advantage of hindsight it seems likely that as MN became able to withdraw into his room, conceal his symptoms and avoid confrontational situations, a 'normalisation' took place. Instances of anger on the ward were no longer thought to be connected with psychotic thinking. He was increasingly viewed as an unusual and angry young man rather than an individual suffering from a severe and enduring mental illness. Upon MN's return home LD wrote in her referral to the Yate CMHT that a recent angry outburst *"did not appear to be due to mental illness and he quickly calmed down"*.
- 4.12.9 We think by the ordinary standards of good clinical practice there should have been routine, recorded updating of risk assessments at the CPA meeting, subsequent reviews and when MN began to miss outpatient appointments. This might have re-focussed attention upon the historical risks, reminding the clinical team that the differential diagnosis of psychotic illness had not been absolutely excluded and that MN was still in possession of knives at home. We note that the homicide involved the use of a knife which was subsequently found by the police at his home, having been identified through forensic evidence.

4.13 A spiral

- 4.13.1 We think it is striking that MN and his family experienced at the outset an unremarkable first onset of psychosis, which was treated in an absolutely standard way. Nowhere, at this stage, was there any mention of MN being unusual. However, once MN had been described as suffering from schizotypal disorder, itself an unusual diagnosis, MN began to be described in medical correspondence as 'a difficult and unusual case'. What had been straightforward became difficult. We examine this 'unusualness' further in Chapter 5.
- 4.13.2 This Chapter reveals the way in which the provisional diagnosis, once proposed, seems to have become self-fulfilling. Since there were no further attempts to medicate him, the florid psychotic symptoms associated with that battleground were avoided. MN was permitted to remain largely unchallenged as to his symptoms whilst withdrawn in his bedroom, both on the ward and at home. He was considered unusual or strange rather than ill, and symptoms interpreted accordingly. A spiral of withdrawal and concealment of symptoms led to yet further withdrawal and concealment of symptoms. There was a gradual collective 'forgetting' of MN's early aggressive psychotic presentation. He became once more the withdrawn individual he had been prior to hospital admission, and the diagnosis of psychotic illness, which had previously been sufficient to justify detention under s2 and s3 MHA, slipped gradually out of sight.

- 4.13.3 It is difficult to see what could have brought the process to a halt. Dr M realised that he needed to probe MN for symptoms, and in June 2001 wrote *"Today's conversation was superficial and defensive as ever..... I pushed him quite hard today to open up to me about his private thoughts. He denied any untoward beliefs and thoughts, as ever"*. Even on the day of the homicide MN had not revealed any unusual thoughts to his family.
- 4.13.4 We conclude that the only thing capable of stopping this spiral was a psychiatric assessment at home as soon as MN had begun to miss appointments. The differential diagnosis had not been completely excluded, and the possibility that MN was suffering from an untreated psychotic illness should have been seriously considered and related risks assessed. A decision was properly made that MN needed to be seen at home but, bearing in mind the diagnostic uncertainties, it should have been by a psychiatrist and/or a CPN rather than a lone social worker.

Poor communication

Taken over the whole period of MN's care, communication with MN's family was poor. They did not know they were 'carers' or what being a 'carer' meant and they were not provided with sufficient information about MN's diagnosis. Communication in hospital and at the point of MN's return home fell below a satisfactory standard. Responsibility for this rested with nursing staff and with Dr J. Once MN was at home the communication initially improved. We find that Dr M made real efforts to communicate with the family, most notably by calling a meeting in January 2001 specifically to talk to them. He did not, however, see them again after that, speaking only to DC once on the telephone in October 2001. The social worker did not go out of his way to speak to the family, but did ask them about MN when the opportunity arose. This was in keeping with his role in relation to MN.

Powerlessness

The family expressed to us their feelings of powerlessness. Since MN was, from their point of view just the same as before, they were unable to provide Dr M with the information on deterioration seemingly necessary for readmission to hospital, and there was a stalemate. Unable to influence change, the family felt dissatisfied and unheard. We make a range of recommendations with the aim of raising clinical awareness of the need to hear from carers in order to make correct diagnoses and provide appropriate treatment. Carers should be valued and the Trust should make a commitment to this. Our Local Recommendation 13 recommends that the Trust gives a public commitment to carers.

Chapter 5

Schizophrenia and Schizotypal Disorder

5.1 Introduction

- 5.1.1 We begin this chapter by examining the clinical issue of diagnosis, for it was this above all else which sent ripples of concern through families and professionals alike. The realisation that a young man living at home thought not to be suffering from schizophrenia was in fact so actively psychotic that his delusions apparently prompted him to kill, has caused shock and anger. Someone, it is widely assumed, must be at fault.
- 5.1.2 We approach this firstly by reviewing current approaches to understanding schizophrenia and schizotypal disorder.
- 5.1.3 Secondly, we look at the diagnosis of schizotypal disorder in the case of MN. Applying current thinking on the subject, was it, we ask ourselves, a reasonable diagnosis for Dr J and Dr M to consider, based on the information they recorded at the time?
- 5.1.4 Following this, we set the diagnostic decision-making in its organisational context. We ask ourselves whether anything could have been done to divert the clinicians from a diagnostic course which, with hindsight we know to have been mistaken.

5.2 Schizophrenia and schizotypal disorder

- 5.2.1 We consider several clinical issues:
- diagnostic criteria for schizophrenia and schizotypal disorder,
 - proposed links between schizophrenia and schizotypal disorder,
 - current views on the continuity of psychotic symptomatology with 'schizotypal' and 'normal' individuals,
 - importance of early intervention in schizophrenia,
 - issues in the diagnosis of MN.
- 5.2.2 There is a degree of uncertainty around the diagnostic criteria for these clinical categories, and around their boundaries. There is also evidence that the two diagnoses may be causally and symptomatically 'linked'. Some authorities regard 'psychotic' symptomatology as a 'dimensional construct' showing continuity with both 'schizotypal' and 'normal' individuals. Additionally, there is much interest in the potential importance of, and difficulties around, early intervention in psychotic disorders.

5.3 Formal diagnostic criteria

- 5.3.1 Psychiatrists in the UK currently use two classifications systems for mental disorders: the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), and the tenth edition of the World Health Organisation's International Classification of Diseases (ICD-10).
- 5.3.2 Neither system has superior validity or status, but in the UK ICD-10 is more often used. This is the longer established classification system. It was historically based upon descriptive definitions but over the years has gradually moved closer to the DSM operational approach of listing symptoms that must be present over particular periods of time. The intention has been to make diagnosis more objective and ensure 'diagnostic reliability', so that any patient could be reliably diagnosed in the same way according to either system. However, that has still not quite been achieved. We shall see that although the criteria for schizotypal disorder in ICD-10 and DSM-IV are very similar the time requirement for symptoms is different. Moreover, in ICD10 it is classified as an illness called schizotypal disorder, and in DSM-IV it is a personality disorder called schizotypal personality disorder (STPD).

5.3.3 Professionals and family can be forgiven for finding it all rather confusing. However, for the purposes of MN's care the distinction between the classifications is a nicety. In practice the impact would have been the same for MN whichever classification had been used since the disorder is differently managed from schizophrenia. Dr J and Dr M both refer to 'schizotypal disorder', which is the ICD-10 classification and unless we are specifically referring to the DSM classification we have also used the term schizotypal disorder in this report.

5.3.4 Diagnosis itself requires some definition. It is generally accepted that the term 'diagnosis' refers both to the process of identifying a disease or disorder, and to the conclusion reached. The diagnostic process is essentially one of iterative hypothesis-testing, during which several disorders are considered as 'candidates' initially (the 'differential diagnosis'), followed at a later stage, usually, by a provisional or a firm diagnosis (the '-preferred' and 'definitive' diagnoses).

5.4 Schizophrenia

5.4.1 Schizophrenia is defined at a symptomatic level. The definition set out in DSM-IV is based on:

- (a) characteristic symptoms in the acute phase (for example delusions, hallucinations, thought disorder),
- (b) time course (continuous signs of disturbance for at least six months), and
- (c) deficiencies in expected level of occupational or social functioning

5.4.2 ICD-10 places more emphasis on certain types of 'first rank' symptoms and requires an illness duration of just one month with the symptoms being present for most of the time, or at some time during most days.

"Either at least one of the following must be present:

- *Thought echo, thought insertion or withdrawal, or thought broadcasting*
- *Delusions of control influence or passivity....*
- *Hallucinatory voices....*
- *Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world.).*

Or at least two of the following:

- *Persistent delusions in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent overvalued ideas;*
- *Neologisms, breaks or interpolations, in the train of thought, resulting in incoherence or irrelevant speech;*
- *Catatonic behaviour.....*
- *'Negative' symptoms, such as marked apathy, paucity of speech and blunting or incongruity of emotional responses."*

5.4.3 In 1962, Meehl adopted the term '*schizotypy*' to refer to the clinical manifestation of a putative genetic vulnerability to (developing) schizophrenia. In 1989 he described this as eccentric behaviour similar to that in people with schizophrenia, but less florid and debilitating⁷.

5.5 Schizotypal disorder

5.5.1 Schizotypal disorder was first included in psychiatric classifications in 1980, in DSM-III. Its validity as a classification remains controversial. In DSM-IV it is classed as a personality disorder, whereas ICD-10 recognises it as a syndrome among the [schizophrenic] psychotic disorders.

⁷ Meehl, 1989, *Schizotaxia revisited*

5.5.2 ICD-10 also advises that: *"This diagnostic rubric is not recommended for general use because it is not clearly demarcated either from simple schizophrenia or from schizoid or paranoid personality disorders"*.

5.5.3 A later review of personality disorder⁸ also noted: *"This category is.... best avoided as its status as a variant of schizophrenia or of personality disorder is not clear"*.

5.5.4 ICD-10 defines schizotypal disorder as:

"A disorder characterized by eccentric behaviour and anomalies of thinking and affect which resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies have occurred

....during a period of at least two years the subject must have manifested either continuously or repeatedly at least four of the following:

- (a) inappropriate or constricted affect (the individual appears cold and aloof)*
- (b) behaviour or appearance that is odd, eccentric, or peculiar*
- (c) poor rapport with others and a tendency to social withdrawal*
- (d) odd beliefs or magical thinking ...*
- (e) suspiciousness or paranoid ideas ...*
- (f) obsessive ruminations ...*
- (g) unusual perceptual experiences ...*
- (h) vague, circumstantial, metaphorical, overelaborate, or stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence*
- (i) occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas ...*

The subject must never have met the criteria for any disorder in the ICD10 definition of schizophrenia".

5.5.5 It is noted that the disorder *"occasionally evolves into overt schizophrenia"*.

5.5.6 In DSM-IV, STPD does not have a two year requirement, referring to 'current and characteristic' functioning. It is defined as:

"A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood ... as indicated by [at least] five ... of the following:

- 1. ideas of reference (excluding delusions of reference)*
- 2. odd beliefs or magical thinking ... (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)*
- 3. unusual perceptual experiences...*
- 4. odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)*
- 5. suspiciousness or paranoid ideation*
- 6. inappropriate or constricted affect*
- 7. behaviour or appearance that is odd, eccentric, or peculiar*
- 8. lack of close friends or confidants other than first-degree relatives*
- 9. excessive social anxiety..."*

5.5.7 The diagnostic criteria of the two systems show similarities. Both refer to:

- unusual or odd affect and behaviour,
- poor rapport and social isolation,
- odd beliefs or magical thinking,
- paranoid, self-referent or suspicious ideas,
- unusual perceptions,

⁸ Marlowe & Sugarman, 1997, *ABC of mental health: disorders of personality*

- unusual patterns of thought or speech, and
- quasi-psychotic episodes.

5.5.8 Individuals may report often feeling they are being watched, that they can make things happen just by making a wish or thinking about them, or that they can know and predict things that others cannot. They tend to lack close friends or confidants, and appear nervous in company.

5.5.9 Schizophrenia can best be distinguished by the presence of hallucinations and/or by ideas that have gone beyond 'odd' to become delusional.

5.6 Suggested links between schizophrenia and schizotypal disorder

5.6.1 The term 'schizophrenia spectrum disorder' is sometimes used to refer to disorders considered to be genetically linked to schizophrenia, including schizotypal disorder⁹. Schizotypal disorder might represent a milder form of disorder along a 'schizophrenia continuum' (or 'partial expression' of an underlying disposition), and a minority of individuals may develop schizophrenia. Claridge (1990, 1997) noted that the 'defining features' of schizotypal disorder were "very much those of the full-blown illness, occurring in mild form", describing schizotypy as schizophrenia's "normal counterpart" and "less deviant bedfellow". Haudest & Parnas (2005) support this view:

"... schizotypy represents a milder, less psychotic, variant of schizophrenia, but there is no clear-cut division between the two disorders... It is mainly the severity of psychosis ... that marks the distinction of schizophrenia from schizotypy ... schizophrenia has variable borders"

5.6.2 In people with schizophrenia, premorbid (pre-illness) developmental and social impairments have been well documented, including schizotypal traits. There is some evidence that people with multiple schizotypal symptoms are at higher risk of developing schizophrenia¹⁰.

5.7 A continuum of psychotic symptomatology

5.7.1 Psychotic symptoms are not rare in apparently mentally healthy population samples. Current psychological models conceive of psychotic phenomena as lying on a continuum with normal psychological processes. As well as such a continuity with 'normal' individuals, there may be a 'spectrum' of disorders or states within a diagnostic rubric.¹¹ Bentall (2003) sets out a 'strong' version of this position:

"... it seems reasonable to assume, as a general principle, that abnormal behaviours and experiences exist on continua with normal behaviours and experiences. This principle of continuity might be formally be stated as follows:

'Abnormal behaviours and experiences are related to normal behaviours and experiences by continua of frequency (the same behaviours and experiences occur less frequently in non-psychiatric populations), severity (less severe forms of the behaviours and experiences can be identified in non-psychiatric populations), and phenomenology (non-clinical analogues of the behaviours and experiences can be identified as part of normal life' ".

5.7.2 Fowler (2002) draws a comparable conclusion:

"It is being increasingly recognised that the severe anomalies of thought, behaviour and affect which characterise psychosis can be viewed as continuous with anomalies of normal experience. Surveys reveal that the presence of anomalies in experience belief and thinking, which have previously been regarded as prodromal features of schizophrenia, are in fact relatively common in the normal population ...

⁹ for example see Meehl, 1989, Varma & Sharma, 1993; Kendler et al, 1995

¹⁰ for example Miller et al, 2002

¹¹ for example Claridge 1990, 1997

It can be useful to think of psychosis as, to some degree, on a continuum with normal beliefs and anomalies ... the anomalous experiences associated with psychotic disorder ... may be recognisably of similar form to schizotypal experiences."

5.7.3 Diagnostic systems such as DSM-IV and ICD-10 apply a categorical model to mental disorders, rather than a dimensional (continuum) approach. However, it is arguable that in nature there are hardly ever true dichotomies.¹²

5.7.4 A dimensional approach suggests that there are more people suffering from schizotypal disorder in the population than schizophrenia. Yet the diagnosis of schizotypal disorder is rarely made. This may be because most individuals who might be classified as suffering from schizotypal disorder do not come to the attention of clinicians or services, being considered unusual or strange rather than mentally ill.

5.8 Importance of early intervention in schizophrenia

5.8.1 The onset of schizophrenic disorders is often gradual, with a shift from unchanged premorbid functioning to a non-specific symptomatic (prodromal) phase, and then to early illness (identifiable psychotic symptoms). It can be hard to define each transition point; in particular, the point at which symptoms are specifically 'psychotic' rather than prodromal is often not clear. Non-specific prodromal symptoms can be present for months or years before a formal diagnosis is made.¹³

5.8.2 Furthermore, attenuated psychotic symptoms, or 'psychotic-like experiences', are relatively common in the general population, indicating that such symptoms do not inevitably develop into a 'full-blown' psychotic disorder. The difficulties or uncertainties have been succinctly described by Phillips et al (2005):

"a period of non-specific symptoms and growing functional impairment .. often occurs prior to the full emergence of the more diagnostically specific positive psychotic symptoms ... There is some uncertainty about which types of symptoms should be used to define 'psychosis' and when a symptom has become sufficiently deviant to be labelled psychotic"

5.8.3 Misdiagnosing schizophrenia as present can have obvious negative, personal consequences, including those of unnecessary drug treatment. However, there is also strong evidence for deleterious effects of delaying treatment in 'true' cases. It is now widely accepted that the early years of psychosis represent a 'critical period', influencing the longer term course, and that delayed treatment increases early relapse and disability.¹⁴

5.9 Summarising the diagnostic history

5.9.1 The Inquiry Panel met with MN but did not undertake a mental state examination. We accept the evidence on diagnosis put before the court in the criminal proceedings and provided by the consultant psychiatrist currently in charge of MN's care, namely that MN had been in an acute psychotic state when he committed the homicide and was, and still is, suffering from schizophrenia.

5.9.2 Bearing in mind the current views on schizophrenia and schizotypal disorder outlined above, we now consider diagnostic decisions as they were made in relation to MN.

5.9.3 We start by summarising from the history that material which, documented at the time, informed the clinicians' decision-making, along with extracts from Dr J and Dr M's medical records and their evidence to the Inquiry on the thinking behind their diagnoses. We repeat the points already made concerning information which was not known to one or other doctor.

¹² Brugha, 2002

¹³ Cunningham Owens et al, 2005; Singh & Fisher, 2005; McGorry & Jackson, 1999.

¹⁴ for example see McGorry [2002], International Early Psychosis Association Writing Group [2005], Drake et al [2000], Norman et al [2005]

- 5.9.4 *Pre-admission* MN was described as a shy, quiet, introverted boy with relatively few friends. By 1997 he was described as strange and odd. He was seen laughing while alone and ‘*talking to dead relatives*’. The family GP noted ‘*seeing famous people ... hallucinations ... sometime thoughts mixed up ... seems depressed, change in personality, locked away in bedroom ... doesn’t sign on because he is king ... laughing to himself*’. DC wrote to Dr M “*...MN talks to himself ... and also laughs out loud ... MN has conversations with people who are dead ... he really believes that he knows these people and that they are in the same room ... Because MN thinks he’s king he doesn’t need to return his library books ... because he’s king he owns the service (library) ... thinks he’s married with children (to the Queen)*”.
- 5.9.5 Dr M saw MN at home and noted “*there were a number of clear indications that he is suffering a psychotic illness. These were exemplified by almost incoherent articulations regarding spirits, dead people, supernatural powers ...*” He said MN was “*presenting with a history, and mental state examination, consistent with a paranoid psychotic illness, probably schizophrenia, associated with illicit drug use, leading to a year long withdrawal from society*”.
- 5.9.6 S2 MHA medical recommendations referred to “*a range of delusional beliefs, totally out of character from his previous character ... completely insightful into his mental illness*”.

Delusional ideas not known to Dr J or nursing staff

The letter from DC to Dr M was not seen by Dr J, who told us he had not known about MN’s claims regarding the library or being married to and having children by the Queen. Nor was that information known to hospital nursing staff.

- 5.9.7 *In hospital* medical notes on admission included “*saying he is a king, speaking of wars ... Impression Psychosis...*”. A drug screen was ‘negative’, making a diagnosis of a drug-induced state less likely, and four days after admission medical notes stated “*talking about seeing dead souls ..*” Dr J noted that when aroused MN spoke about “*telekinesis, psychokinesis, spirits*” in an apparently “*thought disordered fashion*”. Thought disorder was referred to in nursing records on 11 October, and again by Dr J on 16 October. MN spoke of wanting to put an axe through another patient’s head.
- 5.9.8 Dr J prescribed injectable antipsychotic medication in case of “*psychotic aggression*” and MN received depot Clopixol (a trade name for zuclopenthixol decanoate) on 16 October. Dr J’s MHRT report on 20 October stated MN used the terms “*telekinesis and psychokinesis .. in a way which is different from the accepted fashion .. [beliefs] pour forth in a stereotyped and frankly thought disordered fashion .. I would consider it likely that he is currently suffering from a psychotic illness...*”. On 1 November, Dr J supported detention under Section 3, referring to “*a psychotic illness which requires antipsychotic medication*”.
- 5.9.9 Dr J told us that he considered revising MN’s diagnosis within a day or so of the s3 application. He told us MN had improved; “*he clearly became less ill ... a very quiet and compliant patient ... did not give grounds for concern from his behaviour point of view*” and now referred to unusual beliefs as “*something that had happened in the past*”. Dr J said he had regarded MN’s ‘spiritual’ beliefs as “*odd beliefs and magical thinking*”, and “*the beliefs about the kings were quasi-psychotic episodes ... the metaphorical, circumstantial thinking with odd speech – at no point was he grossly incoherent, there was always an element of understanding about that, but the content of the speech was always strange and rather difficult to follow*”. Dr J told us the diagnosis of schizotypal disorder “*arose in the context of MN’s improvement...he had made a lot of progress in the previous two weeks ... the florid positive features of what I categorised as a psychosis initially appeared to have abated and that in my experience was surprising given the very small amount of medication that he had had ... it was my impression clinically that ... the aspect of his care and treatment that had probably been most helpful ... was the removal from the home, a placement in a calm, secure environment, decreasing arousal ... an improvement, predominantly without any antipsychotics..*” He told us that he had come to understand MN’s admission to hospital as a “*life changing experience* for him”.
- 5.9.10 Dr J told us that he made the diagnosis of schizotypal disorder having researched it and in the knowledge that “*it is laden with caution about its use.*”

- 5.9.11 On 6 November, Dr J referred to *"some discrepancies between assessments made prior to admission and his presentation whilst on Balmoral"*. This was the first documented indication of a doubt over diagnosis. Within two days MN was granted s17 community leave for a few hours a day. Medical record entries relating to the presence or absence of psychotic symptoms became sparse. Nursing staff recorded apparent incongruous laughter and self-referent ideas when on leave (11 November), and non-social speech and laughing while moving a window (18 November).

Symptoms indicative of psychosis not known to Dr M

The 'axe' incident, incongruous laughter, self-referent ideas when on leave, and non-social speech and laughing while moving a window were never known to Dr M before the homicide.

- 5.9.12 *Upon MN's return home* Dr M wrote immediately to Dr J expressing a positive opinion that MN should receive *"an adequate trial of antipsychotic medication"*.
- 5.9.13 On 28 or 29 November, Dr M received a faxed letter from DC, who noted: *"I have spoken to Dr J's secretary to find out what is wrong with MN, she rang me back with the diagnosis possible schizotypal disorder"*. This is the first time schizotypal disorder was recorded as a preferred or possible diagnosis. From this point diagnostic opinions clearly diverged.
- 5.9.14 On 13 December Dr M expressed *"very clear concerns"* that MN was psychotic, and indicated that he may require re-admission for drug treatment.
- 5.9.15 On 18 December, MN attended a ward round with Dr J, and the medical entry includes: *"Diagnosis schizotypal disorder"*
- 5.9.16 Following a review in January 2001, Dr M wrote that DC said there had been *"no further evidence of MN talking or laughing to himself in his bedroom"*. DC sent Dr M and Dr J photocopies of MN's diary writings. Dr M felt that these writings were *"consistent with a schizotypal or a schizophrenic illness"*, though he concluded that there were *"clear clinical grounds"* to suspect a psychotic disorder. Dr J told the panel that he had not seen all the pages of the diary and had not agreed with Dr M's diagnosis.
- 5.9.17 Following a further meeting in late January, Dr M expressed his view that *"the diagnosis is likely to be either schizophrenia or schizotypal disorder ..."* Dr M reviewed MN three times during February, noting no real change.
- 5.9.18 After reviewing MN in late March Dr M wrote *"Whilst his inner thoughts remain inaccessible to professionals, his current presentation and level of activity has to be seen as a positive improvement"*. In June Dr M noted *"I pushed him quite hard today to open up to me about his private thoughts. He denied any untoward beliefs and thoughts, as ever"* and Dr M concluded *"It looks increasingly likely that [he] is suffering from a schizotypal disorder"* and *"the diagnosis continues to be most likely a schizotypal disorder"*.
- 5.9.19 On 10 October 2001, after missing an outpatient appointment, MN's mother said her son had stopped claiming benefits again and *"laughs to himself regularly but will deny this irritably when asked about it"*.
- 5.9.20 On 21 November 2001, a year after he had left hospital, Dr J sent Dr M a 'discharge letter', noting that during MN's admission: *"it became more likely that the diagnosis was one of schizotypal disorder rather than frank schizophrenia..."*. Dr M told the panel that at this stage he had not ruled out a diagnosis of schizophrenia, and had continued to wonder if MN had been concealing symptoms.

Dr J may not have seen some of MN's diagnostically relevant diary writings

Dr J believes he saw some, but not all, of MN's diary writings. He did not recognise the lists of words when shown a copy by the panel.

5.10 Making the diagnosis

- 5.10.1 When Dr M established that MN's history and mental state were *"consistent with a paranoid psychotic illness, probably schizophrenia"* he realised that this presentation was compatible with the onset of a mental illness. Schizophrenia being the most common psychotic disorder, Dr M had to look no further than this for a probable diagnosis. Nothing unremarkable or unusual had been noted.
- 5.10.2 In hospital, Dr J noted unusual ideas, abnormal beliefs, jumbled speech, and *"thought disorder – both of form and content"* and he prescribed medication in case of *'psychotic aggression'*. He supported detention under s3 MHA, referring to *'a psychotic illness which requires antipsychotic medication'*. At this time, it seems that both consultants had favoured a diagnosis of psychotic disorder, based on a history of altered social functioning and behaviour, delusions, and thought disorder. That diagnosis, agreed upon by both Dr J and Dr M was, we conclude, entirely reasonable.
- 5.10.3 By 6 November 2000, however, Dr J seemed less sure about diagnosis because MN had seemed to improve so much with so little medication, and his presentation in hospital seemed very different from how he had been on and before admission. Dr J decided not to medicate further in order to test this, telling the Inquiry Panel: *"thinking through the schizotypal disorder diagnosis I thought perhaps this was a viable differential and then, I guess, that strengthened my desire to keep MN medication free at that point in order that we could see if there had been an effect in the depot, if that wore off, if he required any further medication"*.
- 5.10.4 On 28 November 2000, schizotypal disorder was first mentioned as a preferred diagnosis (via Dr J's office). By mid-December, the diagnostic opinions of Drs J and M had clearly diverged: the former supported schizotypal disorder, and the latter schizophrenia.
- 5.10.5 During February and March 2001 there were further indications of relatively improved functioning, with no overt symptomatology. By late March, Dr M felt that a diagnosis of schizotypal disorder was *'increasingly likely'*, and then, in late June, he thought this was the *'most likely'* diagnosis. However, he did not exclude either *'concealed'* symptoms, or a psychotic illness.
- 5.10.6 Hence, by late 2000, Dr J's view was that M's diagnosis was schizotypal disorder, while Dr M still advanced a diagnosis of schizophrenia. During the first half of 2001, Dr M's position was more ambivalent. He lent increasing weight to a diagnosis of schizotypal disorder but explicitly did not rule out a psychotic illness.

5.11 A reasonable diagnosis?

- 5.11.1 After the homicide in 2002, it became clear that MN was suffering from a severe schizophrenic disorder. This naturally raises the question of whether or not this psychotic disorder could, and should, have been diagnosed and treated during the period 2000 - 2001. Applying current thinking on the subject, was schizotypal disorder, we ask ourselves, a reasonable diagnosis to consider at the time? We approach this with an awareness of the clarity of vision provided by hindsight.
- 5.11.2 Our starting point is that Dr J and Dr M were not in possession of the same clinically relevant information.
- 5.11.3 Prior to admission, DC provided Dr M with a letter setting out unusual behaviours and bizarre beliefs. This referred to inherently bizarre beliefs, i.e. that MN stated that he owned the library and its books, and that he was married to and had children by the Queen. Dr J never saw this letter, or became aware of some of these ideas. He suggested that if he had been aware, *"those beliefs would of course lend weight to the fact that this was probably not a schizotypal disorder"*. In other words, these beliefs could be regarded as delusions, and hence as indicating a psychotic disorder, such as schizophrenia. Furthermore, it appears that Dr J did not see all of MN's diary provided by DC after MN had left hospital. It is possible that this information, if seen by Dr J, also would have lent weight to a diagnosis of schizophrenia as opposed to a non-psychotic disorder.

- 5.11.4 During November 2000, nursing staff recorded unusual behaviours (incongruous laughter and self-referent ideas; non-social speech and laughter while moving a window), but Dr M remained unaware of the latter observation, as he also remained unaware of MN's comments about cutting someone up with an axe. None of this missing information could have been crucial to Dr M's conclusion about diagnosis on 27 November, when he expressed a positive opinion that MN should be given anti-psychotic medication. But faced with Dr J's alternative diagnosis, Dr M was not in a position fully to challenge it without the missing, potentially relevant clinical information.
- 5.11.5 With each psychiatrist working from different information, it is possible to see how doubts and differing opinions about MN's diagnosis arose.
- 5.11.6 Dr J told us he researched schizotypal disorder. He would have found that the formal diagnostic criteria for schizotypal disorder resemble those of schizophrenia, and that 'characteristic schizophrenic anomalies' can sometimes be difficult to distinguish both from 'normal' psychological events and from non-specific 'morbid' symptoms (the latter can presage schizophrenia, but do not necessarily do so). The diagnostic criteria for schizotypal disorder include peculiarities of mood, behaviour and speech; social withdrawal; odd beliefs and suspiciousness; and brief, psychotic-like episodes. It is not surprising, therefore, that several authorities regard this diagnosis as an attenuated version of schizophrenia. Nor is it hard to speculate how difficult it can be to firmly distinguish the two categories in a given individual, perhaps especially where there are significant difficulties in engagement or rapport, or where, as with MN, there is adamant denial of symptoms. In clinical practice, categories are attractive. However, they are not always helpful, and not necessarily representative of the complexities of psychological functioning. And MN seemed complex because according to nurses he was quickly free of symptoms with little or no medication. It is possible to see how, with the information he had, Dr J began to wonder whether the diagnosis of schizotypal disorder might fit MN.
- 5.11.7 However, it is widely recognised that schizotypal disorder is a diagnosis made only infrequently in clinical practice. Dr J told the Inquiry that this has been the only time in his professional career, before or since MN, that he has made the diagnosis, and Dr M had made it just once before. Indeed some authorities advise against its general use. This might be taken to indicate that a clinician should exercise particular care in making, and maintaining, such a diagnosis – particularly in the light of accumulating evidence that the consequences of delaying diagnosis and treatment of schizophrenia can be deleterious and long lasting. In other words, the threshold for sustaining this diagnosis should be a high one, and it should be based upon strong and convincing evidence.
- 5.11.8 But far from having strong evidence, Dr J did not have sufficient history to deal with any of the historical points concerning diagnosis. MN was unforthcoming, and Dr J appears not to have spoken to the family at any stage in any detail. There was no basic history-taking from third parties. This would have coloured the diagnostic process as a whole, not just the particular issue of diagnosing one disorder, such as schizotypal disorder. He did not have enough background or collateral information to rule schizotypal disorder, or schizophrenia, out or in.
- 5.11.9 Moreover, of the information Dr J did have at the time, the recurrent references to thought disorder are extremely damaging to a putative diagnosis of schizotypal disorder. For although the boundaries of psychotic symptomatology are often imprecise, thought disorder when florid can be clearly ruled as present or absent, and Dr J recorded more than once that it was a florid and vivid torrent in MN's case. Whichever classification system is used, one cannot say someone is 'thought disordered' and not think they are psychotic¹⁵. So the very description of thought disorder itself needed to be re-examined in order to change the diagnosis.
- 5.11.10 With hindsight it is hard to conceive how Dr J could have so completely changed his mind and thought himself mistaken as to the existence of thought disorder, which now seems to have been so manifestly present. It had been reported by the GP and Dr M, had been the foundation for two MHA sections and for a decision by a MHRT not to discharge. Dr J's reassessment of the diagnosis had led him to reinterpret MN's admission to hospital as a "*life changing experience*" which had benefited MN. But Dr J was working with incomplete information including, as we shall examine later, poor nursing observation.

¹⁵ except in some 'organic' situations, for example confusional states

Dr M also thought he must have been mistaken as to his initial diagnosis, but he lacked much of the inpatient information, and we consider that arrangements for subsequent clinical observation at home were weak.

- 5.11.11 We bear in mind that within such clinical and social work notes as were completed during the sixteen months MN was at home, until the day of the homicide, there were no reported florid symptoms of psychosis and no mention of any threat to anyone. Thus there is no suggestion of a gross error of judgement in the face of symptoms obvious to anyone in direct contact with MN in 2001.
- 5.11.12 We understand too that the clinician is faced with trying to balance these issues with those of maintaining engagement with the individual, and avoiding premature and incorrect 'labelling' and potentially inappropriate medication and other interventions, for example hospitalisation.
- 5.11.13 Nevertheless, in retrospect, it appears clear that MN was suffering from schizophrenia, and that he ultimately did not receive appropriate treatment. We asked ourselves above whether or not this psychotic disorder could, and should, have been diagnosed and treated during the period 2000 – 2001. We answer yes to both.

Psychotic disorder could have been diagnosed

We have no doubt that a diagnosis of psychotic disorder could have been diagnosed. This was not a fresh diagnosis. The symptoms were already recorded and the diagnosis of psychosis already made on the basis of a history of a personality change over the previous two years with negative symptoms, delusions and thought disorder. Those symptoms had been sufficient evidence to justify (i) admission for observation under s2 MHA, (ii) the MHRT's decision not to discharge, and (iii) Dr J's decision to apply for s3. No psychiatrist, doctor, nurse or other professional had raised the possibility of any diagnosis other than psychosis. Dr J did not need to respond to apparent discrepancies with a new diagnosis. He could simply have obtained more information from Dr M, the pre-admission clinical records, the family, GP and nursing staff. Dr J acknowledges that he would have found clinical information confirming the existing diagnosis. During 2000-2001 the opportunity for a return to that diagnosis was always present, based on a re-examination of the history with all the available information.

Psychotic disorder should have been diagnosed

We also conclude that a diagnosis of psychotic disorder should have been diagnosed. That is, those responsible for MN's care and treatment should have taken actions that were likely to have led them sequentially to confirm that diagnosis. Dr J and Dr M should have ensured they had every piece of clinically relevant information available to them from every source. Moreover, given that schizotypal disorder is a rarely used diagnosis in connection with which caution is urged, they should have taken extra care to examine all symptoms in depth. We think it very likely that had they done this they would have found the original symptoms of psychosis clearly confirmed.

The assessment of MN was incomplete

We have posed one other question. Was the diagnosis of schizotypal disorder nevertheless reasonable? We conclude that with the incomplete information Dr J and Dr M had at the time, and with uncertainty as to the status of the diagnosis itself, it was not unreasonable to consider schizotypal disorder. But it then needed a comprehensive re-examination of past and present symptoms. Whichever way one looks at it, there was not enough historical or current clinical information to make any definitive diagnosis, and certainly not to change it. The assessment of MN's mental health was incomplete.

5.12 The legal framework for treatment under the MHA

- 5.12.1 The legal framework for MN's treatment was the MHA, with good practice guidance provided by the Code of Practice.
- 5.12.2 Under s2 and s3 medical treatment can be administered, with or without a patient's consent, for a period of three months, although the patient's consent should be sought and consent or refusal noted.¹⁶ MN's

¹⁶ S63 MHA 1983 and Code of Practice paragraph 16.11. After three months the patient's consent must be sought though it can under certain circumstances be dispensed with under s58 MHA.

medication, when it was administered without his consent, was properly given. Since he first received medication on 5 October 2000, Dr J could have continued to administer medication without MN's consent until 5 January 2001.

Appropriate recording of consent to or refusal of medication

The notes do properly record MN's consent to or refusal of medication, and he did not always refuse. He consented to PRN medication on 6 October 2000, the day after his admission.

- 5.12.3 'Medical treatment', in addition to the administration of drugs for mental disorder, is defined in the MHA as including *"nursing...care, habilitation and rehabilitation under medical supervision"*¹⁷ and the MHA Code of Practice advises that this includes *"the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder"*.¹⁸ The Code of Practice goes on to say *"All treatments.....should be regularly reviewed and the patient's treatment plan should include details of when this will take place"*.¹⁹
- 5.12.4 It is a curiosity that as soon as MN had been made subject to s3 MHA on the basis of treatment with medication for mental illness, Dr J decided MN suffered from schizotypal disorder, widely thought of as a form of personality disorder, for which he did not need treatment with medication. On the face of it, the requirement of treatment for mental illness under s3 might have ceased to be satisfied by the new diagnosis, but there was no record of any discussion about this and the matter was never tested at a Tribunal hearing.

MN did receive treatment under the MHA

MN received medical treatment as defined under the MHA and, although they were not CPA reviews, regular reviews of his treatment did take place in hospital and during MN's period of s17 leave.

5.13 The organisational context

- 5.13.1 When Dr J and Dr M made their decisions as to diagnosis they did so in the context of an out-of-area admission to hospital. That produced several difficulties. Clinical responsibility shifted from one multi-disciplinary team and service to another. Clinical records and information however did not. Nursing staff sought to transfer MN off the ward almost daily, and nursing observation was less than rigorous. With no continuity of staff between hospital and CMHT, arrangements for MN's clinical observation in the community were unsatisfactory.
- 5.13.2 All of these had an impact upon the information available to each psychiatrist. We consider them in turn.

5.14 Out-of-area admission to hospital

- 5.14.1 When MN was admitted to Hillview Lodge it was an out-of-area arrangement made because Dr M had no intensive care beds available in Blackberry Hill Hospital. At the time, Dr J told us, it was unusual for a Blackberry Hill patient to be admitted to Hillview Lodge. It was generally the other way round, and so Dr J had been happy to reciprocate. He thought nursing staff shared his view. Indeed it was Dr J's impression that *"having somebody from Bristol on the ward was not a bad thing because of our reliance on Bristol at the time for overflow admissions"*.
- 5.14.2 Out-of-area hospital admission is common in mental health care around the country. Dr J described the way it usually operated, saying that if he sent someone to, say a London hospital, he would resume responsibility when the patient was discharged home. This had generally worked well. And he thought at the time it had seemed to work well in the case of MN. Dr J told us *"I think if there had been problems at that point then we might have said "whose responsibility is this to react?" But there were no problems and..... it appeared that not only were things steady but in fact things were significantly improving from MN's point of view at that time. So the transfer of care appeared to be a smooth one, such that... my involvement from the middle of January onwards was nil"*.

¹⁷ S145(1) MHA 1983

¹⁸ MHA Code of Practice paragraph 15.4

¹⁹ MHA Code of Practice paragraph 16.35

- 5.14.3 Of course, the position with MN was not quite the 'usual' one described above. When MN left hospital he was on s17 leave rather than discharged, and although Dr J considered there were no problems, his view was not shared by Dr M, whose opinion on diagnosis and treatment differed. This produced at least the potential for difficulty. If Dr M had wanted MN to be recalled to hospital he would have had to persuade Dr J that he should be readmitted to Hillview Lodge, where MN's bed remained and where Dr J was still his RMO.
- 5.14.4 This was not an ideal situation, and in December 2000 Dr M wrote to Dr J *"he remains under your RMO care pro tem, with ongoing attempts to transfer his care to Oakwood House Ward, bed permitting"*. Dr M was referring to s19 MHA, which would have permitted the transfer of MN from one hospital to another. The difficulty was that even though MN no longer actually occupied a bed, he was still *'liable to be detained in a hospital'*.²⁰ In order to transfer MN to the care of Dr M he would have had to transfer MN from a theoretical bed in Hillview Lodge to a theoretical bed in Blackberry Hill Hospital, but there continued to be no 'bed' available there.
- 5.14.5 To relatives of patients, reference to beds that do not appear to be there was confusing. DC told us *"I was puzzled. 'If they sent MN home because they needed his bed, how could they say there was a bed available for him?'"*
- 5.14.6 Dr J told us that the out-of-area arrangement did have an impact on care management generally, and described *"a slight sense of frustration that we could not have the sort of liaison with the community team that we would have had, had the person been from the Bath area.....the natural feeling was that the people we were dealing with were not known to us. It is easier to deal with a group of clinicians....whom one works with every day."*
- 5.14.7 We heard that at the time there was no protocol for the management of out-of-area care. Dr M explained in his evidence *"I am not aware of Trust guidelines about the clinical involvement of referring clinicians in the management of those patients sent to out of area hospital beds."* Dr J was not aware that any out-of-area arrangements had been formalised since the homicide.

Transfer under s19 MHA would have made care simpler

It would have been better to ensure that MN had been transferred back to Dr M under s19 MHA before returning him home on indefinite s17 leave. Dr M would then have become the RMO and MN would immediately have come under his sole care, making diagnosis, treatment and care upon discharge very much simpler.

Hospital arrangements to be explained

Clinicians need to remember that patients and families may not understand hospital arrangements over areas, placements and beds, and time should be taken to explain them.

5.15 Clinical responsibility

- 5.15.1 At the beginning and at the end clinical responsibility for MN was straightforward. Dr M was completely responsible for MN's care before and after he was subject to the MHA.
- 5.15.2 It is also clear that Dr J, as MN's Responsible Medical Officer (RMO), had the final clinical responsibility throughout the time MN was subject to the MHA²¹.
- 5.15.3 During the period MN was in hospital this created no difficulty. But the position became more complicated for the four months between November 2000 and March 2001 when MN was at home on s17 leave. At this point he was still liable to be detained under s3 MHA, still had a bed at Hillview Lodge, and Dr J remained his RMO.

²⁰ S19(1)(a) MHA states *'a patient who is...liable to be detained in a hospital...may be transferred to another hospital....'*

²¹ The RMO is defined under s34(1) MHA 1983 as being, for patients detained or liable to be detained under s2 and s3 *'the registered medical practitioner in charge of the treatment of the patient'*. The doctor to whom this applies will not be professionally accountable for a patient's treatment to any other doctor. RMO responsibility cannot be delegated.

