Strictly Confidential

Independent investigation into the care and treatment provided to Mrs. S by the West London Mental Health Trust and Ealing Primary Care Trust

Commissioned by NHS London Strategic Health Authority

February 2010

NHS London

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Ms S was commissioned by NHS London Strategic Health Authority pursuant to *HSG (94)27*[1].

This Investigation was asked to examine a set of circumstances associated with the death of Mrs. S and the deaths of her two children, Child 1 aged 5 years and Child 2 aged 22 months.

Mrs. S received care and treatment for her mental health condition from the West London Mental Health Trust. Mrs. S was also in receipt of care from a General Practice, Children and Families Division of Social Services and the Health Visiting Service within the London Borough of Ealing and Ealing PCT. It is the care and treatment that Mrs. S received from these organisations that is the subject of this Investigation.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the British Transport Police who granted access to their investigation documentation which enabled the investigation Independent Investigation Team to have access to informative background information.

This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

[1] DoH Guidance EL (94)27, LASSL (94) 27

2. Condolences to the Family of Mrs. S

The Investigation Team would like to extend their sincere condolences to the family and friends of Mrs. S. It is clear from some of the documents examined that Mrs. S was a much loved daughter and family member as well as being a kind and loving mother to her two children. The Independent Investigation Team is aware of the distress caused to the extended family of Mrs. S following the publication of the Trust's Internal Investigation and sincerely hopes that this report does not cause further upset.

The Independent Investigation is also mindful of the impact this report may have on South Asian Communities and respectfully states that investigations of this nature are in the public interest and serve to inform and improve services through greater understanding. An Investigation of this kind does not intend to malign or criticise the beliefs and values of other cultures.

3. Executive Summary

3.1 Incident description and consequences

At approximately one o'clock on 31 August 2005 Mrs. S was seen on Platform One at Southall Railway Station. Platform One is adjacent to the fast down line which is used by express trains travelling away from London which do not stop at the station. The platform has unrestricted access from the booking hall area and there is no gate or barrier to prevent people going there.

At one o'clock the Heathrow Express train left Paddington Station. At seventeen minutes past one the train approached Southall Railway Station at a speed of approximately 100 mph. This was on the fast down line which goes through Platform One.

When the train was approximately half way along the platform the driver saw Mrs. S with her two children jump in front of the train in what appeared to be a deliberate act, and described them as 'holding hands', with the smaller person pulling back. He described seeing them in mid-air and then landing between the running lines in front of the train, tripping and falling over.

The Coroner recorded the circumstances in relation to Mrs. S. The coroner recorded that the deceased took her own life and a verdict of unlawful killing in relation to Child 1 and Child 2.

3.2 Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS London (the London Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance HSG (94)27.

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

3.3 Terms of reference

1. To examine the mental healthcare received by Mrs. S in the context of her life history, taking into account any issue raised by cultural diversity which appear to be relevant, in order to obtain a better understanding, In particular:

The extent to which Mrs. S's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90)23, and local operational policies.

The extent to which her prescribed care plans were:

- Effectively drawn up
- Delivered and complied with by Mrs. S

The appropriateness and quality of any assessment, care, treatment plan and supervision having regard to her past history to include:

- medication
- staff responses to service user and carer concerns
- involvement of Mrs. S and her family in the appropriateness of her care plan
- the range of treatments /interventions considered
- social care interventions
- reliability of case notes and other documentation

Her assessed risk of potential harm to herself and others compiling a comprehensive chronology of events leading up to the suicide and homicides on 30th August 2005. This to include specifically:

- risk of Mrs. S harming herself or others
- training of clinical staff in risk assessment
- systems and procedures in place at the time of Mrs. S's contact with services

2. To consider the effectiveness of interagency working, including communication between the mental health services and other agencies with particular reference to the sharing of information for the purpose of risk assessment.

3. To review and assess compliance with local polices, national guidance and statutory obligations including the appropriateness of use of the Mental Health Act (83) regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

4. To review the Internal Investigation into the care of Mrs. S already undertaken by West London Mental Health Trust and Ealing Primary Care Trust, and any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and assess the effectiveness of their implementation.

5. To comment on the care and support offered to the perpetrator's family at the time of the incident and during the Internal Investigation.