- 5.15.4 In the absence of any planned arrangement, there was immediate confusion over responsibility when MN returned home. The family telephoned Dr J but managed to speak only to his secretary. They then expressed their annoyance to Dr M and he passed that on to Dr J. By January 2001 DC got in touch with social services saying they were *“very confused about MN’s situation, he is now at home but family have had no contact from the hospital – unsure whether he has been discharged”*. Social services wrote firstly to Dr J offering their input but got no reply. After Dr M copied notes of a review meeting to social services they then made contact with him instead. This uncertainty was very unsatisfactory, especially in the context of disagreement between the psychiatrists over diagnosis.
- 5.15.5 Dr J had the bed and was the RMO, but did not think that enforced medication was appropriate. Dr M did think that medication should be given, sooner rather than later – and said so - but he had not got the bed and was not the RMO under the MHA.
- 5.15.6 We wondered how they dealt with this, and we asked Dr J who he considered had been in charge, medically speaking, at this time. He told us *“I have characterised this as a shared care sort of arrangement. Certainly I obviously continued to have RMO responsibility under the MHA without a doubt. I guess officially I continued to have overall consultant responsibility. Because of MN’s return to Bristol and his contact with Dr M, at both the December and January meeting and his subsequent outpatient follow up from then, although it was never formalised in writing from that point, from my understanding, from Dr M’s outpatient clinic onwards, outpatient appointment onwards, that Dr M would have day-to-day responsibility for MN”*.
- 5.15.7 Dr J said it was when the social worker became involved in January 2001 that *“I guess informally my feeling was that MN is now a Bristol patient”* and when Dr M first saw MN in an outpatient clinic in February 2001 that *“I thought, right, okay, MN is by and large Dr M’s responsibility although he still remains liable to be detained obviously so I still had RMO status.”*
- 5.15.8 In the course of hearing evidence it became plain that the family did not understand the connection between the two doctors: *“Dr M probably felt it was schizophrenia but did not like to go against Dr J’s diagnosis – ethics and all that”*. Almost a year after MN’s return home DC thought *“because MN was under Dr J and Dr J done the diagnosis – I think Dr M did not want to go against that”*.

Shared clinical responsibility arrangements were implied and unclear

Although Dr M and Dr J appeared to carry through a planned process of handover of clinical responsibility, there was no written reference to ‘shared care’ or ‘day-to-day care’, and the meanings of these terms are unclear. The arrangements were left as implied, and this was unsatisfactory. The scope of Dr M’s clinical responsibility should have been expressly stated, known to both Dr J and Dr M, their clinical teams, social services, the family and MN himself. At Local Recommendation 2 we recommend that RMO, clinical and CPA responsibilities are clarified when care is shared.

5.16 Clinical records

- 5.16.1 Flow of clinical records is a good indicator of the effectiveness of handover between teams. In this case Dr M’s medical notes, made prior to MN’s hospital admission and containing information about his initial assessment of MN, including the letter from DC describing MN’s belief that he owned the library and had children by the Queen, remained with Dr M’s clinical team. Dr M’s medical records were not transferred to Dr J and he never requested them. He had only a faxed copy of Dr M’s initial assessment and a summary of the MHA assessment. This was, we heard, usual practice. As a consequence, when Dr J made his decisions about diagnosis it was without all the information contained in Dr M’s medical records. Most importantly he had not seen the letter from DC to Dr M until shown it at the Inquiry hearing and told us he had not previously been aware of any documented references to MN’s claims regarding the library or being married to the Queen.
- 5.16.2 Information flow continued to be a problem after MN went home on s17 leave. Dr J’s in-patient records were not transferred to Dr M or requested by him. Neither psychiatrist had sight of the medical notes of the other. Reliance upon discussion and correspondence failed to plug the gaps. Dr J said he had seen only part of MN’s photocopied diary, sent by DC to Dr M, even though it was addressed to both Dr J and

Dr M. Dr M did not receive a discharge summary until he requested it a year later, and even then it did not make any reference to the remark MN had made about wanting to cut someone up with an axe, nor the occasion MN had been reportedly laughing incongruously and believing people were looking at him when he was out with DC, nor his ten-minute conversation with a window.

- 5.16.3 Nor, Dr M told us, had he seen the reports submitted to the MHRT, the decision of the MHRT, the CPA form, the Nursing Care Plan dated 23 November 2000, or any of the in-patient nursing notes.
- 5.16.4 The only information Dr M could recall seeing at the time of MN's discharge on s17 leave was the faxed handover letter written by SL and attached risk assessment. He received Dr J's discharge summary almost a year to the day after MN had gone home.
- 5.16.5 Dr M wrote in evidence to the Inquiry *"The information which was available to me and my Team at the time that we resumed full clinical responsibility for MN's care would appear to be incomplete and as a result misleading."*
- 5.16.6 It is striking that there was never any point at which all of the recorded information about MN was gathered together in one place. Partial information was relied upon without any attempt to discover what was missing.
- 5.16.7 Each psychiatrist unquestioningly accepted the information provided by the other. This accorded with a traditional medical style of handover by letter, but it was not sufficient.

MN's medical records should have been transferred with him

There should have been a procedure in place for automatic transfer of clinical records from Dr M to Dr J and then back to Dr M. Records should follow the patient so that all clinically important information is available in one place. At Local Recommendations 1 and 2 we recommend that healthcare records follow the patient, and that the location of records are made clear to everyone when care is shared.

Dr J and Dr M had a responsibility to obtain the records

In the absence of any automatic transfer of records Dr J and Dr M should each have taken active steps to request the full medical records, particularly since they were embarking on a course of action based upon a diagnosis the authorities advise against using. They were individually responsible for equipping themselves with the information necessary properly to make a diagnosis. Dr J should also have obtained a full family history. This may have uncovered the information missing to him from the records.

5.17 Clinical observation

- 5.17.1 Dr J had decided upon a treatment plan that involved no medication, but keeping a look out for signs of psychosis. Clinical observation was vital to this plan. He described it to us in this way: *"thinking through the schizotypal disorder diagnosis I thought perhaps this was a viable differential and then, I guess, that strengthened my desire to keep MN medication free at that point in order that we could see if there had been an effect in the depot, if that wore off, if he required any further medication either during his time in hospital or subsequently."*
- 5.17.2 For this to work it required SHO, nursing staff, family and social worker to have a clear understanding of the plan itself and both possible diagnoses so they could provide feedback to Dr J on relevant symptoms. But not only was this the first time Dr J had used the diagnosis of schizotypal disorder, neither the diagnosis nor the plan were revealed to the SHO or nursing staff, and Dr J thought that the nurses would have, at best, a *"sketchy understanding"* of the diagnosis. It became clear from his evidence that the social worker did not know the difference between the diagnoses of schizotypal disorder and schizophrenia, and the family did not remember having had it explained to them.

5.18 Observation in hospital

- 5.18.1 None of the evidence we received suggested to us that either Balmoral or Caernarfon Ward were unusually troubled by staffing or other pressures. Charge Nurse DW told us that on Balmoral Ward *"I do remember a fair amount of agency being used but I do not think it was because we had a staffing problem With the complement of employees that we had, we did not have a lot of flexibility to be able*

to call in staff ... I do not think that the ward was any worse off than most wards ... I do not think that there was a staffing crisis" He described Balmoral as "a busy ward, an intensive ward lots of staff were very experienced in dealing with unsettled behaviour". Indeed he said about nurse observation "High Observation levels, yes we would always be observing people But you would not necessarily need somebody on one to one because there would not be a lot happening without staff knowing about it"

- 5.18.2 We asked Dr J for his recollections of the nursing on the unit generally. He could remember only nurse GL as having been on Balmoral Ward in 2000. He did not have a memory that this was a dysfunctional unit or that the care or professionalism of the observations there gave him any cause for concern. DW told us he recalled medical/nursing relationships as being "good".
- 5.18.3 As far as hospital nursing staff were concerned, Dr J could not recall *"having specific discussions with the staff about aspects of MN's behaviour or his interaction or lack of interaction that we needed to be paying particular attention to... I was still seeing this as the early days.....it had been my intention that MN would continue in hospital much longer than he did."* All he had expected from nurses was the collection of *"baseline information rather than at that point actively trying to engage MN in therapies or in talking above and beyond normal everyday interaction..."*, and this was all nurses provided. From the notes we did not see much evidence of staff spending one to one exploratory time with MN to establish what lay behind his pre-admission thoughts and behaviours. Nursing notes reveal that MN was permitted to retreat unchallenged to his bedroom, where he was repeatedly described as settled and isolative, and where as a consequence no psychotic symptoms, if present, could have been seen. There was almost nothing in the nursing notes about contact with the family, and when MN's mother referred to her son as 'normal' the meaning of this was not questioned. They did not seek information from Dr M's team, nor did they take a history from the family although a member of the family was present on the ward almost every day.
- 5.18.4 Dr J had not revealed his revised thinking about diagnosis to nursing staff, so it is not surprising that schizotypal disorder was not mentioned anywhere in the nursing notes and LD, the Ward Manager of Caernarfon Ward who completed the CPA form, informed the Inquiry *"my understanding of MN's diagnosis was that he had had a psychotic episode, use of street drugs and a head injury were mentioned in the history as causative factors. When he was transferred to Caernarfon Ward his treatment plan indicated that he had received medication on two occasions against his will but this had no apparent effect on his mental state, and therefore no further medication had been administered"*. That contradicts Dr J's understanding that MN had made more progress following medication than he would have expected from the dose given, but he had not shared his views with ward staff or indeed the SHO working with him.
- 5.18.5 Medical entries by the SHO were also brief and not of great assistance as to detail, for example *"Not challenged today about beliefs and did not talk about them spontaneously"*. Although in the days prior to MN's home leave the medical notes made reference to MN having been seen talking to a window and a video, there is no reference to any mental state examination as a result of that observation.
- 5.18.6 DW told us that MN's admission out-of-area had not made any difference to MN's care: *"it did not really make any difference to be honest, we were just dealing with people from a different area"*. However, there was no formal protocol covering the transfer of patients back to their own locality inpatient unit. It relied on daily phone calls to find out if a bed had become available. In MN's case, because he had been admitted to a psychiatric intensive care unit, this equated with him being more unsettled. We heard that the receiving unit was more cautious about accepting him without a stable period on an open ward. Nurse DW explained that there was a *"hierarchy of those who had been settled for the longest, almost a queue, and as a bed became available we would move the next one out"*. Although attempts were made by Balmoral Ward to transfer him to Oakwood, on this basis it was unlikely that his transfer would have been effected prior to a settled period on Caernarfon Ward.

MN's nursing care took place in the setting of daily uncertainty over transfer

With no formal system for planning and prioritising MN's return to Oakwood House there would have been a degree of uncertainty for those providing the care and treatment of MN. Indeed, it was not clear from day-to-day whether MN would still be on the ward. Arguably, care management becomes more

perfunctory when staff are aware that a transfer could occur at any time. At worst there is a danger that hospital becomes a holding ground for a patient who belongs elsewhere, with minimal commitment to that patient. At Local Recommendation 2 we recommend the Trust make it clear that inpatient nursing standards must be maintained for patients who are admitted out of area.

Lack of specificity in much of the recorded information about MN

Nursing entries varied in terms of content and quality and the intensity of staff involvement varied considerably from being very actively involved with him on the day of admission and at a couple of flash points during his stay, to otherwise being quite passive with him, for example *"allowed to spend long periods of time in his room"...* *"settled but isolative"...* *"superficially pleasant on approach but depth of underlying psychopathology unexplored"*. They failed to exclude potential morbid symptoms, for example 'NO evidence of thought disorder' or 'NO delusions'. Lack of evidence for the presence of symptoms is not the same as evidence of their absence. There is no suggestion that MN was actually approached. Indeed, it is not clear even now from reading the conflicting records and reports whether antipsychotic medication had brought about a lot of improvement, any or no improvement in MN.

Dr J relied upon inadequate nursing records for his diagnosis

Dr J relied upon this inadequate information, requesting no more than 'baseline information' from nurses. We conclude that observation of MN in hospital was not adequate for the task of making or testing out the diagnosis of schizotypal disorder.

Records should have been integrated

The medical and nursing notes were kept separately, which contravened the Trust's Guidelines for Integrated Records and clearly led to communication difficulties.

The need for skilled nursing and records

It is vital that records provide detailed accounts of symptoms and mental state examinations in a way that makes them useable for diagnosis, risk assessment and treatment, and for justification of detention under, home leave or discharge from, a MHA section. Such records may also be relied upon in reports for MHRT's and at Tribunals and considered to be first-hand evidence of the existence or not of symptoms²². Their importance cannot be stressed enough. Our nursing recommendations emphasise the importance of Trust audit, training and appraisal of nursing staff.

Local Recommendation 14:

Assessing nursing skills and record keeping

5.19 Planning for observation at home

- 5.19.1 Planning for MN's clinical observation at home was, we find, inadequate.
- 5.19.2 It had been decided in a hastily convened CPA meeting on 22 November 2000 that the Yate CPN service would undertake this task. Dr J explained what he had intended at the time: *"My main concern was to pick up early warning signs of things going wrong in the same way that one would use an intensive home treatment to visit on a regular basis in order to pick up signs of relapse or things going wrong or things not working well at home. So that is what my predominant desire was, for a community team member bearing in mind that it was at a point distant from all the ward"*.
- 5.19.3 Dr M wrote to Dr J a few days after the CPA meeting naming PH as the proposed CPN, telling us that at the time he believed MN was suffering from a psychotic illness and had expected MN *"would be discharged on regular treatment and there might be a number of roles for a CPN in monitoring response to treatment, compliance with treatment, perhaps even administering depot treatment"*.

²² See *R (Oao DJ and AN) v MHRT* [2005] EWHC 587 (Admin) April 2005 on the importance of contemporaneous factual evidence at MHRT hearings. See also *In Place of Fear? Eleventh Biennial Report of MHAC* paragraph 1.100 and ref. Sugarman P and Roychowdhury A (2000) 'Injustice in Forensic Psychiatry: the Scott-Moncrieff hypothesis revisited' *Journal of Forensic Psychiatry* 11: 465-469 on the need for precision in psychiatric reporting.

- 5.19.4 At this point, therefore, Dr J and Dr M were in agreement that a CPN should be appointed; though it was for different reasons based on different diagnoses.
- 5.19.5 However, two things prevented allocation of a CPN. Firstly, on 13 December 2000 Yate CMHT decided that neither a CPN nor any other personnel would visit MN at home *"in view of MN's previous hostile reaction to home interventions and taking into account his wider risk assessment including his possession of a knife"*. Secondly, in the opinion of Dr M the diagnosis of schizotypal disorder did not seem to require a CPN. He told us there was a *"lack of a clear role for a CPN"*
- 5.19.6 Dr J told the Inquiry he was *"unsurprised"* at the decision not to allocate a CPN, though he *"did not think there was any reason for anxiety as to risk to those taking on his care upon discharge"*, but *"what I had then assumed would happen is that if there were concerns that mother or family had whilst MN was at home, that those would be relayed direct to us on the ward rather than to a member of the team so that the process of monitoring would be done on a much more long arm way rather than having somebody being able to call and see him."*
- 5.19.7 This accords with the Caernarfon Ward Nursing Care Plan dated 23 November 2000, which stated *"Aim of care/goal: For MN to return to the ward when MN and family feel support necessary. To recommence medication regime when returns to the ward"*. However, neither Dr M nor the family made any mention of this arrangement, and ward staff did not become involved after MN's discharge from hospital on leave.

Dr J and Dr M together failed to set up arrangements for monitoring MN at home

Dr J intended to set up an arrangement in the community for detection of early warning signs by a CPN. He should have planned this in advance but we nevertheless consider it extraordinary that, despite Dr J's clear request, Yate CMHT were able to make the decision not to allocate a CPN without making any clear contingency plan. Dr J had to rely on the family reporting directly to him on MN's mental state although he accepts that his poor relationship with the family might have deterred them from this. We conclude that Dr J intended to monitor the diagnosis of schizotypal disorder but failed, along with Dr M, to set up the mechanisms by which this could be achieved.

5.20 Observation at home

- 5.20.1 It would be good, indeed usual, practice for s17 home leave to be introduced gradually, with days at home followed by nights, then weekends and eventual return home. This permits observation of how a patient will manage at home, and allows feedback from the family. In contrast to this, MN was returned abruptly home and seen three weeks later at an outpatient appointment, while Yate CPN's refused to visit him in the interim. This poor practice right at the outset set the pattern.
- 5.20.2 Observation of MN at home was left to the family, but this was not clinical observation as they were not professionals and they did not know what they should be looking for, either positive or negative symptoms. Use by them of the words 'improvement' or 'better' for example, is not clinically helpful. MN's mother told us that her son was still *"laughing, tapping his foot, thought he could fly – things like this... all the symptoms were still there, but then again I would not know what to really look for if he got worse... what else does schizophrenia do?"* Dr J acknowledged during his evidence to the Inquiry that he had been relying on the family to alert services if there were problems, but realised in retrospect that his communication with them had been poor and this might have deterred the family from making contact with him. Dr M, though he met with the family in January 2001, did not speak with them again until he rang DC after MN had begun to miss outpatient appointments. Only then did he realise that the person he had considered to be his family informant had not been in touch with MN or his mother for some time. Yet following the missed appointments Dr M continued to rely on the family for evidence of symptoms, telling us of his *"belief that the family would alert us in the event of a significant deterioration in his health"*.
- 5.20.3 But, it might be said, MN had a social worker. Was it not his task to monitor MN's mental state? It seems not. When, after two months at home, social services allocated a social worker it was not at the request of either clinical team for the purpose of observing MN's mental state or looking for psychotic symptoms. It was at the request of the family and because social services were complying with their obligation to offer aftercare under s117 MHA. In March 2001 LMcC wrote that he saw his role being *"To*

support MN in the community. To seek to help him return to either employment or training.” Dr M told us he understood that the social worker’s “main role was to build a therapeutic relationship with MN focussing on work and training issues” and “trying to engage rather than challenge or assess his mental state in detail”. LMcC was not sent a copy of the CPA care plan and there was never any suggestion that he would take on the role of care co-ordinator.

- 5.20.4 LMcC told us he did not consider it made any practical difference from his point of view whether MN suffered from schizophrenia or schizotypal disorder: *“I do not know enough about the range of symptoms and what the diagnosis specifically means... my angle on working with people is that I’m trying to develop a relationship and trying to be supportive and trying to help them make positive and constructive steps in their lives.”* Asked about schizotypal disorder he replied *“I could not say with any degree of certainty, but I would say that it is a psychotic disorder”* and *“I could not give you a formal idea of what the symptoms are.... but it is people who have difficulties perceiving what reality is”*. He said he had not looked it up. Asked for his understanding of MN’s mental disorder at the time, he told us *“I think he had a schizophrenic illness....Dr M did talk about not being sure whether he had a schizotypal disorder. The diagnosis was Dr M’s responsibility; he knew a lot more about it than I do”*.
- 5.20.5 Had anyone, we wondered, ever plumbed MN’s inner thoughts? We asked Dr M, who replied: *“Probably not a professional, no”*. Yet Dr M had tried. Far from accepting the re-diagnosis he pointed out that this had resulted in an even greater determination to probe; *“because this was a change for me....I expected him to be proven to have a diagnosis of schizophrenia”*. He reminded us that he had pushed MN quite hard to reveal symptoms, because of his *“worry that he had concealed symptoms, but also my impotency in what to do about it”*.
- 5.20.6 Of course, MN did eventually reveal his inner thoughts to LMcC on the day of the homicide. We note that by this time Dr M had changed the basis upon which LMcC was visiting. For the first time, on 15 January 2002, he had asked LMcC to monitor MN’s mental health. LMcC’s direct questions to MN about his mental state on 27 March 2002 represented an attempt to do exactly what he had been asked to do by Dr M.
- 5.20.7 It is an irony that LMcC, in discussion with his supervisor, had concluded that a social worker was not the best person to carry out the task of monitoring MN’s mental health and that *‘assertive outreach [teams] have a smaller caseload....they can do a lot more chasing people up....figuring out where they are, and they can spend a lot longer seeing them.’* Just at the point that he killed, arrangements were finally being made for MN to be seen by CPN’s, not in a CMHT but in an assertive outreach team.

Family should not have been relied upon to report matters of clinical significance

Dr M made efforts to draw out psychotic symptoms from MN, and we have already noted in Chapter 4 that he took steps to hear from the family. However, the family was not asked to report any specific features of MN’s behaviour, and did not understand precisely what would constitute deterioration. They should not have been relied upon as the only informants upon matters of clinical significance.

Social worker inadequately prepared by Dr M for task of monitoring MN’s mental health

When the social worker was allocated it was not envisaged that he would monitor MN’s mental health, and LMcC did not consider diagnosis was relevant to his help with MN’s employment and training. When LMcC was asked to monitor MN’s mental health, Dr M should have discussed the diagnosis with him so that LMcC was quite clear as to the symptoms of schizotypal disorder and schizophrenia, and understood what he should be looking for in MN. The social work records were brief and would not have been helpful for the monitoring of MN’s mental health. At Local Recommendation 14 we recommend that the Trust and social services audit the standard of records, providing training where necessary to improve it, and that staff appraisal assesses social work skills.

Arrangements for clinical observation of MN were unstructured and unsatisfactory

Over a year after it had been decided that a CPN would not be visiting MN it was decided to make a referral for CPN input from an assertive outreach team. This may have been exactly the right course of action but it was far too late. Arrangements for clinical observation of MN bore the hallmarks of a lack of planning, coming together in an unstructured way that failed to provide either Dr J or Dr M with the information they needed properly to make a diagnosis and provide treatment for MN.

5.21 Impact upon diagnosis

- 5.21.1 We conclude that the out-of-area admission led to lack of shared medical records, daily uncertainty about MN's continued presence on the ward inhibiting commitment to MN's nursing care, poor communication with the community over arrangements for s17 home leave, and confusing clinical responsibility once at home.
- 5.21.2 Although these factors undoubtedly had an impact on MN's diagnosis and treatment, each member of the clinical team also had an individual duty to MN. That duty was to mitigate wherever possible the effect of these system defects. The taking of a detailed history from the family, asking directly for records that had not appeared, asking nursing staff and SHO to probe further into symptoms and triggers for disturbance, were all actions that could have been taken.
- 5.21.3 Instead the continued failure to dig deep either into the past or into MN's present thinking allowed the perpetuation of the diagnosis of schizotypal disorder, and MN was increasingly seen as unusual rather than ill.

5.22 'Unusual'

- 5.22.1 We have noticed use of the word 'unusual' a number of times in the original documentation and in the evidence we have heard, and we think this deserves some mention.
- 5.22.2 Dr J, reacting to the diagnostic differences between himself and Dr M, said it was *"not an ideal situation and it is, I think I am right in saying, a unique situation, certainly in my twelve years as a consultant. Firstly, there is usually considerably greater concordance of thinking between the two clinicians; secondly, it has been unusual for somebody to have required an admission to an HDU (High Dependency Unit) and then not to have continued to be unwell, such that they would require, in a very straightforward, commonsensical sort of fashion, medication"*.
- 5.22.3 In January 2001 Dr M wrote to Dr J *"this is a most difficult and unusual case"*, and writing again in March 2001 referred to this *"difficult and unusual case."*
- 5.22.4 In his evidence Dr M, reflecting with hindsight upon the homicide, remarked upon how unusual it was for someone suffering schizophrenia to be capable of concealing their symptoms so well. Dr M described to us how *"over a number of outpatient reviews, I found it impossible to shake or penetrate his bland and unremarkable mental state"*. It is an irony that it was MN's apparent 'normality' which made him seem, medically speaking, unusual. Dr M pointed out *"His apparent normality during the earlier part of the day of the homicide.....deprived his family of any opportunity to seek help from our Team or others"*.
- 5.22.5 And of course, the choice of schizotypal disorder as a diagnosis was itself unusual. Of those from whom we heard evidence, only Dr M had once previously encountered a patient with an established diagnosis of schizotypal disorder.
- 5.22.6 This has prompted us to ask ourselves whether MN was an unusual patient, and we conclude from the utterly unremarkable diagnosis and treatment of him up until his detention under s3 MHA that he was not. Nothing in the pre-admission notes, section papers or MHRT reports suggested MN was out of the ordinary. It was only after the diagnosis of schizotypal disorder had been made that Dr M described MN's case as unusual and difficult.
- 5.22.7 Indeed it seems that MN's 'unusualness' first arose early in November 2000, when Dr J was faced with an apparent 'discrepancy' as he described it. He found himself trying to fit together a picture of a young man who seemed, based on the nursing reports he had received, to be very 'settled', improving with little medication, described by his family as 'normal' and who prior to admission appeared, from Dr J's limited information, to have been no more than 'odd'. This was not quite what Dr J had expected from an individual suffering from a psychosis. So he initially did exactly the right thing. He decided to gather more information. He intended to speak to the family and Dr M.

- 5.22.8 But well-intentioned as he was, Dr J did not take a family history or obtain the pre-admission medical records, and it is not clear from the evidence that he spoke to Dr M at this stage. Instead he relied upon nursing observation, and began to consider an unusual diagnosis that would fit those facts.
- 5.22.9 It has been said, in an entirely different, legal, context *"It would need more cogent evidence to satisfy one that the creature seen walking in Regent's Park was more likely than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian."*²³
- 5.22.10 Although the diagnosis made by a psychiatrist is not the same as a legal decision, we think there is a lesson here. Schizotypal disorder was a rarely used diagnosis, which some authorities advise against using, and schizophrenia was a common mental illness. Dr J should have needed more cogent, in other words stronger and more convincing, evidence to satisfy himself that MN suffered from schizotypal disorder rather than from schizophrenia.

5.23 A choice

- 5.23.1 Even if Dr J had remained convinced with all the possible information that schizotypal disorder was a viable diagnosis, in testing out the two diagnoses he had a choice. Either he could have decided on a course of active treatment for schizophrenia, concluding if antipsychotic medication was ineffective that he suffered from schizotypal disorder. Or he could have decided to proceed as if MN was not mentally ill, putting in place a robust monitoring plan, and concluding if psychotic symptoms emerged that he was in fact mentally ill.
- 5.23.2 Dr J decided on the latter. He informed the Inquiry that he was keen to avoid inappropriate treatment of MN with anti-psychotic medication if he did not have a psychosis; *"if improvement could be brought about by non-medication (which all of us – clinicians and family – believed was happening), then surely that represented the greatest benefit to MN and the least risk to him of potential harmful side-effects"*. Dr J has drawn the Inquiry's attention to a World Health Organisation international outcome study which demonstrated that 15% of those presenting with a schizophrenia-like illness in developed world centres recovered completely within 4 months and stayed well for 2 years. He points out that treating such patients with medication at the earliest appearance of symptoms, without thought for the expected outcome, may lock the person experiencing a brief psychosis into a long-term career as a psychiatric patient. Of course, the existence of MN's symptoms, according to the family history, went back at least one year and probably two.
- 5.23.3 Moreover, despite Dr J's recollection, there does not appear to have been family agreement to this plan upon MN's return home. DC, capturing the essence of the two treatment options in her letter to Dr M (and which was forwarded on to Dr J on 29 November 2000) wrote *"I was even more concerned when he [Dr J] mentioned he would let MN home and see if he gets worse, and if so, he would have him back in hospital.....this was the opposite of what you [Dr M] wanted to do in the beginning, as you wanted to get MN now before he got worse....I do not feel MN will get better on his own...."*
- 5.23.4 Dr J's decision represented a fork in the road. One way led to a diagnosis of schizophrenia and treatment with anti-psychotic medication, probably against MN's wishes and, if the diagnosis was wrong, unnecessary treatment with potentially harmful side-effects and the unjustified stigma of mental illness. The other way led to no medication, an avoidance of labelling as mentally ill and, if the diagnosis was wrong, untreated schizophrenia with possible risk to his own health and that of others.
- 5.23.5 Dr J told us that having decided upon his plan of action *"a change of course was no more or less problematic with the diagnosis of schizotypal disorder than any other diagnosis. If the clinical picture had changed, then so would the diagnosis"* (Dr J's emphasis). However, the diagnosis of schizotypal disorder was unusual and it required particularly careful analysis of symptoms; for example, whether ideas were delusional or represented 'magical thinking'. This diagnostic course required the clinical resources and skills to monitor and observe MN closely at home.

²³ Lord Hoffman in *Re H (Minors) (Sexual Abuse: Standard of Proof)* [1996] AC 563, quoted in *R (DJ and AN) v Mental Health Review Tribunal* [2005] 1 MHLR 56, which examines the standard of proof to be applied in MHRT's

Choosing schizotypal disorder

We conclude that in choosing the path of schizotypal disorder and sending MN home without discussion of diagnosis with the family, to a different psychiatric team, without any in-patient medical records, without a discharge summary, without any planned clinical observation in the home and bearing in mind the higher threshold for recall when on extended s17 leave²⁴ and even higher threshold for further assessment under the MHA, Dr J was, without intending it, making any change of course hugely problematic. Of course, Dr J was not to know that since MN was not suffering from schizophrenia, a CPN would not be allocated, and we make it plain that he could not have anticipated future events. But prior to MN's return home Dr J should have ensured that his reasonable intention to monitor MN's mental health robustly in the community was capable of follow through. Once the diagnosis was established and MN was back with his family it became very difficult to 'disprove' it. Negative symptoms of schizophrenia were not considered as a possible explanation for his social withdrawal.

5.24 What if?

- 5.24.1 What if MN had been diagnosed as suffering from a psychotic disorder? It is clear from the definitions above that psychosis does not necessarily mean schizophrenia. There are other forms of psychotic illness including transient psychotic states. Indeed Dr J told us that, on reflection, that might have been a logical diagnosis to consider at the time, and it could have resulted in an entirely reasonable decision not to medicate.
- 5.24.2 For psychosis to be considered as schizophrenia, symptoms of schizophrenia must be present for a given length of time as described above. Brief, time-limited symptoms, even if florid, are not enough. That is why before admission Dr M gave only a provisional opinion: "*probably schizophrenia*". S2 MHA is deliberately intended to provide time for assessment.
- 5.24.3 But what if all the information had been available and a firm diagnosis of schizophrenia properly made? Would that have prevented the homicide? We cannot say that it definitely would.
- 5.24.4 There are differing views on the approach to be taken to an individual who is in the early stages of schizophrenia and not showing severe symptoms. These approaches can be briefly described as either 'early intervention' or 'minimum intervention'.
- 5.24.5 The early intervention argument has been mentioned earlier in this chapter. It is now widely accepted that it is desirable to treat schizophrenia with antipsychotic medication as early as possible to prevent serious and irreversible damage later on. But that will often need to be weighed against the minimum intervention principle of the least restrictive alternative, or the minimum interference necessary, both of which are well-established legal principles.
- 5.24.6 So it may be desirable that an individual receive medication, but it may not be so necessary that it justifies forcing it on them. Whether to assess under the MHA, and even if detained under the Act, whether to impose medication, are decisions that involve matters of patient autonomy, the interests of the patient and the public interest.
- 5.24.7 We cannot be sure that if MN had been firmly diagnosed as suffering from schizophrenia he would have continued to be treated with medication right up until the homicide. Medication could have been imposed on him in hospital, but even if it had been effective there would inevitably have come a time when he was sufficiently well to return home and be discharged from section. If after that MN had refused medication, but at the same time appeared symptom-free, it may have been difficult to instigate a fresh assessment under the MHA.

²⁴ The MHA requires that revocation of leave and recall to hospital has to be '*necessary...in the interests of the patient's health or safety or for the protection of others*' and must be by notice in writing to the patient and the MHA Code of Practice advises "*The rmo must consider very seriously the reasons for recalling a patient and the effects this may have on him or her*".

- 5.24.8 These are of course imponderables, but they do make it clear that a diagnosis of schizophrenia could not alone have been enough to prevent the homicide. It was, however, an essential starting point. To that extent an accurate diagnosis would have reduced the risk of homicide.

5.25 The balance

- 5.25.1 Whatever the diagnosis, clinicians wrestle with matters of freedom and human rights. Dr M referred in a letter to *“very difficult ethical issues”*.
- 5.25.2 Written following a homicide committed against a member of the public, it might be expected that this report would urge caution, and it does. We suggest that any psychiatrist weighing up matters of individual liberty and public interest give a thought to the following recent legal quote, which we think expresses very well the way that the interests of the patient and the public may sometimes be served by the same course of action:

“Liberty, autonomy and bodily integrity are interests which traditionally have received a high degree of protection under the common law and are now afforded the added protections conferred by the [European] Convention [of Human Rights].....But there are powerful interests that may pull in the other directions. Not merely, if most obviously, the public interest but also.....the patient’s own interests. It is, after all, no kindness to someone who in truth needs it to deny him the treatment which may not only protect him from the risk of harm or self-harm but also, if he is ‘cured’, remove or reduce the prospects of future compulsory detention..... the interests of the patient, as objectively ascertained, and the interests of the public will frequently not be in conflict..”²⁵

- 5.25.3 Erring on the side of non-intervention might sometimes appear to be sounder in terms of individual rights and freedoms, and as a tactic for trying to encourage continuing engagement and development of a more robust therapeutic relationship. But clinicians who choose this path need to be careful that well-motivated commitment to the least restrictive alternative does not produce benign neglect.

5.26 In summary

- 5.26.1 This has been a complicated chapter. Some of the criticisms have been particular to one of the psychiatrists but not the other. We make it clear that both, in our view, took great care with their decision-making. The integrity of neither is in doubt.
- 5.26.2 However, Dr J made a statistically unusual decision involving a rarely used clinical diagnosis which, being taken on uncertain ground, without a family history and without communication and information-sharing with Dr M, should at least have been followed up with proper care planning and collaboration to check its ‘stability’. In other words, processes should have ensured that it was a diagnosis that could continue to be positively made and preferred over time.
- 5.26.3 Dr M made the same decision as to diagnosis, without sufficient information from inpatient records and without putting into place the close clinical monitoring necessary to check that the diagnosis could continue to be preferred whilst MN was at home. He should have regularly reviewed the risks associated with non-treatment of the differential diagnosis of schizophrenia.

Conclusions

We reach three conclusions of general significance on the subject of diagnosis. These should stand as a cautionary note for clinical readers of this report.

- An unusual diagnosis should be used only when the evidence supporting it is strong and convincing
- Where there is a differential diagnosis, the treatment plan should be the one which represents the greatest potential benefit and least risk to the patient and/or others, unless there is a compelling reason to the contrary, and risks associated with the untreated diagnosis should be regularly reviewed
- The benefits of early intervention in schizophrenia are so great that any decision to deprive an individual of that benefit should be taken with particular care.

²⁵ Munby J in *R (DJ and AN) v Mental Health Review Tribunal* [2005] 1 MHLR 56

In the case of MN we conclude that

- (i) Neither consultant psychiatrist had enough information to make the unusual diagnosis of schizotypal disorder, or to prefer it over time.
- (ii) If all the available information had been taken into account by both psychiatrists, it is probable the diagnosis of psychotic disorder would have been confirmed or reinstated.
- (iii) The organisational setting contributed to the poor information available, with out-of-area admission leading to:
 - failure to share records between the hospital and community
 - unclear clinical responsibility
 - poor communication in the planning of aftercare
 - poor arrangements for clinical observation.
- (iv) Although they were disadvantaged by the out-of-area admission, each psychiatrist failed to mitigate the effect of this by taking active steps to obtain sufficient information from records, other professionals and family to make, maintain and review MN's diagnosis properly.
- (v) The benefits of early intervention for schizophrenia, which had briefly seemed there for MN, were lost with the change of diagnosis and withdrawal of medication

Early intervention in psychosis

In its early stages psychosis may be difficult to detect, especially in young people when it is important to avoid reaching a diagnosis prematurely. We recommend the establishment of services within the Trust which focus specifically on early intervention in psychosis. The need for such a service has been recognised nationally for some time²⁶, and since this homicide the Trust has begun an examination of how it could be achieved. We consider this should now be given high priority.

Local Recommendation 15:

Urgent need for 'early intervention in psychosis' service

²⁶ In the National Service Framework for Mental Health (1999), the NHS Plan (2000) and the Department of Health Mental Health Policy Implementation Guide (2001). Initiatives which have been nationally recognised include the Initiative to Reduce the Impact of Schizophrenia (IRIS) Clinical Guidelines (2001) and the Newcastle Early Psychosis Declaration of June 2002.

Chapter 6

The Care Programme Approach

6.1 CPA locally and nationally

6.1.1 The Care Programme Approach (CPA) should provide the care planning framework for all mental health care in this country. That we are criticising its use and effectiveness in this Inquiry Report is of concern because it has been operational nationally since 1990. That these criticisms follow criticisms made in two previous independent homicide inquiries locally is of even greater concern.

6.1.2 In this Chapter we shall examine how CPA operated nationally and in the case of MN. It is a subject which touches almost every aspect of mental health care, and this chapter is lengthy.

6.1.3 We begin by reviewing the national framework for CPA and its inclusion in the MHA Code of Practice. We follow this with an examination of CPA as it applied to MN's care. We then hear how CPA worked for the psychiatrists and CPNs, looking more deeply at its operation in the CMHT, locality and Trust. We consider how social work fitted into CPA. We examine some specific issues connected with CPA, including risk assessment. The very fact that this is so wide-ranging a chapter says it all. CPA is at the very heart of mental health care. But, we ask ourselves, could it have made any difference to the course of events if CPA had operated successfully in MN's case? We answer in the affirmative.

6.1.4 And so we shall express a view shared with the more optimistic witnesses, that CPA has the potential to provide exactly the unified framework for care that was intended. However, the predominant message from many giving evidence for this chapter is one of slow progress on CPA, some lack of commitment, and difficulty with full implementation in the context of a huge Trust and complex local commissioning arrangements.

6.2 CPA: the national policy framework

6.2.1 The Care Programme Approach was introduced in 1990 by the Department of Health,²⁷ to provide a national framework for the care of mentally ill people outside hospital. It required Health Authorities, in collaboration with Social Services Departments, to put in place specified arrangements for care and treatment in the community. In 1994 the Department of Health issued further detailed policy guidance²⁸ to health professionals and service providers, which included a requirement in Health Circular HSG(94)27 that Trust policies ensure the existence of procedures for risk assessment upon patients' discharge from psychiatric hospital.

6.2.2 In November 1995, as part of its response to *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, the Department of Health consolidated all of these expectations in a guidance document entitled *Building Bridges*²⁹.

6.2.3 In 1999 the Department of Health published its *National Service Framework for Mental Health: Modern Standards and Service Models*, and in order to update CPA procedures it issued a policy booklet, *Effective Care Co-ordination in Mental Health Services: Modernising the CPA*³⁰. These are current today.

²⁷ Department of Health joint Health/Local Authority Circular HC (90) 23, LASSL(90)11, *Caring for people: the CPA approach for people with a mental illness*

²⁸ *Health of the National Key Area Handbook 2*; HSG (94)27 *Guidance on the discharge of mentally disordered people and their continuing care* and NHS Executive *Audit Pack for monitoring the CPA (1994)*

²⁹ Department of Health, 1995

³⁰ 'Effective care co-ordination in mental health services: modernising the care programme approach – A policy booklet', 1999, NHS Executive and Social Services Inspectorate

- 6.2.4 The policy booklet simplified previous CPA procedures by establishing two 'levels' of CPA, enhanced and standard, which would apply to all users of secondary mental health services. It also merged social services' care planning arrangements with CPA and referred to it as the Integrated Care Programme Approach (ICPA). We note that the initials ICPA are widely used in the Trust where the Trust's ICPA Policy Framework, procedures and paperwork all refer to it. However, ICPA has not become universally used and nationally the Care Programme Approach is still generally referred to as the CPA, or often simply CPA. We shall use CPA unless we are referring specifically to the local policies and procedures, but the reader will find the terms used interchangeably.
- 6.2.5 We now look at the booklet in a little more detail. It is relevant to the care of MN because it had been noted on the CPA form at Hillview Lodge that he was subject to the highest level of CPA, but Dr M gave evidence he had treated MN as on the lowest or 'standard' CPA, and considered in doing so that he had complied with national guidance. We quote below from the Department of Health policy booklet on the difference between standard and enhanced CPA.
- 6.2.6 Standard CPA was described in this way: *"The characteristics of people on standard CPA will include some of the following:*
- *they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;*
 - *they are more able to self-manage their mental health problems;*
 - *they have an active informal support network;*
 - *they pose little danger to themselves or others;*
 - *they are more likely to maintain appropriate contact with services".³¹*
- 6.2.7 Although the above characteristics could place an individual on standard CPA even if there were two or more professionals involved, the guidance suggested a simple approach to recording standard-level CPA when only one professional was delivering care: *"where the service user has standard needs and has contact with only one professional, that professional will in effect be the person who coordinates their care and any clinical or practice notes will constitute the care plan and record of review. Service users should be given the opportunity to sign the agreed care plan and then receive a copy. It is not necessary to engage in further bureaucracy for the care of such people. As a minimum, service providers must ensure that central records are maintained on all those in contact with services and that care planning and review take place regularly".³²*
- 6.2.8 Enhanced CPA was described like this: *"People on enhanced CPA are likely to have some of the following characteristics:*
- *they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;*
 - *they are only willing to co-operate with one professional or agency but they have multiple care needs;*
 - *they may be in contact with a number of agencies (including the Criminal Justice System);*
 - *they are likely to require more frequent and intensive interventions, perhaps with medication management;*
 - *they are more likely to have mental health problems co-existing with other problems such as substance misuse;*
 - *they are more likely to be at risk of harming themselves or others;*
 - *they are more likely to disengage with services".³³*
- 6.2.9 Risk assessment was described as *"an essential and on-going part of the CPA process".*

³¹ As above paragraph 57

³² As above paragraph 19

³³ As above paragraph 58

- 6.2.10 Care plans *“for severely mentally ill service users should include urgent follow-up within one week of hospital discharge. Care plans for all those requiring enhanced CPA should include a “what to do in a crisis” and a contingency plan”*.
- 6.2.11 Carers’ needs were considered important; *‘The process of the CPA is clearly intended to deliver care to meet the individual needs of service users. However, those needs often relate not just to their own lives but also to the lives of their wider family. The CPA should take account of this, in particular the needs of children and carers of people with mental health problems and must comply with the Carers (Recognition and Services) Act 1995 and the NSF standard on caring for carers’*.
- 6.2.12 National guidance also includes reference to the allocation of a named care co-ordinator whose task it is, with multi-disciplinary managerial and professional support, to keep in close contact with the patient, monitor that the agreed programme of care is delivered, and take immediate action if it is not. The responsibilities of the care co-ordinator were described in more detail in *Building Bridges*. They are to:
- *“Use their professional skills collaboratively in assisting patients and maintaining close and regular contact with them. This should involve consultation with carers. Contact should be maintained until the patient no longer requires CPA or until the role has been transferred to another keyworker.*
 - *Provide support and care in a positive, assertive manner which is as acceptable to the user/patient as possible.*
 - *Act as a consistent point of contact for users, carers, local authority care managers and other professionals.*
 - *Be aware of other resources, and provide information or refer as appropriate.*
 - *Assist in planning and then monitoring the delivery of the agreed care package, record decisions made about it and ensure that it is reviewed at regular intervals.”*
- 6.2.13 To those care co-ordinator responsibilities were added the task of initiating appropriate action if the patient defaults from follow-up or displays symptoms of behaviour recognised as presaging relapse.³⁴

6.3 CPA and the Code of Practice

- 6.3.1 In order to imbed CPA firmly into the structure of mental health services the Code of Practice,³⁵ when revised in 1999, incorporated the practice standards defined in national CPA guidance, stating in relation to CPA and treatment:

“15.5 Treatment plans are essential for both informal and detained patients. Consultants should co-ordinate the formulation of a treatment plan in consultation with their professional colleagues. The plan should form part of a coherent care plan under the CPA.....and be recorded in the patient’s clinical notes.

*15.6 A treatment plan should include a description of the immediate and long term goals for the patient with a clear indication of the treatments proposed and the methods of treatment”.*³⁶

- 6.3.2 In connection with CPA and care plans the Code of Practice has this to say:

“27.1 ...a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully without danger to themselves or other people. The planning of this needs to start when the patient is admitted to hospital.

27.2 These objectives apply to all patients receiving treatment and care from the specialist psychiatric services, whether or not they are admitted to hospital and whether or not they are detained under the Act. They are embodied in the Care Programme Approach.... The key elements of the CPA are:

³⁴ see *Audit Pack for Monitoring the CPA: NHS Executive 1994*

³⁵ The Mental Health Act Code of Practice is published under Section 118 of the MHA by the Secretary of State for Health

³⁶ MHA Code of Practice paragraph 15.5-15.6

- *Systematic arrangements for assessing people's health and social care needs;*
- *The formulation of a care plan which addresses those needs;*
- *The appointment of a key worker [now referred to as a care co-ordinator] to keep in close touch with the patient and monitor care;*
- *Regular review and if need be, agreed changes to the care plan.”³⁷*

6.3.3 The Code of Practice goes on to describe the aftercare arrangements that have to be made for a patient under s117 MHA, and the connection with CPA:

“Section 117 of the Act requires Health Authorities and local Social Services Authorities, in conjunction with voluntary agencies, to provide aftercare for certain categories of detained patients. This includes patients given leave of absence under section 17. The aftercare of detained patients should be included in the general arrangements for implementing CPA, but because of the statutory obligation it is important that all patients who are subject to section 117 are identified and records kept of them”.³⁸

6.3.4 The Code of Practice gives clear guidance on discharging or granting of leave to a patient:

“27.5 Before the decision is taken to discharge or grant leave to a patient, it is the responsibility of the rmo to ensure, in consultation with other professionals concerned, that the patient's needs for health and social care are fully assessed and the care plan addresses them.

27.6 The rmo is responsible for ensuring that:

- *A proper assessment is made of risks to the patient or other people....”³⁹*

6.3.5 And on the subject of who should be involved in consideration of a patient's aftercare needs, the Code of Practice says it should include the patient, rmo, nurse, social worker, GP, CPN, nearest relative and carer,⁴⁰ who must consider:

- (a) the patient's own wishes and needs....*
- (b) the views of any relative....*
- (c) the need for agreement with authorities and agencies in the area where the patient is to live.....*
- (d) the establishing of a care plan, based on proper assessment and clearly identified needs, including...*
 - *out-patient treatment....*
 - *a contingency plan should the patient relapse*
- (e) the appointment of a key worker... to monitor the care plan's implementation, liaise and co-ordinate where necessary and report to the senior officer in their agency any problems that arise which cannot be resolved through discussion*
- (f) the identification of unmet need.”⁴¹*

6.3.6 The Code of Practice advises that the professionals concerned should then *“establish an agreed outline of the patient's need”* adding that *“all key people with specific responsibilities with regard to the patient should be properly identified.... The plan should be recorded in writing”.⁴²*

6.3.7 Finally on the subject of aftercare, the Code of Practice states:

“The care plan should be regularly reviewed. It will be the responsibility of the key worker to arrange reviews of the plan until it is agreed that it is no longer necessary. The senior officer in the key worker's

³⁷ MHA Code of Practice paragraphs 27.1-27.2

³⁸ As above paragraph 27.3

³⁹ As above paragraphs 27.5-27.6

⁴⁰ As above paragraph 27.8

⁴¹ As above paragraph 27.10

⁴² As above paragraph 27.11

agency responsible for aftercare arrangements should ensure that all aspects of the procedure are followed.”⁴³

- 6.3.8 The introduction to the Code states *“The Act does not impose a legal duty to comply with the Code but as it is a statutory document, failure to follow it could be referred to in evidence in legal proceedings.”* Recent case law has confirmed that the Code of Practice has the status of guidance from which any departure should be supported by ‘cogent’ reasons⁴⁴.
- 6.3.9 It has been made clear that whilst NHS bodies have the lead responsibility for implementing the CPA, the responsibility for making sure staff know about the CPA and related provisions⁴⁵ rests with NHS Managers and Directors of Social Services.⁴⁶ We shall examine the local policy and procedural arrangements for CPA after we have looked at the way in which MN actually received his CPA care.

6.4 Summary of MN’s care under the CPA

- 6.4.1 Many of the facts have been dealt with in Chapter 2, and where relevant we refer back to that history.
- 6.4.2 When MN was admitted to hospital on 5 October 2000 he should have become subject to the CPA to ensure that adequate treatment and care plans were made well in advance of his discharge or extended leave from hospital.
- 6.4.3 The first mention of CPA in fact came on 20 November 2000, when the nursing note of a ward round stated *“Dr J will phone mother to arrange CPA”*. He did not do so and instead, two days later, when MN’s mother and her sister had returned MN to the ward after taking him into town, Dr J called an impromptu CPA meeting.
- 6.4.4 This meeting was unsatisfactory in a number of ways already outlined in Chapter 2. MN told us he had not known what CPA was or meant. Dr M was not invited, MN’s mother did not find it easy to express her views in front of MN, and there was no mention of diagnosis or the rationale for not medicating MN. Yet MN was sent home from the hospital on extended s17 leave with immediate effect, causing Dr M to express in strong terms his dissatisfaction that MN was not receiving medication. This was a matter which should have been discussed at a CPA meeting in advance of Dr J’s decision to send MN home.
- 6.4.5 Since the homicide, but not in the context of this Inquiry⁴⁷, Dr J has accepted that the s17 home leave decision was prompted in part by a need for MN’s bed. Such pressure is undoubtedly part of life on an acute psychiatric ward, but earlier planning and earlier CPA meetings would have ensured that diagnosis, medication and arrangements for discharge were already in hand. It would also have engaged MN and his family, as carers.
- 6.4.6 Information was entered onto a CPA care plan form during the meeting, indicating that MN was subject to the highest of three ‘levels’ of CPA referred to as ‘multidisciplinary’.
- 6.4.7 The care plan form was based on out of date national guidance, but more importantly, it was confusing and contradictory, describing Dr J as the Care Co-ordinator but also stating that the Care Co-ordinator had yet to be appointed and was to be a CPN from Yate CMHT. There had been no discussion with the CPNs and when they were sent a referral by LD, Caernarfon Ward Manager, they subsequently refused to undertake the task. Dr J did not at the time describe himself as the Care Co-ordinator and in practice no-one was ever appointed to fulfil the role.
- 6.4.8 The team discussed the nurse referral on 27 November 2000 and as a result Dr M then wrote to Dr J in the following terms: *“I felt I should write as a matter of urgent priority.....I would be happy to attend a*

⁴³ As above paragraph 27.12

⁴⁴ R v Ashworth Hospital (now Mersey Care NHS Trust) ex parte Munjaz [2005] UKHL 58 paras 21 & 107

⁴⁵ Further guidance on discharge from hospital and continuing care is contained in HSG(94)27/LASSL(94)4 and Building Bridges

⁴⁶ MHA Code of Practice paragraph 27.4

⁴⁷ This arose in the context of investigation of a complaint made to the Trust by the family.

ward review of MN following his trial s17 leave provided that I am given sufficient notice.....There is very great concern about the notion of Yate CMHT reassuming responsibility for the patient if he remains untreated, given the florid nature of his initial presentation when assessed at home."

- 6.4.9 Once completed the CPA form was faxed to the Yate team on 28 November 2000, and found its way onto the Yate medical records, though neither SL, the Locality Co-ordinator, nor Dr M recall ever having seen it. No new CPA form was completed in Yate and MN's name was never entered onto the South Gloucestershire CPA register.
- 6.4.10 Mention on the CPA form of an arrangement to see MN on 1 December 2000 came to nothing. As we have described in Chapter 2, Dr M subsequently attended Dr J's ward round at Hillview Lodge on 13 December 2000, where MN was reviewed for the first time since going home. Afterwards he wrote at length to Dr J, reasserting that MN remained in Dr J's care and stating that Yate CMHT members would not make home visits.
- 6.4.11 Neither the hospital's notes of that meeting, nor those of the next ward rounds on 18 and 22 December 2000, refer to CPA.
- 6.4.12 We have also described how, after discussion with Dr M in early January 2001, social services managers took the initiative in allocating LMCC as social worker to attend to MN's practical needs under s117 MHA. That initiative coincided with a request to social services from MN's aunt for help to the family in clarifying his current situation. LMCC noted '*CPA at Cedar House (Blackberry Hill Hospital) 17/1/01 – will attend.*' MN's name was never placed on the South Gloucestershire register of patients subject to s117 aftercare under the MHA.
- 6.4.13 Dr J and Dr M both made notes of the review meeting on 17 January 2001, which was also attended by LMCC, MN, his mother and aunt. It was not described by either of them as a CPA meeting, although LMCC's subsequent note of the meeting was prefaced by the initials '*CPA*'. From this date no further mention was made of CPA by Dr J or Dr M.
- 6.4.14 Care of MN was shared between Dr J and Dr M until March 2001, after which MN's medical care was covered by Dr M, whose recording of outpatient appointments was largely contained in letters to Dr J, the GP and LMCC. Dr M told the Inquiry that although it had not been recorded anywhere at the time he had decided, in agreement with the Yate Team and LMCC, that MN would be subject to 'standard' CPA, this being the lowest level of CPA, and that his clinical letters would satisfy CPA requirements under national guidance.
- 6.4.15 With no written record of this we have had to rely upon recollections, and unfortunately there has not been unanimity on the subject. LMCC and SL informed us that they had not agreed that MN's CPA requirements would be satisfied by Dr M's clinical letters.

6.5 Three questions

- 6.5.1 The history of MN's care under CPA leaves us with several questions, which we aim to answer in the remainder of this chapter:
- Should MN have been on standard or enhanced CPA?
 - Were Dr J, Hillview Lodge staff, Dr M, LMCC and the Yate Team adhering to local CPA procedure, Trust policy and national guidance in the assessment, care planning and review of MN?
 - Was local procedure, Trust policy and national guidance together sufficiently robust to provide MN with the CPA care planning he needed?
- 6.5.2 We heard from Dr J, Dr M, and SL the Yate CMHT Locality Co-ordinator. We also asked the Trust's senior managers and CPA co-ordinator to explain the development and implementation of CPA in Yate CMHT, South Gloucestershire Locality and the Trust.
- 6.5.3 We begin with the psychiatrists involved in MN's care, then consider the CPNs, after which we examine CPA in South Gloucestershire and the Trust. It will be evident that recollections, both in connection with

MN's care and CPA generally, differ. We present the evidence as we have heard it, and seek to understand the reasons for some apparently conflicting views. Risk assessment, whilst part of CPA, has a separate history in South Gloucestershire and we deal with that later in this chapter. Social work too operated outside of CPA for much of the time and we reserve a separate section for that.

6.6 The psychiatrists and CPA

- 6.6.1 Dr J's statement to the Inquiry said *"It is my understanding that the procedure we followed was within the letter and the spirit of the CPA procedure. MN's initial period of trial discharge under Section 17 was documented on a Trust CPA form and forwarded to appropriate individuals. In addition, the CPN service was sent a risk assessment, and partly as a result of this the CPN team declined to take him on. At each subsequent CPA meeting risk factors were addressed....."*
- 6.6.2 He explained that it would have been more usual to have invited the CMHT to the pre-discharge CPA meeting. It was also unusual *"to have a CPA at such speed"* and *"to be making that decision [about s17 leave] at the CPA having not cleared it with the team first"*. He did not consider, however, that the lack of a CPN would have altered his decision regarding extended home leave.
- 6.6.3 Dr J informed us that although he had not noted it at the time, and no CPA documentation had been completed, he considered that the review meeting of 17 January 2001 had been a CPA meeting.
- 6.6.4 It appears that the CPA form completed at Hillview Lodge was connected with the old Bath Mental Health Care NHS Trust Policy dated 1997, which was still in place at that time. Although the CPA meeting was unsatisfactory in the ways already outlined and did not conform to the standards of the MHA Code of Practice for detained patients, Dr J did hold the only CPA meeting concerning MN, and Hillview Lodge did complete the only CPA documentation during the whole of the period of MN's care.
- 6.6.5 Dr M's written statement to the Inquiry referred to his letter of 26 January 2001 to Dr J in which he said that MN *"had agreed to meet myself and LMCC with a view to advice and training [for MN]."* He added in his evidence to us *"this agreement represented the narrow basis on which MN had agreed to remain in touch with our service. We had explained the CPA to him with the expectation of his attendance at regular review meetings. He made it very clear that he did not agree to this process, but would meet with myself or LMCC at clinic appointments or home visits to discuss practical concerns such as training or finance.....For these reasons and in line with his diagnosis of schizotypal disorder, I took the view that full implementation of the standard policies of enhanced CPA would have been both unwarranted and impractical in that MN would not have attended CPA meetings"*.
- 6.6.6 By way of further explanation, in an additional statement, Dr M added: *"The Trust's policy framework for ICPA [Integrated Care Programme Approach] (revised October 2003) builds on previous publications in laying out guidance for the application of the Care Programme Approach. In particular, it sets out some of the characteristics of patients requiring standard, versus enhanced level CPA. In doing so, the document illustrates some of the dilemmas which our Team faced in managing MN's care after his discharge from hospital. Although MN had some of the characteristics of service users requiring an enhanced CPA approach, he did not have others such as a therapeutic requirement for frequent or intensive interventions, and his unwillingness to participate in this CPA approach led to the adoption of the less formal unenhanced one, with regular contact and support for carers. This unwillingness characterised his view of our service from the outset, and was not seen as symptomatic of illness, more of his shyness and diffidence."*
- 6.6.7 We asked Dr M if it would have made any difference if MN had been fully included in the CPA process. He replied *"I do not believe it would have.....I, with the team including LMCC, took a decision to manage MN effectively as a patient on unenhanced CPA with myself as care co-ordinator and with the clinic letters I wrote effectively acting as unenhanced care programme approach paperwork. It was recognised by the Trust that for patients on such a tier of CPA clinic letters were the CPA paperwork."*

- 6.6.8 Evidence to the Inquiry does not support Dr M on this point. LMcC informed the Inquiry through his solicitor that *"at no time did he have a meeting with Dr M and the Yate Team to discuss MN's care in this manner"* and SL, the Locality Coordinator *"confirmed that such a meeting did not take place"*. There is nothing in the local procedure or Trust Policy Framework current at the time to indicate that clinic letters were accepted in the way described by Dr M. We examine the CPA procedure in more detail below.
- 6.6.9 We asked Dr M if the inclusion of MN on a CPA register might have triggered the requirement for a review. He concluded *"Whether he (MN) would have attended, I do not know. In all likelihood there would have been the family plus myself and LMcC and at such a meeting we would have looked at the evidence for the need for a more assertive approach, including a MHA assessment, for example. I remain of the view that the evidence was not strong enough to precipitate such a review, given the information that LMcC and I had."*
- 6.6.10 In conclusion, Dr M, acknowledging the value of full CPA documentation, said *"I do honestly believe that in each of the assessments I carried out in MN's case in the community that I went through my own check list of is he paranoid.....angry....irritable, any signs of hallucination, any evidence of drugs, any threat. These questions I will always ask but I accept that it would be better practice and a recommendation for the future that they be more fully documented."*
- 6.6.11 Reflecting now upon his clinical management of MN, Dr M described to us the difficulties experienced by psychiatrists struggling to provide a professional service in the setting of limited resources. He wrote *"My management of MN reflected a sincere and, with hindsight, mistaken belief that a less formalised approach was appropriate in the light of his clinical presentation rather than a resistance to CPA: It represented a divergence from my normal practice of adhering to CPA guidelines; it also reflected the impact of my workload upon my decision making..... correct adherence to CPA might... have led to a different outcome in MN's case, but such an adherence was wholly incompatible with the "fire fighting" practice of psychiatry which I was forced to adopt given the number of patients. An important part of the pragmatism of my management of MN... was to do with resources.*

When I resigned from my post in the Summer of 2003, the population of my sector was approximately 75,000 persons. This is more than double Royal College of Psychiatrists recommended numbers. Despite repeated representations to the Trust, the PCT and other bodies to appoint a second consultant in my sector, this was still no nearer realisation when I left".

- 6.6.12 Dissatisfaction on the subject of resources had been so great, Dr M told us, that in the autumn of 2001 he had *"joined a group of six Consultant Psychiatrists from the then Avon and Wiltshire Mental Health Trust. This group was formed to protest about the chronic under funding of Mental Health Services in Avon. Our campaign included petitioning both local politicians and also government Ministers including Alan Milburn, Secretary of State for Health, to whom we wrote on 1/10/2001, demanding resources to redress "the chronic extremely low interest and investment in Mental Health Services in Avon". This campaign was just one of a number of efforts made by myself, and also SL over a number of years to improve matters in Yate. Despite this, in eight years of my tenure in the post, my workload and job plan was never reviewed by the Trust"*.

6.7 The community psychiatric nurses and CPA

- 6.7.1 The decision not to appoint a CPN to visit MN should not have been simply a 'one-off' decision made at the outset but a continuing decision, in the sense that at any time a CPA review could have revisited the subject of CPN involvement. We wished to know how well Dr M and the CPNs worked together to operate CPA in Yate CMHT.
- 6.7.2 In her written statement to the Inquiry, SL, Locality Co-ordinator, Yate CMHT described her team's engagement in the CPA process in 2001: *"The Team was piloting the ICPA paperwork..... All the CPNs were keen to improve documentation and the illustration of thoughtful care. As a Team we decided to pilot the paperwork, in part because of the CPN interest and also because I had been a member of the South Gloucestershire Integrated Care Programme Approach Steering Group... Unfortunately we failed to engage our medical colleagues in this process.... There was also a confusion at one stage when risk assessment and risk management were seen to be separate from the CPA and I recall writing to [RP,*

Chief Executive of the NHS Trust] stating exactly what we as a Team were going to do because of the muddle. I never received a reply".

- 6.7.3 SL described an absence of care planning and risk assessment: *"In MN's case there is no evidence of discharge planning in line with the principles of CPA.. Yate Community Mental Health Team were not informed of MN's period of leave until after the event..... the Risk Assessment I received was the Risk Assessment completed on admission with no appropriate community Risk Management Plan which we would have expected to be involved in.... Dr M makes several references to 'risk' but there is no CPA or Risk Management paperwork to illustrate the thoughts that lie behind his decisions. There were no CPA Care Plans written so none were provided to MN or his carer. There is no evidence of any time limits re reviews to risk, e.g. home visiting."*
- 6.7.4 We asked SL about her team's non-participation in MN's care, for example, at the meeting on 17 January 2001 after which he was seen only by Dr M and LMcC. SL said *"I did not know about it.....I think I had assumed there was no noise about the case.....that all was going okay and it fell off the end somewhere.....I had no knowledge of any of the meetings that happened and I do not think anyone else did."* PH thought Dr M may have been seeing patients who were technically part of the Yate CMHT catchment area, but about whom the rest of the team had little knowledge.
- 6.7.5 SL expressed warm regard for Dr M as a humane person: *"His patients really love him....he has got very astute skills and I have seen him work with some really disturbed people in a warm, human way."*
- 6.7.6 Some five months after the homicide Dr M left the team for a scheduled period of sabbatical leave, and since then they have had fourteen locum consultant psychiatrists. SL said this had left her feeling it was *"hard to get a sense of corporate responsibility. I do not experience it from the higher echelons of the Trust"*.
- 6.7.7 Neither was it helped, she told us, by that fact that *"Yate CMHT is under resourced to the extent that we have not been able to take advantage of any training opportunities in the last 2 years"*.
- 6.7.8 In his evidence to the Inquiry Dr M expressed his concern at any suggestion that in Yate CMHT there had been a *"split into two camps, namely the medics represented by myself and the nurses represented by SL"*. He had not been aware, he told us, of any such split; *"It is true that there was discussion and debate about the ability of medics to complete the very considerable paperwork within for example the tight confines of an outpatient clinic and there was also Team agreement that for Level 1 or uncomplicated cases, then a full Maudsley style letter to the GP would satisfy the requirements of CPA. I recall that the Trust also officially supported this interpretation of the CPA protocol"*.
- 6.7.9 *"In my experience"*, Dr M wrote to the Inquiry, *"the Yate CMHT was a happy and functional working unit. I believe it enjoyed a reputation as a good place to work and a number of nurses opted to transfer to work with us on that basis and my Specialist Registrar posting was voted the most popular in the Trust"*.

Confusion over acceptable CPA practice

There appears to us to have been an unsatisfactory degree of confusion in the evidence to the Inquiry over what was or was not acceptable CPA practice in the case of MN and generally in the Yate Team. We have therefore examined the development and implementation of CPA in South Gloucestershire.

6.8 CPA in South Gloucestershire

- 6.8.1 Yate CMHT is, and was during the period of MN's care, within South Gloucestershire Locality. The history of CPA practice in the locality was described to the Inquiry by IMcI, CPA Co-ordinator for the locality in these terms: *"Following the launch of the NHS policy document 'Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach' in October 1999, which raised new standards for the integration of the Care Programme Approach (CPA) and Care Management, my role was to develop an integrated CPA system and oversee its implementation in South Gloucestershire mental health services.....I spent the initial few months in consultation with other Trusts in order to see what had already been developed and the pitfalls of implementation. As a result and in the absence of any Trust lead, I put together a draft integrated CPA system for South Gloucestershire which we agreed to pilot in both Yate CMHT and the Access (Assertive Outreach) teams, from April 2000. Both of these*

teams supported the CPA process and were keen to assist develop suitable tools by trialling them in their practice. During that period, there was no formal Avon & Western Wiltshire Mental Health care NHS Trust (as the Trust was then called) ICPA policy, as the new Trust had only recently been formed and the localities were still working to old standards and policies."

- 6.8.2 We have seen Yate Operational Policy June 2000, and Avon & Western Wiltshire Trust & South Gloucestershire Social Services, South Gloucestershire Locality ICPA/CM Integrated Assessment Pack June 2000 devised by IMcl, which together appear to make up the CPA policy and paperwork, piloted by Yate CMHT and current during the period that MN was receiving care from Dr M and LMCC.
- 6.8.3 Before examining these in detail it is helpful to know a little of the local history of CPA, in that prior to the 1999 Department of Health changes to CPA, most mental health services had operated three levels of CPA. This was true of Bath Healthcare NHS Trust and Frenchay NHS Trust, both predecessors of the present Trust covering Hillview Lodge and the Yate Team. At the point that these Trusts merged to form Avon & West Wiltshire Healthcare NHS Trust in April 1999, each new locality operated a three-level CPA policy inherited from the old Trusts. However the three levels were different in each Trust. Bath NHS Trust, covering Hillview Lodge, used three levels of CPA. The lowest level applied where only one professional was involved, the next was described as 'complex' and the highest level was 'multidisciplinary'. When MN's CPA form was completed at Hillview Lodge it was on one of these old forms and MN was put on the highest 'multidisciplinary' level of CPA. Yate inherited Frenchay Trust's three-level CPA, but here the lowest level did not require placement on any CPA register or that any special documentation be completed. However, by November 2000, the situation had changed in Yate because South Gloucestershire documentation had been updated, as we shall see below.
- 6.8.4 The following documents taken together appear to represent the CPA policy and documentation applicable to Yate CMHT during much of 2000 and up until June 2002.

(1) Yate Community Mental Health Team Operational Policy dated June 2000. This set out the philosophy, aims, referral criteria, allocation process, accountability and responsibility, complaints, confidentiality, quality assurance and audit procedures of the Team. In addition it included a section on the *'roles and responsibilities of the key worker'* and *'discharge'*. Under *'roles and responsibilities of the key worker'* was written: *"The keyworker must use the Care Programme Approach to ensure all of the following:*

- 1) a thorough assessment of the individual*
- 2) a clear formulation of the problem*
- 3) a written package of care agreed with the client – which may include referring to other members of the team or agencies*
- 4) written outcome criteria*
- 5) a set date for the review of care, within six months, and thereafter as indicated by the client's progress, but within one year.*
- 6) in addition, keyworkers may use the team meeting, or arrange a professionals meeting, to discuss concerns or the need to involve other members of the team or other agencies.*

THE KEYWORKER IS RESPONSIBLE FOR ENSURING THAT ALL OF THE ABOVE IS DOCUMENTED USING AGREED PAPERWORK. (Capitalisation in the document)

(2) Avon & Western Wiltshire Mental Health Care NHS Trust and South Gloucestershire Social Services, Draft Integrated CPA/CM Integrated Assessment Pack, South Gloucestershire Locality, dated June 2000. This document, compiled by IMcl, describes the ICPA paperwork to be completed. On its front sheet it states *'The initial document was issued for consultation during April/May 2000 which has realised a number of amendments throughout. The pack will now remain in its current form for the duration of the trial period between August – October 2000, following which further evaluation will take place'.*

A flow chart is included which indicates that, if accepted by the service, the first action is to appoint a Care co-ordinator and then to complete a Standard or Enhanced Care Plan, followed by other

paperwork as necessary and a review. The document goes on to list the ICPA paperwork, giving guidance on its completion, including

- *Referral Information Front Sheet* containing basic information
- *Core Initial Assessment* will allocate a Care Co-ordinator
- *Mental Health & Additional Assessment Areas*. These include Carer's Self Assessment, it being *'the Care Co-ordinator's responsibility to ensure a service user's 'carer' receives a Carer's Self Assessment sheet'*
- *Consent to Sharing Information*
- *Risk Profile and Risk Management* referring to a Risk Policy dated August 2000
- *Care Plan*. The guidance sets out the characteristics of people on standard and enhanced CPA as described in the 1999 Department of Health booklet (paragraphs 6.2.6 & 6.2.8 above). The guidance states that Care Plan forms are to be completed for those on standard and enhanced ICPA. Guidance on completion states *'Care Plans are designed to summarise needs and interventions and should be drawn up in consultation with the Service User and their advocate where applicable. Review and evaluation of the Care Plan should be ongoing and at each formal review the date of the next review should be set and recorded. However, any member of the care team, Service User or carer/advocate should be able to ask for a review at any time. If refused, then the reasons why must be fully explained and documented'*
- The *'Standard Level Care Plan'* requires completion of a form containing details of the individual's address, GP, carer, consultant, care co-ordinator, services involved, the individual's strengths and needs, a review date, provision for the service user to record whether he or she agrees with the Care Plan, and for their signature on the Plan.
- The *'Enhanced Level Care Plan'* additionally provides for information about other staff involved, legal status, crisis plan, unmet needs and carer's needs.
- *Care Plan Review*. This is to be completed where there are significant changes or developments. If *'substantial changes are made to the Care Plan then a new one should be completed and circulated'*.

(3) Avon & Wiltshire Mental Health Partnership NHS Trust in Partnership with the Local Authority Social Services Departments within the Trust Area, Policy Framework for the Integrated Care Programme Approach, dated November 2000. This Trust Policy Framework for the Integrated Care Programme Approach was written by PMcK, who at the time was the Trust's Associate Nursing Director. It specified the operational standards to which each Area of the Trust should adhere:

'Each Area of the Trust will agree and operate joint procedures with the relevant local authority and in compliance with the following principles. Co-ordinating CPA across the Trust and working towards core principles will keep differences in each area to a minimum.' The 'core principles' included:

- Allocating individuals to standard and enhanced CPA according to the characteristics described in the 1999 Department of Health booklet;
- establishing *'a single overall Care Plan agreed with the service user, the professionals and, where appropriate, the carer'* ;
- identifying the Care Co-ordinator;
- for all those requiring enhanced CPA, providing a "What to do in a crisis?" contingency plan;
- requiring at the minimum an annual review of CPA;
- in relation to carers the framework stated *'Individuals who provide regular and substantial care for a person on the CPA must be offered an assessment of their caring, physical and mental health needs, on at least an annual basis and their own written Care Plan, which is given to them and implemented in discussion with them.'*

The framework stated that administrative arrangements were a matter for local areas:

"Area CPA procedures will define how....."

- *CPA meetings are conducted*
- *Administrative arrangements, communication and records are to be handled..".*

(4) A Memo from Yate Team dated 5 January 2001 but with no named sender and no indication to whom it was sent, referring to the latest version of the ICPA paperwork and stating:

"ALL TEAM MEMBERS: Please note that this paperwork replaces all current paperwork. All new patients require the following:-

- Referral Information/Front Sheet
- Core Initial Assessment
- Mental Health Assessment
- Standard Level Care Plan or Enhanced Level Care Plan

RISK ASSESSMENT: New referrals seen in the community. A Risk Screen must be completed; a copy of which will be attached to each new referral. A Risk Screen for Initial Assessments must then be completed. Further specific Risk Screening may be identified and an accompanying Risk Management Plan must be completed if required. (See AWWMHT Policy on Implementation of the assessment and management of risk caused by patient behaviour or vulnerability. August 2000)". (Emphasis in the document)

- 6.8.5 Having piloted the ICPA 'Assessment Pack' from April 2000, we heard from IMcI that the Yate Team used this paperwork throughout the remainder of 2000 and it was this which was operational in November 2000 when MN returned home on s17 leave.
- 6.8.6 It seems clear from the introduction to the ICPA Assessment Pack of June 2000, the Policy Framework of November 2000 and from the Yate CMHT letters of January 2001, that this 'Assessment Pack', sometimes described as a 'policy' was, with minor amendments, current throughout the period of MN's care at home until the homicide. We have not been referred to any other policy or paperwork that was operational in South Gloucestershire during 2001 and the early part of 2002. Although described as a 'policy', PMcK appears to have been referring to this document when he told us *"I have checked and confirmed with IMcI that the policy he developed for South Gloucestershire continued throughout the period of 2001 until the launch of the new [Trust] policies in June 2002"*. We examine the development of the Trustwide ICPA Policy in the next section of this chapter.

Dr M was required by the Trust to adhere to the South Gloucestershire CPA procedure
There was a clear CPA procedure in existence in Yate CMHT, dated June 2000, which had been developed by South Gloucestershire's CPA Co-ordinator and was presented in a document headed Avon & Western Wiltshire Mental Health Care NHS Trust and South Gloucestershire Social Services. We are satisfied that this document, with the title 'ICPA Assessment Pack' and variously described as a 'system', 'process', 'procedure', 'policy' or 'tools', was current throughout the time that MN was receiving care at home and until the homicide. The Trust required that local procedures be developed within a Trust framework and the South Gloucestershire procedure appears to have satisfied Trust requirements. We are in no doubt that Dr M and all health members of Yate Team should have adhered to this local procedure from June 2000 until June 2002, when a Trustwide CPA policy replaced it.

Dr M did not adhere to South Gloucestershire CPA procedure:

- **The South Gloucestershire CPA procedure required completion of documentation at both levels of CPA:** Although the Department of Health booklet stated that doctors' clinical records could constitute the care plan and review for standard CPA, the South Gloucestershire CPA procedure required completion of documentation including a Standard Level Care Plan form.
- **No Standard Level or Enhanced Level documentation was completed on MN**
- **MN should have been placed on Enhanced Level CPA:** MN appeared to fit the level of enhanced CPA. He was in contact with two agencies, there had been mention of substance misuse and MN had made it clear he would not comply with any medication which might be prescribed for his mental disorder. Moreover MN was until March 2001 subject to s3 MHA, the medical recommendations stating this was for his own health and safety and, in the view of one doctor, for the protection of others. The CPA requirements for detained patients set out in the MHA Code of Practice would seem to fit only with enhanced level CPA. And from October 2001 MN had disengaged from services.

- *MN had not been properly placed on any level of CPA:* In evidence to the Inquiry Dr M has, since the homicide, said that MN was on Standard CPA and he did not need to complete formal CPA paperwork because the 1999 Department of Health booklet did not require him to. No contemporaneous records support Dr M's claim that MN had been placed on Standard Level CPA. It was not mentioned anywhere. Indeed, there was no recorded discussion or decision about any level of CPA once MN returned home. If it had been properly decided that MN should be placed on Standard Level CPA, local policy and national guidance would, at a minimum, have required the appointment of a care co-ordinator and placement of MN's name on the CPA register, neither of which took place.
- *No evidence that the Trust accepted clinic letters as Standard Level CPA documentation:* Dr M's assertion that the Trust accepted clinic letters as CPA documentation is not borne out by the Trust policy framework which made it clear that area CPA procedures were to be complied with as they concerned administrative arrangements and records. These, in South Gloucestershire, required completion of standardised CPA forms for both levels of CPA. It is of concern that Dr M was able, apparently routinely, not to adhere to local CPA policy.

Local procedure set a high standard for CPA care planning

In summary, the local South Gloucestershire Integrated Assessment Pack was a thorough document designed to provide a high standard of care for those subject to CPA. Indeed it set a higher standard for recording of standard level CPA than the Department of Health. MN and his family should have been able to expect that the service they received would comply with the high standard of the South Gloucestershire policy. Clearly it did not.

Responsibility for failures of CPA

We conclude that there was a serious failure to adhere both to local CPA policy and Trust framework policy requirements of CPA once MN had returned home. Responsibility for this rests with Dr J, Dr M and the Yate Team including LMcC, who all knew that MN was at home, and who could and should have raised the issue of CPA, notified the South Gloucestershire CPA Co-ordinator and ensured that the necessary documentation for care planning and risk assessment was completed.

- Dr J was MN's RMO. He retained final clinical responsibility for MN's care until s3 was discharged in March 2001. He should have checked in advance that Yate Team would accept the arrangements he proposed and once MN was at home he should have ensured that an alternative Care Co-ordinator was appointed once Yate CPNs had declined to take on the task.
- Dr M had accepted clinical responsibility for MN. He should have seen the Hillview Lodge CPA form, which was placed on MN's medical file. He should have discussed CPA with Dr J, LMcC and the Yate Team, in order to decide upon responsibility for CPA, level of CPA and the appointment of a Care Co-ordinator, and recorded all discussions. He should have notified the South Gloucestershire CPA Co-ordinator that MN was receiving a service and needed to be on the local CPA and s117 registers, or at least ensured this was done by a member of the Yate Team. He should have completed CPA care plan documentation to comply with the local policy even if he had decided MN was to be on a standard level of CPA. He should have placed MN on Enhanced Level CPA he should also have completed a crisis contingency plan, risk screen and risk management documentation. He should have conducted CPA reviews, especially at the point that MN began to miss appointments and he should have ensured that MN's carers knew they were entitled to a formal review of CPA.
- SL and the Yate Team had discussed MN within a week of his return home on s17 leave. They must take some responsibility for failure to complete CPA documentation and failure to notify the CPA Co-ordinator that MN was receiving a service and was subject to CPA and s117 aftercare. When the Hillview Lodge CPA form was faxed to Yate Team it was addressed directly to SL, who should have seen it. Administrative systems within the Team should have ensured that at least someone saw the CPA form before it was filed.
- LMcC would have been the most obvious person for the role of Care Co-ordinator, but we can find no sign that this was discussed in any meetings. LMcC complied with his own socials services' requirements when he completed social services' Care Management documentation in March 2001. We were told that the Integrated ICPA/CM Assessment Pack did not become operational for social services until December 2001. Although LMcC's records during January to March 2001 indicate

that he expected MN's care to come under the CPA, there is no record that he raised this issue with Dr M or the Yate Team. LMcC must take some share of the responsibility for CPA failures.

A central point in MN's care

MN's return home on s17 leave was a central point in the history of his care. We conclude that a combination of out-of-area admission and the existence of two different CPA systems resulted in a serious discontinuity of care at this crucial point. Without the issue of diagnosis this might not have been critical, but disagreement between the psychiatrists only emphasised the separate operation of the two teams. Resolution of the clinical issues required a settled CPA framework for MN's care but no-one took responsibility for MN's care under CPA once he returned home. This state of affairs was unacceptable.

6.8.7 In an attempt to understand what lay behind these apparent failings to adhere to local CPA policy and procedure, we asked IMcI to comment on the application of CPA in MN's case. He described to us his shock at discovering after the homicide that he, as manager of the CPA register and s17 aftercare register, knew nothing at all about MN: *"We did not know anything about that client until a week after the homicide happened...I was steaming"*.

6.8.8 He stated *"What the tragedy has thrown up, in respect of the s17 notification is that there was no communication with the South Gloucestershire CPA Lead who maintains the register that this gentleman had been admitted to hospital.... in another locality under Section 3 of the Mental Health Act and, subsequently did not therefore appear on the [s17] Register and was not monitored...."*

CPA is the framework for care co-ordination and resource allocation in mental health services – that is perfectly clear. Considerable efforts were made by many clinical staff and teams in this locality, in conjunction with social services colleagues, to embrace this concept. Unfortunately, many staff are unable to grasp the concept and see CPA and formal risk assessment as a 'bureaucratic burden', something to be 'tagged on' to the care process, and regarded by many as damaging to their therapeutic relationship with clients.

That attitude is reflected in this tragic case – systems and procedures were in place and were monitored, some multi disciplinary teams were actively engaging in the process but without the support of the medical staff which, in this case, was demonstrated by the Consultant Psychiatrist declining correct procedure, it will always struggle to succeed."

6.8.9 Asked to be more specific IMcI added that the consultant he was referring to was Dr M. He went on to say *"he was seeing this client for a considerable period of time, he should have been engaging in formal risk assessment and CPA, yet it was not being done"*. IMcI remarked that Dr M was not exceptional in this; *"his attitude just summed up many of the consultants up and down the country, I do not feel like I want to do this, therefore I am not going to do it.... Dr M has not said specifically to my face, unlike some consultants, that they are not going to do this....to be fair to him, he just did not do it"*.

6.8.10 On the subject of the Yate Team IMcI told us *"I will defy anybody in the Avon & Wiltshire Trust to find a team that is as supportive and does a damn good job in terms of CPA and risk assessment as the Yate CMHT. They are absolutely top quality, but that is the community team, that is the CPNs and the social worker, that is not the psychiatrist... that is the CPNs. I need to clarify that quite clearly"*.

6.8.11 We note how very different the evidence is from Dr M who told us *"I had a very active involvement in the CPA process which I fully supported. Much of my clinical time was taken up attending CPA meetings involving my patients"*. He recalled that IMcI *"kept a 'league table' of CPA application....he used to tell both our Team and others how Yate led this league consistently, and he held us up as a shining example of how other Teams should operate"*. Dr M added that he had given a *"warm welcome to the introduction of new paperwork"* and that this had *"followed many meetings and discussions between SL, IMcI and others"*.

6.8.12 Dr M told us he contributed actively to the development of risk assessment, saying *"I played a role in the development of Risk Assessment paperwork at Trust level, being an active member of a subcommittee of the Trust's Clinical Governance Committee"*.

Adherence to CPA procedure was, and still is, an issue in Yate CMHT

It is of concern that we have heard differences of opinion on such fundamental matters as the way that CPA should have been managed and recorded. This cannot have helped Team unity. With the passage of time it is now impossible to capture the spirit of the Yate Team as it was then. Sadly we have received evidence suggesting that, although the Team was highly regarded, there were difficulties beneath the surface which had not been thoroughly explored at the time. This was not a setting in which CPA could have been expected to flourish. It is evident that IMcI worked hard to produce a local procedure for CPA in South Gloucestershire, and experienced frustration that the tools he devised were not uniformly adhered to. This appears to have been the case generally, and not only in the case of MN. Furthermore, it appears from paragraph 6.12 in this chapter that the issue of operational responsibility for CPA is still troubling staff in Yate CMHT. We recommend the Trust review CMHTs, ensuring that management, leadership and decision-making roles and responsibilities are made clear and specify roles and responsibilities in connection with the operation of CPA.

Local Recommendations 16 and 17:

Review of CMHTs; specifying staff operational responsibilities for CPA

6.9 Trust-wide CPA

- 6.9.1 We wished to understand the Trust-wide position in relation to CPA in November 2000, because this was when MN's care apparently went from one system of CPA operated at Hillview Lodge to another system of CPA operated at Yate CMHT.
- 6.9.2 Not only had MN been admitted to hospital out-of-area, but he had also been admitted to an entirely different CPA system. The consequences of this were never envisaged or planned for at the outset.
- 6.9.3 Why, we wondered, were there separate CPA systems operating in different parts of the Trust? Was there a Trust-wide CPA register?
- 6.9.4 PM, Acting Director of Social Services for South Gloucestershire told us *"my understanding is that AWP operated almost a federal type of structure for some time and localities were very much developing policy frameworks, procedural guidance, almost in isolation"*.
- 6.9.5 All the evidence confirms that, at the time, localities were effectively operating their own systems, albeit under the banner of the Trust's Policy Framework, published in November 2000.
- 6.9.6 PMcK, now Nurse Director of the Trust, explained to us the complicated history of CPA and the position during the time MN was at home, from November 2000 to March 2002.
- 6.9.7 In the autumn of 2000 PMcK had been appointed as Associate Nurse Director under the then Nurse Director of the Trust, DN. He had been given a specific task. With the newly formed Avon & West Wiltshire Trust waiting for Swindon and Salisbury to join, PMcK's job was to develop a *"framework policy"* for ICPA. The aim of the framework policy was set out in the following way in a letter from SH, General Manager, to DH:

"The Trust is fully committed to the development of an integrated approach to CPA and care management with each of its partner social services agencies. The aim of the policy is to enable the Trust to achieve a coherent approach to CPA yet, at the same time, retain the opportunity for each of the geographic areas of the Trust to determine local integrated procedures and practices with their local authority colleagues. Whilst the documentation is comprehensive, it is hoped that reasonable latitude has been left for local application and interpretation whilst safeguarding the clinical governance requirements of the Trust".

- 6.9.8 PMcK described his task to us in this way: *"my brief was to try to set out a framework document, which would ensure that the existing ICPA policies, as inherited from the various localities, were set out in a structured and systematic way across the Trust. At the time I did not have a brief, and in fact had resistance from all of the local CPA leads to the ideas of developing a Trustwide policy"*.