6. To comment on the decision taken by the Area Child Protection Committee not to undertake a Chapter 8 review of the case.

7. To consider such other matters as the public interest may require including the support offered to Mrs. S's family following hers and the children's deaths.

8. To consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence.

9. To prepare an independent report by HASCAS, for Ealing Primary Care Trust, and any other relevant bodies.

10. Use *root cause analysis* as appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.

11. To ensure that any action plan and recommendations take full account of the progress that both NHS Trusts have made since the completion of the Internal Investigation report.

3.4 The Investigation Team

This Investigation was undertaken by the following Independent Investigation Team of professionals who are independent of the healthcare services provided by the West London Mental Health Trust and the Ealing Primary Care Trust.

Helen Waldock, Investigation Project Lead, Director of Nursing HASCAS
Dr Elizabeth McDonald, Consultant Psychiatrist
Jasvinder Sanghera, Karma Nirvana
Sally Gooch, Independent Health Visitor Consultant

Independent Advice to Independent Investigation Team
Ashley Irons, Solicitor, Capsticks
Janet Mountford, Children's Health Service Manager
Alan Watts, Independent Social Worker Consultant

3.5 Findings and Conclusions

Key Causal Factors

The Independent Investigation Team did not find any key causal factors relating to the care and treatment of Mrs. S and the subsequent events of August 2005. Whilst there are a significant number of contributory factors highlighting some failures, omissions and missed opportunities there is insufficient evidence to state that any one of these would have unconditionally had a direct causal relationship to the occurrences in August 2005.

Contributory Factors

The Independent Investigation Team found 20 factors that contributed to the less than effective care and treatment package that Mrs. S received.

Contributory Factor 1: There was a lack of understanding of the significance of the cultural aspects of Mrs. S's background. This was a repetitive finding throughout the Investigation.

Contributory Factor 2: Mrs. S was not interviewed on her own at any of the medical consultations so there were missed opportunities for her to freely express herself if she had wished to do so.

Contributory Factor 3: The formulation that Mrs. S was depressed because of her marital problems rather than vice versa was a contributory factor in the care and treatment of Mrs. S.

Contributory Factor 4: There was a lack of capacity within the Out Patient System/ Community Mental Health Team (CMHT) to medically review people in a timely manner**.**

Contributory Factor 5: Not referring Mrs. S for psychological therapies was a missed opportunity in the light of her previous positive response.

Contributory Factor 6: There was a lack of inter disciplinary working and nurse clinical leadership within the CMHT.

Contributory Factor 7: There was a lack of communication between Out Patient Appointment system and the duty system resulting in referrals not being followed through and full needs assessments being offered.

Contributory Factor 8: Part of the role of the duty system is to gather further information and this did not occur in this case in 2004 or 2005. Throughout this time there was intensive involvement with the Health Visiting team and potentially vital information (for example frequency of contact and interventions) was not fed into the decision making process. This may have altered the decision to take no further action in 2004 and potentially the diagnosis made by the psychiatrists. The Independent Investigation Team regards this as a contributory factor and a fundamental flaw in the care pathway within the CMHT at that time.

Contributory Factor 9: There were missed opportunities to offer Mrs. S a full and timely needs assessment via the duty system which may have contributed to a better understanding of her situation**.**

Contributory Factor 10: Mrs. S's needs might have been better met through the allocation of a Community Psychiatric Nurse who may have been more focused on monitoring and trying to stabilise Mrs. S's mental state prior to social engagement.

Contributory Factor 11: As a consequence of the lack of formal assessment there was no case formulation or care plan to address Mrs. S needs.

Contributory Factor 12: There was a failure to adhere to National and Local CPA standards and policy.

Contributory Factor 13: The Independent Investigation Team found that the care coordinator failed to understand the significance of her own observations or apply her knowledge of mental health and South Asian culture. The care coordinator had a limited understanding of the role and function of a care coordinator as outlined in the CPA policy and consequently failed to meet the requirements of this role working within the confines of a generic social worker rather than the role of a social worker within a specialist mental health team.

Contributory Factor 14: There was a failure to adhere to the local risk assessment policy.