- 6.9.9 Because the Trust had just come together *"different areas...had established forms of core assessment and care plans, which they argued very strongly were connected to the service users and the stakeholders, including the local authorities"*. The framework document, PMcK told us, *"set out standards, but had to agree to allow localities to do different sets of paperwork"*.
- 6.9.10 In MN's case there had been different CPA paperwork at Hillview Lodge and in Yate CMHT. Hillview Lodge were still using old Bath Mental Health Care NHS Trust (one of the predecessor Trusts) CPA forms, with the old reference to three CPA levels. This was still based on 1990 national CPA standards. We have seen the Bath Mental Health Care NHS Trust Policy for the Care Programme Approach dated 27 January 1997, which set out CPA levels as minimal, complex and multidisciplinary. MN was placed on the latter, the highest level defined as being *"for those users where there is:- Multiple mental health and social care needs; High risk of vulnerability; Section 117 – Aftercare under the 1983 MHA"*.
- 6.9.11 Yate on the other hand had updated their old Frenchay Healthcare NHS Trust (another predecessor Trust) paperwork and were using CPA forms devised by IMcI based on two levels of CPA, as in the 1999 national guidance. There is no record that MN was placed on either of those two levels. It was precisely this sort of problem that the framework document sought to address. PMcK told us it had been intended that *"if a CPA form travelled from one part of the Trust to another, people could recognise the same headings, structures, and recording systems"*, and so the framework document stated *'In order to facilitate the development of Trustwide information systems in conjunction with each local authority, the components and layout of CPA documentation should follow a standard design'*.
- 6.9.12 PMcK emphasised to us that when he wrote the framework document he had *"neither the authority nor the influence to change policy"*. However, when in April 2001 he was appointed as Acting Nurse Director, PMcK told us *"I specifically did set about trying to use the influence and potential authority that came with the post to try to develop a Trustwide policy and a set of associated documentation. I was concerned about...the lack of continuity of multiple policies, the difficulties of transferring from one area to another and the potentials for breakdown in communication"*.
- 6.9.13 PMcK told us he began by instituting a Trustwide review, during which time local policies remained operational.
- 6.9.14 The goal of one Trustwide policy was achieved over a period of about a year, with June 2002 as the effective start date. PMcK told us *"The process took a year to negotiate and implement due to the complexities of such a large Trust and the need to get sign up from the multiple stakeholders, which included service users and local authorities"*.
- 6.9.15 FI, as Director of Operations for the Avon part of the Trust and responsible for implementation of CPA in South Gloucestershire from April 2001, confirmed that at the outset they did not aim for one Trustwide policy, attempting instead *"to find some form of consensus. Largely that consensus was around a framework rather than one policy fits all"*.
- 6.9.16 FI said the Trust was coping with *"resistance from different professionals, different localities or an individual...around particular aspects. They like the current process, they like the current paperwork and they do not want to move away from that"*.
- 6.9.17 There had also been, PMcK said, no central Trust CPA register. Each area would have had its own CPA register. IMcI confirmed that in South Gloucestershire the CPA register system relied upon information being sent to him when a person was accepted onto CPA. There was no system for placing an individual on the CPA register of another locality, and no cross-locality access to registers.
- 6.9.18 The system for placing individuals on the s117 Aftercare Register was similar but relied upon information from social services and health. Although letters had been written from social services to Dr J in December 2000, and to Dr M in January 2001, both mentioning s117, no-one let IMcI know that MN was subject to s117. Nor was there ever any formal ending of s117.

There was no Trustwide CPA register and no means of tracking CPA between areas
There was no Trust-wide CPA system in November 2000. With separate CPA procedures operating in different localities using different documentation, no unified health record or single CPA record to travel with the patient, and no central CPA register, a patient could move from one part of the Trust to another without any information moving with them at all. This is exactly what happened with MN when he left Hillview Lodge and went home. Reliance was then wholly upon clinical information sharing, which proved insufficient.

Dr M was able, apparently routinely, not to adhere to the Trust Policy Framework or local CPA procedure

Whilst it was perhaps inevitable that the period of change during the merger of Trusts would prove difficult, the publication of the Policy Framework document should have reinforced the fact that the standards of the existing local South Gloucestershire CPA procedure were to be followed. It should not have been possible for Dr M to depart from local policy with the claim that *"It was recognised by the Trust that for patients on [standard] CPA clinic letters were the CPA paperwork"*.

6.10 Connections with previous homicide inquiries

6.10.1 Three issues in MN's care linked with weaknesses in CPA have also arisen in two previous homicide inquiries commissioned within the AGW SHA area. These have already been the subject of those inquiries' recommendations. We examine risk assessment below in more detail and consider all again in connection with this Inquiry's recommendations in Chapter 8. They are:

- Risk assessment
- Missed appointments procedures and contingency planning for non-concordance
- Poor provision of information to carers.

6.11 Risk assessment within CPA

6.11.1 There was no Trust-wide risk assessment policy at the time of the homicide. Unfortunately, the history of risk assessment in the Trust is as complicated as the history of CPA, with which it is necessarily linked.

6.11.2 The June 2000 'South Gloucestershire draft Integrated CPA Assessment Pack' stated *'Risk Profile and Risk Management. Refer to AWWT Policy on Risk Assessment (August 2000)'*. A Yate Team Memo in January 2001 stressed that a risk screen *"must be completed"* for initial assessments, and that *'an accompanying Risk Management Plan must be completed if required. (See AWWMHT 'Policy on Implementation of the assessment and management of risk caused by patient behaviour or vulnerability. August 2000)'*.

6.11.3 Piecing together the evidence from SL, IMcI and PMcK, it seems that the August 2000 risk assessment 'policy' referred to in the South Gloucestershire ICPA procedure was originally developed in 1999 by a Wiltshire psychiatrist for Avon & Western Wiltshire Mental Health Trust, and in fact had the status of a 'draft commended policy', as it was described to us by PMcK. It was this draft commended policy that was in place in October 2000 when MN was admitted to Hillview Lodge, and the risk assessment completed by nurses on 5 and 9 October 2000 had been based on that.

6.11.4 In November 2000 the Trust Policy Framework document further promoted this 'draft commended policy', stating *"Risk assessment and risk management is the foundation of effective services for people with serious mental health problems. It is therefore essential that clinical risk policies developed by the Trust are shared with and implemented jointly with colleagues and other agencies, particularly primary care and social services"*. IMcI told us that between January and May 2001 South Gloucestershire locality embarked on a series of multi-agency risk training sessions *"studying how risk assessment and management – as a fundamental part of the CPA process – may be integrated into current practice"*.

6.11.5 However, the draft policy received a mixed reception. It included complex risk screens, and IMcI explained *"there was great resistance from both clinical and medical staff across the Trust to both the policy and tools as they were seen as cumbersome and threatening to therapeutic relations between staff and service users"*.

- 6.11.6 We heard that the 'commended' policy subsequently went through more than one process of review by the Trust, with the tools gradually becoming simpler. It is no longer used by the Trust.
- 6.11.7 It is clear that Yate Team used these *"commended risk assessment tools"* as they were described by PMcK, but also added their own risk management plan. SL, Locality Co-ordinator of Yate CMHT described their approach in a letter to the Trust Chief Executive RP, dated 28 August 2001, copying it to PMcK, IMcI, MS, Dr MM and Dr SO'C. Under the heading '*Risk Assessment and Risk Management at Yate Community Mental Health Team*' SL stated:
- 'In the light of the difficulties we perceive with the Trust's current risk Policy the members of the Yate Community Mental Health Team would like to inform you of the way in which we are currently assessing and managing risks to our clients. All new clients are assessed using either of the Trust's Risk Assessment Screens. They may also be used for existing clients if clinical concerns indicate. For any category of risk that is identified by the above, a risk management plan or a specific professional management plan is devised that provides a description of the risk, specific indicators of any increased risk, previous helpful/non-helpful strategies and a risk management plan. We also construct Crisis Plans and use Relapse Prevention Strategies as required.*
- We believe that we are taking seriously our responsibilities to our clients and our employers, and that our paperwork provides evidence of a thoughtful approach towards clinical risks. We are more than happy to provide evidence of the work that we are doing and hope that our current work will be supported by the Trust.'*
- 6.11.8 A two page pro-forma attached to the letter was divided into four sections headed '*Description of risk; Specific indicators of increased risk; What has previously been effective or non-effective; Management Plan*'.
- 6.11.9 IMcI explained that *"they were using the Trust screen but then they were adopting the risk management plan which I had put together as part of the South Gloucestershire initial CPA pilot paperwork..... I was concerned it was all very well assessing risk, but you still had to formulate a management plan of how you were going to address areas of concern"*.
- 6.11.10 The status of this independent decision on risk assessment is uncertain. PMcK told us he did not consider it had gone through the correct channels to be accepted as local policy, though SL said she had not been told that, either by PMcK or by any of the other people who had received copies of her letter. Indeed she had not, she explained to us, received any reply to the letter.
- 6.11.11 The position at the time of the homicide was described to us by PMcK as follows: *"At the time of the incident, South Gloucestershire was working to their own ICPA policy, although they were asked to complete Trustwide risk assessment screens"*. It appears they were doing that in Yate CMHT, and in addition using a risk management plan devised by IMcI.

No up-to-date risk assessment on s17 home leave

Risk assessment conforming to the Trust 'draft commended policy' was completed on only one occasion during the eighteen months that MN received mental health services. This was in the first few days of MN's hospital admission and was carried out by Staff Nurse GL. If that risk assessment was to stand as an assessment upon s17 leave or discharge from hospital, it needed to be reviewed and updated. Yet there was no documented risk assessment associated with the one completed CPA form.

No structured risk assessment once MN at home

Nor did any structured risk assessment take place once MN was at home. This was despite the existence of a South Gloucestershire ICPA Assessment Pack describing risk assessment requirements, an internal memo to staff saying that a risk screen 'must' be undertaken for all initial assessments, a very comprehensive Trust 'commended' policy and tools, and a South Gloucestershire risk management plan.

Risk assessment must be an integral part of CPA review

It is difficult to fault Yate CMHT on their principled approach to risk assessment set out in a letter by SL. And yet in MN's case it did not take place as intended. We can only conclude that documented risk assessment fell by the wayside along with CPA and s117. Our description in Chapter 5 of the way that the memory of risk appeared to fade with MN's changed diagnosis serves only to underline the importance of keeping a clear record of risk assessment and ensuring it is an integral part of CPA review. At Local Recommendation 10 we recommend the Trust review its ICPA Policy to ensure that risk assessment is always recorded at CPA reviews.

6.12 CPA then and now

- 6.12.1 In June 2002, the Trust began operating a Trustwide ICPA policy and Yate's local operational system ceased to be applicable. That Trustwide policy has remained in existence and is current now.
- 6.12.2 In one important respect the new Trust policy requires less of consultant psychiatrists than the previous Yate procedure did. Instead of requiring that they complete ICPA documentation for patients on standard CPA, it permits consultant's clinic letters to stand as the ICPA record when the patient is being treated as an outpatient and no other professionals are involved. This is in keeping with the 1999 Department of Health policy booklet (see paragraph 6.2.7 of this report)
- 6.12.3 Expressing her frustration with the new Trust ICPA Policy, SL told us that Yate CMHT had piloted new ICPA paperwork and she felt that the team's opinions had not been accepted by the Trust. She thought that CPA, as it was eventually decided upon, was largely missing the *"medical element"* but, she told us, *"I have no backing from the Trust, because nobody will take on the doctors"*.
- 6.12.4 Describing the current operation of CPA SL said: *"They just do their letters. They do letters instead of the ICPA documentation, so the actual way the documentation is organised and written never gets completed."* She believed that doctors looked at the CPA documentation completed by other staff, but generally the paperwork at the end of CPA review was completed by the care co-ordinator, and in practice doctors are not appointed as care co-ordinators.
- 6.12.5 In the team there were, she said, disputes over completion of paperwork. CPN PH referred to the way that this caused friction within the team. SL told us: *"we have had, say, a patient a doctor would like some [CPN] help with.....we have actually sat there and said "Yes, we will become involved when you do the paperwork....We are happy to do our own paperwork, but we are not housekeeping for the whole team"*.
- 6.12.6 SL added: *"To this day we have had little success in getting junior or senior doctors to complete the paperwork which drives the process and illustrates the pattern of care. This can cause friction between individuals and professions and can lead to professional envy where one group of professionals are seen to be 'beyond the law'.....I remain concerned that to date the implementation of ICPA and the completion of ICPA paperwork in this Trust remains patchy. There is absolutely no doubt that [it] remains patchy. There is absolutely no doubt that the ICPA paperwork is lengthy and requires a large amount of time to be dedicated to its completion. I estimate an increase in administrative time for clinicians of approximately 20%."*
- 6.12.7 Coping with the demands of paperwork is an issue that has troubled ICPA operation from its inception nationally.
- 6.12.8 According to PMcK the government *"had to review CPA because three-quarters of the country were not doing it.... When they launched CPA [in 1990] they never lens-looked at people's capacity, their operational systems and how they worked. They just said do this, so what people saw was a load more paperwork with no extra support."*
- 6.12.9 Giving his opinion on the Department of Health's 1999 revised CPA, PMcK added *"At the time of the 1999 review, there was a general view that consultants, in particular, were resisting the implementation of ICPA. The main reason given for this was the heavy dependency on completion of detailed paperwork. Much of that paperwork related to the social care needs which many consultants and, indeed, other health professionals did not see as appropriate or best use of their time to complete.....My opinion was, and still is, that they made the process simpler, i.e. they reduced the*

dependency on formal completion of documentation for anybody who would be defined as standard ICPA.

- 6.12.10 PMcK expressed his disappointment with the Government's 1999 guidance on CPA: *"they [the Government] diluted ICPA and assessment to say particularly consultants could write in their own records rather than do structured risk assessments for lots of their patients we see in out-patients.... That was a huge area of disappointment because they actually backtracked further because they knew at that point they were having trouble getting compliance nationally with ICPA..."*
- 6.12.11 Nevertheless, confronted with similar problems of compliance with paperwork in the Trust, the Trust decided to adopt the 1999 national guidance. PMcK told us *"we permitted consultants to document a core assessment in free text for patients who were deemed to be on standard ICPA, and who were only under the care of one professional.....In our policy, I'm explicit about the point that it is only where one professional and the GP are offering the care to the service user. In my view, once more professionals become involved, whether it is a consultant or any other staff member, they must complete formal documentation as this is the only way that we can guarantee effective communication of assessment and care planning information"*.
- 6.12.12 It appears however, that the demanding requirements of CPA paperwork have remained, and continue even now to cause difficulty within mental health teams, according to SL above.
- 6.12.13 Indeed, the very principle of CPA seems to have been challenged by some staff. FI, Director of Operations for the Avon part of the Trust and accountable for CPA, remarked in his evidence to us that some people, both medical and other staff *"did not readily accept ICPA and its importance then and, to some extent, still now there are people who challenge whether or not it is a paper-filling exercise as opposed to a care-giving exercise"*.
- 6.12.14 Consultants, he thought, varied as to the extent they were signed up to CPA. They might say they are *"signed up to it, but what that actually means on a practical day to day basis around how they do it, how they behave, how they manage their teams, how they accept referrals, how they review their cases, how they risk assess, you might get different answers about that"*. Illustrating how difficult that makes it for managers, FI pointed out *"Until we get sign-up to a reasonably unified system, our ability to monitor performance is difficult. If some people are wedded to particular processes or particular documentation, or actually, a lack of documentation, and would say "I actually write to GP's and tell them what is going on. That is CPA, the thing is, it is very hard to monitor"*.
- 6.12.15 The 'patchiness' of compliance with CPA in the Trust is illustrated by figures from an audit carried out in 2002, which rated South Gloucestershire ICPA standards as 35% as against other localities where standards ranged from 70% to 90%.
- 6.12.16 We wondered how this patchiness had come about. PMcK commented *"I think the Trust did and still does struggle from the impact of working across a variety of local authorities, and numerous PCTs who have a different outlook on the needs within their local area. This has resulted in a very difficult and complex negotiation/consultation process within policy development, and particularly within the application of the policy into practice"*.
- 6.12.17 PMcK described the difficulty of dealing with localities at different stages of integration, and with different funding arrangements, in order to get sign-up to ICPA and Risk Assessment Policies across the Trust: *"we constantly had to negotiate with not just one local authority but with the various local authorities connected to the various localities, there was constantly a feeling that no matter how much you did, all it would take was two people to block it and you would be back to square one"*.
- 6.12.18 As to the present position, he told us *"most of the areas now have signed up to the policies. I say most because I think there is some final work to be done in South Gloucestershire but in principle they have agreed to integration and joint teams and have been planning, but they are the slowest of all of them to move forward"*. We consider the issue of integration of health and social services in South Gloucestershire later in this chapter.

- 6.12.19 FI thought that the huge size of the Trust, one of the largest in the country, produced inherent difficulties with Trust-wide application of policies. He felt that devolution to local partnerships emphasised local solutions to such an extent that *"there is never an Avon view of anything because there is not an Avon to view"*. Added to that, *"alongside Avon sat the Wiltshire and Swindon areas of the Trust who also had a number of PCT's and unitary authorities to which they related. This further complicated arriving at a Trust-wide approach"*.
- 6.12.20 Attempts to create Trustwide records have also proved problematic. CPA and s117 aftercare registers do not yet cover the whole of the Trust. MF, the Trust PAS (Patient Administration System) Manager who provides information technology advice to the present ICPA Policy Group, said that although there is now the technical facility to enter ICPA information onto a central electronic Trust Mental Health Information System (MHIS) called MARICIS, this is not being done across the Trust. DH, Locality Manager for the Trust in South Gloucestershire did not think there was a system for doing this at all; *"No, there is still no central system within the Trust [for getting patient information recorded centrally]"*.
- 6.12.21 We wondered how the system would operate now if a patient followed the same admission and discharge path as MN. MF explained that since information was not yet being entered onto MARICIS in Hillview Lodge, CPA information would still not have been available to Yate on a central CPA register. MF told us *"I think exactly the same thing would probably happen at the moment"*.
- 6.12.22 With the information on MARICIS not yet up-to-date and much of it patchy, MF explained that they were not at the moment creating triggers for CPA review.
- 6.12.23 Nor is there a Trustwide s117 aftercare register. IMcI told us that the present system for notification of s117 had been worked out between himself and KB in South Gloucestershire Social Services: *"at the end of each month the medical records team on health send me an inpatient MHA sections listing. On an individual basis, from Social Services, every time they deal with someone who would be subject to s117 aftercare they send me an email at the time so I can cross reference the two, but there is still nothing at Trust level"*.
- 6.12.24 PMcK described some positive aspects of the operation of CPA throughout the Trust. A National Service User Survey in 2004 covering almost half of Mental Health NHS Trusts nationally revealed that the Trust was *"doing pretty well in relation to things like patients having a copy of their care plan and information on crisis services."* PMcK added: *"from a policy point of view, I think we are now at a point where we are clearer on what we need to do, particularly based on lessons learned. Although the policy feels more robust than in the past, I still have concerns about the gap between policy developments, and practice and improvement. I believe the Trust is moving forward with ICPA and risk assessments, and we are gaining ground, but there is still considerable room for improvement."*
- 6.12.25 Resources had, and still have, an impact upon full implementation of CPA across the Trust. Dr M told us *"correct adherence to CPA might... have led to a different outcome in MN's case, but such an adherence was wholly incompatible with the "fire fighting" practice of psychiatry which I was forced to adopt given the number of patients"*. The issue prompted Dr M to join a group of local psychiatrists who in 2001 made representations to the Secretary of State for Health on *"the chronic extremely low interest and investment in Mental Health Services in Avon"*. Some five months after the homicide Dr M left the team for a scheduled period of sabbatical leave and SL told us she has seen fourteen locum consultant psychiatrists come and go since then. Neither was it helped, she told us, by the fact that *"Yate CMHT is under resourced to the extent that we have not been able to take advantage of any training opportunities in the last 2 years"*. She told us it had left her feeling it was *"hard to get a sense of corporate responsibility. I do not experience it from the higher echelons of the Trust"*.
- 6.12.26 FI confirmed that CPA *"is not the top priority for our organisation... how are we going to break even, how are we going to balance the books? Currently within the AGW health area that is the only priority that exists, to break even, and everything else is secondary"*. Amongst the *"secondary things"* came *"things that would improve star performance...and ICPA is not one of them either. If you look at the star ratings, ICPA is one of the factors, it is not a key indicator"*. Put bluntly CPA *"is important but it is not top of the list"*.

- 6.12.27 PMcK and FI both made suggestions for improvement. FI suggested CPA should be made a key indicator and *"I think it would be helpful if the Inquiry actually felt able to make it clear to all local agencies, ourselves, our practitioners on a local basis, our partners (social services, PCT's, AGW) that actually it needs to be higher up the agenda than it is".* He added *"If it is left just to the Trust to do it, I guess I have a fear that we will be in this place in two years time again".*
- 6.12.28 PMcK said: *"consultant's contracts, consultants' ways of working are being reviewed.... I think this is just a great opportunity to redefine the ground rules of what is the basic tool for providing care, and within that therefore an expectation that that [CPA] is a must do and deliverable as opposed to an add-on".*
- 6.12.29 Nationally and locally, it might be thought that CPA would by now be firmly embedded without any need for such moves, but FI was clear: *"there might be a presumption that after 10 to 14 years it has been implemented, I guess my view on the ground is I do not think it has..... In our Trust, right here and now, it is still patchy..... I do not believe it is fully implemented across the country".*

Current concerns about the operation of CPA in the Trust

We have heard concerns about the current CPA situation in the Trust, not just from one or two sources, but from several, cutting across professional groups and managerial level.

Raising the profile of CPA locally

We do not overlook the fact that in the difficult circumstances described above there is nevertheless a Trust CPA Policy, and has been since June 2002. PMcK deserves particular credit for this. However, that these issues continue to be problematic four years after the homicide is particularly troubling. What should be done about this range of problems? We make three Local Recommendations in response. Firstly, Local Recommendation 5 is aimed at ensuring there is a functioning Trustwide CPA register, through requiring that all CPA information is entered onto the Trust's central electronic record, that it is made clear whose task this is, and that CPA reviews are triggered. Secondly, at Local Recommendation 17 we recommend that the Trust ensures that roles and responsibilities of operational staff are clearly specified, understood by them and included in performance reviews of all staff members concerned. Thirdly, it is, in our view, vital that the Trust gives unequivocal support to CPA and we recommend that a public commitment is made to it.

Local Recommendation 18:

Making a public commitment to CPA

National action needed

We are concerned, however, that some of the above problems are so deep-seated that they may only be amenable to national change. Suggestions made by PMcK and FI are especially helpful, and we take the two issues of (i) making CPA a key indicator and (ii) incorporating CPA into consultant contracts, forward into Chapter 9 where they become part of National Recommendations G and H.

6.13 The place of social work in CPA

- 6.13.1 LMcC was not part of Yate CMHT. He was employed by South Gloucester Social Services. As MN's social worker he could nevertheless have become the care co-ordinator under CPA, this task generally being undertaken by a social worker or a CPN, but he was never asked to take on that role. Employed by social services rather than health, and operating with entirely different documentation, he was separate from the CMHT to such an extent that whilst Yate CMHT had decided that no one from its CPN team would visit MN at home because of possible risk to themselves, no-one questioned the appropriateness of LMcC doing just that. Where, we wondered, did social services fit into the CMHT structure and within CPA?
- 6.13.2 There were, we established, two issues. Firstly, until December 2001 social services operated their separate Care Management system for care planning, and secondly, health and social care services were separate and social workers were not attached to specific local CMHT's. Plans for integration of the two services in South Gloucestershire had, we discovered, been off and on over the years, producing a great deal of uncertainty. The services remain un-integrated.

- 6.13.3 Beginning with the subject of the operation of CPA, we had noted that South Gloucester Social Services was one of the agencies which had reservations about the Trustwide CPA policy. We asked LMcC and his managers about social services' engagement in the CPA process. LMcC's statement said *"As for CPA our practice is substantially different now because of this case. At the time it was less specific..... Social Services did their own documentation Care Management. Social Services did its own paperwork alongside our health colleagues..... Dr M would complete a letter summary of the meetings we had with MN and his family. None of these letters was in the format of CPA but that was effectively what these meetings were."* He added *"As for multi disciplinary review of CPA, members of our team would attend a meeting with Yate team on a weekly basis. This was the principal face to face opportunity to review cases."* In terms of the status of CPA generally, he commented *"At the time my recollection is that efforts were being made to implement CPA more formally. My recollection at the time was that Consultants were not required to carry out CPA as formally as other health practitioners and so Dr M conducted his work in his own style."*
- 6.13.4 We asked LMcC if social services procedures were parallel to health services. He thought they were *"overlapping, in the sense that.....we were doing Care Management and doing our own paperwork. We were trying to be explicit about what we were doing, why we were involved. There was not that same sense of we are all doing this together. The whole thing about CPA – there is one care co-ordinator and they make sure they liaise with everybody. That did not really seem to be happening back then."*
- 6.13.5 In contrast to the situation in 2001 - 2002, LMcC described current joint working on CPA. *"We have paperwork that we have all agreed. It is very comprehensive. We are more definite on Care Co-ordinator allocation. We make it clear whose responsibility it is to do the paperwork....the whole process is a bit more formal in terms of reviewing."* He also acknowledged the present value of one register for all health and social services patients and the focal role of IMcI as its administrator.
- 6.13.6 Reading over the full CPA document and risk assessment procedures, LMcC commented that at the time these were *"just two of the numerous documents we have got dotted around all over the place. It is impossible to retain all of the recommendations and guidelines about how we are supposed to do all of this process."*
- 6.13.7 KB was social services Team Manager (Mental Health) at the time MN was first referred to the team in 2000 and throughout the period he received a service from the Department. He was LMcC's line manager. He described the situation relating to CPA at that time: *"In 2000 there were no agreed policies and procedures in place for CPA and risk assessment between the Trust and SSD. The Trust had been working with the Local Authorities to develop locally based CPA and risk assessment policies and procedures. This proved to be a complex and time-consuming task. The Trust then decided that rather than locally based policies and procedures it required a Trust wide policy and procedure. This then led to further work on agreeing a set of policies and procedures across the whole of the Trust area."*
- At the time of MN's initial involvement with services in South Gloucestershire Yate CMHT were involved in a pilot of CPA. My recollection is that this pilot was to test out how the CPA paperwork impacted on the CMHT's practice.*
- In December 2001 the SSD Mental Health Team adopted the CPA and risk assessment policies and procedures developed in partnership with the Trust. This followed a delay whilst a working electronic version of the documentation was produced. Up to this point the SSD Mental Health Team had been continuing to use the Department's Care Management policies and procedures."*
- 6.13.8 In terms of the application of CPA to MN's care at that time, he stated *"It is clear there was no identified care co-ordinator and clearly although CPA is described in various documents, MN's care was not properly delivered under a CPA framework."*
- 6.13.9 We asked him, as a social services manager, what he would currently recommend in relation to CPA. He replied *"I think the important areas are around the compliance and the use of CPA – a diligent use of CPA across the Trust."* He added that such an understanding *"does not always seem to be around within the Trust, and with practitioners it is still difficult to get CPA paperwork out of them."*

Separate Social Services Care Management system was not helpful

At the time of MN's return home from hospital and up until December 2001, social services were operating their own Care Management system with paperwork separately managed from health CPA documentation. There can be no doubt that this was unhelpful to the provision of mental health care. Fortunately this changed, and by the time of the homicide social services had adopted the Trust's CPA and risk assessment policy and procedure, and ceased to use Care Management. However, there is no record that this had any impact upon the care provided to MN, perhaps because CPA procedures were interpreted by Dr M as being satisfied by clinical letters. Whichever system was being used by social services, in practice it had no relevance to the care received by MN.

CPA procedures have improved

We note that like Dr M, LMCC in evidence referred to review meetings and clinic letters having been 'effectively' CPA. KB, LMCC's line manager, was more forthright in his opinion that MN's care was not properly delivered under CPA. It is encouraging to hear from LMCC that CPA procedures have improved, although KB considers there is still a problem of commitment to CPA paperwork.

6.14 Integration of health and social care

- 6.14.1 In recent years many mental health services around the UK have chosen to integrate their health and social care, bringing social workers and CPN's together into one organisation in one location; it is generally recognised that this is likely to lead to better service delivery. During the period that MN received his care the services in South Gloucestershire were not integrated, and when we heard evidence that was still the case.
- 6.14.2 We heard from FI, Director of Operations for the Avon localities within the Trust, and PM, Acting Director of Social Services since September 2003, on the difficulties of integration in South Gloucestershire.
- 6.14.3 FI gave evidence that when he came into post in April 2001 there had been *"a lack of continuity in management...for the locality going back a number of years....management cover for the locality had been given in a number of ways but not by someone substantively in post"*. He added *"South Gloucestershire was going through a particularly bad patch....There were significant financial pressures, really a lack of consensus about integration, about whether or not we were doing it, and that left it at a disadvantage"*.
- 6.14.4 Other localities either already had integrated health and social care or were moving in that direction, but *"there was a lack of momentum in South Gloucestershire which made the staff worried, and there was a general sense of unease and low morale in the service"*.
- 6.14.5 It did not help that South Gloucestershire had, FI told us, struggled to find its identity, having been created from very rural areas and the deprived North Bristol fringe. At the time there was a feeling amongst health staff that resources and staff had gone to Bristol City, leaving South Gloucestershire deprived of investment.
- 6.14.6 PM told us that much work was *"jointly undertaken during this period (2001) culminating in a joint report (co-authored with the Chief Executive of the PCT) to the Council's Cabinet in June 2001. This report... clearly demonstrates the mapping of a shared pathway to integration together with a focus on CPA implementation"*. That report, he explained, triggered the appointment of a joint Locality Manager, but unfortunately he was dismissed by the Trust a year later causing *"considerable tension and loss of trust at the time and was indicative of more deep-seated difficulties in terms of the Council and PCT forming an open and trusting partnership with AWP [the Trust]"*.
- 6.14.7 There were and are funding considerations. FI told the Inquiry *"social services sometimes are very suspicious of health and actually how much they are going to put in....Social Services were anxious about health shifting costs onto the responsibility of Social Services"*. FI told us *"Currently...there is no decision about whether we will have an integrated service or not"*.
- 6.14.8 PM also touched on a subject that has proved sensitive for social services in connection with integration. This is the issue of professional identity, bound up with concerns over medical dominance and resistance within social care to what is referred to as the 'medical model'. PM explained *"there is*

enthusiasm tempered with anxiety about identity and maintaining a professional identity....that is understandably expressed by social work practitioners".

- 6.14.9 The effect of non-integration in Yate CMHT was described to us by SL: *"structurally, the social work element was completely separate and is still to a degree"*.
- 6.14.10 FI said he had the impression there was a *"lack of a shared meaning of what integration meant. During the year the new Locality Manager was in post it became clearer that Social Services and the Trust had a different understanding. It was understood that the role of the Locality Manager jointly reporting to social care and health would be to develop a programme for joint agreement on how to take integration forward. What transpired was the realisation of a lack of a shared understanding"*.

Integration should be achieved urgently

Fully integrated mental health and social care services are most likely to facilitate CPA because offices, managerial structures and files will be shared. During the period that LMcC was visiting MN it appears that at senior management level there were unsuccessful attempts at integration between health and social care in South Gloucestershire. Disagreements over funding, coupled with lack of management continuity, low morale, professional anxiety within social services over the model for integrated service delivery, and a lack of shared understanding over what integration meant seemed to prevent progress. Yet some of these issues will be familiar to almost every other successfully integrated service. The fundamental factor of difference for South Gloucestershire was, according to FI, *"the lack of general/clinical management continuity and leadership"*. We have been told that since the homicide some significant practical moves towards integration have been made, including co-location, shared access to records, single point of service access and joint eligibility criteria. There remains the issue of a single management structure, which we have been informed will be achieved by the end of March 2007.

Local Recommendation 19:

Completing integration of health and social care

6.15 Tensions

- 6.15.1 Implementation of CPA and attempts at integration in South Gloucestershire were, and are, taking place in the context of other tensions within mental health services locally, some of them financial, some connected with commissioning arrangements. RP, Chief Executive of the Trust, described the difficulties of commissioning mental health services by five PCTs. He said *'We have to run around between one PCT and another negotiating five or six different types of delivery plans. It is just not a sensible situation.'* In relation to establishing agreements with the six social services authorities, he described South Gloucestershire as *'the most difficult. It is the only one in which we still do not have very clear agreements.'*
- 6.15.2 Both PM and FI referred us to a Health Advisory Service (HAS) Review dated March 2002. This had concluded in PM's words *"that many stakeholders felt the current situation was dire, leading individuals to see external agencies as a source of problems rather than potential solutions.....I think there was implicit in this document some criticism of AWP [Trust] around its willingness to let other agencies in"*. FI made it clear to us that he did not share the conclusion or views expressed here by PM.
- 6.15.3 In 2004 another review was published, this time the *'Review of the Commissioning Arrangements in South Gloucestershire PCT and Compliance with the National Service Framework for Mental Health'* was conducted by the Health and Social Care Advisory Service (HASCAS).
- 6.15.4 Under the heading *'Tensions in the Mental Health System'* it stated: *"There are evident tensions between the three main organisations responsible for commissioning and providing the local mental health services to South Gloucestershire, namely the PCT, the Local Authority and the Avon and Wiltshire Partnership Trust. Within the Avon and Wiltshire Partnership Trust the review team heard 'stories' about tensions between the management of the localities and that of the central Trust"*.

- 6.15.5 The HASCAS report identified several issues with national implications, among them *'the relative newness of the major organisations involved in the commissioning and provision of mental health services, and the effect of repeated organisational and management reconfigurations in recent years.'*
- 6.15.6 Introducing its conclusions, the HASCAS report stated *'The South Gloucestershire Health and Social Care Community faces a severe test of its capacity to deliver a jointly agreed mental health strategy for adults of working age. There are many issues to be resolved including financial pressures and a history of not delivering local mental health strategies.'*
- 6.15.7 Responding to the review, FI told us *"it would be true in my view, to say there was an ongoing dialogue between the locality and the Trust centre. This was true then and now in respect to where decision-making sat within the organisation. The dialogue continues around the devolution of decision-making and is inevitable and perhaps a healthy tension. I do not believe there was anything sinister or different in the situation vis-à-vis South Gloucestershire compared to any other locality".*

Failure to implement CPA across the Trust during the period of MN's care

All of the evidence has shown that in the years 2000 to 2002 there were gross failings in the implementation of practice guidance on CPA, which had been issued sequentially since 1990 by the Department of Health.

Implementation of Trustwide CPA hampered by Trust and social services reorganisations

It seems that in the past, local CPA policies had been adopted with some success after CPA was first introduced in 1990, with the NHS Trusts then providing mental health services in the Avon area, in association with local offices of the then Avon County Social Services. In the late 1990s, both health and social services experienced major changes in their organisational structure. Social services were devolved from Avon County to four unitary councils. Health care commissioning responsibilities were subsequently devolved to the emerging NHS Primary Care Trusts, and in 1999 NHS mental health services became combined to cover Avon and West Wiltshire. Swindon and the rest of Wiltshire joined the Trust in April 2001 to become one pan-Avon and Wiltshire Trust. By 2000 there was clearly no uniform local policy on CPA, and many witnesses to the Inquiry have described confusions resulting from the wide variations in procedures and associated practice between NHS localities and with local social services departments.

CPA had almost no impact on MN's care

In MN's case the impact of CPA on his treatment and care was almost nil.

- Only one formal recognised CPA meeting took place, on 22 November 2000
- Only one element of CPA documentation was completed, this being the CPA care plan form dated 22 November 2000
- The form was inadequately completed with some inaccurate details
- Dr M did not see the CPA care plan form, and the social worker was not sent it. Neither of the two professionals involved in MN's care in the community had therefore seen the one completed CPA document
- MN's name was never placed on the Trust CPA register
- The CPA process was not explained to MN and his family
- Code of Practice Guidance relating to MN as a detained patient was not followed by Dr. J as RMO, in that:
 - (a) CPA planning for home leave and discharge did not begin on admission (Code of Practice paragraph 27.1).
 - (b) The CPA meeting did not decide upon a treatment plan which included long term and short term goals, MN's health and social care needs were not fully assessed and not addressed in his care plan (Code of Practice paragraphs 15.5 to 15.6 and paragraph 27.5)
 - (c) MN's aftercare needs were not decided in agreement with authorities and agencies in the area in which MN was to live (Code of Practice paragraph 27.10(c))
 - (d) There was not a proper assessment of MN's risk to himself or other people (Code of Practice paragraph 27.6)

- (e) No care co-ordinator was appointed to keep in close touch with MN and monitor his care (Code of Practice paragraph 27.2)
- (f) The social worker, as a key person in MN's care, was not named in the care plan (Code of Practice paragraph 27.11)
- (g) There was no review of the CPA care plan (Code of Practice paragraphs 27.2 and 27.12).

Absence of CPA meant care was not standardised

The absence of a formal CPA structure for MN's care meant that his progress, treatment and care were not reviewed in a standardised way. Instead, treatment and care at home followed the traditional lines of outpatient appointments with the consultant, whose medical notes were mainly contained in his related correspondence. This treatment was supplemented by some practical support from the social worker, who completed his department's separate care management documents and made brief sequential notes of his contacts with MN. The consultant psychiatrist and social worker had a good communicating relationship and regular contact at CMHT meetings. Those meetings did not question the absence of CPA records, planning and reviews.

The need for a Trust review of CPA

Most witnesses have spoken positively of the current situation relating to CPA, but there remain signs that it is seen as an adjunct to treatment and care, rather than the core procedure for its delivery. What has become all too apparent is that MN was in all probability not the only patient in 2000-2002 for whom the CPA, rather than being a comprehensive framework for all treatment and care, was merely a set of initials. In MN's case, national CPA standards of practice and co-ordination of care were very remote from what he and his family actually experienced. We recommend that the Trust reviews the extent to which detained patients are receiving CPA according to the guidance set out in the MHA Code of Practice, bearing in mind the failures to achieve this in MN's case described at (a) to (g) above.

Local Recommendation 20:

Reviewing CPA standards in the Trust

6.16 What difference could CPA have made?

- 6.16.1 We have concluded that there were failures to meet local, Trust and national standards of CPA during MN's care. But did these failures have any direct impact upon the diagnosis? Could strict adherence to CPA have reduced the risk of homicide?
- 6.16.2 There were several points at which adherence to local and national standards of CPA could, we think, have made a difference. Whilst we cannot be certain of the impact that this would have had upon diagnosis or treatment, with more complete information available the chances of a correct diagnosis would have been improved. As such these were missed opportunities.
1. *In hospital.* Dr J acknowledged in his evidence to the Inquiry that planning for MN's return home "was precipitative...it was hasty. I think that it was non-ideal and I fear that it did not reflect good practice with regards to discharge planning of any sort". If CPA planning had begun earlier and included Dr M, the Yate Team CPNs, social worker and the family, this could have made a difference to decisions over treatment plans at a crucial point. Missing pieces of the history could have been pieced together. A care co-ordinator could have been decided upon, and concerns over staff safety dealt with. The level of CPA could have been agreed between the teams. Responsibility for CPA and clinical care could have been decided in advance of s17 leave. But most importantly the difference of opinion between the two psychiatrists on diagnosis and treatment could have been addressed whilst MN was still in hospital. A referral to an independent expert might even have been the appropriate course at this point. One of the major problems caused by events as they actually unfolded was that complex diagnostic issues, which were absolutely fundamental to MN's treatment, were being addressed when MN had already gone home and no-one other than the family was available to observe him.
 2. *Upon return home.* It is clear that once MN was at home, the situation was perceived as different and there was no further formal CPA. The diagnosis of schizotypal disorder itself contributed to this. For, even though he disagreed with the diagnosis, Dr M told us "a more formalised intensive ICPA approach was considered and rejected because of the revised diagnosis on the one hand and

because of the impracticality and unworkability given his personality style on the other hand". We note that, if the diagnosis had been psychosis, the same behaviour would have suggested negative symptoms and lack of insight, leading to exactly the opposite conclusion - that full CPA was just what was needed. This was a very unsatisfactory state of affairs. We are in no doubt that a CPA review should have taken place as soon as it became apparent that there was disagreement over diagnosis, and that there was to be no CPN to act as care co-ordinator as envisaged by Dr J. It was not even clear at this point whose job it would be to organise CPA care planning. The nurse referral to Yate team suggests CPA was handed over to Dr M, but Dr J organised the next review of MN and remained the RMO. This should have been discussed between Dr J and Dr M. It should have been agreed who would produce a revised CPA care plan to include LMcC, and either appoint him as care co-ordinator or name someone else. At this stage, in the midst of confusion, a comprehensive gathering together of information and a plan for MN's close monitoring at home might still have resulted in more shared clinically relevant information and a re-evaluation of the diagnosis.

3. *Upon discharge from s3.* Discharge of MN from s3 MHA was a legal decision made by Dr J, who remained the RMO but had not seen MN for two months. Dr J told us that this represented a change of plan, since he had originally envisaged he would have the full six months of the s3 to decide whether to readmit MN to hospital for medication. From this point onwards the threshold for readmission was higher, because it would have required use of the MHA. This required CPA review and a revised care plan.
 4. *Prior to reducing frequency of outpatient appointments.* In June 2001, before Dr M decided to reduce outpatient appointments to three-monthly, Dr M should have instigated a full CPA review. This would have permitted Yate CMHT to express their views on a reduction in contact. As it was, we were told by SL, Locality Co-ordinator, that the CMHT did not know about Dr M's change of plan for MN. She believes the CMHT would have questioned such a lengthy gap between appointments. This would also have been the right time to include the GP in planning if that had not already been done
 5. *When appointments were missed.* When MN started to miss appointments he had not been seen by Dr M or LMcC for four months, and a full CPA review within Yate CMHT should have considered whether this was a matter to be addressed urgently and if so, how. Risk assessment should have been based on the possibility of both schizotypal disorder and untreated schizophrenia. As it was four further months passed before assertive outreach was considered and, in the end, the initiative for this came not from Dr M but from social services. LMcC told us *"I do not know what else other than a referral to the assertive outreach team would have worked"*. This was just the sort of decision that should have been made earlier and at a CPA review with family and all relevant professionals present.
- 6.16.3 One consequence of the lack of formal CPA throughout the above period was the absence of a care co-ordinator who, according to the national guidance, would have been responsible for *"maintaining close and regular contact"* with the patient, consulting with carers, being aware of other resources, referring on as appropriate, and who would have been pivotal in monitoring delivery of the agreed care package and ensuring it was reviewed at regular intervals (see paragraphs 6.2.12 – 6.2.13 above for the responsibilities of the care co-ordinator). Instead, elements of the care co-ordinator role were shared in an unplanned way at different times between Dr J, Dr M and LMcC. We conclude that formal CPA reviews were more likely to have been held if there had been a care co-ordinator with these specific designated tasks.
- 6.16.4 Unfortunately, as the move away from a diagnosis of psychosis gathered pace, the opportunity to retrieve the situation through CPA reviews receded. The key moment might have been the point at which MN missed appointments. At this stage CPN input could have been reconsidered either from Yate CMHT or, as eventually decided, the Assertive Outreach Team.
- 6.16.5 By the day of the homicide MN had not been seen by Dr M for nine months, or by LMcC for eight months. In the previous fourteen months Dr M's only contact with the family had been one telephone conversation with DC. This was simply insufficient. Had MN been placed on the CPA register, failing

the key opportunities as above, at least formal reviews would have been triggered after six months and a year, in May 2001 and November 2001.

- 6.16.6 When MN killed was he still subject to CPA? This question was never asked at the time because he had never formally been subject to CPA in the first place. If CPA is to end, it should be a decision not a withering away. That in itself requires a CPA review in order that all potential players can express a view on the matter.

Use of CPA would have made it more likely that information was properly obtained

We conclude that there were crucial points throughout all services' care of MN when planned CPA meetings or CPA reviews could have, at least partially, mitigated the effects of unclear clinical responsibility, out-of-area arrangements, incomplete clinical records and poor clinical observation as described in Chapter 5. We cannot of course know what decisions would have been made, even with full consultation and with all the relevant clinical information to hand. However, adherence to the principles of practice codified in the CPA would have made it more likely that information was obtained and risk managed comprehensively.

CPA care plans properly made in hospital and reviewed after missed appointments would have provided the best opportunities to review the diagnosis

Could this have changed the diagnosis? We conclude that the greatest opportunity for changing the diagnostic course came in hospital. After this the diagnosis itself interfered with the CPA process, and it became harder to turn back from the course that had been set. At one other crucial stage, that of the missed appointments, an urgent CPA review might have galvanised Yate CMHT into action, with attendance of a CPN at MN's home in order to explore the possibility that he was suffering from untreated schizophrenia. We cannot, of course, know what difference a CPN home visit would have made during the eight months prior to the homicide because the available information on MN's mental state during that period is so sparse, but it is possible that if probed for symptoms MN's psychotic disturbance would have been detected earlier.

A CPA meeting could have decided upon referral to an independent expert

With differing psychiatric opinions on diagnosis and descriptions of MN as 'unusual', referral for an independent opinion could have been an appropriate way to proceed. At Local Recommendation 3 we recommend that the Trust incorporate this as a good practice point into ICPA Policy.

CPA has a preventive function

Could good CPA practice have prevented the homicide? CPA is not a panacea for all ills. We certainly cannot conclude that adherence to it would have prevented the homicide. CPA can nevertheless be seen as having a preventative function. It is reasonable to suppose that, if followed, CPA will reduce the possibility of miscommunication, raise standards of patient care and make untoward incidents less likely. As such it has the potential to operate as a failsafe procedure, using Root Cause Analysis terminology.

CPA failures were opportunities lost

In summary, we conclude that the CPA failures were opportunities lost. CPA was devised to provide a planned, predictable framework for good practice. It was not used as intended. If it had been, the chances of accurate diagnosis and treatment would have increased. And the earlier that CPA care planning had begun, the more likely it was that a diagnosis of psychosis would have been confirmed or reinstated. Unfortunately, the diagnosis of schizotypal disorder itself undermined the CPA process as time went on.

6.17 Three answers

- 6.17.1 Earlier in this chapter we asked three questions. We reply here, briefly summarising our findings and locating responsibility for improvement at local, regional and national levels. We consider national concerns more fully in Chapter 9.

6.17.2 *Should MN have been on standard or enhanced CPA?*

We are in no doubt that MN should have been subject to enhanced CPA when he left hospital, for at least as long as he was subject to s3 MHA. Surprisingly however, nowhere in national guidance is level of CPA related to detention under the MHA. This is despite the fact that the Code of Practice guidance

on CPA for detained patients clearly envisages from its high standards that such patients will be on an enhanced level of CPA.

The need for national consistency on level of CPA for detained patients

There should, we conclude, be consistent and unambiguous advice that patients who are detained for treatment must be placed on enhanced CPA, whether or not they are on s17 leave. Our recommendations are directed locally, and nationally where in Chapter 9 this becomes National Recommendation G.

Local Recommendation 21:

Ensuring that patients detained under the MHA are on enhanced CPA

- 6.17.3 *Were Dr J, Hillview Lodge staff, Dr M, LMCC and the Yate Team adhering to locality CPA procedure, Trust CPA policy and national CPA guidance in the assessment, care planning and review of MN?*

At the time a Trust Policy Framework required adherence to different local CPA procedures within the Trust. Dr J and Hillview Lodge staff adhered to their local procedure to the extent that a CPA meeting was held in hospital and a CPA Care Plan produced, but their practice did not meet the standards of CPA for detained patients contained in the MHA Code of Practice. When MN went home no-one adhered to the local South Gloucestershire CPA procedure or the Code of Practice.

The need for co-ordination of CPA across services

Professionals must accept individual responsibility for failures to adhere to CPA procedures and guidance. However, they were not helped by inconsistencies, across services and at different levels of the service – local up to national – which weakened CPA. The creation of the new Trust contributed by leaving services fragmented for a time despite the hard work of committed managers. However, health and social care services are still not fully integrated. There is still not a Trustwide electronic CPA register. As this is written further change is taking place with the merger of Strategic Health Authorities. And the ability of the national electronic health information system to operate effectively across organisational boundaries has been questioned. It is vital, especially at times of change, that CPA remains consistent for individuals who, for a variety of reasons, might find themselves moving from one area to another. PCT commissioning arrangements must emphasise the need for co-ordination of CPA services across boundaries, with providers and local authorities sharing operational systems and electronic records in anticipation of the national computerised information system.

Regional Recommendation:

Ensuring co-ordinated planning of CPA services and records

- 6.17.4 *Was local procedure, Trust policy and national guidance together sufficiently robust to provide MN with the CPA care planning he needed?*

We answer, yes, it should have been. There is no doubt that together the local South Gloucestershire procedure, Trust policy framework and national guidance, including the Code of Practice, set high standards for CPA. This should have been sufficient to ensure that MN received effective care under the CPA. Yet it was not.

The need for national prioritisation of CPA

Responsibility for failing to ensure that CPA was operating effectively must rest with those at every level in the Trust and localities whose task it was to implement local policy and national CPA practice guidance. However, we have been asked by witnesses to find that the problems of compliance with CPA go beyond Avon & Wiltshire Mental Health Care NHS Trust. We have been invited to conclude that there is a need for national change in order to assist the operation of CPA. Whilst this does not divert us from placing responsibility locally, the witnesses' reflections on CPA are based upon long experience, and the suggested means of prioritising CPA through inclusion in consultant contracts and making CPA a key indicator were also proposed by participants in the Inquiry's national seminar. We take these suggestions forward to Chapter 9 where they become National Recommendations A and D.

6.18 CPA in the national picture

- 6.18.1 In conclusion, serious shortcomings in adherence to local CPA procedures and national CPA expectations, including those under the MHA Code of Practice, have been described to us as commonplace by operational staff and senior managers. We have been told that these shortcomings are current and that even now CPA is challenged both operationally and as to its core principles. It has been suggested to us that it has not been fully implemented throughout the country.
- 6.18.2 Without a fully operational CPA system it appears from the evidence of this Inquiry that professionals tend to revert to a 'default position' of defensive, independent working which may lower the standard of service delivery.
- 6.18.3 It was for this reason that in 2004 we held a national seminar, inviting attendance at the highest national level. The results of that Seminar were fed into the scrutiny process for the Mental Health Bill. Regrettably this has delayed the publication of our report, but since these issues from MN's case appear to be truly national in character, urgent concerted attention at the highest level is essential. Details of the Seminar, along with national recommendations are contained in Chapter 9.

Chapter 7

Root Cause Analysis

7.1 Seeking causation

- 7.1.1 Seeking causation seems to be a fundamental human need. Responsibility, punishment, knowing how to correct mistakes, learning from experience all require that first of all we establish what went wrong.
- 7.1.2 Those with an interest in causation in this Inquiry include the victim's family, MN's family, MN himself, those responsible for his care and treatment, and the State which has required that such investigations take place.
- 7.1.3 Where the State may have failed to protect an individual's right to life under Article 2 of the European Convention of Human Rights (ECHR) there should always be some form of effective investigation and where this has not been undertaken within criminal proceedings or at an inquest this will also be one of the responsibilities of mental health homicide inquiries such as these. In the case of *Edwards v UK* in 2002 where both the perpetrator of the homicide and the victim were mentally ill and in the custody of state authorities, the elements of an effective investigation were described as including independence, public scrutiny and the power to compel witnesses.⁴⁸

"The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances. However, whatever mode is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next-of-kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures....."

For the same reasons, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests."⁴⁹

- 7.1.4 When this Inquiry was commissioned the method for carrying out an effective investigation in mental health homicide inquiries was not specified in Department of Health guidance⁵⁰. Even if, which was the exception, the Secretary of State decided that a statutory inquiry should be held, there was no formal legal framework for them. By convention homicide inquiries adopted an inquiry-style of procedure which was broadly inquisitorial, with a legally qualified Chair, evidence heard from witnesses individually and findings made on the basis of the evidence. There was a great deal of variation with some inquiries questioning witnesses through Counsel to the Inquiry and some allowing witnesses or their representatives to question each other. Others, like this one, permitted questioning only directly by the panel. A combination of 'Salmon principles' and 'Crampton letters', both named after cases, were relied upon to ensure fairness to witnesses by providing them with information about any potential criticism and an opportunity to respond before the report was published.
- 7.1.5 Homicide inquiries have also been subject to the criticism that they repeat the same findings again and again, they may fail to see system failures and instead find fault with professionals who are subjected to a great deal of stress through the Inquiry process, in ways which are demoralising and do not help those same people improve services. Sometimes the criticism is that no fault is found and organisations are left with a residue of complicated recommendations which may seem unmanageable and unconnected with the problems.

⁴⁸ *Paul and Audrey Edwards v UK* (Application no. 46477/99) Strasbourg 14 March 2002

⁴⁹ *Ibid* paragraphs 69 & 73.

⁵⁰ Department of Health Circular HSG (94) 27

7.1.6 Procedural change has come from two directions during the course of this Inquiry. The Inquiries Act 2005 has redefined the basis under which inquiries may be commissioned by Government Ministers in future. We deal with this later in the chapter. New Department of Health guidance deals directly with mental health homicide inquiries.

7.2 RCA and homicide inquiries

7.2.1 On 15 June 2005 the Department of Health issued guidance that replaced paragraphs 33-36 in HSG (94) 27 and now covers inquiries such as this, stating:

'SHA independent investigations...should use a process, such as root cause analysis (RCA) which will facilitate:

- *openness*
- *learning lessons*
- *creating change*'.

7.2.2 In anticipation of that new guidance we determined at the outset that we would use a RCA approach as far as possible. Each panel member attended at least one training day on RCA run by the National Patient Safety Agency (NPSA) and familiarised themselves with the purpose and use of the working tools published by the NPSA. Hazel Crook, NPSA Patient Safety Manager for the South West Peninsular advised on the RCA process for the Inquiry on the basis that the facts were anonymised. She had no role in any of the conclusions or final recommendations.

7.2.3 This Chapter describes the principles of RCA, their application in the case of MN and some of the lessons learned in terms of process. We begin by looking at what RCA is. Then we touch on some of the criticisms of RCA emanating from clinicians and the world of 'complexity science'. We then consider the very different approach of the 'inquiry' model. We describe this Inquiry's procedure and follow this with our own RCA, applying it to MN, his care and his treatment.

7.3 What is RCA?

7.3.1 Simplicity is attractive. For the simpler the cause, the more straightforward might be the solution.

7.3.2 Some events are amenable to straightforward analysis and RCA has grown out of the practical application of deductive reasoning to a range of untoward incidents in fields as diverse as the aviation industry and building safety as well as health care and treatment.

7.3.3 In its training pack the NPSA describes the process of identifying root causes in this way:

"Identify the contributory factors having the biggest impact on system failure = ROOT CAUSES".

7.3.4 It goes on to define a root cause:

"A Root Cause is a fundamental cause which if resolved will eradicate, or significantly contribute to the resolution of the identified problem to which it is attached both within the local department and more widely across the organisation".

7.3.5 RCA is the process by which root causes are identified. The analysis involves the initial gathering together of information in the form of a tabular time line. This pieces together the history, categorises events into chosen groups and identifies 'service delivery problems'. Thereafter the information is analysed using a variety of analytical tools, the emphasis being on those which are suitable for particular tasks, improvisation being encouraged.

7.3.6 By analysing information inside the organisation itself RCA focuses upon the participation of those involved in the incident, gathering them together and looking for systemic causes. It recognises that errors within organisations often fall into recurrent patterns and seeks to identify them so that they can be changed.

- 7.3.7 RCA aims to repair organisations which have been damaged by the experience of an untoward incident, making RCA a hands-on management and learning process. With a culture of ‘fair blame’ and an understanding of risk, the organisation is then better equipped to prevent further incidents:

“Studies have shown that the best way of reducing error rates is to target the underlying systems failures, rather than take action against individual members of staff. It is vital that we confront two myths that still persist in healthcare, as identified by Dr Lucian Leape from the Harvard School of Public Health:

- *The perfection myth: if people try hard enough they will not make any errors*
- *The punishment myth: if we punish people when they make errors they will make fewer of them.*

At the NPSA, we recognise that healthcare will always involve risks. But that these risks can be reduced by analysing and tackling the root causes of patient safety incidents”. (emphasis in original text)

- 7.3.8 The NPSA describe the replacement of the previous HSG guidance in terms of the advantages of RCA:

“Replacement of HSG. Investigation and learning following homicide and suicide:

Current process overdue for replacement:

- *Not sensitive enough to needs of families, staff or patients*
- *Variable quality of reports and investigation*
- *Lengthy and cumbersome procedures*
- *Same recommendations reappear*
- *Losing credibility with service staff*

Investigation and learning following homicide and suicide:

Progress towards a better alternative:

- *Investigate effectively – Root Cause Analysis*
- *Skilled support for families and victims*
- *Publish findings openly*
- *Independent investigation when public concern is high*
- *Find the cause not the culprit*
- *Learn the lessons that make for safe services.”*

- 7.3.9 RCA allows for some involvement of independent individuals from outside the organisation but it is largely focussed on work with and within the organisation.

- 7.3.10 RCA is appealing because it suggests that complexity can be reduced to simplicity. And by emphasising not individual but system failures, RCA seems to offer the tantalising possibility of a pain-free inquiry.

- 7.3.11 However RCA relies upon the assumption that there can be a relationship of cause and effect. In this case the effect – that of a mentally ill man killing someone – may not necessarily have a predictable cause.

7.4 Complexity Science

- 7.4.1 Beginning a debate within the world of psychiatric care on what has become known as ‘complexity science’ an article by Plsek and Greenhalgh in the British Medical Journal in 2001 entitled *The Challenge of Complexity and Healthcare*⁵¹, included the following comment:

⁵¹ Plsek and Greenhalgh (2001), *The Challenge of Complexity and Healthcare*, BMJ, 323, 65-628

“A complex adaptive system is a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents... The behaviour of a complex system is often non-linear... Because the elements are changeable, the relationship non-linear, and the behaviour emergent and sensitive to small changes, the detailed behaviour of any complex system is fundamentally unpredictable over time”.

7.4.2 Focussing on the human body and behaviour for the purposes of their article *Complexity and Clinical Care*, Wilson, Holt and Greenhalgh,⁵² wrote in the same year:

“For all these reasons neither illness nor human behaviour is predictable and neither can safely be ‘modelled’ in a simple cause and effect system. The human body is not a machine and its malfunctioning cannot be adequately analysed by breaking the system down into its component parts and considering each in isolation. Despite this fact, cause and effect modelling underpins much of the problem solving we attempt in clinical encounters; this perhaps explains why we so often fail”.

7.4.3 They concluded:

“...illness (and health) results from complex, dynamic, and unique interactions between different components of the overall system. Effective clinical decision making requires a holistic approach that accepts unpredictability and builds on subtle emergent forces within the overall system”.

7.5 Complexity and RCA

7.5.1 These views underline the need to guard against retrospectively drawing intuitively appealing conclusions in complex situations – for example, where there are several possible diagnoses, potential interventions, and individual professionals and family members with different perspectives.

7.6 Inquiries Act 2005

7.6.1 Taking a very different approach from that of RCA, there is the tradition of the public inquiry. The recent Inquiries Act 2005 sets out a comprehensive statutory framework for inquiries set up by Ministers to look into a wide range of matters of public concern. These might be either very serious in themselves, for example a major railway accident, or a series of incidents giving rise to concern, such as high incidence of deaths involving a hospital procedure. Draft Inquiry Procedure Rules, recently published for consultation, allow frameworks to be proportional to the seriousness of the matter under investigation⁵³.

7.6.2 Legal in its style, the ‘inquiry’ approach, whether statutory or not, bears in mind that:

- The European Convention of Human Rights requires an ‘effective investigation’ where the state might be responsible for a death. Standards are set for the independence of the inquiry and it must be publicly accountable with published reports and possibly public hearings
- Findings may be made against professionals who could be subject to disciplinary or even criminal proceedings and this requires scrupulous attention to fairness, with the hearing of evidence from individuals separately, permitting attendance by legal representatives and ensuring that witnesses who are criticised have an opportunity to respond before publication. Under the Inquiries Act witnesses can be compelled to attend.

7.7 Deciding upon a procedure for this Inquiry

7.7.1 This Inquiry started under the aegis of one Department of Health guidance and finished under another. It began with an ‘inquiry’ approach but ended having used elements of RCA along the way.

7.7.2 Our initial gathering of evidence took place at private hearings attended by individuals accompanied by representatives if they wished. We considered it was essential to hear ‘uncontaminated’ evidence from professionals who, whilst working in a team, might be deterred from giving frank disclosure of their

⁵² Wilson, Holt and Greenhalgh (2001), *Complexity and Clinical Care*, Brit Med J, 323, 685-688

⁵³ Department for Constitutional Affairs, *Draft Inquiry Procedure Rules*, 1 March 2006

recollections and opinions if we heard from them together. If there was any possibility of organisational dysfunction – itself something we might wish to hear about – this might mean there could be issues of power, control and professional identity potentially unsettling witnesses and hindering our fact finding.

- 7.7.3 Of course, we bear in mind that there are advantages to seeing the organisation working – or not working – by observing its operation first hand. But having weighed up the advantages and disadvantages, we decided that we would not be able to do justice to the requirements of an effective investigation in any other way.
- 7.7.4 The terms of reference deliberately ensured that the procedure was flexible and, when it became clear during the hearings that there could be issues of national concern on CPA, we were able to take another decision and seek expert national advice, which was given on the basis of ‘Chatham House rules’ that no comments would be attributed to named individuals.
- 7.7.5 Having obtained evidence from witnesses, the Inquiry Panel met together on several occasions and sought advice from the NPSA who supported our approach and provided helpful ideas. At this stage we found the RCA tools extremely helpful and used them to formulate a tabular time line, which proved to be an enormous document. As material for publication it was impractical.
- 7.7.6 We also used methods such as the RCA ‘fish bone diagram’ and the ‘why chart’, taking individual points in the history for detailed analysis. We could not share this outside of the panel because it was based entirely upon the evidence we had heard and was confidential to each witness.
- 7.7.7 Only when we had written a draft of the report, received replies from witnesses who had been criticised and redrafted sections were we in a position to consider the factual part of the report complete.
- 7.7.8 At that stage we began a ‘Recommendation Consultation Process’. We met with
- i. a group of managers from the highest levels in the Trust, social services and PCT, most of whom had already given evidence
 - ii. MN’s mother and DC
 - iii. MN and his solicitor
 - iv. the daughters and son-in-law of Mrs H, the victim of the homicide
 - v. We had already heard from representatives of MIND and Rethink in the Bristol area.
- 7.7.9 Following this consultation we finalised our recommendations, and based upon this AGW SHA drew up an action plan. The Inquiry’s terms of reference provide for a review of progress on the action plan in six months and again in a year’s time.

7.8 Our observations on the procedure

- 7.8.1 Having reflected upon the inquiry process we offer a few observations as to procedure. Firstly, inquiries such as these sit uncertainly somewhere in the middle ground between statutory inquiries and RCA. At worst this could be their weakness, but at best it is their strength.
- 7.8.2 There are certainly some practical difficulties marrying the two approaches. Once an inquiry has embarked upon formal evidence taking from individuals in private, it becomes impossible to share that evidence with other witnesses where there might be a breach of confidentiality, or premature leakage of untested facts or provisional findings into the public domain. This means the ‘inquiry’ approach, once embarked upon, makes it more difficult to capture fully the essence of team functioning or malfunctioning. There may be some advantage to a meeting of participants in the inquiry prior to the formal evidence gathering.
- 7.8.3 Furthermore the root causes, simply expressed in single sentences were not sophisticated enough to be used, on their own, as findings to go to witnesses for their comments. In practice, the root causes described at paragraphs 7.9.8 to 7.9.10 below were incorporated into the text of the report. Witnesses then received that text in the form of ‘Crampton letters’ allowing them to respond to any criticisms made.

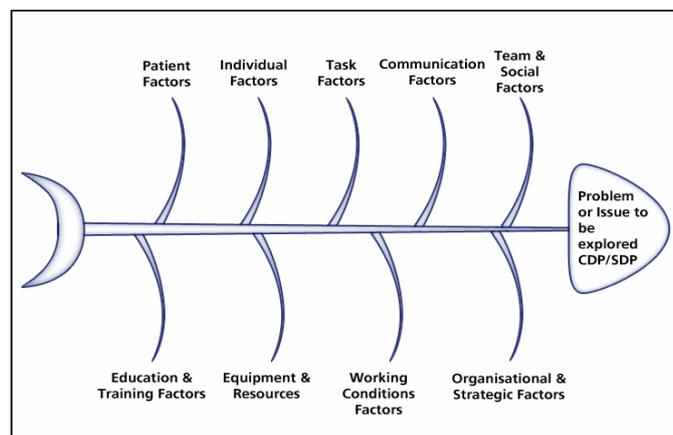
7.8.4 The strength of the 'hybrid' investigation is that it has the authority of the inquisitorial inquiry but also the flexibility of RCA to analyse evidence in a structured way in order to reveal patterns. Once the facts have been dealt with, we have found that consultation upon recommendations can be fully interactive, involving meetings with the organisations concerned, the family of the victim, the family of the patient and the patient himself. Recommendations focus attention on the future and away from the negative consequences of blame. Involvement of the inquiry in action planning helps to ensure a working relationship with the organisations which have been criticised, bringing about improvement based on the recommendations. Even once the report is published the inquiry should not, in our view, end there. With review of progress on the action plan over the coming year and Inquiry review reports made public, an Inquiry can act as a focus for positive change in an organisation long after the report has been published. This marks it out as different from many high profile statutory inquiries, which simply publish a report and the matter is over.

7.9 RCA and MN

7.9.1 It would be usual to begin an analysis of a large amount of material with a chronology in tabular form, and this is how we brought together all the material from medical, nursing and social work records. This was a working document and it grew as we heard evidence, becoming a RCA tabular time line that included reference to policy and commentary upon service and care delivery problems. It was this which became the history in Chapter 2.

7.9.2 Much of our RCA was completed on flip charts. We focussed upon discrete moments, examining the impact on them of family, professional, managerial, policy and other factors.

7.9.3 The fishbone diagram below made available by the NPSA was adapted to examine four separate decisions and events; not to medicate MN on 1 November 2000; to send MN home on 22 November 2000; to discharge MN from s3 in March 2001; and the homicide. By examining each of the factors it was possible to see the position from the point of view of the family, the professionals, in terms of the structure of CPA, policy, strategic and legal framework. We could see interactions between them and patterns emerging over time. We found, for example, that information about diagnosis, treatment and symptoms had not been shared with the family, nor had there been planned CPA meetings or reviews. The factors emerging from these analyses formed the basis of our Chapters 3, 4, 5 and 6.



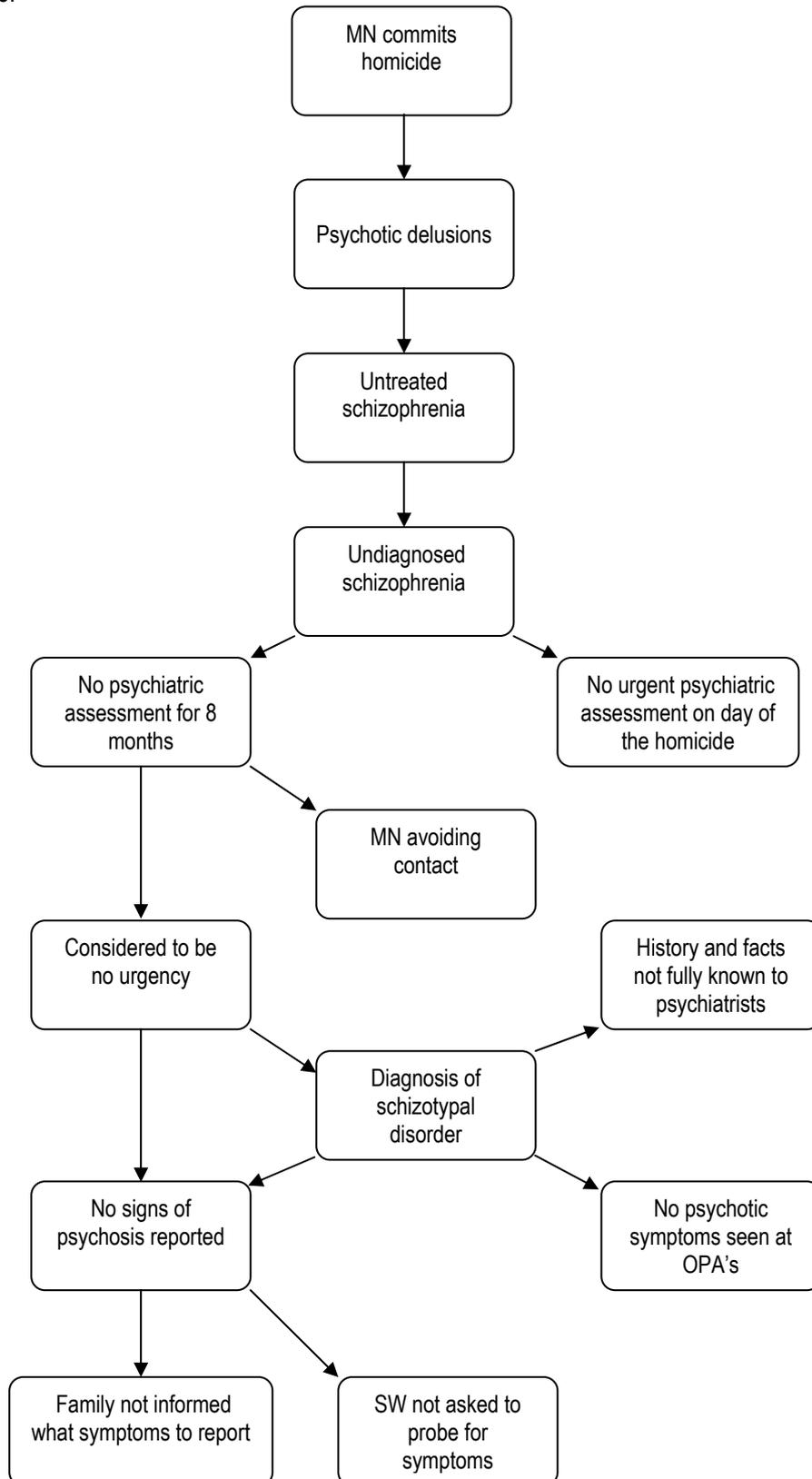
7.9.4 The 'why chart' proved a useful tool, although the limitations of deductive reasoning need to be acknowledged. In the 'Why Chart' below each arrow represents the question 'why?' It does not work the other way around. For example, although one can ask why MN committed the homicide and answer 'because he was suffering from psychotic delusions', it does not follow that someone suffering psychotic delusions will commit a homicide. Indeed MN had psychotic delusions for a long while and did not commit homicide. Starting with the end-point and working backwards to the killing does not produce a necessary causal link and may result in hindsight bias. Caution is required when analysing information in this way.

7.9.5 Of course further 'Why Charts' can be used; for example, to ask why the history and facts were not known to the psychiatrists. But at each stage one is further and further removed from the homicide

itself. There is a danger of over-simplification and the tool is not suitable for use once the questions start to produce multiple answers when the risk of hindsight bias increases.

7.9.6 We remind ourselves of the definition of root cause given by the NPSA: *“A Root Cause is a fundamental cause which if resolved will eradicate, or significantly contribute to the resolution of the identified problem to which it is attached both within the local department and more widely across the organisation”.*

7.9.7 There may be several root causes. The chart below considers the period of eight months prior to the homicide.



7.9.8 The points with the potential for organisational change during those eight months were:

- No psychiatric assessment
- Full history and facts not known to psychiatrists
- Family not informed of the symptoms they should report
- Social worker not asked to probe for symptoms
- No urgent psychiatric assessment on the day of homicide.

7.9.9 The inherent unpredictability of psychotic delusions makes it impossible to conclude there was a direct causal link between any one of these factors and the homicide. However, taken together as causes of MN suffering from incompletely diagnosed and untreated schizophrenia right up until the homicide, these factors are sufficiently proximate to have made a difference to the outcome. To that extent they can be described as fundamental or root causes. We have not described schizotypal disorder as a root cause because it was a professional decision, but factors influencing that diagnosis were causes because they were amenable to organisational change.

7.9.10 As important as root causes, if not more so, are the 'barriers' which RCA describes as having a preventative function. In this case we include:

- Adherence to CPA procedures, which would have ensured allocation of a care co-ordinator and full review during the eight months MN was not seen
- A missed appointments policy which would have ensured that diagnosis was reviewed, risk assessed and a CPA meeting called when MN missed appointments
- Avoidance of out-of-area admission in the first place, and failing that the transfer of medical records would have ensured that between them MN's psychiatrists had all relevant information available to them. Records should travel with the patient
- Information as to diagnosis and symptoms provided to the family in the context of CPA would have helped them understand what needed to be reported and to whom
- Allocation of a CPN or social worker with the expressed task of visiting MN at home and probing for symptoms relevant to diagnosis would have been more likely to uncover concealed symptoms
- A procedure for immediate reporting of specific serious threats of violence, by mobile telephone to police, psychiatrist and GP might have led to the setting up of an urgent psychiatric assessment, though the homicide occurred so quickly it might not have been possible to prevent it.

7.9.11 The emphasis of RCA is upon systems failures which are amenable to change, thereby offering some hope of reducing future such incidents. In the case of MN there were also professional 'barriers' which would have reduced the likelihood of a misdiagnosis of schizotypal disorder:

- Improved guidance to psychiatrists on the use of 'rare' diagnoses indicating the importance of obtaining a comprehensive history and background
- Improved early intervention strategies where diagnosis is uncertain.

The contribution of Root Cause Analysis

We have found RCA to be a most useful tool. It is, however, deceptively simple. Each factor above required detailed examination of much documentary, written and oral evidence, and a careful objective comparison of witnesses' interpretation of events and version of the facts as they perceived them. It is not the quick option it might appear to be. Nor does it tell the story or do justice to the sheer complexity of the people and systems providing care to MN. We owe a duty to those witnesses who are accountable as employees of the NHS and Local Authority. We owe a further duty to MN himself who is the mentally ill subject of this Inquiry, and to his family who were his carers. We owe a special duty to the family of the victim, who have themselves been made victim by events, to be accountable in terms which may help them both in their grievous loss and their need to understand. RCA in that sense is a somewhat blunt tool which cannot readily be sensitised to the finer nuances of feeling and interpretation. It can add a degree of scientific rigour; it may help inquiry panel members to maintain objectivity, but it does not replace an inquisitorial process conducted with due sensitivity for the subject matter of an inquiry such as this.

Chapter 8

Local recommendations

8.1 Previous local homicide inquiries

- 8.1.1 Our terms of reference refer to two other local homicide inquiries which, sadly, have several themes in common with MN.
- 8.1.2 In order to draft our recommendations it has been helpful to re-examine these previous inquiry reports. Some professional witnesses who gave evidence to this Inquiry also did so in one or both of the two previous inquiries. The families of MN and the victim of the homicide are aware of the other inquiries and know that this report will refer to them. We are grateful to the family of Mrs H in particular, for being prepared to share this part of the report with the relatives of two previous victims of homicide.

8.2 Independent Inquiry into the Care and Treatment of RG⁵⁴

- 8.2.1 This Inquiry report, published in 2001, examined the care and treatment of Richard Gray who, whilst conditionally discharged under s37/41 MHA and suffering from schizophrenia for which he was being treated, killed the mother of his two children during the early stages of her labour with their third child. The unborn baby died with the mother.
- 8.2.2 The victim had been denied involvement in CPA planning for RG's care and had not been informed that he had mentioned thoughts of killing her, yet the decision to permit his attendance at the birth had been left with her. She had been given responsibility without information.
- 8.2.3 Information concerning risk was not shared within the team; only one structured risk assessment was completed during a period of eight years and that was not shared with social services.
- 8.2.4 The report stated *"There was no planned or co-ordinated arrangement for risk assessment. Responsibility for risk assessment was diffuse and unclear. No joint policy or procedure had been agreed between the Trust and social services Risk assessment did not always take place upon discharge from hospital"*.

8.3 Independent Inquiry into the Care and Treatment of MM⁵⁵

- 8.3.1 Published in 2003, this report investigated the care and treatment of MM, a young man who, having completely disengaged from psychiatric care for eighteen months and whilst suffering from untreated schizophrenia, attacked and killed his father. The family lived and the homicide occurred in a village near Winterbourne where MN committed this homicide.
- 8.3.2 Relatives/carers: During the eighteen months MM was refusing help his consultant psychiatrist believed she had left channels of communication open, but MM's father did not understand how to refer, had lost trust in mental health services and had given up seeking help, even though he was frightened of his son and knew he was mentally ill.
- 8.3.3 The report recommended *"The Trust should produce a leaflet for users and carers which summarises mental health services.....It should provide information on the service a user and carer can expect. If the patient concerned is subject to ICPA the care co-ordinator should be named.....information leaflets for carers should spell out what it is reasonable for them to provide or put up with, when to seek help and whom to approach if they fear for their safety"*.

⁵⁴ Summary Report published by the then Wiltshire Health Authority and Wiltshire Social Services October 2001

⁵⁵ www.agwsha.nhs.uk/publications.htm

- 8.3.4 **Non compliance/disengagement:** MM had been out of contact with services for eighteen months, sometimes sleeping on the streets and begging. There had been no contingency plan made to deal with his non-compliance even though it had been anticipated.
- 8.3.5 The report noted the National Confidential Inquiry figure that 71% of patients convicted of homicide were out of contact with services, adding *"The Trust had no written policies on non-compliance or disengagement. This was not, and is not, unusual. The National Confidential Inquiry....1999 found that only a minority of Trusts did so. Their recommendations concerning disengaged patients include the need for a comprehensive social and clinical care plan..... and assertive outreach in response to loss of contact with patients.... They recommend a written policy on non-compliance which is made known to staff, patients and families"*.
- 8.3.6 The report recommended *"Our single most important recommendation for action by the partnership Trust and local social services is the development of a joint policy to target the care of non-compliant, disengaged patients. That policy should be drawn up with the assistance of local advocacy, user and carer groups"*.
- 8.3.7 CPA: The only CPA meeting ever held took place on the day MM was discharged from hospital and s37 MHA. No SW was invited and there was no assessment of MM's s117 aftercare needs. There was no formal written risk assessment. The CPA care plan named the consultant as care co-ordinator but she was too busy to take on the task. The level of CPA was not indicated and there was no date for review. MM's name was erroneously removed from the CPA register and no formal CPA reviews were triggered.
- 8.3.8 It was concluded *"Generally, we conclude that CPA procedure and practice, as it applied to MM at that time, was poor and of a standard that did not meet statutory requirements.... Weaknesses included a failure to take account of HSG (94)27 requirements concerning risk assessment and contingency planning for non-compliance and a low expectation concerning advance planning for discharge. Care plans, by their design, invited brevity. Neither policy nor training encouraged rigorous completion of documentation....Trust policy should have set a standard rather than reflecting established practice of the most pressured mental health teams"*.

8.4 Three inquiries

- 8.4.1 These three local homicide inquiry reports, RG, MM and MN in the five years from 2001 to 2006, have five common themes, particularly those of MM and MN, as we describe below.
1. **Carer responsibility without support:** In each of the inquiries relatives or carers had been given responsibility without support. They were expected to make decisions that required an understanding of psychiatric symptoms but without the information necessary to do so. In each case carers had expressed frustration at their inability to obtain information, the partner of RG and mother of MN complaining about the conduct of CPA meetings. In the cases of MM and MN, having failed to obtain help, the relatives gave up asking. Professionals waited for reports of deterioration which never came, creating the illusion that things were fine. The message is that when a family is not actively seeking help it should not be assumed everything is all right. Levels of tolerance can increase as feelings of helplessness and isolation set in. If they are to be relied upon as partners in the care process, families need intensive support and information and this must be regularly reviewed.
 2. **Poor management of disengagement from services:** MN was just as much out of contact with services isolated in his bedroom at home as MM was wandering the streets. In both cases it had been anticipated that they would probably not co-operate with psychiatric care, but there was no contingency planning for this and insufficient monitoring of the situation in the community.
 3. **Inadequate CPA:** CPA arrangements were inadequate in the cases of MM and MN. Out of date documentation was used in both cases. MM's name was erroneously removed from the CPA register and MN's name was never placed on it. In each case there was only one CPA meeting, which took place upon leaving hospital. CPA forms were completed very briefly with no structured risk assessment and no contingency plan for non-compliance, despite evidence in both cases of likely non-cooperation with services. Care coordinators were named who, for different reasons,

were unable to take on the task. No social worker was invited to either CPA meeting, and no s117 assessment of aftercare needs took place before returning home. There were no CPA reviews in either case. The above represented a significant failure to adhere to MHA Code of Practice guidance for detained patients as well as the Trust's operational policies on CPA.

4. **Lack of structured risk assessment:** Formal structured risk assessment was minimal in all cases. In RG's case there was only one in eight years, in MM's case there was none and in MN's case one such assessment which was not updated.
5. **Youth and early intervention in psychosis:** MM and MN were both young and thought by professionals to be 'alternative' or taking drugs, though in fact drugs were not found to be a significant feature of their mental illness. Issues of freedom and personal autonomy were cited in both cases as reasons for non-intervention. Extra care needs to be taken to monitor mental illness in young people where it might be difficult to identify symptoms, make a diagnosis and assess the right time to intervene.

8.5 Consultation upon the recommendations

- 8.5.1 We asked for views upon the local recommendations this Inquiry should make. We heard from individual witnesses and consulted the Trust, South Gloucestershire Social Services, the PCT, MIND, Rethink, the family of MN, MN himself and the family of the victim. This was a most helpful process

8.6 Mental health service commissioners and providers

- 8.6.1 It was intended that ownership of the recommendations should pass to those who must create an operational action plan and bring about service improvements. We found the organisations concerned keen to embrace solutions and they responded with some very specific suggestions, many of which we have incorporated into our recommendations.
- 8.6.2 The two previous homicide inquiries had already led to some local policy amendments, though these were not in place until after the homicide with which this Inquiry is concerned. The Trust ICPA Policy now has detailed procedures for dealing with disengagement from CPA/care, contingency planning, and procedure when appointments are missed including CPA review and risk assessment if there is a pattern of repeated missed appointments. A complex risk assessment screen was simplified to make it more user-friendly and the ICPA Policy now requires completion of a risk assessment and management plan prior to leave or discharge from hospital and upon CPA review. This policy is in our opinion generally comprehensive on these particular points, though we recommend some further amendment on risk assessment.
- 8.6.3 Following the recommendations of the previous homicide inquiries and in conjunction with the a Bristol Mind User-Focussed Study of Three Inpatient Units in Bristol, a Patient Information Booklet was also produced by the Trust and this, we are informed, is widely available in the Trust area. It is a comprehensive, well set-out document, its value resting with its use and distribution.
- 8.6.4 The consultation process in this Inquiry identified several significant areas for our local recommendations, whilst at the same time generating suggestions for national action which we take forward for consideration in Chapter 9:
 - **Out-of-area admission:** A need to tackle this from a prevention point of view, ensuring there is sufficient capacity to provide services within an area, in addition to the management of out-of-area admission when it is unavoidable. We were shown a *Good Practice in the Transfer of Service User Care between Mental Health Districts* document dated May 2005.
 - **Administrative support for CPA:** Professionals are generally relied upon not only to complete CPA documentation as part of their primary responsibility for clinical records, but also to arrange CPA meetings and enter information onto the Trust electronic system. However, without any standardisation of arrangements and with all staff under clinical pressure, this is not being done consistently across the Trust. As a result CPA operates less well than it could do and there is no reliable Trustwide CPA register. Moreover, use of clinical time for the administrative functions of CPA is considered a waste of resources. Citing local authority child protection meetings as an

example, it was suggested that administrative staff were needed to set up CPA meetings, organise reviews and co-ordinate paperwork. There were views both that there should be national level commitment to funding of administrative support for CPA and that this should be a local resource matter. We take this issue forward to Chapter 9 where we have linked it with National Recommendation A.

- **Moving CPA up the agenda:** This led on to discussion about how to move CPA up the agenda through performance ratings in order to ensure that resources are indeed used for the benefit of CPA. The agreed view was that CPA should be a key indicator so that it is a target to be achieved and maintained. It should also be made part of all staff appraisal, making it a high priority throughout. These points are taken forward to Chapter 9 and incorporated into National Recommendations A and D.
- **Early intervention in psychosis services:** Issues concerning good practice in relation to diagnosis and communication with families would, it was thought, best come within development of early intervention in psychosis services throughout the Trust areas. We were shown a *Trust Strategy for Early Intervention in Psychosis Services* dated July 2003, *Confidentiality and Information Sharing with Families and Carers* dated May 2006, and a *Family Work in the Avon and Wiltshire Partnership NHS Trust* document dated May 2006.