Contributory Factor 15: The Independent Investigation Team regards the omission to formulate a care plan as a failure on the part of the Health Visitor (HV) to fulfil her role.

Contributory Factor 16: Reflective practice was under developed in HV 2.

Contributory Factor 17: There were further missed opportunities for the Health Visiting services to reflect on the case in relation to the high Accident and Emergency attendance.

Contributory Factor 18: The Children and Families social worker did not liaise with the care coordinator about the impact that Mrs. S's mental health problems were having or could have, if her condition deteriorated, on the children not just on her physical ability to care for them but also in her emotional ability to care for them.

Contributory Factor 19: The professionals involved did not liaise sufficiently, share and collate all the information available, or reflect on and plan the care that could have been offered to Mrs. S. This had a direct influence on how she was perceived and is a significant contributory factor in the inadequacy of the care and treatment offered to Mrs. S.

Contributory Factor 20: Clinical practice within the Mental Health Trust did not conform to internal policies and procedures.

Service Issues

The Independent Investigation Team found three service issues:

Service Issue 1: Medication was changed by the CMHT based on a brief assessment over the phone and without the patient being seen.

Service Issue 2: Individual clinicians within the CMHT did not produce and maintain Mrs. S's clinical records to a professional standard. Local team management systems failed to detect these shortcomings.

Service Issue 3: HV2 failed to document the assessment of the family's health and needs.

Conclusion

Mrs. S had three distinctive episodes of care with the Mental Health Trust between 2002 and 2005. It is the final episode of care from 11 May 2005 until 31 August 2005 that has been the focus of this report. Both The Mental Health Trust and the PCT staff interviewed were of the belief that there was nothing in Mrs. S's history or presentations, whether known or not known at the time, that were predictive to the events of August 2005. Whilst it is impossible to say that the events of August 2005 could have been avoided, it is possible to say that the way that Mrs. S's and her situation were perceived influenced the care and treatment plan and this could have been managed more effectively in that her mental illness could have been assessed and monitored more robustly.

Whilst it is probably only with hindsight and a great deal of reflection that there is some clarity about what may have led to events that occurred on 31 August 2005 there are lessons that can be learnt across all services to the approach taken in the mental health care of South Asian women.

As stated in the discussion and analysis in Casual Factor 1:

It is relatively rare for women to kill their children[2] *and the Independent Investigation Team can only speculate as to what Mrs. S's thoughts were at this time. What is clear is that the power, fear and control factors that operate within the honour system to the detriment of women played a significant part in the lives and deaths of Mrs. S and the children. It is the Independent Investigation Team's conclusion that to a certain degree Mrs. S was driven to commit suicide and there is a need to acknowledge this over and above the suicide being committed as a result of the depression brought on by the marital problems. However it would be wrong to stereotype all Asian women in this way and clearly state that the importance of living and working in a multi cultural society cannot be relegated to second place and the onus has to be on those who provide the services to be aware of these factors and ask the right questions.*

[2] Friedman S, Horwitz S, Resnick P, M.D. 2005 Child Murder by Mothers: A Critical Analysis of the Current State of Knowledge and a Research Agenda American Journal of Psychiatry 162:1578-1587

3.6 Recommendations

Recommendation 1: The Cultural Competencies Toolkit needs a separate section to address the cultural issues that are clearly significant to experiences in South Asian culture. Reference needs to be made to honour codes and 'izzat' both of which are fundamental to the experiences of South Asian communities. In highlighting these experiences examples can be given about help-seeking behaviour, births, practices, customs and other areas that are relevant to the communities being addressed including sources of help.

Recommendation 2: Learning from the cultural issues raised in this report need to be incorporated into the clinical leadership programmes offered by the Trusts.

Recommendation 3: All service users must be offered the opportunity to be interviewed on their own. When there are specific cultural or gender issues where this is not appropriate a chaperone should be considered. When there are known instances of abuse or coercion the service user must not be seen with the perpetrator.

Recommendation 4: The Independent Investigation Team recognise that the Mental Health Trust has taken action to address the medical capacity within the CMHT and would like to support the Trust further by recommending that the Trust works with the Commissioners in Primary Care to develop a protocol to transfer those patients who are well and stable within their "mental illness" to primary care services and thereby more effectively use specialist mental health services to treat and monitor those who are unstable or unwell.