8.7 Advice and advocacy services

8.7.1 AB, Senior Advice Worker for Rethink, formerly the National Schizophrenia Fellowship and TH, Advocacy Services Co-ordinator for Bristol MIND provided us with helpful suggestions:

- **Guidance on confidentiality:** We heard about a “*screen of confidentiality that is brought down*” by professionals when, for example, carers telephone and say they are concerned about their relative. There is, we were told, a need to explain the issue of confidentiality properly to staff, service users and carers. Confidentiality is not breached by listening.
- **Advocacy services in the Trust:** We were told that most Trusts in the South West of England fund advocacy services, but this does not happen in Bristol. Advocates were described as being able to convey people’s real concerns, especially bearing in mind that relatives are the main observers of behaviour once a patient is at home.
- **Independent psychiatric opinions:** Referral for an independent opinion has to be made by the patient’s consultant, who may not agree. It was hoped there would be a way to make it easier for independent opinions to be obtained. We have placed this into the domain of the multidisciplinary setting of CPA.

8.8 MN’s family

8.8.1 In our meeting with MN’s mother and DC the following suggestions were made, many of which have been incorporated into our recommendations:

- Where there is more than one carer it should be agreed who will be the named contact.
- Family members should know they are formally classed as ‘carers’ and have their rights and responsibilities explained to them.
- There should be a carers’ assessment at the beginning and at key points in the patient’s progress through the mental health system.
- Carers and family should be given information at key points; when the patient first enters the mental health care system, when he or she is admitted to hospital, and on leaving hospital.
- There should be a leaflet explaining key terminology used by health and social care professionals.
- There should be a ‘jargon free’ explanation of the Mental Health Act.
- One professional should make regular visits (every 3 – 4 weeks) to the patient at home on leave and whilst subject to s117 aftercare in order to note any changes. Staff continuity would ensure changes in the patient are tracked effectively.
- Carers should be supported by a professional trained in work with families.

- Professionals should seek the patient's agreement to the sharing of diagnosis and treatment details with carers and family. Where not initially given, agreement should be sought again on a regular basis. Where a patient continues to refuse, professional staff should be meticulous in sharing non-confidential information, including any concerns about risk.

8.8.2 DC and MN's mother in fact provided us with a note of their suggestions, signed by both of them; with their agreement we reproduce it in full below:

'Suggestions to the Inquiry

When I look back at what happened to MN and to me, there are various suggestions I would make in how people should deal with carers.

1. *It would have been helpful to have some information about medication and how medication is dealt with in hospital.*
2. *It would have helped to have some explanation about the procedure for sectioning and for leave and for care planning. I did not understand what sectioning meant. I did not understand about section 17 leave or CPA meetings.*
3. *It would have been helpful to have a key person to talk to in hospital who had responsibility for keeping in touch with carers.*
4. *We were very confused about what was wrong with MN and his diagnosis. It would have been helpful to have someone explain what his diagnosis was. We were only told on the telephone by Dr J's secretary.*
5. *I think hospital staff should have been more welcoming.*
6. *As for being discharged, I think there should have been more information about when MN was to be discharged and there should have been a meeting before he was sent home. We should have been aware of what to look for and why he was being sent home and what the plan was. We should have met with Dr J and MN being present as well but it is also difficult to voice opinions when MN was there and it seems to us that a doctor should have also talked to us on his own to plan what was to happen.*
7. *At Fromeside [Medium Secure Unit] we had been given a booklet about how Fromeside works with all our questions answered. I think it would be helpful if there were some sort of booklet like that.*
8. *We did not know what to look for when MN was discharged and it would have been helpful to have information about how to look for signs of what was wrong and be given times when we should telephone someone if we were worried. We assumed that things would just go on as before.*
9. *We think there should have been regular meetings with social worker and doctor after MN was discharged.'*

8.9 MN

8.9.1 MN told us he thought patients should be given information about their mental illness even though they might not believe they are ill. There should be a specific person whose responsibility it is to explain this. Patients should be asked if they are happy for the sharing of information with their family/carers. He would, he said, have agreed to this. MN wishes he had been stopped from carrying out the homicide on that day, and through his solicitor suggested a recommendation that threats of serious violence should be acted upon without delay in order to reduce risk.

8.10 The family of the victim

8.10.1 We completed our consultation by speaking to the family of the victim, recognising that their pain will never end and for whom this was very difficult. They described the continuing impact of the killing within their local community and spoke of how society must balance risk against security, emphasizing the importance of being able to trust those who make decisions about the care of the mentally ill. They expressed the hope that there would in the future be some understanding of the cause of mental illness, and that our recommendations would address the following concerns:

- there should be effective monitoring and supervision of people with mental disorders who are treated in the community after discharge from hospital treatment, especially in cases involving potential risk

- there should be better treatment and appropriate care for those with severe mental illnesses
- The public have a reasonable right to expect levels of protection and control appropriate to each patient's circumstances, with double checking where any question of risk exists so that decisions are not the responsibility of a single person
- Whatever changes are introduced as a result of our findings, the result must be a service which can be trusted by the public and patients alike.

8.10.2 Two points stood out. Firstly, double-checking of risk could and should be achieved by effective operation of CPA, which would ensure individual opinions on risk are shared. We have already described CPA as having a preventative function. Secondly, it is vital that services can be trusted. Those responsible for commissioning and provision of services at every level should ensure that they respond publicly to the recommendations made in this report to ensure that there is confidence in the mental health service.

8.10.3 It was an appropriate way to end our Inquiry – with a view from those most painfully and immediately affected by the homicide.

8.11 Local recommendations

8.11.1 Our local recommendations are described below. There is one regional recommendation listed after that. National recommendations are contained in Chapter 9.

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
1 (11,79)	Trust and social services	<p>Using records effectively</p> <p>(1) Good practice in record-keeping: The Trust and social services should ensure through suitable training, monitoring, management and audit processes, that practitioners consistently maintain accurate and relevant records which fulfil standards of good practice under CPA.</p> <p>(2) Healthcare records should follow the patient: Wherever and whenever a service user is seen within the Trust the full healthcare record should be made available to the psychiatrist responsible for their care and treatment as soon as possible and at least within five working days.</p> <p>(3) Integrating records: Separate systems of medical, nursing and other records are discontinued, so that patient healthcare records are fully integrated.</p>
2 (11,78,79,81)	Trust and PCTs	<p>Management of out of area admission</p> <p>(1) Prevention: In line with National Service Framework guidance, the Trust should work in partnership with Commissioners to ensure that the capacity of local mental health services is sufficient to minimise the risk of individuals being admitted to inpatient care away from the usual inpatient unit for the area.</p> <p>(2) Clarifying RMO, clinical and CPA responsibility: The Trust should ensure that together its ICPA Policy and its Good Practice in the Transfer of Service User Care Between Mental Health Districts includes:</p> <ul style="list-style-type: none"> • Clear guidance on where consultant responsibilities lie when there is out of area admission and detention under the MHA with s17 leave. The guidance should refer to the following consultant responsibilities:

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
		<ul style="list-style-type: none"> i. RMO ii. day-to-day clinical supervision iii. organising of CPA in hospital iv. ensuring there is a care co-ordinator managing CPA in the community v. arranging hospital re-admission and a bed should it be needed. <ul style="list-style-type: none"> • A requirement that these various responsibilities be recorded in CPA documentation by or on behalf of the consultant responsible for CPA. • Good practice guidance that every effort should be made to avoid arrangements which are confusing and have gaps or lack continuity. <p>(3) Explaining arrangements to service users and carers: Where responsibility is shared or unclear the service user and carer should be told who to contact if they have a concern.</p> <p>(4) Location of healthcare records: The ICPA Policy should make it clear where the healthcare records must be located.</p> <p>(5) Maintaining inpatient care standards: Trust good practice guidance should stress the importance of maintaining nursing standards when a patient is cared for out of area. This should be reviewed through regular clinical audit.</p>
3 (25, 60)	Trust	<p>Diagnosis and CPA</p> <p>(1) Recording of diagnosis and treatment in CPA care plans: The Trust should review its ICPA Policy to ensure that each Care Plan describes the diagnosis and differential diagnosis if there is one, and includes a clear treatment and management plan, unless there is a clinical reason not to do so which is noted in the medical records. Where consent is needed for disclosure of information this should be recorded</p> <p>(2) Consideration of an independent opinion: The Trust should provide good practice guidance in its ICPA Policy to the effect that where, in the context of a CPA assessment of health and social care, it becomes apparent that there is dispute or uncertainty about a diagnosis, consideration should be given to the appointment of an independent expert to provide an opinion</p>
4 (25)	Trust and social services departments	<p>Ensuring s117 aftercare planning takes place</p> <p>The Trust should review its ICPA and section 117 policies, and work with local authorities to ensure that the responsibilities of the Trust and social services to carry out a s117 aftercare assessment before any extended leave of absence are explicitly addressed and incorporated into CPA care planning. A multi-agency audit of the use of this policy should be included in the Trust and Local Authority annual audit cycle.</p>
5 (25,110)	Trust	<p>Ensuring a functioning Trustwide CPA register</p> <p>The Trust should</p> <p>(1) ensure that relevant policies and procedures require that CPA care plans and risk assessments are</p> <ul style="list-style-type: none"> • completed for all users accepted by the Trust, and • recorded on paper in the form required by the Trust ICPA Policy,

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
		<p>and</p> <ul style="list-style-type: none"> • for patients subject to both standard and enhanced CPA, entered electronically in the Trust MHIS (Mental Health Information System) <ol style="list-style-type: none"> (2) make it clear who is responsible for entering information onto MHIS and provide any necessary training (3) ensure the MHIS central electronic repository is readily accessible wherever the Trust provides care other than in domiciliary settings (4) establish the MHIS information as the basis of the Trust CPA register, which should satisfy the Department of Health requirement for central records on all those in contact with services as described at paragraph 6.2.7 of this report (5) use the CPA register to trigger CPA reviews (6) audit compliance and publish figures for the numbers of patients on the CPA register (7) prepare for a link between the CPA register and national computerisation of health care records (8) Provide regular reports to the Trust Board on the implementation of CPA
6 (26)	Trust	<p>Consistency of nursing and CPA care plans The Trust should ensure that overarching CPA care plans make reference to any other contemporaneous care plans, such as nursing or psychology, attaching copies of them to the patient's CPA document where possible.</p>
7 (30)	Trust and social services	<p>Ensuring a care co-ordinator is always appointed The Trust should review its ICPA Policy as necessary and give a commitment that under no circumstances will a service user be deprived of a care co-ordinator under CPA. If it is assessed that care cannot be delivered safely for any reason, alternative care or supervision options and appropriate referral should be considered. This should be explained to the service user and carer(s) and recorded in ICPA documentation.</p>
8 (35)	Trust	<p>CPA review upon change in legal status under the MHA The Trust should include within its ICPA Policy a requirement that upon and preferably before, any change in a patient's legal status, a CPA review meeting be held, so that legal implications for the patient and nearest relative can be fully explained and amendments to CPA arrangements made if necessary.</p>
9 (39)	Trust	<p>Review of discharge summaries</p> <ol style="list-style-type: none"> (1) The Trust should review the way in which discharge summaries are written, both when a patient leaves hospital on S17 leave, and on subsequent discharge from Section. (2) The summary should show the detailed decision as to why discharge became appropriate. It should specify the arrangements for follow up treatment and care, with particular reference to the review of clinical factors which have not been fully defined in the period of assessment and treatment, particularly any factor which may involve risk for the patient or others.

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
10 (40,107)	Trust	<p>Assessing and recording risk The Trust should review its ICPA and risk assessment policies to ensure that</p> <ol style="list-style-type: none"> (1) when risk is assessed, any risk associated with a differential diagnosis is taken fully into account (2) CPA reviews always record risk assessment, even if it is to note that there is no risk.
11 (51)	Trust and social services	<p>Home visits following missed appointments The Trust should ensure that its ICPA Policy, its Outpatient Non-Attendance and Failure of Patients to Keep to Home Visit Arrangements Policy, and its home visiting protocols for CPN's and ASW's, together state in clear terms that there must be a CPA review and risk assessment, urgently undertaken if necessary, before a home visit is made to a patient who has missed appointments, not been assessed for some time and whose mental state is unknown.</p>
12 (53)	Trust and social services	<p>Responding quickly when threats of serious violence are made The Trust and Social Services should require that any member of staff who receives direct threats of serious violence immediately report those threats to the psychiatrist responsible for the service user's care and the police, so that risk can quickly be assessed and a clear contemporary record established there and then. All CPNs and ASW's should be provided with mobile telephones.</p>
13 (57,59,65)	Trust and social services	<p>Making a commitment to carers</p> <ol style="list-style-type: none"> (1) Prioritisation: The Trust should give a commitment in public to all service users and carers that they will prioritise partnership working with them, and will make this clearly evident throughout the whole ICPA Policy. (2) Training: Trust and social care providers' staff induction programmes should always include a presentation from a carer and a family worker, in order to develop practitioners' understanding of family work and how to work collaboratively with carers. (3) Understanding confidentiality: The Trust and social services should ensure their health and social care staff undergo training to understand that: <ul style="list-style-type: none"> • they need information from carers to provide effective psychiatric care and carers have a right to provide such information. There are no issues of confidentiality involved in this communication and carers should be told this • confidentiality issues arise only when personal information about the service user's mental condition is provided to carers. Under these circumstances consent should be sought from the service user unless there is an issue of risk, when consent is not needed and carers and family should be informed. Whether consent is given or withheld should be recorded. (4) Carers and communicators: Carers should be told that they have formal status as 'carers' and that they are entitled to a Carers Assessment of their Needs. The identity of carers should be recorded on ICPA documentation and there should be agreement over who will

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
		<p>be the main communicator with the clinical team, bearing in mind that this person may not always be the main carer. Where carers are relied upon to observe the patient, describe behaviour or symptoms and express opinions upon risk, they should be provided with written contact details and all the necessary information about diagnosis and medication so that they are able to undertake this task, and it should be recorded that this has been done. Carers should be supported in their own right</p> <p>(5) History taking: Relevant family history should be investigated comprehensively and form part of each service user's record. Immediate family members should be involved in this information gathering and their contribution identified for appropriate use in treatment and care planning, including risk assessment.</p> <p>(6) Carers must be involved in care: Guidance should be issued to all staff that carers and other family members must be involved in care, treatment and risk assessment, and their views established and recorded when CPA plans are made and reviewed.</p> <p>(7) Providing public information about services: The Trust should publish an organisational chart that is kept up to date to ensure that service users and their carers know where different services are located and how they link together. This, the Patient Information Booklet, information about confidentiality, the MHA, the Trust ICPA Policy and other relevant policies should be available to the public on the Trust website in easy to read format as well as in full, with guidance on how to understand them</p> <p>(8) Supporting advocacy services: The Trust should consider how it might support advocacy services across the Trust, reporting on the options available.</p>
14 (81,83)	Trust and social services	<p>Assessing nursing and social work skills and record keeping</p> <p>(1) The Trust should audit its nursing records and managers should monitor audit findings as part of their regular performance management process</p> <p>(2) Where poor standards of nursing records are identified, the Trust and social services should provide training to improve those standards</p> <p>(3) Social work records should be similarly audited by social services staff</p> <p>(4) As part of their individual appraisal system, all professionally qualified staff should be assessed to ensure they have the appropriate skills, knowledge and competencies required to: build effective therapeutic relationships with each patient; use interviewing skills to elicit information relevant to diagnosis; obtain a comprehensive clinical and social history; and engage with the family and other carers.</p>
15 (88)	Trust and PCT's	<p>Urgent need for 'early intervention in psychosis' services</p> <p>The Trust, jointly with its commissioning colleagues, should make a public statement on the progress being made towards the establishment of Early Intervention Services throughout the Trust area. Development of these services should now be considered urgent. It should be based on the highest national standards set for such services since 1999:</p> <p>(1) The service should be publicised</p> <p>(2) its ethos should be that early intervention in psychosis is of such</p>

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
		<p>potential benefit to service users and carers that they must be entitled to early assessment, treatment, care and information</p> <p>(3) acceptance criteria should be broad, with diagnostic uncertainty being acceptable, indeed desirable until full assessment has taken place, recognising that some individuals will not go on to develop psychosis</p> <p>(4) the Trust must provide sufficient specialist staff trained in 'first episode of psychosis' approaches and 'family interventions in psychosis' to ensure that:</p> <ul style="list-style-type: none"> • service users with possible signs of an emerging psychosis are fully assessed and monitored • service users with a first episode of psychosis are followed up • assessment always includes a family history • families are routinely involved in the planning of treatment and care • information about psychosis, advocacy services and carer support is provided to families.
16 (103)	Trust	<p>Review of Community Mental Health Teams The Trust should review the composition, management and effectiveness of Community Mental Health Teams to ensure:</p> <p>(1) there is a framework for allocating and reviewing patients' care using the full range of professional resources of the team</p> <p>(2) all team members and managers have a clear understanding of their roles, duties and responsibilities in terms of management, leadership and decision making</p> <p>(3) consultant psychiatrists play a full part in hospital and community multi-disciplinary teams.</p>
17 (103,110)	Trust	<p>Specifying staff operational responsibilities for CPA The Trust should ensure that the roles and responsibilities of staff involved in the operation of CPA, (medical, nursing, therapists and operational support staff) are clearly specified, understood by them and included in performance reviews of all staff members concerned, particularly bearing in mind the past and present operational problems of CPA described in paragraphs 6.7 and 6.12 of this report.</p>
18 (110)	Trust	<p>Making a public commitment to CPA The Trust should give public commitment to CPA as the main framework for delivery of treatment and care throughout the Trust and in association with local Primary Health Care and Social Services providers</p>
19 (113)	Trust	<p>Completing integration of health and social care The Trust and South Gloucestershire Council should ensure that significant progress continues to be achieved in the operational integration of mental health and social care adult mental health services in South Gloucestershire, by implementing single management arrangements for adult mental health teams no later than 31 March 2007.</p>
20 (115)	Trust	<p>Reviewing CPA standards in the Trust The Trust should set up a comprehensive, systematic review of the way CPA is applied across services in the Trust's area. The Trust review should:</p>

Local Recommendations

Rec No. (page in report)	Organisations	Local Recommendation
		<p>(1) consider the extent to which CPA for detained patients meets the standards set out in the MHA Code of Practice guidance (referred to at paragraph 6.3 of this report) bearing in mind the areas of failure in MN's case listed (a) to (g) in this report's commentary under paragraph 6.15.7</p> <p>(2) consider the extent to which Standards Four and Five of the <i>National Service Framework for Mental Health (1999)</i> are satisfied, bearing in mind that these Standards apply equally to patients on standard and enhanced CPA, in particular that:</p> <p><i>"All mental health service users on CPA should</i></p> <ol style="list-style-type: none"> 1. <i>Receive care which optimises engagement, anticipates a crisis and reduces risk</i> 2. <i>Have a copy of a written care plan which</i> <ul style="list-style-type: none"> - <i>includes the action to be taken in a crisis by the service user, their carer and their care co-ordinator</i> - <i>advises their GP how they should respond if the service user needs additional help</i> - <i>is regularly reviewed by their care co-ordinator</i> - <i>enables access to services 24 hours a day 365 days a year....</i> <p><i>After a period of care away from home, a service user should have</i></p> <ul style="list-style-type: none"> • <i>A copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator and specifies the action to be taken in a crisis."</i>
21 (118)	Trust	<p>Ensuring that patients detained for treatment under the MHA are on enhanced CPA</p> <p>The Trust should, with immediate effect, amend its ICPA Policy to make it clear that patients who are liable to be detained for treatment under the MHA, whether or not subject to s17 leave, must always be placed on an enhanced level of CPA. The presumption should be that patients discharged from such detention and therefore subject to s17 aftercare will remain on enhanced level CPA until s17 ceases to apply. During this period any alteration in CPA level should be agreed only after a review involving the patient, carers and other agencies involved in the patient's regular support.</p>
Terms of Reference	Trust, PCT's and social services	<p>Reviewing progress on recommendations</p> <p>The Trust together with PCT's and local social services should keep under review the progress made on the recommendations contained in this Inquiry's report, the Lessons Learned and associated Recommendations of the Multi-Disciplinary Audit completed in February 2003, reporting back to this Inquiry in six months' time. In particular the following subjects should be examined:</p> <ul style="list-style-type: none"> • Out of area admissions • Non attendance for patients on CPA • Transfer of documentation (section papers and medical notes) • Changing a diagnosis in early psychosis • Discharge summaries • Co-ordinated risk assessment, risk management plans, documentation, communication and reviews. • The engagement of patients and carers.

8.12 Regional recommendation

Page	Organisation	Regional Recommendation
(118)	SHA	<p>Ensuring co-ordinated planning of CPA services and records The SHA should ensure that all PCTs commissioning services from the Trust:</p> <ol style="list-style-type: none"> <li data-bbox="576 300 1414 465">(1) Co-ordinate service specifications Co-ordinate their planning and services specifications within the requirements of national CPA guidance, so that patients moving across PCT boundaries are not put at risk of becoming lost within the network of service delivery systems in the greater Bristol area. <li data-bbox="576 472 1414 667">(2) Ensure operational systems are shared In conjunction with local Social Services require that all treatment and care plans, including those shared with primary health care providers, are based on the same operational principles and systems, particularly with regard to electronic records and documentation, so that the risks of losing essential information and divergent actions are minimised. <li data-bbox="576 674 1414 837">(3) Require the involvement of service users and carers in care planning Require care planning and delivery under CPA to involve patients and carers so that their status as participants as well as recipients is fully acknowledged.

Chapter 9

National recommendations

9.1 Why national recommendations?

9.1.1 Fifteen years after the Government introduced the Care Programme Approach we heard repeated evidence from witnesses asserting that CPA is not fully implemented either in the Avon & Wiltshire NHS Partnership Trust or nationally.

9.1.2 Does this matter? Yes it does. In MN's case we describe at paragraph 6.15 above how a functioning CPA would have provided opportunities for sharing of information, re-examination of MN's misdiagnosis and 'double-checking' of risk as the family of the victim described it to us. CPA is at the heart of mental health treatment and care.

9.1.3 For reference, key comments on CPA can be found in this report at:

- Chapter 6 which deals entirely with CPA
- Commentary to paragraph 6.15.7 which summarises the inadequacies of CPA in MN's case
- Paragraph 6.12 which describes current reported problems with CPA in the Trust
- Paragraph 6.17.2 which describes the specific concern of detained patients and CPA
- Paragraph 8.4 which refers to previous local homicide inquiries in which CPA was criticised
- Paragraph 8.6.4 which refers to suggestions for improvement made by local commissioners and providers.

9.1.4 The national concerns raised with us can be summarised briefly:

1. National CPA guidance is inconsistent as it concerns detained patients and should be amended as a matter of urgency
2. More needs to be done nationally to prioritise CPA, through making it a key performance indicator, incorporating clinical governance firmly into consultant contracts and then ensuring that clinical governance explicitly incorporates CPA practice
3. The administration of CPA requires operational support, the resources for which should be identified nationally.

9.1.5 Of course, we have needed to be careful that focusing upon national recommendations is not a diversion from local improvement. We therefore make comprehensive recommendations for local action. Almost all of our local recommendations refer to CPA.

9.1.6 But as our evidence mounted in the Inquiry process, we needed to establish whether there was indeed a wider national problem that needed to be addressed. We therefore commissioned research and organised a seminar attended by national figures, all of whom had an interest in the subject. This was not a theoretical exercise. It was intended to establish whether there was in fact any issue with CPA nationally and, if so, what recommendations for action might be needed.

9.2 National seminar on CPA

9.2.1 The Inquiry was fortunate in that the Mental Health Act Commission and the Sainsbury Centre for Mental Health were already producing a paper connected with the subject. With the support of AGW SHA, the Inquiry commissioned further work by Mark McCarthy, Professor of Public Health, University College, London and Lesley Warner of the Sainsbury Centre who were asked to respond to a series of specific questions which would assist the seminar's deliberations on CPA. This support paper for the seminar is

reproduced in full at Appendix E of this report along with a short additional paper on good practice and CPA at Appendix F.

9.2.2 Professor McCarthy presented the paper at a confidential national seminar on 12 November 2004, held specifically to examine the issues of CPA arising from this Inquiry and the two previous local homicide inquiries. Professor Kamlesh Patel OBE, Chairman, Mental Health Act Commission, was facilitator for the seminar which was entitled *'Is CPA Working? A seminar to consider the future of mental health care planning'*.

9.2.3 The Inquiry Panel attended and the following were participants:

- Lord Victor Adebowale CBE, Chairman, Turning Point
- Terry Butler CBE, Co-chair of Mental Health Committee Association of Directors of Social Services
- Angela Greatley, Chief Executive, Sainsbury Centre for Mental Health
- Christopher Heginbotham, Chief Executive, Mental Health Act Commission
- Ian Hulatt, Mental Health Advisor, Royal College of Nursing
- Detective Superintendent Mark Jackson, representing the Assistant Commissioner Specialist Crime Directorate, Metropolitan Police Service
- Professor Sir Ian Kennedy, Chair, Health Care Commission
- Professor Mark McCarthy, University College London
- Simon Lawton-Smith, Senior Fellow, Mental Health, The King's Fund
- Baroness Elaine Murphy of Aldgate, Chairman of North East London Strategic Health Authority, former UK advisor on Mental Health to the WHO
- Dr Madeline Osborne, Deputy Director, Mental Welfare Commission for Scotland
- Dame Denise Platt DBE, Chair, Commission for Social Care Inspection
- Anne Richardson, Mental Health Service, Department of Health
- Nigel Shackelford, Head of Case Working, Mental Health Unit, The Home Office
- Les Sharpe, Chair, CPA Association
- His Honour Judge Phillip Sycamore, Liaison Judge for Mental Health Review Tribunals
- Lesley Warner, Senior Researcher, Sainsbury Centre for Mental Health
- Professor Richard Williams, Chair of Welsh Division and Director of Conferences, Royal College of Psychiatrists

9.2.4 Each participant gave an undertaking that the subject matter of the seminar would remain confidential until publication and it was decided that 'Chatham House' rules would apply in that no comments would be attributed to individual participants. It was made clear that the verbatim transcription of the seminar would become part of the MN Inquiry record.

9.2.5 We summarise below the major points arising from the seminar discussion, including some unattributed quotes to provide a flavour of the conversation. This should be read alongside the following appendices of this report:

Appendix D	Inquiry Programme for the Seminar setting out questions for discussion
Appendix E	Support Paper by Professor McCarthy and Lesley Warner
Appendix F	Additional Support Paper by Professor McCarthy and Lesley Warner
Appendix G	National Seminar Recommendations

9.2.6 It should be borne in mind that when the seminar was held it had been expected that there might be a new Mental Health Bill and that this would require Mental Health Tribunals to make orders and approve care plans. As this report is written there has been no mention of care plans in the Department of Health's proposals for amendment of the 1983 MHA. However, it is anticipated that there will be compulsory treatment supervised in the community. Care planning would seem to be an essential component of this and the seminar deliberations on care plans and legislation continue to be relevant.

9.2.7 The reader should also be aware that shortly after publication of this report Strategic Health Authorities around the country will merge to form new, larger authorities covering regions. However, the views expressed at the seminar as they concern SHAs will have continued applicability under the new arrangements.

9.3 Is CPA working?

9.3.1 Professor McCarthy introduced his paper by summarising:

- There is very little evaluative or outcome-based evidence on the use and implementation of CPA, though there is quite a lot of descriptive and observational evidence. Outcome studies in the US had found that case management in community mental health services was superior to ad hoc arrangements and it had been on this basis that CPA had become a requirement in the UK.
- Such literature as there is refers to difficulty with the implementation of CPA. It is not standardised across the country and implementation is 'patchy'. Clinicians find it bureaucratic, complex and time-consuming, saying that it cuts across their own professional approach and the therapeutic relationship. It is also criticised as being overly risk-focussed, bearing in mind that those subject to enhanced CPA will be the tip of an iceberg
- There are standards set for CPA. The National Service Framework mentions CPA in four of its seven standards. The Healthcare Commission examines CPA only as one of a number of aspects of mental health care. The CPA Association provides audit tools.
- Electronic CPA forms were a requirement by 2002 according to the National Service Framework but they have not been implemented across the country. No systematic, clear method has been provided that can be implemented. Although the NHS Executive Mental Health Information Strategy is moving forward with the electronic record no single CPA electronic form has been proposed.
- Of the seventeen homicide inquiry reports examined, all mentioned the CPA, not always negatively but over all they found evidence of incomplete or ineffective implementation. The 2001 National Confidential Inquiry's review of suicides and homicides recommended a major overhaul of the operation of the CPA with the establishment of national criteria for enhanced CPA which would emphasise the importance of risk.
- Although risk assessment is part of CPA there is no nationally directed standardised form of doing risk assessment and no national standardised method of recording.

9.3.2 Risk was described as an important issue for all organisations. It has been said that reliability-seeking organisations are preoccupied with failure, learn from near misses and reward staff for reporting them. The possibility of error should always be evident in discussions and meetings.

9.3.3 Professor McCarthy concluded by asking this question. *"Is CPA at the heart of practice then? In my opinion it appears to be, from the issues that we have seen, the relationship between society, professionals and the patient. It is the framework, it is the structure and it includes risk. To improve CPA we would need full implementation, clearer criteria, evident co-ordinator, evident assessment, clear contingency planning, clear crisis planning, involving carers...full staff involvement...clear dates for further action, multidisciplinary team work, wider assessment and better recording...."*

For good practice there should be clarity of purpose, there should be prioritisation of the CPA within the culture of clinical practice and there should be...training, both in-service training for current professionals and internalised so that the CPA becomes the way of working within mental health services, and others working with mental health services should understand it. There could and should be audit, both of existing structures but also of the needs of patients that are being met by this process, and that audit in my opinion would be the mechanism of learning whether the CPA is effective or not.

So we have a question: is the CPA a performance indicator or can it be a performance indicator? Can we find out how mental health services are operating through the CPA? Can the CPA offer us both process records and individual clinical care decisions and also tell us whether the system itself is working? We do not have enough information as yet derived from the CPA to evaluate it ...we could learn from it, we need to do so...

In conclusion, the evidence suggests that the CPA is good for patients and a good system where it is implemented; the CPA appears to be the best approach that we have got; full implementation requires systems thinking; CPA monitoring and the quality spiral could enhance care if it were more effectively implemented; CPA could provide data for inquiries but a reliability culture would regard the present situation as unacceptable".

- 9.3.4 A radical approach to the discussion was decided upon. The seminar would consider whether, in its view, CPA should remain at all. If not what should be in its place? And if it should remain, how might it be improved?
- 9.3.5 The seminar's deliberations focussed upon the purpose of CPA, the need for electronic records, standards, accountability and the connection between CPA and mental health legislation.
- *The purpose of CPA:* There was consensus that CPA is more than data management. It is a practice structure and indeed over time it has become synonymous with good practice.
 - There must also be an element of public accountability. CPA is there to provide a good service to all users of secondary mental health services. Moreover, although it may not have prevention of homicide as its aim, research from around the world indicates that good CPA and good community engagement with services will prevent acts of violence and homicide. When people are engaged with services the levels of violence and aggression drop.
- 9.3.6 There was a consensus that relying on practitioners to talk to one another is not enough. A system is necessary and if it were not CPA something similar would be needed. CPA should therefore stay. But if in principle CPA is a good thing why, it was asked, is it not working? What is going wrong? What improvement is necessary?
- *CPA and information:* There is certainly a culture of opposition to CPA, with groups of professionals feeling antipathy. Part of that antipathy is due to a lack of resources and the apparently meaningless 'filling in of forms'.
 - However, it has often been found in the NHS that good quality data are kept when there is a strong use for it subsequently. CPA data may be better kept if it were regularly used for review by those operating the service. Lack of data would then immediately become evident.
 - There was agreement that the advantages of electronic storage of CPA information include:
 - (i) A reduction in administrative time because the same electronic system can be used by different professionals in different settings
 - (ii) A standardised documentary system which can provide data for regular monitoring, assessment of performance and an audit trail
 - (iii) Ensuring that as people move around their records and files follow them.
 - Available evidence suggests that at the moment there is insufficient information stored to do any of the above effectively. The London Integrated Mental Health Electronic Records (IMHER) Project on CPA Information Systems, reporting in December 2003 stated *'In several Trusts it is not possible to accurately estimate the number of service users currently subject to enhanced CPA. In some cases we found CPA cases open on which there had been no activity for over 18 months'*.

- Yet examples were given of the way that information has been efficiently gathered in other areas of health. Issues about security and data protection have been overcome and it is possible to track individuals and groups of individuals, accessing information which make it possible to get a picture of services locally and nationally.
- Why then, has this been done in areas of health care such as coronary and cancer care but not in mental health? The answer is that far more resources were put into those other information systems to collect numerical data to meet targets for national purposes. This has not been the case with mental health. As a result the information systems are not in place.
- In short there was agreement that comprehensive CPA information management was essential. However concern was expressed that the National Programme for IT Development (NPfIT), rather than progressing this, was the cause of difficulty. There was evidence that the use of electronic CPA forms had been put on hold in some places because of the implementation of NPfIT. And NPfIT had not addressed the issue of collaborative care and the need to make electronic data available across other services, citing the issue of patient confidentiality. This is a complex topic. A shared understanding is needed of what is meant by confidentiality and who should have information, including service user and carers.

9.3.7 The link was also made between information and standards. With data properly collected it should be possible for service users, the public, providers and commissioners to know what kind of service is being provided locally and how it measures against national standards:

- *CPA and standards:* The seminar considered the advantages and disadvantages of national and local standards. Local ownership was thought important but the very fact of developing an audit tool meant there would be standard requirements of people locally, against which they would have to report.
- There was agreement with the regional view expressed by one participant *"I do not think we should overlook the Strategic Health Authority's role for performance and management. We have talked about local ownership and we can be an external monitor and assessor, but if there are blockages locally it is the strategic health authority that should really be intervening in that and, certainly, the self-audit and the analysis could go to individual strategic health authorities to take action and you could call to account the strategic health authorities on the action they have taken, and we could ask local authorities to do the same"*.
- There was discussion about finding a performance indicator that identified outcomes based on quality of CPA. It was thought it would make a difference if CPA was a clinical audit as this would get it onto the agenda of clinical audit structures. Targets are needed for CPA because it is a historical reality that targets drive priorities within the NHS.
- Consensus was reached that there should be a requirement for health care bodies and social care bodies to complete an audit which the Health Care Commission and the Social Care Commission should determine and report, and that these should feed into ratings.

9.3.8 The subject of standards flowed into that of accountability:

- *CPA and accountability:* High level ownership was considered vital. At national level, responsibility for CPA rests with the Department of Health. However, there is no one individual in the Department with that responsibility, nor is there any clear understanding of how that responsibility should be carried through. The Health Care Commission and Social Care Commission could monitor CPA within a framework of national targets and standards and inform the Department of Health on achievements, but in the words of one participant *"I do not think that the responsibility and accountability for service delivery can lie with the monitors of performance"*. This was identified as a *"very key point, that there is nobody in the Chief Executive office of the NHS who has responsibility for delivering this"*.

- A recommendation should emphasise that *“it should be the people who are responsible for the strategic development of the NHS and health care system nationally who are accountable for [CPA]”*. In practical terms *“there would be real value in this group suggesting that the performance management office of the NHS Executive should have somebody within it who is responsible for delivering mental health targets”*.
- A further suggested recommendation concerned local accountability. The 1999 guidance already says that responsibility for CPA rests with Trust chief executives, who in practice appoint lead officers for CPA who may or may not report directly to the Board. Chief Executives should *“be accountable for ensuring CPA processes are properly in place and that clinical governance arrangements take into account the requirements of CPA”*.

9.3.9 One further matter occupied the minds of seminar participants. This was how CPA fitted into proposed new legislation:

- ***CPA, legislation and national guidance:*** At the time of the seminar it was expected that a new Mental Health Bill would give Tribunals order-making powers and require them to review care plans. The seminar was greatly concerned at the potential for confusion should there appear to be a Tribunal care planning system running in parallel to CPA. As a result a detailed recommendation was made from the seminar that care plans should not be separate from a proper CPA process. It was suggested that the recommendation should be raised with the Parliamentary Scrutiny Committee which was carrying out the pre-legislative scrutiny of the Bill (this was in fact done). We comment below on CPA and anticipated amendments to the MHA.
- In order to ensure that there was to be one mental health care planning system it was proposed that the Department of Health consider whether in the event of a new Bill, revision would be needed to the Code of Practice and national CPA guidance.

9.3.10 In conclusion, the seminar participants were unanimous in their support for CPA as the one national mental health care planning system. It was agreed that it would be difficult and undesirable to find any substitute for CPA.

9.3.11 However it needs to be strengthened both in terms of its potential, if properly recorded, to be a means of setting and monitoring standards of mental health care, and as a single good practice standard accepted and used across professional groups. No one means can achieve this. Professional capacity remains an issue, training is vital, ensuring that CPA is taught and assessed as part of professional education and that it is part of employment contracts. There needs to be a co-ordinated approach at every level but with clear accountability at the highest level.

9.3.12 The national recommendations arising from the seminar were later finalised in discussion with individual seminar participants and sent to the Pre-legislative Scrutiny Committee examining the Mental Health Bill and to all participants in the seminar. The recommendations, as written, are at Appendix G of this report.

9.3.13 On behalf of the family of the victim, MN's family, MN and all the professionals involved in MN's care we express our thanks and appreciation to all the participants in the seminar.

9.4 Seminar afterthoughts

9.4.1 The purpose of this seminar and its research was to establish whether problems experienced locally with CPA were indeed local or whether they were national.

9.4.2 The key issues locally were at the time of MN, and still are

- Poor compliance with CPA from overworked professionals, psychiatrists in particular
- Poor information systems with a continued reliance upon paper based communication and an absence of functioning Trustwide CPA or s117 register

- Poor administrative management of CPA at case level. We are struck by how different it could have been if a designated CPA administrator had simply arranged the hospital CPA meeting well in advance. And in Yate Team a CPA administrator or clerk responding to automatic prompts from a central register would have picked up that MN needed to have the basic components of CPA and reviews put in place.
- 9.4.3 All of the above are, of course, connected. And they are essentially operational. This is about basic management.
- 9.4.4 Are these simply local problems? The seminar and research leaves us more concerned rather than less. For the observational evidence is consistent. There is a problem with the implementation of CPA nationally. It is clear that this is not uniformly the case and that services vary around the country. Why that should be so is not known. There is very little outcome research and we recommend the Department of Health consider commissioning a national study of the effectiveness of CPA, with the purpose of indicating weaknesses and how they can be rectified.
- 9.4.5 However, the problems, where they are reported nationally, are exactly those described in this Report. Moreover they are also the same problems experienced in 1999 when the Department of Health simplified CPA in response to difficulties with compliance.
- 9.4.6 CPA continues to be beset with difficulties. And yet the seminar was clear that it was the best system we had and should be strengthened.
- 9.4.7 What are the answers? In our opinion there needs to be a recommitment by the Government to CPA nationally. There must be acceptance of responsibility within the Department of Health for delivery of CPA. There must be a clear statement that this is the one framework within which mental health care is delivered in this country. In order to strengthen that framework there should be national commitment to:
- *A national electronic mental health information system* with administrative support. This should be achieved by ensuring that the National Care Records System currently being developed is compatible with CPA, bearing in mind that mental health services rely upon sharing of information between health and social care
 - *Creation of key performance indicators* by the Health Care Commission and Social Care Commission, those key indicators to be connected with the establishment of electronic information systems for mental health, the infrastructure to support CPA, and professional training in CPA. There must be local ownership but with national oversight and financial incentives
 - *Ensuring that all patients who are detained for treatment under the MHA are on enhanced level CPA*, thus removing any ambiguity from national guidance. Whether or not detained, on s17 leave, or discharged and subject to s117 aftercare, such patients should be entitled to the standard of care expected by the MHA Code of Practice
 - *Ensuring that patients compulsory treated in the community under any amended mental health legislation are on enhanced level CPA*. Moreover any Tribunal considering such an order should be required to review, or at least consider, the CPA care plan.
- 9.4.8 We confess to a degree of impatience. After sixteen years it is shameful that this national framework which relies so heavily upon the sharing of information is not supported by any electronic information system. We should not have to hear that psychiatrists do not have the time to complete paperwork or that there are no resources for administrative support for CPA. Nor should we hear, in a mental health Trust that CPA is not a top priority. We should certainly not hear a consultant psychiatrist claim that Department of Health CPA guidance sanctioned provision of virtually no formal CPA for a detained patient living at home. And it is disheartening to hear a manager say that without Government intervention, Trusts will be in exactly the same place in two years time.
- 9.4.9 It is expected that the Government will introduce compulsory supervision of treatment in the community through amended mental health legislation. We cannot emphasise too strongly that this must be backed up by an effective framework for community care. Tribunals are likely to have their appeal function extended to include automatic referrals in a way which could amount to a review of compulsion. For those subject to compulsory supervised treatment in the community this must, in our opinion, include a

review or at least a consideration of their CPA care plans. Moreover such patients should, in our view, receive enhanced level CPA care, as we recommend for all detained patients now.

9.4.10 We recommend that the Mental Health Act Commission review the current operation of CPA care plans for detained patients, bearing in mind how important they are likely to become for patients compulsorily treated in the community as a result of any future legislation.

9.4.11 This Inquiry has been uniquely fortunate. It has been able to gather information locally and nationally, from practitioners, managers, providers, commissioners, professional organisations and those whose national concerns are research and monitoring of standards. We have heard from advice and advocacy organisations whose primary interest is in the improvement of services for all, and from those, including the Home Office, Mental Health Review Tribunal, Mental Health Act Commission and police, whose involvement is with individuals representing a greater degree of assessed risk. And of course we have heard from the service user at the centre of this Inquiry, his family and from the family of the victim who have suffered so tragically.

9.4.12 We express the strong hope that their efforts will not be wasted. Our terms of reference require us to review progress on these recommendations in six months' time.

9.5 National recommendations

9.5.1 The following national recommendations contain the recommendations arising from the seminar but with some amendment to take into account that there is not now to be a Mental Health Bill and that the recommendation concerning standards needed to be strengthened to ensure its applicability to the increasingly pluralistic landscape of service provision which includes increasing numbers of Foundation Trusts and independent service providers.

9.5.2 We also include national recommendations arising directly out of the Inquiry evidence and local consultation process. As discussed above there are significant points of commonality between the concerns and solutions raised locally and nationally and many of them are incorporated into single recommendations.

National Recommendations

	Organisations	National Recommendation
A	Health Care Commission and Commission for Social Care Inspection	<p>Standards</p> <p>(1) The Health Care Commission and Commission for Social Care Inspection should jointly review the way in which they assess the effective implementation of CPA and develop key indicators that will more effectively measure performance in this area. Key indicators should include</p> <ul style="list-style-type: none"> • Progress towards operation of electronic mental health information systems • Evidence of an administrative infrastructure to support professionals in their operation of CPA • Arrangements for training of professionals in CPA <p>(2) Quality of CPA for all psychiatric patients, whether subject to an order or not, should be a key element in the standards based system of assessment for mental health providers and therefore CPA should be at the heart of the annual health check/performance assessments for health and social care organizations.</p>
B	Secretary of State for Health	<p>Accountability</p> <p>(1) The Secretary of State should clarify where within the NHS Chief Executive's office responsibility lies for delivery of mental health services based on CPA</p>

National Recommendations

	Organisations	National Recommendation
		<p>(2) The Secretary of State should make it a clear responsibility of Strategic Health Authority Chief Executives that they ensure through performance management that provider/PCT Chief Executives are accountable for ensuring that CPA processes are properly in place across health and social care.</p> <p>(3) ensure that all registered private and voluntary health and social care providers are accountable for ensuring that CPA processes are properly in place and where applicable clinical governance arrangements take into account the requirements of CPA</p> <p>(4) The Department of Health should state firmly in 'Standards for Better Health' that CPA is an essential component of the core standards.</p>
C	Department of Health	<p>Electronic information systems for mental health services The DOH should ensure that the final specifications of the National Care Records System pay adequate attention to the requirements of mental health services and in particular that they support CPA.</p>
D	Department of Health	<p>Contracts of employment In line with CPA policy the contracts of employment for all practitioners should include the explicit requirement that practitioners working with adults of working age should use the CPA as the basis for delivering mental health treatment and care. This requirement should be reflected in practitioners' job plans and compliance should be monitored in annual appraisals, thus facilitating the identification and review of the requisite managerial, administrative infrastructure support for practitioners.</p>
E	Department of Health	<p>Confirming commitment to CPA In the light of the weight of evidence seen and heard by this Inquiry, the DOH should re-assert that CPA still constitutes the main national guidance on operational standards in mental health services for all providers and the professional staff employed by them.</p>
F	Department of Health	<p>Review and study of the effectiveness of CPA</p> <p>(1) The Department of Health should commission a comprehensive review of the Care Programme Approach to establish conclusively</p> <p>(a) that all health service commissioners have specified its standards as the basic requirement for delivery of mental health treatment and care</p> <p>(b) the extent of the adoption of CPA as the main operational tool for delivery of mental health care by all health and social services providers nationwide</p> <p>(c) that the guidance provides clear and unambiguous definitions around the eligibility criteria for CPA</p> <p>(2) The Department of Health should consider commissioning a national study of the effectiveness of CPA, with the purpose of indicating weaknesses and how they can be rectified.</p>
G	Department of Health	<p>CPA and patients detained for treatment The Department of Health should ensure that national and local operational guidance on CPA clearly states that persons who are liable to be detained for treatment under the MHA, notably those on s17 leave or receiving aftercare under s117, should always be placed on an enhanced level of CPA. Any ambiguity of advice to staff contained in local practice policies should be amended with immediate effect</p>

National Recommendations

	Organisations	National Recommendation
H	Department of Health	<p>Amended legislation and associated guidance</p> <p>(1) The Department of Health should ensure that patients subject to compulsory supervised treatment in the community under any amended mental health legislation are placed on an enhanced level of CPA, and their care plans reviewed or at least considered when any Tribunal hears an appeal or automatic referral of their continued compulsory treatment in the community</p> <p>(2) Upon any amendment of the Mental Health Act the Department of Health should consider what further national guidance is needed to ensure that the Care Programme Approach is comprehensively operated as the main framework for mental health treatment and social care provided under the NHS. All relevant primary and secondary legislation and guidance, namely statutory aftercare, requirements of clinical supervision, matters to be considered by Tribunals, national CPA guidance and MHA Code of Practice should be linked together to create one unambiguous and unified CPA care planning system.</p>
I	Mental Health Act Commission	<p>Detained patients and CPA standards</p> <p>The Mental Health Act Commission should ensure that in the current biennial review period, the standards for CPA incorporated in the MHA 1983 Code of Practice are systematically reviewed on every Commission visit, incorporated in each visit report and given appropriately full account in the Biennial Report.</p>
J	Secretary of State for Health, Department of Health, Health Care Commission, Commission for Social Care Inspection and Mental Health Act Commission	<p>Review of these recommendations</p> <p>The organisations listed in these national recommendations should review progress on them and report to this Inquiry in six months time so that the Inquiry can comply with its Terms of Reference.</p>

Chapter 10

Conclusions

10.1 Error and 'fair blame'

- 10.1.1 This Inquiry has exposed professional error. Put in its simplest terms schizophrenia was incompletely diagnosed, with the consequence that MN received no antipsychotic medication for sixteen months prior to the homicide.
- 10.1.2 Of course, no-one can be sure that if MN had been firmly diagnosed as suffering from schizophrenia he would have continued to be treated with medication right up until the homicide. Medication could have been imposed on him in hospital, but even if it had been effective there would inevitably have come a time when he was sufficiently well to return home and be discharged from section. If after that MN had refused medication, but at the same time appeared symptom-free, it may have been difficult to instigate a fresh assessment under the MHA.
- 10.1.3 These are imponderables, but they do make it clear that a diagnosis of schizophrenia could not alone have been enough to prevent the homicide. It was, however, an essential starting point. To that extent an accurate diagnosis could have reduced the risk of homicide.
- 10.1.4 MN, his family and the public properly placed their trust in psychiatrists whose task it was correctly to diagnose mental illness. However it would be a mistake to single out individuals for blame.
- 10.1.5 This Inquiry raises an issue of general applicability where professionals are relied upon for their expertise.
- Alone professionals can and do make errors
 - Preventive measures and failsafe procedures are needed to avoid professional error and detect it quickly when it occurs. These are best provided by
 - (i) operational systems which require sharing of information and decisions with other professional groups
 - (ii) empowering of users and consumers of services so that they are fully informed, involved in decision-making and aware of the standard of care they are entitled to expect
- 10.1.6 In mental health care the preventive and failsafe systems should be provided by (i) effective CPA and (ii) users and carers who are informed, involved and empowered.
- 10.1.7 This report describes not only professional error, but the failure of both of these preventive measures.
- 10.1.8 It was this multiple failure which produced the circumstances in which MN was at home unmedicated, unseen for eight months and suffering from a psychosis which by then included dangerous delusional ideas.
- 10.1.9 We have used the idea of failsafe procedures or 'barriers' to prevent harm or as the framework for our conclusions. This approach will be familiar to those who have used Root Cause Analysis. It acknowledges that error will always exist, that organisations should tackle the risk of error by building preventive structures or 'barriers' to failure into systems, and it uses the expression 'fair blame' which we find helpful. Of course, this is the world of people not machinery, and it is appropriate to add that the 'failsafe' system of CPA can be expected to reduce the risk of error, but not eliminate it entirely. It should be seen as a way of making errors safer.

- 10.1.10 Firstly we review our findings on professional practice. Secondly we describe our conclusions on the operation of CPA. Thirdly, we present our conclusions on the position of the family in the care structure. Following this we describe a spiral in which these various failures interacted with each other making it ever more difficult to escape from the misdiagnosis.
- 10.1.11 Finally, we review the implications of these failures. We refer to the need for specific improvements in psychiatric service provision, an urgent need for recommitment to a strengthened CPA locally and nationally, and a commitment to informing and empowering carers.
- 10.1.12 Before reading the conclusions below, we must urge caution. Hindsight can play tricks and produce apparent causal links which are not justified by the evidence. Moreover we also discovered good practice. We make it clear that we found no reason to question the integrity of any of the witnesses who gave evidence.

10.2 Professional practice

10.2.1 Professional judgements were, we found, exercised in the context of an admission to hospital out of area. This contributed to the poor information available, unclear clinical responsibility and poor arrangements for aftercare. Our recommendations are aimed at making out of area admission less likely and reducing the disruptive impact of them. Nevertheless each of the professionals had a responsibility to mitigate the effects of this. The following summarises our key findings:

- (1) *Information gathering by professionals was seriously inadequate.* Although they were disadvantaged by MN's out-of-area admission, neither psychiatrist took active steps to obtain sufficient information from records, other professionals and family to make, maintain and review MN's diagnosis properly. Not one of the professionals involved ensured that all the available information was gathered together in one place.
 - The medical records of one psychiatrist were never seen or sought by the other.
 - No comprehensive family history was ever taken from the family.
 - Nursing notes were largely superficial, rarely recording the presence or absence of symptoms and there was almost no mention of planned discussion with the family in either nursing or social work records.
 - A discharge summary was a year late and not requested by the community psychiatrist until then.
 - CPA documentation completed in hospital was not seen by the community team or by the social worker despite being on the file.
 - No system was put in place for the monitoring, observation and gathering of information on MN's mental health at home.
- (2) *Assessment of MN's mental condition was incomplete.* In the absence of comprehensive information, MN's mental health was not fully assessed.
- (3) *There should not have been a diagnosis of schizotypal disorder.* This was an unusual diagnosis made with insufficient information and without putting into place the monitoring required to verify it. The hospital and community consultant psychiatrists must share responsibility for this.
- (4) *The original diagnosis of psychotic disorder could and should have remained.*
If all the available information had been taken into account by both psychiatrists, it is probable the diagnosis of psychotic disorder would have been confirmed or reinstated. Psychosis, probably schizophrenia, had been the consistent view expressed in the medical recommendations for s2 and s3 MHA and in the reasons given by a MHRT not to discharge MN.
- (5) *Risk was insufficiently assessed.* Risk assessment should routinely have included an assessment of risks associated with the differential diagnosis of schizophrenia which was never completely excluded and was untreated.
- (6) *As soon as MN started to miss appointments he should have been visited at home.* Prior to the day of the homicide MN had not been seen by a professional for eight months. Arrangements should have been made for him to be visited at home by a psychiatrist, CPN or social worker as soon as it became clear that he was actively avoiding appointments.

(7) *By the day of the homicide it was probably too late to avoid the killing.* By the time he was seen by the social worker MN was in an advanced state of untreated schizophrenia with emergent florid symptoms. It would have been difficult immediately to put into place the assessment necessary to detain MN in time to prevent the killing which took place less than an hour later. However, the simple provision of a mobile telephone might have made a difference.

10.2.2 This report recognises the difficult task which confronts psychiatrists, who must often balance the interests of individuals in not being assertively treated and their right to receive more interventionist treatment against their wishes. It is hoped that this report will cause psychiatrists to pause a moment before embarking upon an unusual diagnosis and treatment. Our report recommendations for improvement of professional practice are concentrated on:

- *Diagnosis.* An unusual diagnosis should be used only when the evidence supporting it is strong and convincing. It should be remembered that diagnostic uncertainty is better than incorrect diagnosis
- *Risk assessment.* Where there is a differential diagnosis, risks associated with the untreated diagnosis should be regularly reviewed
- *Early intervention in psychosis.* In its early stages psychosis may be difficult to detect, especially in young people. At the same time the benefits of early intervention in schizophrenia are undoubted. High priority should be given to the establishment of services within the Trust which focus specifically on early intervention in psychosis.

10.3 CPA

10.3.1 The Care Programme Approach national care planning framework, usually referred to as CPA, is at the heart of mental health care in England and Wales. It provides the means to ensure that professionals do not make decisions alone. We repeat the words of the family of the victim that decisions about risk should not be made by professionals in isolation, but always 'double-checked'. CPA has the potential to operate as a failsafe procedure. Its failure to do so in this case had a direct impact upon MN's care.

10.3.2 CPA can be seen as both an operational framework and as a practice standard for care planning. This is a somewhat artificial divide since they are clearly linked: the structure is needed to meet the standards. But responsibility for the operational framework rests with those managers whose task it is to implement the national framework of CPA. Responsibility for adhering to the local and national practice standards of CPA rests with the practitioners who must operate it at a day-to-day level.

10.3.3 We summarise the Inquiry's key findings separately under the headings of the operation of CPA and the practice standards of CPA.

10.3.4 *The operation of CPA:*

- (1) There was no Trust-wide CPA system during the whole of the period MN was receiving care.
- (2) Separate CPA systems operated side by side within the same Trust each having been inherited from predecessor Trusts and there was no operational means of connecting them.
- (3) There was no functioning Trustwide CPA register, electronic or otherwise.
- (4) MN was admitted out of area to one CPA system and sent home to another CPA system. Neither provided the framework for his care.
- (5) The operation of CPA should include social services but
 - Social services operated a separate care planning system entirely.
 - Health and social care services were located in separate buildings with separate records.
- (6) There were differences of opinion within the community mental health team over responsibility for completion of CPA documentation
- (7) The community consultant psychiatrist did not adhere to the requirement of the local CPA system that he complete CPA documentation for patients on Standard Level CPA. The Trust did not or could not enforce the local system. National policy did not assist the locality or the Trust because it

set lower standards than the local system, permitting psychiatrists' clinic letters to stand in place of formal CPA paperwork for patients on Standard CPA.

- (8) There is no national guidance which requires that patients detained for treatment under the MHA be placed on Enhanced Level CPA and the community psychiatrist considered it was satisfactory to place MN on Standard Level CPA. Together with national recording standards, this permitted the community psychiatrist to claim that compliance with CPA could be satisfied by such minimal use of procedures that it was virtually non-existent. We do not believe this could have been the intention of the Department of Health and we recommend that the position is clarified nationally.
- (9) We conclude that the structure within which MN's CPA care planning took place was so seriously fragmented that this had a direct and detrimental impact upon MN's care.

10.3.5 *The application of CPA as a practice standard:*

- (1) Only one CPA meeting was ever held. This was in hospital where the only CPA documentation was completed and the only structured risk assessment undertaken. To his credit the hospital psychiatrist placed MN on the highest level of CPA and believed he had arranged for a CPN to be a care co-ordinator to monitor MN at home in the expectation that MN might need to be readmitted to hospital for medication.
- (2) However none of this had been planned in advance, the risk assessment was out-of-date, the issue of diagnosis and treatment was not discussed and MN's social care needs were not fully assessed. The hospital psychiatrist's practice met none of the standards set out in the Code of Practice guidance for detained patients, in that
 - CPA planning for home leave and discharge did not begin on admission.
 - The CPA meeting did not decide upon a treatment plan including long-term and short term goals
 - Health and social care needs were not fully assessed and addressed in the care plan
 - Aftercare needs were not decided in agreement with authorities and agencies in the area in which MN was to live
 - A proper assessment of risk to himself or other people was not undertaken
 - No contingency plan for relapse was included in the care plan.
- (3) When MN returned home the CPA documentation, although sent to the community was unseen by the team. There was then open disagreement between the two psychiatrists over diagnosis and the suggested CPA arrangements were ignored. No care coordinator was appointed and no CPA reviews took place. The community psychiatrist's practice failed to conform to the Code of Practice guidance in that
 - No care co-ordinator was appointed to keep in close touch with MN and monitor his care.
 - The social worker, as a key person in MN's care, was not named in the care plan.
 - There was no review of the CPA care plan
- (4) MN was detained under s2 and then liable to detention under s3 MHA, for a total period of five months following which he was subject to s117 aftercare under the MHA. Yet there was almost no adherence to the MHA Code of Practice guidance on CPA for detained patients by either consultant psychiatrist. As far as CPA was concerned, MN's status as a detained patient was largely irrelevant.

10.3.6 CPA could have provided a simple but effective framework for MN's care and treatment. It failed to do so. We find that this had a direct effect on the course of events.

10.3.7 *Missed opportunities:*

There were five occasions when adherence to CPA procedures and practice standards could have resulted in a revision of the diagnosis and treatment. Each of these represented a missed opportunity to retrieve a situation which, apart from the adoption of an uncommonly used diagnosis, was not unusual in terms of clinical presentation.

- *In hospital.* If the community psychiatrist had been invited to attend at a planned CPA meeting in hospital, diagnosis and treatment could have been discussed and appointment of a CPN as care co-ordinator agreed in advance of s17 leave. One of the major problems caused by events as they unfolded was that complex diagnostic issues, which were absolutely fundamental to MN's treatment, were being addressed when MN had already gone home and no-one other than the family was available to observe him.
- *Upon return home.* A CPA review should have taken place as soon as it became apparent that there was disagreement over diagnosis and that there was to be no CPN to act as care co-ordinator as envisaged in hospital. The diagnosis of schizotypal disorder and MN's unwillingness to co-operate contributed to the community psychiatrist's decision not use any formal CPA.
- *Upon discharge from s3 MHA.* This changed the legal basis of involvement and a review should have been held.
- *Prior to reducing the frequency of outpatient appointments.* This represented a change of plan which the community team CPNs said would have resisted had they known.
- *When appointments were missed.* A CPA review should have been called immediately MN was actively avoiding appointments. The family should have been invited, risk assessment should have taken into account the possibility that MN was suffering from untreated schizophrenia, and options for action could have included referral to the Assertive Outreach Team, a CPN visit or psychiatric assessment at home.

10.3.8 We conclude that CPA as a failsafe system failed to function. In its absence clinicians operated according to a 'default position' of individual working which in this case also failed.

10.3.9 This inquiry makes comprehensive Local Recommendations intended to improve the functioning of CPA, bearing in mind that this is third local homicide in five years which has expressed concern on the subject.

10.4 The voice of the family

10.4.1 One further check against professional failure existed and that was the family. Provided with information about diagnosis and treatment, a family or carer can become a partner in the clinical team. Armed with knowledge of the standards reasonably to be expected from professionals and the CPA, families have the potential to act as external checks on services being received.

10.4.2 The family of MN were right to complain that there had been insufficient care planning before MN went home and right to complain that they had not been informed about his diagnosis or the significance of recurring symptoms. The family were dependent on professional expertise and they were let down.

10.4.3 We are in no doubt that MN's relatives did everything possible to obtain help for him. At the outset they did the most any family could do, by contacting their GP who arranged admission to hospital under s2 MHA. Between them at different times the family spoke to ward nursing staff, made telephone calls to Dr M, Dr J, social services, and Rethink. They wrote letters, attended meetings, complained they had been given too little information, crept into MN's bedroom and secretly photocopied his diary as evidence of his bizarre writings and took him to outpatient appointments. In hospital they were so attentive to MN that a member of the family visited almost daily and brought home-cooked food in for him. This was a family who cared and wished to be involved.

10.4.4 However, they were saddled with the worst possible combination of responsibility for reporting on MN's mental health without the information to undertake the task. This was especially so bearing in mind that the diagnosis was unusual and required an in-depth understanding of distinctions between, for example, 'magical thinking' and delusions. It was already a matter of disagreement between the two consultants. It could not be expected that the family would be able to report on such complex symptoms. Too much was asked of them.

10.4.5 We uncovered much in the family evidence which, whilst retrospective, indicates how far removed professionals were from understanding life within the MN family home, let alone inside MN's mind. This, we conclude, was how misdiagnosis manifested itself. Things did not fit because the right questions were not asked. Incorrect assumptions were made. Revisiting the history with the advantage of hindsight, misinterpretation by professionals was pervasive.

10.4.6 The powerful message throughout is that things should not have been taken at face value:

- *Quiet and isolative.* MN was reportedly quiet and isolative in hospital, but he had been quiet and isolative at home too, for over a year. It did not mean he was not mentally ill. If nurses and psychiatrists had challenged MN on his delusions it is likely they would have found the disturbed young man who was still talking and laughing to himself regularly when out with his family. If they had inquired even further, for example into why he had spent ten minutes talking animatedly to a window, it is likely they would have established the continued existence of hallucinations or delusional thinking
- *'Normal'.* MN's family sometimes referred to MN as 'just the same', 'normal' or even slightly improved, but if they been asked to explain they could have described, as they did to us, that they meant MN was the same disturbed young man he had been before admission, with all his delusions, though he might sometimes have been happier or more settled
- *Schizotypal disorder.* The hospital consultant psychiatrist, finding MN quiet, isolative and 'just the same' came to the view that he was suffering from schizotypal disorder, but had he discussed diagnosis with the relatives and taken a full family history, the family would have been able to describe a clear change in personality going back several years and accounts of elaborate delusional ideas along with evidence of hallucinations, all indicating the presence of a psychotic disorder.
- *Co-operative.* Once at home MN was described as co-operative, but this was not surprising since he had himself set the limits of the professional intervention he would be prepared to accept, these being help with employment and training. Had he been regularly probed for psychotic symptoms, had he been asked to take medication, he might have been less cooperative but he was not challenged in this way.
- *No psychotic symptoms.* MN seemed not to be showing psychotic symptoms in OPA's but had he been assessed at home as he was for s2 MHA he might have been less able to conceal his symptoms.
- *Silence from the family.* It might have seemed to professionals that the family's silence and lack of further referral indicated MN was, if not well, at least not unwell. But it was a mistake to reach that conclusion. Having already once alerted the GP, resulting in a MHA admission and a return home unmedicated on the basis that he was not mentally ill, the family had every reason to believe they simply had to accept MN as he was. There would have been no point referring the same things again. And there was no explanation of the symptoms they should be looking for.
- *No apparent risk.* MN seemed not to represent a continuing risk to anyone, but the memory of his assessed risk on admission, linked with his possession of knives, seemed to fade with the change in diagnosis and no further risk assessment considered the possibility that he might in fact be suffering from untreated schizophrenia.
- *Unusual.* And finally but most crucially, it seemed to professionals that MN was just an unusual, sometimes angry, young man with bizarre ideas, whereas in fact he was suffering from the schizophrenia which had led his family quite appropriately to initiate his admission under section to hospital.

10.4.7 Like many other such investigations, including two other local homicide inquiry reports, we conclude that there was a failure to listen to the relatives. Listening in this case meant active listening, trained listening, enquiring. The family were simply not asked and therefore did not tell.

10.4.8 We recommend that the Trust make a commitment to carers and address the many issues connected with provision of information, in particular clarifying the matter of confidentiality for the benefit of professionals, service users and carers.

10.5 A spiral

- 10.5.1 One of the important lessons to be learnt from this Inquiry is that in the early stages of psychotic illness the process of assessment may take a long time. During this period diagnostic uncertainty should be acceptable.
- 10.5.2 Problems in the case of MN did not arise because the diagnosis was uncertain but because it was incorrect. Uncertainty produces open mindedness. This diagnosis of schizotypal disorder closed down options.
- 10.5.3 We conclude that the diagnosis of schizotypal disorder itself interfered with the care and treatment of MN. It meant he was not challenged to take medication and was permitted to remain withdrawn in his bedroom both in hospital and at home. It also meant no care co-ordinator was appointed to monitor him and therefore no symptoms were seen. This in turn seemed to confirm the diagnosis and he was permitted to continue untreated and withdrawn in what became a spiral.
- 10.5.4 The situation should not have arisen. Having arisen, CPA reviews should have been held, providing a means by which the diagnosis could be revisited and the downward spiral broken.
- 10.5.5 Finally, if the family had been fully informed about diagnosis and CPA standards they may have been able confidently to become partners with the clinical team in the care of MN. Failing that they might have felt empowered to complain yet more loudly if it was clear that professional expertise was failing both MN and themselves.

10.6 Final comments

- 10.6.1 This homicide was not, we conclude, predictable or foreseeable. This was explained at the outset in our introduction at Chapter 1. However, we do conclude that it may have been preventable by an improved standard of mental health service to MN.
- 10.6.2 Our Root Cause Analysis of the eight months prior to the homicide reveals that the fundamental or root causes of MN remaining at home suffering from undiagnosed and untreated schizophrenia were that he had not had a psychiatric assessment in those eight months, neither the family nor the social worker knew what symptoms to look for and the psychiatrist had not received or obtained sufficient information from the records to make a correct diagnosis. Communication and information through CPA could have been the means by which the diagnosis was re-examined, thus providing a 'barrier' to professional failure.
- 10.6.2 Responsibility for the poor service MN received must be shared between the consultant psychiatrists who were responsible for diagnosis, the managers at every level who were responsible for the implementation and operation of CPA, and all the professionals who together and individually should have ensured that local and national guidance on CPA standards of care planning were met.
- 10.6.3 There is one further problem to be considered. To be effective, preventive, 'barrier' or failsafe systems need to be capable of (i) detecting error, (ii) dealing with the error, and (iii) continuing to operate despite error. They need a means of operation which is independent of its participants. However:
- CPA was under the control of the consultant psychiatrists who could decide when and how it would be used, and who chose largely to ignore it.
 - Psychiatrists were the guardians of information and did not provide the carers with the information they would have needed in order to know whether MN was receiving an adequate service.
- 10.6.4 Effectively, the psychiatrists were their own arbiters of good practice. This was and is not satisfactory.
- 10.6.5 In addition to the professional responsibility of the psychiatrist to share information, it is important that the Trust takes responsibility for providing information to users and carers so that they know what standard of service they should expect. We recommend that the Trust website includes the CPA policy

and information about the MHA, diagnosis and medication and that funding to support local advocacy groups is considered. We also recommend that the roles and responsibilities of staff for CPA are reviewed carefully by the Trust to ensure that CPA cannot be undermined by uncooperative professionals.

- 10.6.6 Advised by leading figures in the field of mental health, and having consulted with commissioners and providers locally, we make wide-ranging national recommendations directed towards strengthening CPA at all levels. These include embedding CPA into employment contracts and professional structures and setting standards through making implementation of CPA a key performance indicator. The national care records system currently being developed should provide the means for CPA to be operated electronically with information shared between relevant organisations, taking into account confidentiality.
- 10.6.7 CPA remains at the heart of mental health care. If the reader should find that this report has focussed upon risk, well perhaps that is inevitable in such a report. However, we emphasise that CPA is applicable to all those within secondary mental health services and improving it should raise standards for all.
- 10.6.8 Where risk is concerned it may be assumed that the MHA can be relied upon as a safeguard. However, in MN's case it was not sufficient. Even though MN was subject to s3 and on s17 leave this did not ensure he received care according to the basic standards of CPA set out locally and nationally.
- 10.6.9 If future mental health legislation is to incorporate within it a provision for compulsory supervised treatment in the community, it will become essential that CPA can be relied upon to provide a safe framework for care. CPA should have a preventive function on a large scale as well as for the individual.
- 10.6.10 The last word must go to the victim's family who asked us to make recommendations for mental health services the public can trust. We return to the subject of failure and repeat the comment made by Professor McCarthy at the national seminar held by this Inquiry, that *"reliability-seeking organisations are preoccupied with failure, learn from near misses and reward staff for reporting them. The possibility of error should always be evident in discussions and meetings"*. Raising standards of care for all but at the same time planning for the possibility of professional failure, building in systems to prevent and detect it offers the best chance of a mental health service the public can trust.

APPENDIX A

Terms of Reference

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MN

Terms of Reference

1. Purpose of the Inquiry
 - 1.1 Through a retrospective review of the care and treatment of Matthew Newland prior to the homicide of Mrs Adelaide Howard on 27 March 2002 to identify what happened, how and why.
 - 1.2 Through a review of service development since the homicide to see whether lessons have been learned and to identify what still needs to be done to minimise any future risk of homicide.
 - 1.3 To make any recommendations for improvement.
 - 1.4 To publish a report of the Inquiry's findings and recommendations as required by NHS Circular HSG(94)27.
 - 1.5 To advise the Health Authority on production of an action plan.
 - 1.6 To review that action plan.
2. Methodology
 - 2.2 The inquiry Panel will investigate the root causes of the homicide within the organisations responsible for the care and treatment of Matthew Newland by
 - a) Establishing a timeline of events relating to the care and treatment received by Matthew Newland
 - b) Reviewing the extent to which that care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health
 - c) Examining the professional judgments involved
 - d) Hearing from the families and other carers of the victim and of Matthew Newland
 - e) Reviewing the local structures and processes in place for managing clinical risk, including
 - Risk assessment of patients who are not compliant with treatment and disengage from psychiatric care
 - Risk assessment of patients during leave from psychiatric hospital under s17 MHA 1983
 - Involvement of family and carers in risk assessment
 - Recording of information concerning risk assessment and sharing of risk management information between professionals
 - Adherence to Care Programme Approach procedures concerning the completion and circulation of documentation, allocation of the role of care co-ordinator and multi-disciplinary care planning during leave from hospital under s17 MHA 1983
 - Adherence to procedures for aftercare planning under s117 MHA 1983
 - Progress towards integrated case records
 - Safety of staff undertaking home visits and guidelines on action to be taken where staff consider that there may be an immediate risk of violence to themselves and/or other people

- 2.3 The Inquiry Panel will review what lessons have been learned since the homicide and consider any recommendations need to further improve service delivery by
- a) Receiving documentary evidence of relevant policies and procedures
 - b) Taking into account the findings of the internal review of this homicide, any other relevant published homicide inquiries carried out by the commissioning body or predecessor bodies and any other relevant publishing guidance, reports, research or sources of expertise
 - c) Consulting with such staff, professionals, interested organisations, families and carers of the victim and of Matthew Newland as it considers necessary, individually and/or in groups
- 2.4 The Inquiry will examine whatever documentation it considers is necessary and request evidence from whomever it considers appropriate in order properly to carry out its investigations.
- 2.5 The Inquiry will produce a written procedure outlining what can be expected of the process by those who will give evidence or otherwise be involved in the inquiry process.
- 2.6 The Inquiry Panel will produce a report which will include the findings and recommendations of the Inquiry, and produce an executive summary of the report if asked to do so.
- 2.7 The Strategic Health Authority will consult with the Inquiry Panel in order to produce an action plan based on the recommendations.
- 2.8 The Strategic Health Authority will publish the Inquiry report and at the same time make the action plan public.
- 2.9 The Inquiry Panel will conduct a review of progress against an agreed action plan six months after publication of the report.
3. **Ethos of the Inquiry**
- 3.1 To carry out only such investigation of the evidence as is necessary for the purpose of the Inquiry.
 - 3.2 To make any findings on individual professional practice fairly and sensitively and without pressure of time.
 - 3.3 To give appropriate time and attention to the needs of the victim's family and carers, including agreeing appropriate communication arrangements with the families involved.
 - 3.4 To respect the confidentiality of the patient's family, carers and all other persons affected by the Inquiry.

GCD/10.12.03

APPENDIX B

Procedure for the Inquiry

PROCEDURE TO BE ADOPTED BY THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MN

1. The following describes the procedure which the Inquiry will follow in order to obtain evidence, investigate the root causes of the homicide and produce its Report. This procedure should be read with the Terms of Reference for the Inquiry.
2. Following a review of the documentation, the Inquiry will consider which individuals should be invited to give evidence on the facts.
3. Each individual identified by the Inquiry will receive a letter which will
 - inform them of the terms of reference and the procedure to be adopted by the Inquiry;
 - invite them to provide a written statement on identified issues;
 - explain that, after receiving their statement, the Inquiry will decide whether they should also be invited to attend the Inquiry to give oral evidence;
 - inform them that if or when they attend the Inquiry they may bring with them a friend, relative, member of a trade union, lawyer, member of a defence organisation, advocate or anyone else they may wish to accompany them, with the exception of any other individual also giving evidence to the Inquiry;
 - inform them that it is they who will be asked questions and be expected to answer;
 - inform them that their evidence will be recorded, and a verbatim transcript sent to them for their signature confirming its accuracy.
4. Any points of potential criticism will be put, either orally when an individual gives evidence or in writing at a later time, and they will be given a full opportunity to respond before the Report is written.
5. Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances.
6. Anyone else who feels they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider.
7. All sittings of the Inquiry will be held in private.
8. The evidence which is submitted to the Inquiry, whether orally or in writing, will remain confidential to the Inquiry, save as disclosed within the body of the Inquiry's final Report and executive summary.
9. Findings of fact will be made on the basis of evidence received by the Inquiry. Comments on the facts which appear within the narrative of the Report will be based on those findings.
10. The Inquiry Panel will base its analysis of the root causes of the homicide on the findings of fact and it will consult further with any individuals it considers are relevant to its decision-making. The consultation may be individually or in groups.
11. Conclusions as to root cause will be shared in writing with those individuals consulted and those affected by them and an opportunity provided for response in writing or orally.

12. Any recommendations contained in the report will be based upon the findings of fact and the analysis of root cause.
13. The findings and recommendations of the Inquiry will be contained in a final Report which will be presented to Avon, Gloucestershire and Wiltshire Strategic Health Authority, which will make arrangements for publication.

APPENDIX C

List of Witnesses

Families and friends

JA, daughter of victim, Mrs AH
DH, son of victim, Mrs AH
JH, husband of victim, Mrs AH
JH, daughter-in-law of victim, Mrs AH
SW, daughter of victim, Mrs AH
SB, aunt of MN
DC, aunt of MN
DCr, aunt of MN
RCr, grandmother of MN
SL, member of MN family
JN, brother of MN
LN, mother of MN
MN
PN, father of MN
VN, sister of MN
JO, friend of MN's mother
CP, friend of MN's family
CB, unconnected with either family

Professional

(Position at the time of giving evidence unless otherwise stated. Witnesses whose names have subsequently changed through marriage are referred to as they were known during contact with MN)

FA, Director of Corporate Planning and Partnerships, South Gloucestershire Primary Care Trust
AB, Advice Worker, Rethink
JB, South Gloucestershire Social Services
KB, Service Manager, South Gloucestershire Social Services
Dr B, General Practitioner, Yate Health Centre
Dr C, Senior House Officer, Hillview Lodge (*MN inpatient period*)
TC, Staff Nurse, Balmoral Ward, Hillview Lodge (*MN inpatient period*)
DC, Assistant Director of Social Services (Community Care), South Gloucestershire Social Services
LD, Ward Manager, Caernarfon Ward, Hillview Lodge (*MN inpatient period*)
MF, MARACIS Manager, Avon and Wiltshire Mental Health Partnership NHS Trust
NG, IM&T department, Avon and Wiltshire Mental Health Partnership NHS Trust
DH, Locality Manager, Avon and Wiltshire Mental Health Partnership NHS Trust
SH, Locality Manager, Avon and Wiltshire Mental Health Partnership NHS Trust
PH, Community Psychiatric Nurse, Avon and Wiltshire Mental Health Partnership NHS Trust (*At time of MN first contact with the Trust*)
TH, Advocacy Services Co-ordinator, MIND
AE, Head of Information Management and Technology, Avon and Wiltshire Mental Health Partnership NHS Trust
FI, Avon Director, Avon and Wiltshire Mental Health Partnership NHS Trust
Dr J, Consultant Psychiatrist, Avon and Wiltshire Mental Health Partnership NHS Trust (*Throughout MN contact with the Trust*)
Dr B J, Director of Psychology, Avon and Wiltshire Mental Health Partnership NHS Trust
DL, Assertive Outreach Team, Avon and Wiltshire Mental Health Partnership NHS Trust
KL, Nursing Assistant, Hillview Lodge (*MN inpatient period*)

JL, Team Manager, Avon and Wiltshire Mental Health Partnership NHS Trust
SL, Yate Community Mental Health Team Locality Co-ordinator
TM, Staff Nurse, Balmoral Ward, Hillview Lodge (*MN inpatient period*)
LMcC, Social Worker, South Gloucestershire Social services
BMcD, Locality Manager, Avon and Wiltshire Mental Health Partnership NHS Trust (*At time of homicide*)
IMcI, CPA Lead for South Gloucestershire, Avon and Wiltshire Mental Health Partnership NHS Trust
PMcK, Director of Nursing, Avon and Wiltshire Mental Health Partnership NHS Trust
JM, Team Manager, South Gloucestershire Social Services
Dr M, Consultant Psychiatrist, Avon and Wiltshire Mental Health Partnership NHS Trust (*Throughout MN contact with the Trust*)
PM, Director of Social Services, South Gloucestershire Social Services
Dr O, Locum Consultant Psychiatrist, Avon and Wiltshire Mental Health Partnership NHS Trust (*At date of MN's arrest*)
Dr O'C, Medical Director and Consultant Psychiatrist, Avon and Wiltshire Mental Health Partnership NHS Trust
RP, Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust
Dr T, Consultant Forensic Psychiatrist, Avon and Wiltshire Mental Health Partnership NHS Trust
Dr V, Consultant Psychiatrist and Deputy Medical Director, Avon and Wiltshire Mental Health Partnership NHS Trust
RW, Head of Social Work, Avon and Wiltshire Mental Health Partnership NHS Trust
DW, Charge Nurse, Balmoral Ward, Hillview Lodge (*MN inpatient period*)

APPENDIX D

Programme for Inquiry Seminar

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MN

Is CPA working? A confidential seminar to consider the future of mental health care planning

12 November 2004, Parliament Chamber, Middle Temple, 10.00am to 4.00pm

Background

CPA (Care Programme Approach) has been the mental health care planning structure in England and Wales since 1991. It is incorporated into the Mental Health Act Code of Practice and has been the subject of a number of Department of Health Circulars and Guidance.

This confidential seminar is arranged by an independent inquiry into the care and treatment of a man who committed a homicide whilst receiving care within a large mental health Trust in England. Avon, Gloucestershire and Wiltshire Strategic Health Authority are the commissioners of the Inquiry. They support this seminar and have agreed to fund the cost of research associated with it.

The effectiveness of mental health care planning is questioned in this and two previous homicide Inquiries commissioned by the same SHA

- Two out of the three homicides were committed by young men who had disengaged from treatment and care over a long period. There was an absence of contingency planning, they were not on the CPA register and therefore had no CPA review
- Prior to all three homicides members of the family had expressed dissatisfaction at being excluded from care planning. Two of those family members were killed

Several major concerns emanate from these Inquiries

- fragmentation of mental health care brought about by complex organizational structures seems to make it difficult to create and sustain a working CPA system
- psychiatrists, social workers and nurses have different professional accountability structures and this may produce variable commitment to CPA
- Adherence to CPA does not appear to be enforceable
- failures in the operation of CPA may put users, carers and staff at risk
- evidence suggests that failures in the functioning of CPA are widespread nationally

Purpose

The Inquiry wishes to be advised by the Seminar whether there are national recommendations it should make directed towards improvement of mental health care planning.

To this end the purpose of the Seminar is to examine

- whether CPA is, nationally, meeting the standards set by the Department of Health in Circulars, other Ministerial Guidance and the Code of Practice
- what factors may impede the effective operation of CPA

- whether CPA is capable of providing effective Mental Health Tribunal care planning in the terms envisaged by proposed new legislation

The seminar will be asked to propose national recommendations for improvement.

Research for the Seminar

In order properly to inform the Seminar discussion, research has been commissioned by the Inquiry. This is being undertaken by Mark McCarthy, Professor of Public Health, University College, London jointly with the Sainsbury Centre for Mental Health. The researchers will review the history of CPA and all relevant literature and research on the subject, addressing the following questions.

1. Does the literature and research on CPA produce any consensus view on the question 'what is CPA?' Are any specific therapeutic or preventative claims made for CPA?
2. Measured against the Code of Practice and DoH circulars and other guidance is CPA meeting the standards set for
 - Completed CPA care plans at the point of extended s17 leave, discharge from hospital and discharge from detention under the MHA
 - Contingency planning for future non-compliance with treatment
 - Review of care plans
 - Risk assessment, review and management
 - Involvement of users and carers in CPA care planning and review
3. What data on CPA is collected within the NHS nationally? What information does it provide on standards and application of CPA?
4. Do homicide and suicide inquiry reports tell us anything about adherence to CPA?
5. Is there any statistical information available from Mental Health Review Tribunal decisions concerning CPA/aftercare and the reason for adjournment/decision to discharge or not discharge?
6. Does the research indicate whether professionals work together effectively in the operation of CPA?
7. Drawing upon research, literature and information from representative organisations, what is the extent of user and carer satisfaction with CPA?
8. Is CPA inclusive? Does it operate equally well for patients living at home, those admitted informally to hospital, those detained under the MHA, those on s17 leave and those discharged home?

The results of this research will be gathered into a brief paper and presented by the researchers at the start of the Seminar.

Seminar questions

Is CPA working?

During the morning the seminar will be invited to consider the question; is CPA working? In so doing it will be asked to consider the following points.

1. Based upon the commissioned research, in what ways does CPA work well and in what areas is it weak? Is the present position acceptable?

2. Is CPA optional?

- CPA came into being after the MHA 1983. It therefore has no statutory force
- Reference is made to CPA in the Code of Practice and in a number of Department of Health Circulars and Guidance. Is that sufficient to make adherence to it mandatory?
- MHRT's are required to consider aftercare arrangements. Aftercare is included in the MHA 1983 at s117. But there is no requirement to take account of CPA planning. Does that matter?

3. What impact does professional accountability have on the operation of CPA?

- Psychiatrists have responsibility for medical treatment, produce their own medical assessments and hospital discharge summaries
- Nurses produce nursing care plans and their own nursing risk assessments
- Social Workers authorised under the MHA complete their own assessment documentation
- Contractual employment arrangements are different for each professional group.

4. Do other legislative requirements compete with or complement CPA?

- Completion of documentation for assessment under the MHA
- Authorisation of s17 leave
- S117 aftercare assessment
- Carers' needs assessment
- MHRT medical, nursing and social circumstances reports

5. Does successful CPA require a shared information system?

- Across organisations? If so which organisations?
- How much sharing of information is acceptable given confidentiality, consent and human rights?

6. Is the organisation of CPA helped or hindered by

- The joint and several responsibilities of Trusts, PCT's, Localities and SSD's for commissioning and providing mental health services
- Integration between social services and Trusts

7. Under new legislation will Mental Health Tribunal care plans be CPA plans?

What needs to be done?

The Seminar is asked to propose national recommendations for improvement which the Inquiry can include in its published Report.

National recommendations will address the following points of relevance to the Inquiry, to local commissioners and providers of services, and to users and carers

- How to set measurable national standards for care planning
- How to ensure that professional practice conforms to those standards
- How to audit care planning nationally
- How to ensure compliance with care planning within a new legislative framework.

APPENDIX E

Support Paper for Inquiry Seminar



Support Paper for the Seminar on the CPA
being held in the Parliament Chamber, Middle Temple
on 12 November 2004

by

Lesley Warner, Senior Researcher
The Sainsbury Centre for Mental Health

and

Mark McCarthy, Professor of Public Health
University College London

1. Does the literature and research on the CPA produce any consensus view on the question 'what is the CPA?' Are any specific therapeutic or preventative claims made for the CPA?

The Care Programme Approach for people with a mental illness referred to specialist mental health services (CPA) was introduced in 1990 as the framework for the care for people with mental health needs⁵⁶. The key elements were the systematic assessment of individuals' health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the service user's changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users and their carers.