Recommendation 5: The Nurse Lead Practitioner plays an integral and important role in the day to day running of a CMHT and greater efforts must be made to ensure the post is covered whether this is through enabling a suitable team member to act up or offering the post as a development opportunity to the wider Trust. Consideration also needs to be given to how this post is professionally supported to reduce attrition rates.

Recommendation 6: The Trust needs to review the CMHT Operational Policy to ensure that all the contributory factors noted in this report have been addressed, in particular the role and function of duty workers and the interface between the OPA and duty systems.

Recommendation 7: Priority needs to be given to the development of the CMHT practitioners to ensure that the operational policy and the changes therein are implemented. Further, practitioners must be given the opportunity to develop as advanced practitioners through non medical prescribing, Adult Mental Health Practitioners, coaching, and mentoring etc to ensure their full development to meet patient needs and the challenges of the future.

Recommendation 8: The Trust needs to introduce and develop the concept of case formulation to underpin and promote robust clinical practice and to embed policy within practice.

Recommendation 9: The CPA policy was reviewed in 2008. The Trust should undertake a full audit to ensure that the revised policy had been implemented effectively and that practitioners are operating appropriately.

Recommendation 10: Consideration needs to be given to the development of core competencies for duty workers, team leaders and managers that are in keeping with the Knowledge and Skills Framework and the National Occupational Standards to support the implementation of the Operational Policy. Core competencies should be completed with Care Coordinators as part of their annual appraisal process.

Recommendation 11: The Trust needs to revisit the supervision policy with a view to enhancing integrated practice and not limiting this to uni professional groups.

Recommendation 12: Whilst some of the record keeping issues have been negated through the introduction of the electronic record system (RiO) i.e. dates and names, clinical files should be scrutinised as a matter of course during supervision to ensure they are up to date and that Trust policy is being followed especially in relation to the CPA process. Managerial supervision notes should be recorded in the clinical file.

Recommendation 13: Clinical files should be scrutinised as a matter of course during supervision not only for accuracy but also quality and appropriateness of mental health interventions.

Recommendation 14: The PCT should actively take responsibility for developing reflective practitioners and where there are staff who fail to engage with this or show no evidence of continuous learning, their capability for the job should be reviewed in the context of performance appraisal.

Recommendation 15: Ealing Primary Care Trust should require both GPs and Health Visiting staff to consider whether inappropriate anxiety in a parent as exhibited by one who takes the children too frequently to the doctor, hospital or health visitor clinic may be pathological and share that information with the CMHT if it is involved.

Recommendation 16: Where it is known that a parent is in receipt of mental health services the assessment of the children must incorporate the views of the care coordinator or the clinician working with the service user.

Recommendation 17: The RiO system will assist in supporting local management to ensure that policies are adhered to in a timely manner however it will not ensure the quality of what is recorded. It is therefore recommended that a protocol be developed through the clinical governance system in conjunction with the commissioners' to ensure that core assessments, risk assessment, crisis and contingency plans and care plans are completed to an acceptable standard.

Recommendation 18: Where it has been identified that there is a gap in the skill or knowledge base of a practitioner this must be immediately incorporated into their Continuing Professional Development Plan and form part of their annual appraisal.

4. Incident Description and Consequences

At 10:56am on Wednesday, 31 August 2005 Mrs. S was seen on Closed Circuit Television (CCTV) walking towards Southall Railway Station along South Road with her two children, Child 1 and Child 2. Child 2 was in a push-chair, being pushed by his mother.

They were then seen by members of staff at Southall Railway Station on four occasions up until 13:00 hours. On two occasions members of staff prevented them from going down to Platform One, which is a non-stopping platform at Southall Railway Station. On those occasions, Mrs. S had said that she wanted to take the children to watch the fast trains.

Platform One at Southall Railway Station is adjacent to the fast down line which is used by express trains travelling away from London which do not stop at the station. The platform has unrestricted access from the booking hall area and there is no gate or barrier to prevent people going there.