In 1999, the Government's commitment to the CPA as the framework for care co-ordination was confirmed. The CPA was revised and integrated with Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the framework for assessment, care planning and review of care by health and social care staff in all settings⁵⁷. It does not only apply to those in hospital, or just to detained patients, but also applies to informal inpatients and to those in community settings. The booklet dealt with: achieving integration of the CPA and Care Management; achieving consistency in implementation of the CPA nationally; achieving a more streamlined process to reduce the burden of bureaucracy; and achieving a proper focus on the needs of service users. Two tiers of CPA were established nationally, standard and enhanced, and key workers were replaced by care co-ordinators. Standard CPA is described as being for those people whose needs can be met by one agency or professional or who need only low key support from more than one agency or professional, who are more able to self-manage their mental health problem, who pose little danger to self or others, and who are more likely to maintain contact with services. People on the enhanced CPA level are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services.

As the framework for the delivery of care, the CPA itself is not designed to be therapeutic, although the interventions delivered as part of the CPA Care Plan would have that aim.

The CPA has its origins in case management, which was introduced in North American mental health services in the 1970s as a way of ensuring that services were provided in a co-ordinated, effective and efficient way⁵⁸. Research into case management in the US and UK has demonstrated that it is effective in terms of maintaining contact with people who have serious mental health problems and ensuring they receive the health and social care they need^{59, 60}.

Views of professional groups

In 1991 the Royal College of Psychiatrists (RCP) published a guide to good practice in the aftercare of potentially violent or vulnerable patients discharged from in-patient psychiatric treatment⁶¹. This group broadly coincides with those who are subject to enhanced CPA, and the guide contains all the elements of the CPA, including - involving the patient and their carers; carefully organised aftercare; close multidisciplinary working co-ordinated by a key worker; an aftercare plan based on assessed needs,

⁵⁶ Department of Health. (1990) Caring for People. The Care Programme Approach for people with a mental illness referred to specialist mental health services. Joint Health/Social Services Circular. C(90)23/LASSL(90)11.

⁵⁷ NHS Executive & Social Services Inspectorate. (1999) Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach. A Policy Booklet. NHSE and SSI.

⁵⁸ Stein L and Test M. (1980) Alternative to mental hospital treatment 1. Conceptual model, treatment program and clinical evaluation. Archives of General Psychiatry; 37, 392-397.

⁵⁹ Ford R, Beadsmoore A, Norton P, Cooke A and Repper J. (1993) Developing Case Management for the long term mentally ill. Psychiatric Bulletin; 17; 7; 409-411.

⁶⁰ Ford R, Beadsmoore A, Ryan P, Repper J, Craig T and Muijen M. (1995) Providing the safety net: Case management for people with a serious mental illness. Journal of Mental Health; 1, 91-97.

⁶¹ Royal College of Psychiatrists. (1991) Good medical practice in the aftercare of potentially violent or vulnerable patients discharged from in-patient psychiatric treatment. Council Report CR12.

discussed and agreed at a review meeting; a systematic aftercare record and regular reviews, with revised care plans kept in patients' notes.

More recently, an editorial in the *Psychiatric Bulletin* urged psychiatrists to support implementation of the CPA as part of the profession's commitment to 'improving the quality of psychiatric practice and therefore of care for our patients'⁶². A consensus statement by the College of Occupational Therapists and RCP recognises the role of the CPA as providing 'the framework for good practice in delivering care to people with mental health problems'⁶³. The Royal College of Nursing, while supportive of the CPA, has urged the government to better define the role of the CPA, and to set UK-wide standards⁶⁴. A position statement by the British Association of Social Workers mental health special interest group recognises the need for multi-disciplinary team work⁶⁵.

2. What are the standards set for the CPA in the Code of Practice, DoH circulars and other guidance?

2.1 *The National Service Framework*

The National Service Framework (NSF) for Mental Health includes several standards relating to the CPA⁶⁶. Standard four says that all mental health service users on the CPA should receive care which optimises engagement, prevents or anticipates crisis, and reduces risk. They should have a copy of a written care plan which includes the action to be taken in a crisis by service users, their carers and their care co-ordinators, and is regularly reviewed by the care co-ordinator.

Standard five says that service users who are admitted to hospital should have a copy of a written aftercare plan, agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

Standard six says that carers should have an assessment of their own needs, and a written care plan. Additionally they should, with the service user's consent, receive information on the services and treatment available to the person they care for, and what to do in a crisis.

2.2 *The Mental Health Act Code of Practice*

The Code of Practice to the Mental Health Act 1983 was last revised in 1999⁶⁷. Section 27, relating to aftercare following discharge from hospital, reiterates the need to implement the CPA for all patients and restates the key elements of the CPA.

2.3 *Completed care plans at the point of extended S17 leave, discharge from hospital and discharge from detention under the CPA*

The Code of Practice to the Mental Health Act 1983, in Section 27, also states that 'the aftercare of detained patients should be included in the general arrangements for implementing the CPA,' including patients provided with aftercare under S117 and those granted leave of absence under S17. Before discharging, or granting leave to a patient, the RMO, in consultation with other professionals concerned, must 'ensure that the patient's needs for health and social care are assessed, and that the care plan addresses them'. This should include assessment of risk. In addition, under Section 22 of the Code, the Hospital Managers should ensure that the Trust provides reports, including any reports about after-care, to Mental Health Review Tribunals within the time limits set in the Tribunal rules.

⁶² Lelliott P. (1997) Should psychiatrists support CPA, guidelines and routine outcome measurement? *Psychiatric Bulletin*; 21, 1-2.

⁶³ College of Occupational Therapists and the Royal College of Psychiatrists. (2002) *Mental Health and Occupation in Participation*. A Consensus Statement. CR109.

⁶⁴ At: www.rcn.org.uk/downloads/congress2004/reportcouncil.pdf

⁶⁵ At: www.basw.co.uk/mhsig

⁶⁶ Department of Health. (1999) *A National Service Framework for Mental Health: modern standards and service models*. Department of Health.

⁶⁷ Department of Health and Welsh Office. (1999) *Code of Practice to the Mental Health Act 1983 (Revised 1999)*. The Stationery Office.

2.4 *Contingency planning for future non-compliance with treatment*

The 1999 revision of the CPA stipulated that 'care plans for all those requiring enhanced CPA should include a contingency plan'⁶⁸.

2.5 *Review of care plans*

The 1999 revision of the CPA also spelt out the need for review and care planning to be regarded as ongoing processes, but removed the requirement for a nationally determined review period. It specified that at each review meeting, the date of the next review must be set and recorded, and that any member of the care team, or the service user or carer, could ask for a review at any time.

2.6 *Risk assessment, review and management*

Risk assessment was identified as an essential and ongoing part of the CPA by the revision of the CPA, which stated that care plans for all those requiring enhanced CPA should include a plan for "what to do in a crisis".

2.7 *Involvement of service users and carers in CPA care planning & review*

Standards for involving service users and carers are included in the 1999 revision of the CPA, and in the National Service Framework.

3. What data on the CPA is collected within the NHS nationally? What information does it provide on standards and application of the CPA?

Performance Monitoring 2003-2004

The Healthcare Commission (HCC) has taken over from the Commission for Health Improvement (CHI) the responsibility to assess Trusts' performance against the standards in the NSF⁶⁹. Their Performance Ratings for 2003/04 show Trusts' performance against a number of standards⁷⁰. One of these is CPA Systems Implementation. To achieve this, care plans must be held on an electronic central database which is regularly updated and available 24 hours a day.

In 2003/04:

- 47 Trusts (57%) achieved this key target
- 26 underachieved (31%)
- and 10 significantly underachieved (12%).

In addition to key targets, a number of other factors are grouped together under the heading called 'A Balanced Scorecard'. Within a Clinical Focus grouping, there is an indicator called CPA/complex care indicator, for which Trusts are assessed on the CPA status of service users receiving complex specialist mental health care. This is assessed by examination of the Mental Health Minimum Data Set (MHMDS), a computerised record of all episodes of care (FCEs), submitted quarterly by Trusts.

The HCC's presentation of the aggregated results for the components of Clinical Focus do not show how Trusts performed on this one factor, but overall:

- 47 Trusts scored high (57%)
- 21 scored medium (25%)
- and 15 scored low (18%) on Clinical Focus.

Reports on all Trusts' performance is published on the HCC website⁷¹.

⁶⁸ As 2.

⁶⁹ Healthcare Commission. (2003) Key Targets for the Star Ratings 2003/04 - key targets for mental health services. Healthcare Commission.

⁷⁰ Healthcare Commission. (2004) NHS Performance Ratings 2003/04. Healthcare Commission.

⁷¹ At: <http://ratings2004.healthcarecommission.org.uk/Search/SearchResults.asp?TrustType=MH>

Performance monitoring 2004-2005

The Healthcare Commission's key targets for the star ratings in 2004-05 for mental health trusts again include CPA Systems Implementation, and the CPA/complex care indicator within the 'Balanced Scorecard'⁷². An additional target relates to the full implementation of the MHMDS, which includes information on each service user's CPA level, date last seen, and details of care co-ordinator. Performance will again be assessed through examination of the quarterly MHMDS submissions.

Developing performance monitoring nationally

CHI, the HCC's predecessor, started the process of assessing mental health Trusts and awarding a star rating to each based on how well they fulfilled a number of criteria as part of its routine clinical governance reviews in England and Wales⁷³. Trusts were required to submit annual returns for the achievement of a number of targets, known as the 'traffic light system' as ratings were either green - completed, amber - near completion, or red - not met. If targets had not been met, Trusts had to explain why, and say what action would be taken to rectify this, by whom, and by when. This system of assessment has been continued by the HCC.

Many Trusts publish information concerning local implementation of the CPA on their web sites including:

- Key Performance Indicator Summary Reports (e.g. South London & Maudsley NHS Trust⁷⁴)
- CPA audit reports (e.g. Bradford District Care Trust⁷⁵)
- reports to the Trust Board (e.g. Leeds Mental Health Trust⁷⁶; North East London Mental Health Trust⁷⁷)
- and Service and Financial Frameworks Reporting (SaFFR) Indicators (e.g. North Dorset PCT⁷⁸).

Information on good practice is published in 'The Approach', the quarterly journal of the CPA Association⁷⁹.

Self assessment systems

Trusts can also audit their own performance in implementation of the CPA. The Department of Health first published an audit pack for monitoring the CPA, drawn up in collaboration with the Royal College of Psychiatrists, in 1996⁸⁰, and this was revised and reissued in 2001⁸¹. Services were expected to use the audit tool for 'reporting into NHS clinical governance structures and Local Authority Cabinets and Scrutiny Committees'. Clinical governance provides systematic feedback at the local level to those bodies with responsibility for the level and quality of services, with reporting based on service user feedback and objective data.

The CPA Association has also published an audit tool which mental health services can use to survey the views of service users on the enhanced level of CPA, with a number of different issues being examined sequentially over a three year period⁸². This can be complemented by a survey of carers, an audit of case files, and a review of the organisational implementation of the CPA.

⁷² At: www.healthcarecommission.org.uk/assetRoot/04/00/19/06/04001906.pdf

⁷³ Commission for Health Improvement. (2003) Star ratings for mental health trusts.

At:

www.chi.nhs.uk/Ratings/Trust/Overview/mht_overview.asp

⁷⁴ At: www.slam.nhs.uk

⁷⁵ At: www.bdct.nhs.uk

⁷⁶ At: www.leedsmentalhealth.nhs.uk

⁷⁷ At: www.nelmht.nhs.uk

⁷⁸ At: www.northdorset-pct.nhs.uk

⁷⁹ Care Programme Approach Association. The Approach. Quarterly Journal of the CPAA.

⁸⁰ Department of Health. (1996) An audit pack for monitoring the Care Programme Approach. NHS Executive.

⁸¹ Department of Health. (2001) An audit pack for monitoring the Care Programme Approach. Department of Health.

⁸² Care Programme Approach Association. (2003) National Standards and CPA Association Audit Tool for the Monitoring of the Care Programme Approach. CPAA.

Local leadership

Since the modernisation of the CPA in 1999, a lead officer for CPA in each Trust is responsible for 'ensuring that audit of practice is undertaken and that feedback is provided to practitioners and managers alike⁸³. In short the lead officer will be responsible for the strategic oversight and development of the care co-ordination process'.

Service user and carer involvement

The same policy booklet said that local service providers should ensure that a system is in place to collect data on all service users, including total numbers in contact with services, and the numbers on enhanced and standard CPA. The requirement to maintain local Supervision Registers was abolished with effect from 2001, provided the Regional Office was satisfied that the Trust had 'robust CPA arrangements' in place. These include: multi-disciplinary and inter-agency training in risk assessment and CPA; user-led evaluation in place; agreed protocols for sharing information with the police, probation, prison and court liaison services, and with local independent and voluntary sector agencies; all members of the multi-disciplinary team have access to the latest care plan during and out of office hours; care plans held centrally within a database that is regularly updated; 24 hour access to services for all service users on the enhanced CPA; an audit has been undertaken using either the DH 1991 Audit Pack or an equivalent local tool⁸⁴.

A number of Trusts are employing the User Focused Monitoring model developed by The Sainsbury Centre for Mental Health to audit their services, including CPA implementation, from the service users' point of view^{85, 86}. Trusts known to take this approach include Cambridge and Peterborough Mental Health Partnership Trust⁸⁷, Camden & Islington Care Trust⁸⁸, Derbyshire Mental Health Partnership Trust⁸⁹ and West Sussex Health and Social Care Trust⁹⁰.

The Healthcare Commission is now responsible for the programme of national patient surveys initiated by CHI, and the first patient survey in mental health was completed in 2004. This is the largest ever survey of service users, in which the views of more than 27,000 people were obtained by means of a postal questionnaire⁹¹. Ten questions on the CPA were included. About half the respondents said they had been given (or offered) a copy of their CPA Care Plan, and altogether three quarters said they definitely, or to some extent, understood what was in it. Most people agreed, at least to some extent, with what was in their Care Plan. Half the service users had not had a review in the past year; of those who had, most felt they had been given the chance to express their views at the meeting. Two thirds of respondents knew who their care co-ordinator was, and a similar number had seen them within the last month. The national report, reports for all individual Trusts, and the detailed responses for the questions on the CPA, for each Trust, are available on the HCC's website^{92, 93}. Some Trusts (e.g. Surrey Oaklands Trust⁹⁴) publish their local findings from the National Patient Survey on their web sites.

Rethink obtained the views of 3,000 service users and found that about half of them did not know if they had a care plan, but 90% of those who had a care plan felt their views and preferences were considered when their care plan was developed⁹⁵.

⁸³ As 2.

⁸⁴ Department of Health. (2000) Abolition of the Supervision Register; Criteria for a Robust CPA. Department of Health.

⁸⁵ Rose D, Ford R, Gawith L, Lindley P and the KCW Mental Health Monitoring Users' Group. (1998) In Our Experience: User-Focused Monitoring in Kensington & Chelsea and Westminster Health Authority. The Sainsbury Centre for Mental Health.

⁸⁶ Rose D. (2001) Users' Voices. The Sainsbury Centre for Mental Health.

⁸⁷ At: www.cambsmh.nhs.uk

⁸⁸ At: www.candi.nhs.uk

⁸⁹ At: www.derbyshirementalhealthservices.nhs.uk

⁹⁰ At: www.wshsc.nhs.uk

⁹¹ Healthcare Commission. (2004) Patient Survey Report 2004 - mental health. Healthcare Commission.

⁹² At: www.healthcarecommission.org.uk/assetRoot/04/00/81/83/04008183.pdf

⁹³ At: www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/

⁹⁴ At: www.surreyoaklands.nhs.uk

⁹⁵ Rethink. (2003) Just one per cent: The experiences of people using mental health services. Rethink.

Trusts are required to develop Electronic Patient Records (EPR) as part of the NHS Information Strategy⁹⁶. Some mental health services were among the early demonstrator sites, and there is information from Cornwall and West Surrey of electronic record systems successfully being set up⁹⁷. The London Development Centre (NIMHE) is working towards a shared eCPA system for all ten mental health service providers in the region⁹⁸.

4. Do homicide and suicide inquiries tell us anything about adherence to the CPA?

Where a person in contact with specialist mental health services has committed a homicide, the Health Authority concerned is obliged to should set up an independent inquiry into the circumstances⁹⁹. These inquiries' terms of reference typically include the examination of the appropriateness and quality of any assessment, care plan, treatment or supervision provided to the individual.

Seventeen inquiry reports published between 2000 and 2004 were obtained from the web sites of Strategic Health Authorities, along with information on the action plans or progress reports relating to a further two inquiries, obtained from other internet sources (these are listed at the back of this paper). Altogether, these related to the care and treatment of 22 individuals, known to mental health services, who had committed homicides.

While many of these inquiry reports made recommendations about the effective implementation of the CPA, none found the CPA an unhelpful approach, nor recommended that it be abolished in favour of another system of organising care. Rather, they found evidence of incomplete or ineffective implementation in some areas, leading to negative outcomes.

Recommendations from the reports examined include:

- local practice to be driven by adequate local policies and procedures, based on national standards;
- the need to ensure comprehensive multi-disciplinary assessment, care planning, and review processes
- service users and carers to be fully involved in the CPA process;
- care plans to be detailed, and to include information on signs of relapse;
- service users to be placed on the appropriate level of CPA, with safeguards to ensure they are not removed from the CPA by one professional acting without agreement at a multidisciplinary review;
- CPA reviews to be held regularly and to properly fulfil their role;
- the need for clear (and not overly burdensome) documentation, easily accessible by all agencies involved;
- the need to clarify the effective role of (an appropriate) care co-ordinator and to ensure accountability for ensuring specified actions are carried out, overseen by a robust management system;
- staff from health and social services should have proper training in the implementation of the CPA;
- the need for regular auditing of the CPA;
- the need to implement an effective risk assessment and risk management system;
- drawing up contingency plans for working with people whose care plans fail, and those who are difficult to engage with services;
- the need for effective liaison and communication with other services.

In addition, Trusts are required to provide information to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, which is co-ordinated by the National Institute for Clinical

⁹⁶ NHS Executive. (1998) Information for Health. An information strategy for the modern NHS 1998-2005. NHSE.

⁹⁷ NHS Information Authority. (2003) ERDIP. Lessons Learned. National Strategic Frameworks Topic. NHSI. At: <http://www.nhsia.nhs.uk/erdip/pages/demonstrator/searchpage.asp?keyselect=Mental%20health>

⁹⁸ Thomas K and Balls G. (2003) How standard are enhanced CPA implementations in London? A discussion document for the IMHER clinical panel.

⁹⁹ Health Service Guidance HSG(94)27.

Excellence in association with the Royal College of Psychiatrists. Their findings are published periodically^{100, 101, 102}.

The 2001 report of the National Confidential Inquiry recommended a major overhaul of the operation of the CPA, with the establishment of national criteria for enhanced CPA which would emphasise the importance of risk¹⁰³.

Appleby, commenting on the 1999 report, recommended an overhaul of the CPA system to ensure priority for enhanced level care be given to service users in high risk groups, especially those with a history of violence¹⁰⁴. He also argued that CPA documentation should be redesigned and simplified to make it compatible with clinical and risk assessment, and to facilitate transfer of information between services.

5. Is there any statistical information available from Mental Health Review Tribunal decisions concerning CPA/aftercare and the reason for adjournment/decision to discharge or not discharge?

The Mental Health Act Commission, in its most recent Biennial Report, comments that 'healthcare professionals or Home Office officials may be summoned before the Tribunal to account for delays in implementing discharge plans'¹⁰⁵. However, we have not found any statistical information relating to MHRT decisions concerning CPA/aftercare.

6. Does the research indicate whether professionals work together effectively in the operation of the CPA?

As previously described, since 1999 the CPA and local authority Care Management have been integrated to form a single care co-ordination approach for adults of working age with mental health problems¹⁰⁶. The requirement for health and social services staff to work together in this way has been facilitated by a number of recent changes to the way mental health services are provided.

There are currently 83 NHS organisations providing mental health services in England¹⁰⁷. Five of these are Care Trusts, newly created organisations which combine both NHS responsibilities and local authority health responsibilities under a single management, to deliver integrated health and social care services. A further 20 are Partnership Trusts, in which health and social care staff are contracted to work closely together, usually sharing clinical and office bases and with common paperwork, e.g. for the CPA. The number of Care Trusts and Partnership Trusts is expected to increase.

¹⁰⁰ Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. (1996) Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. Royal College of Psychiatrists.

¹⁰¹ Appleby L et al. (1999) Safer Services. Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Department of Health.

¹⁰² Department of Health. (2001) Safety First. Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Department of Health.

¹⁰³ As 47.

¹⁰⁴ Appleby L. (2000) Safer services: conclusions from the report of the National Confidential Inquiry. *Advances in Psychiatric Treatment*; Vol. 6, 5-15.

¹⁰⁵ Mental Health Act Commission. (2002) Placed amongst strangers: Tenth Biennial Report, 2001-03. London; The Stationary Office.

¹⁰⁶ As 2.

¹⁰⁷ At: www.nhs.uk/england/authoritiestrusts/mentalhealth/default.aspx

The integration of Community Mental Health Teams (CMHTs) is subject to performance management by the Healthcare Commission, one of the key targets being the degree to which CMHTs have integrated health and social care staff within a single management structure. In the review for 2003/04:

- 80% of Trusts achieved this target
- Trusts underperformed (6%)
- and 11 significantly underperformed (13%)¹⁰⁸.

More recent information from the Durham mapping returns for September 2004 shows that of the 821 CMHTs currently recorded nationally, 775 (94%) are now reported to be integrated¹⁰⁹.

The literature shows that joint working in the CPA is more successfully achieved in some areas than in others. A number of research studies have examined the implementation of the CPA in different areas, and some have identified issues of inter-professional and inter-agency working. North and Ritchie found a lack of joint working between health and social services in implementing the CPA¹¹⁰, while Rospopa concluded that the CPA formalised existing systems of good practice, and was achievable through effective communication and collaborative working between agencies¹¹¹. A national survey in 1999 found that multidisciplinary working was 'widespread', although conclusions could not be drawn about its quality¹¹². Some findings from the Inquiry Reports, previously discussed, also relate to issues of joint working.

Anecdotal evidence suggests that one problem to be overcome with integration is in reconciling different IT systems, as typically health and social services' systems are not compatible with each other. The concern over confidentiality issues and sharing of information presents an obstacle in many cases, and requires national and local discussion to resolve.

7. Drawing upon research, literature and information from representative organisations, what is the extent of service user and carer satisfaction with the CPA?

More information is available about service users' involvement in, and satisfaction with, the CPA, than that of carers. An examination of 11 other studies published between 1999 and 2004 show that service users' knowledge of, and involvement in, the CPA process is patchy, although the literature suggests that the situation is improving over time. Many studies found that where service users were involved in planning their own care, they were more satisfied overall with the care they received. Service users in an area where CPA and Care Management had been integrated were statistically more satisfied with services than those in the districts where the systems were separate, and the authors concluded that service user involvement and choice are facilitated by the integration of health and social care¹¹³. Research carried out in another area found a statistically significant improvement in service users' knowledge about aspects of the CPA over the course of two years¹¹⁴.

¹⁰⁸ At: <http://ratings2004.healthcarecommission.org.uk/Search/SearchResults.asp?TrustType=MH>

¹⁰⁹ At: www.dur.ac.uk/service.mapping/amh/index.php

¹¹⁰ North C and Ritchie C. (1993) Factors Influencing the Implementation of the Care Programme Approach. HMSO.

¹¹¹ Rospopa J. (1998) The care programme approach. *Nursing Times*; 94: 13, 55-57.

¹¹² Schneider J, Carpenter J and Brandon T. (1999) *British Journal of Psychiatry*; 175; 422-425.

¹¹³ Carpenter J, Schneider J, McNiven F, Brandon T, Stevens R and Wooff D. (2004) Integration and Targeting of Community Care for People with Severe and Enduring Mental Health Problems: Users' Experiences of the Care programme Approach and Care Management. *British Journal of Social Work*; 34; 313-333.

¹¹⁴ Rose D. (2001) *Users' Voices*. The Sainsbury Centre for Mental Health.

There is less information on carers' experience of the CPA. A study in London (Wolfe et al, 1997) found a low level of carers' involvement in the CPA process¹¹⁵, a national survey in 1999 found that overall carers 'sometimes' attended CPA meetings¹¹⁶, and many of the Homicide Inquiry Reports examined make reference to carers' lack of inclusion in relation to the person they were caring for. Standard six of the NSF gives carers the right to an assessment of their own needs, and a written care plan, but Rethink's 2003 survey of nearly 1,500 carers found that only 20% had had an assessment, and over half of those who were assessed did not have a care plan¹¹⁷.

8. **Is CPA inclusive? Does it operate equally well for patients living at home, those admitted informally to hospital, those detained under the MHA, those on S17 leave and those discharged home?**

In the course of their contact with mental health services, many long term service users subject to the enhanced CPA will receive care in a number of residential and community settings. As the CPA spans all these episodes, how well the CPA works within the various individual elements of care does not seem to have been assessed.

An alternative question is whether the CPA works equally well for individuals on the standard and the enhanced levels. Some commentators have recommended refocusing the CPA towards the people with the most complex needs, i.e. those currently eligible for the enhanced level of CPA, arguing that this would free clinical teams from the burden of fulfilling the administrative demands of the standard level CPA.

The director of a NIMHE regional development centre has recently argued that, although the principles of the CPA are sound, its implementation is problematic, recommending streamlining the CPA, coupled with performance management, to release staff time which is currently 'invested in bureaucracy'¹¹⁸.

In the opinion of another NIMHE RDC Chief Executive, and a senior officer in a third RDC, the way forward may be to remove the requirement for mental health practitioners to use the CPA for service users who fulfil the current criteria for the standard level. It is felt this would remove an irksome administrative burden and free up time for them to focus on people whose needs are more complex.

¹¹⁵ Wolfe J, Gournay K, Norman S and Ramnoruth D. (1997) Care programme approach: evaluation of its implications in an inner London service. *Clinical Effectiveness in Nursing*; 1: 85-91.

¹¹⁶ Schneider J, Carpenter J and Brandon T. (1999) *British Journal of Psychiatry*; 175; 422-425.

¹¹⁷ Rethink. (2003) Under pressure: The impact of caring on people supporting family members or friends with mental health problems. Rethink.

¹¹⁸ Mahoney J. (2004) Speak Out. *Health Service Journal*; 114; 2925; 25.

Inquiry Reports:

Armstrong K, Berry A, Craig R, Statham R and Whittle K. (2004) Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Mark Towell. Northumberland, Tyne and Wear Strategic Health Authority.

Bhatoa J, Brabbins C, Davis H and Hargreaves R. (2003) Report of the Independent Inquiry: Reference 2000/315, Bradford.

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Crissel M, Collins P, Manby M and Brown D. (2004) Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Damien Neaven. Northumberland, Tyne and Wear Strategic Health Authority.

Curwen M, Holloway F and Tarbuck P. (2003) Independent Report into the Care and Treatment of A. North West London Strategic Health Authority.

Downham G, Campbell A, Procter A and Clark C. (2003) Report of the Independent Inquiry into the Care and Treatment of Matthew Martin. Avon, Gloucestershire and Wiltshire Strategic Health Authority.

Eldergill A, Bowden P, Murdoch C, Walker J and Welch N. (2001) Report of an Independent Inquiry into the Care and Treatment of Mark Longman, Paul Huntingford and Christopher Moffatt. Summary. North & Mid Hampshire Health Authority and Hampshire County Council Social Services Department.

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Gledhill K, Farrell M, Gay A and Hughes C. (2004) Report of the Inquiry into the Care and Treatment of Joe Janes. Kent and Medway Strategic Health Authority.

Holwill D, Mackay J and Radford M. (2003) Report of the Independent Inquiry into the Care and Treatment of Mr Gregory Marden. Leicestershire, Northamptonshire and Rutland Strategic Health Authority.

Johns G, Bowden P, and Shepherd D. (2002) Report of the Independent Inquiry into the Care and Treatment of Winston Williams. Thames Valley Strategic Health Authority.

Joyce L, Hale R, Jones A and Moodley P. (2003) Report of an Independent Inquiry into the Care and Treatment of Daksha Emerson MBBS, MRCPsych, MSc and her daughter Freya. North East Thames Strategic Health Authority.

McKay J, Higgo R and Morris M. (2004) The Independent Inquiry into the Care and Treatment of a Patient known as P. South West Peninsula Strategic Health Authority.

Mishcon J, Sensky T, Lindsey M and Cook S. (2000) Report of the Independent Inquiry into the Care and Treatment of Daniel Joseph. Merton Sutton & Wandsworth Health Authority and Lambeth Southwark & Lewisham Health Authority.

Price C, Parshall A and Walker M. (2004) Report of an Independent Inquiry into the Care and Treatment of Chandran Sukumaran. North East Thames Strategic Health Authority.

Smallridge P, Frederick C, Walsh P and Bowden P. (2004) A review of the circumstances leading up to and surrounding the care and treatment of Ms Sarah Lawson. Surrey and Sussex Strategic Health Authority & West Sussex County Council.

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West Yorkshire Strategic Health Authority. (undated, put probably 2003) Progress Report on Independent Inquiries Ref. 1999/195 and 1999/246. (*Inquiry Reports not obtained.*)

Winter D, Berry A, Whittle K and Smith H. (2002) Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Raymond Wills. Northumberland, Tyne and Wear Strategic Health Authority.

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Marsh J and Sanbrook M (1999) Everyone has a stake in mental health. How users of mental health care services led the involvement of all stakeholders to set priorities for improvement in Bristol, UK. Published on www.tqp.com.

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Sainsbury Centre for Mental Health. (2003) Money for Mental Health: a review of public spending on mental health care. Briefing 22; SCMh.

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Barking and Dagenham Primary Care Trust: www.barkinghaveringhamhealth.nhs.uk

British Association of Social Workers: www.basw.co.uk

Care Programme Approach Association: www.cpa.co.uk

College of Occupational Therapists: www.cot.org.uk

General Social Work Council: www.gsc.org.uk

Marsh and Sandbrook TQP: www.tqp.com

(a consultancy organisation skilled at facilitating service user-led research.)

Mental Health Foundation: www.mentalhealth.org.uk

Mental Health Nurses' Association: www.amicus-mhna.org/index.htm

NHS Information Authority: www.nhsia.nhs.uk

National Institute for Mental Health in England: www.nimhe.org.uk

NIMHE, London Regional Development Centre: www.londondevelopmentcentre.org

NIMHE, South East Regional Development Centre: www.sedc.org.uk

National Mental Health Partnership: www.nmhp.co.uk

National Patient Safety Agency: www.npsa.nhs.uk

Rethink (formerly the National Schizophrenia Fellowship): <http://www.rethink.org>

Royal College of Nursing: www.rcn.org.uk
Royal College of Psychiatrists: www.rcpsych.ac.uk
Social Care Institute for Excellence: www.scie.org.uk

Additional information received from other organisations and individuals:

Regional Development Centres (NIMHE),
Healthcare Commission,
LIT Lead,
Richmond Fellowship,
Trust CPA Managers,
Trust Operational Manager,
Young Minds.

APPENDIX F

Additional Support Paper for Inquiry Seminar



Information on Good Practice in Implementing the CPA

for the Seminar on the CPA

being held in the Parliament Chamber, Middle Temple

on 12 November 2004

The Context

Project on the CPA

The Sainsbury Centre for Mental Health (SCMH) is currently working on a project, in collaboration with The Mental Health Act Commission (MHAC), to examine the quality of CPA care planning for patients who have been detained under the Mental Health Act more than once in a three year period. We are assessing the factors that contribute to the best quality of care and the most effective care planning for these patients and have developed a tool for use in monitoring, assessing and evaluating care planning through an examination of CPA care plans and case notes, and patient interviews. This is being used to establish a baseline on the role of CPA care planning for this group of patients.

The Steering Group

This work is guided by a steering group that includes representatives from MHAC and SCMH, a representative from the London Development Centre of the National Institute for Mental Health in England (NIMHE), a mental health Trust operational manager with hands-on experience of implementing the CPA in inpatient settings, a service user, and the Secretary to the CPA Association (CPAA).

Review of the Literature

The steering group asked SCMH to conduct a review of the literature relating to CPA care planning. The literature review will form part of the final project report, and has also be published on the SCMH website at www.scmh.org.uk.

Example of Good Practice

In addition to published literature, information was provided by the CPAA on the format and content of CPA care plans, and a number of examples of CPA documents currently in use were obtained from a number of Trusts. It was the view of the steering group that the enhanced electronic CPA (eCPA) used by South London and the Maudsley NHS Trust (SLaM) was an example of good practice. Information on the Key Performance Indicators, including progress being made on CPA compliance, was found on the Trust's web site at www.slam.nhs.uk.

SLaM's eCPA is therefore being tabled at this seminar. Further information can be obtained from: Martin Lawlor, Business Manager, Southwark Directorate; email martin.lawlor@slam.nhs.uk.

Other information from SLaM

Staff at SLaM have developed 'The Patient's Journey', a single, integrated clinical information process, designed to include all relevant information about patients' care from their first contact with the Trust until their final discharge from the service. It supports the CPA, and will also meet the requirements for the Mental Health Minimum Data Set and other statutory returns. Currently a paper record, it will in due course become the electronic patient record for the Trust. It will continue to evolve; introduced seven months ago, sections are already being revised in light of feedback from clinicians. Service users involved in the consultation process so far have been positive. A copy of 'The Patient's Journey' is being tabled. Further information can be obtained from: Matthew Broadbent, Project Lead; email: matthew.broadbent@slam.nhs.uk.

APPENDIX G

National Seminar Recommendations

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MN

The Inquiry

1. This homicide inquiry is commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority. The panel have recently completed hearing evidence. No findings of fact have yet been made but questions have arisen concerning the effectiveness of the Care Programme Approach as the national framework for mental health care planning.
2. CPA has featured as a problematic area in two previous homicide inquiries commissioned by the SHA. Of particular concern has been the management of individuals who have been subject to detention under the MHA, been returned home and become uncooperative with care leaving vulnerable relatives with the task of identifying a patient's deterioration in mental health and alerting services. The unenforceability of CPA care planning, risk assessment and contingency planning have been major issues.

National Seminar

3. The panel commissioned research and sought advice from an authoritative national group comprising lead figures from the Health Care Commission, Mental Health Act Commission, Department of Health, Home Office, Mental Health Review Tribunal, Royal College of Psychiatrists, Royal College of Nursing, Police, Association of Directors of Social Services, Sainsbury Centre for Mental Health, University College Department of Public Health, King's Fund, CPA Association, Turning Point and the Scottish Mental Welfare Commission¹¹⁹.
4. This group met at a confidential seminar in November 2004 which considered the question "Is CPA working?"
5. The detail of this seminar will not be revealed until the report of the Inquiry is published. However, it was the strongly held view of those present that action on certain recommendations arising from the seminar should not be delayed until that date. The Inquiry panel has adopted the seminar recommendations and they are presented now to ensure that there is an opportunity for their consideration as part of the scrutiny of the draft Mental Health Bill and preparation for new legislation. The recommendations and a review of progress on them will in due course be published in the full report of the Inquiry.

Recommendation 1 : Standards

- The Health Care Commission and Commission for Social Care Inspection should develop a CPA self-audit tool which health and social care providers would be required to complete and return by a due date, with outcomes of the audit tool built into performance assessment for health and social services.
- Quality of CPA for all psychiatric patients, whether subject to an order or not, should be a key element in the standards based system of assessment for mental health providers

¹¹⁹ Research was commissioned from Mark McCarthy, Professor of Public Health at University College, London jointly with the Sainsbury Centre. The seminar was facilitated by Professor Kamlesh Patel OBE. Attendees are listed at the end of this document.

Recommendation 2 : Accountability

- The Secretary of State should make it a clear responsibility of Strategic Health Authority Chief Executives to ensure through performance management that provider/PCT Chief Executives are accountable for ensuring that CPA processes are properly in place and clinical governance arrangements take into account the requirements of CPA
- ensure that all registered private and voluntary health and social care providers are accountable for ensuring that CPA processes are properly in place and where applicable clinical governance arrangements take into account the requirements of CPA
- ensure the Department of Health states firmly in 'Standards for Better Health' that CPA is an essential component of the core standards

Recommendation 3 : Legislation

- Care plans in a new mental health act should be based on or linked with CPA to create one unambiguous and unified care planning system.
- The Pre-legislative Scrutiny Committee of the Draft Mental Health Bill should consider the following inclusions in secondary legislation:
 - a) Any care plan prepared, amended, reviewed or included by the clinical supervisor in an application for an order must be a care plan which conforms to current Department of Health guidance on the Care Programme Approach and which meets the requirements of the Code of Practice
 - b) The managers of a hospital must (at s31(1) and s31(2) of the draft Bill) secure that a care plan prepared and included in the patient's records is a care plan which conforms to current DOH guidance on care plans within the CPA and is prepared in a form specified for CPA
 - c) Care plans prepared for the purpose of an application for an order (under ss39-43 of the draft Bill) must be in a form which meets the requirements of the CPA and must contain the following information concerning the relevant conditions for an order and whether the patient should be provided with resident or non-resident treatment, being
 - I. An assessment of the patient's risk of suicide and self-harm
 - II. An assessment of any risk to his health or safety
 - III. An assessment of any risk to other persons
 - IV. In each of the above an assessment of the risks should the patient be discharged from an order or become a non-resident patient
 - V. A contingency plan for disengagement and non-concordance which should include warning signs, crisis planning and contact arrangements in the event that the patient becomes a non-resident patient
 - VI. A description of alternatives to an order
 - VII. The nominated person and carer's views following consultation where appropriate
 - VIII. Information from other agencies involved in the patient's care
 - IX. A statement of arrangements for the patient's care upon discharge from the order

Recommendation 4 : Guidance

In the event that the draft Mental Health Bill becomes law in a form which includes care plans, the Department of Health should consider whether any further guidance is needed to ensure that the Care Programme Approach is comprehensively operated as the main framework for mental health treatment and social care provided under the NHS.

The rationale for the recommendations

6. The Care Programme Approach (CPA) has been the care planning framework for mental health care for thirteen years, has been the subject of much Department of Health Guidance and has been included in the MHA Code of Practice since 1993. It is the one structure which applies to all service users whatever tier or specialist area of the mental health services they are in and whether detained under the MHA or not. It is the only system of care planning which is shared by all mental health professionals.
7. The seminar heard that after thirteen years CPA is still not fully implemented across the country, does not appear to be working well in many places, there is variable professional commitment, no standardised method of recording and no national monitoring or evaluation which would enable service users and carers to know whether they are receiving an adequate standard of mental health care, or enable commissioners and providers of services to know whether they are providing it.
8. The seminar expressed its commitment to the principle of CPA, but concluded that if it is to remain as the national framework for mental health care planning it must be fully implemented. That is most likely to be achieved by embedding CPA into established structures and systems. The Health Care Commission and Commission for Social Care Inspection should have a role in monitoring standards of CPA. Department of Health guidance and mental health legislation should together provide an integrated and enforceable care planning system.

Care plans and CPA

9. The third and fourth recommendations are intended to ensure that CPA and care plans in new legislation are connected through legislation and Department of Health guidance.

The principle

10. Legislation and Department of Health guidance on CPA should be expressly linked because
 - Unless it is explained further, any reference in the draft Bill to a care plan prepared by a clinical supervisor could mean a care plan *in addition* to or *instead of* the CPA care plan. This could confuse and undermine care planning rather than strengthen it
 - There should be consistency between different government departments over guidance and legislation
 - Service users will move in and out of compulsion under legislation and there should be the fullest possible continuity in the care planning provided at different points within the system. There is otherwise a danger that individuals will be lost between systems especially when compulsion ends.

The Proposals

11. Our recommendations propose that all patients remain subject to CPA. Those also subject to compulsion would form of a sub-group of patients subject to CPA and Department of Health guidance would need to be revised to ensure there is a tier of CPA applicable to patients subject to residential or non-residential orders.
12. This sub-group or tier of CPA would contain those individuals who are most at risk to themselves or to others. Risk assessment, crisis and contingency planning should already have been included in a CPA care plan but these elements would become the statutory prescribed information required in any care plan prepared, amended, reviewed and included in an application for an order (under ss39-43 of the draft Bill).
13. Mental Health Tribunals would receive care plans which comply with CPA requirements and contain the statutorily prescribed information. This would enable the Tribunal to decide whether the relevant conditions are met and whether a residential or non-residential order should be made.

14. The Tribunal would be required to satisfy itself that any care plan attached to an order it makes contains the prescribed information.

The practicalities

15. Upon admission under compulsion the managers of the hospital must 'secure that a care plan is prepared and included in the patient's records during the initial period'. The principle behind CPA is that it too should begin upon the patient's admission to hospital. The managers must know whether the statutory care plan is in addition to or part of the CPA care plan.
16. It would make practical sense, for managers and clinicians, if all care plans were CPA care plans but with statutory variations, for example, a 'CPA care plan prepared under s31(1)' or a 'CPA care plan prepared under s39(3)'.
17. The requirement at s31(2)(b) that the care plan be in the 'form prescribed' provides an opportunity to standardise care planning and ensure continuity of CPA as a patient moves into and out of compulsory assessment or treatment. One core CPA care plan from the start would also provide scope for electronic records to be used.

Service users and carers

18. CPA guidance makes a commitment to inclusion of the service user and carer in the care planning process and states that they should be provided with copies of the CPA care plan. Legislation should at all costs avoid potential confusion arising from the existence of different care plans and at s31(4) and (5) it would be most straightforward if they understood they were to be consulted and provided with a CPA plan but as required under legislation

Code of Practice

19. The revised Code of Practice under new legislation should fully incorporate the requirements of CPA and further emphasise the principle that care plans for each patient subject to compulsion should be framed as part of the CPA which applies to all patients receiving care and treatment for mental disorder.

18 February 2005

APPENDIX H

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APPENDIX I

Abbreviations used in the Report

AGW SHA	Avon, Gloucestershire & Wiltshire Strategic Health Authority
AOT	Assertive Outreach Team
ASW	Approved Social Worker
CM	Care Management
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DSM-IV	American Psychiatric Association's Diagnostic and Statistical Manual
ECHR	European Convention of Human Rights
GP	General Practitioner
HAS	Health Advisory Service
HASCAS	Health and Social Care Advisory Service
ICD-10	Tenth edition of the World Health Organisation's International Classification of Diseases
ICPA	Integrated Care Programme Approach
ICU	Intensive Care Unit
IMHER	Integrated Mental Health Electronic Records
MHA	Mental Health Act 1983
MHAC	Mental Health Act Commission
MHIS	Mental Health Information System
MHRT	Mental Health Review Tribunal
NIMHE	National Institute for Mental Health in England
NPfIT	National Programme for IT Development
NPSA	National Patient Safety Agency
NSF	National Service Framework
PAS	Patient Administration System
PCT	Primary Care Trust
PRN	Medication given when required
RCA	Root Cause Analysis
RMO	Responsible Medical Officer
SHO	Senior House Officer
SN	Staff Nurse