At 11:43am, Mrs. S called her husband from a public telephone at the railway station and she said, “I am sorry. I am sorry for everything. Say sorry to everyone. I have always loved you. I am going”. She confirmed that the children were with her. This was seen on CCTV and the time was confirmed by the billing records from the telephone in question.

At approximately 13.00 that afternoon Mrs. S was seen on Platform One at the bottom of the stairs holding one child by the hand with another child in her arms.

At 13.00 hours the Heathrow Express train left Paddington Station. At 13.17 the train approached Southall Railway Station at a speed of approximately 100 mph. This was on the fast down line which goes through Platform One.

The driver saw two people, one taller than the other, walking towards the edge of the platform and he sounded his high lobe warning horn to warn them of his approach. He saw them take two or three steps backwards and believed that they had responded to the horn.

When the train was approximately half way along the platform the driver saw them jump in front of the train in what appeared to be a deliberate act, and described them as 'holding hands', with the smaller person pulling back. He described seeing them in mid-air and then landing between the running lines in front of the train, tripping and falling over.

The driver applied the emergency brakes at 13:17 hours, then he heard a contact. The timing of the emergency brakes being applied is confirmed by the black box which is kept by the train**.**

The Coroner recorded the circumstances in relation to Mrs. S in "that it was at about 1:15pm on 31 August 2005, the deceased was struck by a high speed train on the tracks at Southall Station. She had been suffering from a depressive illness and jumped from the platform with her two young children intending to cause all three deaths". The Coroner recorded that the deceased took her own life.

In relation to Mrs. S's daughter, Child 1, the Coroner recorded it was 1:15pm that she was struck by the train, and added that her mother pulled her by the hand as she jumped from the platform intending to cause her death. A verdict of unlawful killing in relation to Child 1 was made. Likewise with her son, Child 2, his mother carried him in her arms as she jumped from the platform intending to cause his death. The Coroner again recorded a verdict of unlawful killing.[3]

[3] West London Coroners Court Transcript

5. Background and Context to the Investigation

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

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

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

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

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

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

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

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

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

6. Terms of Reference

An external investigation should demonstrate and promote good practice by being open and honest in addressing any shortfall in service provision to service users and carers. The introduction of a Clinical Governance framework of setting standards, sharing information and developing partnerships should already have encouraged a culture of openness. Services for patients and improved quality of care should flourish thus moving away from the 'blame culture'. The main outcome must be to increase public confidence and to promote professional competence.

Therefore such an investigation should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar happening. To enable this task to be carried out, the investigation Independent Investigation Team will use the following Terms of Reference:

1. To examine the mental healthcare received by Mrs. S in the context of her life history, taking into account any issue raised by cultural diversity which appear to be relevant, in order to obtain a better understanding, In particular:

The extent to which Mrs. S's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90)23, and local operational policies.

The extent to which her prescribed care plans were:

- Effectively drawn up
- Delivered and complied with by Mrs. S

The appropriateness and quality of any assessment, care, treatment plan and supervision having regard to her past history to include:

- medication
- staff responses to service user and carer concerns
- involvement of Mrs. S and her family in the appropriateness of her care plan
- the range of treatments /interventions considered

- social care interventions
- reliability of case notes and other documentation

Her assessed risk of potential harm to herself and others compiling a comprehensive chronology of events leading up to the suicide and homicides on 30th August 2005. This to include specifically:

- risk of Mrs. S harming herself or others
- training of clinical staff in risk assessment
- systems and procedures in place at the time of Mrs. S's contact with services

2.To consider the effectiveness of interagency working, including communication between the mental health services and other agencies with particular reference to the sharing of information for the purpose of risk assessment.

3. To review and assess compliance with local policies, national guidance and statutory obligations including the appropriateness of use of the Mental Health Act regarding admission, discharge and the granting of leave, and compliance with Human Rights legislation.

4. To review the internal investigation into the care of Mrs. S already undertaken by West London Mental Health Trust and Ealing Primary Care Trust, and any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and assess the effectiveness of their implementation.

5. To comment on the care and support offered to the perpetrators family at the time of the incident and during the internal investigation.

6. To comment on the decision taken by the Area Child Protection Committee not to undertake a Chapter 8 review of the case.

7. To consider such other matters as the public interest may require including the support offered to Mrs. S's family following hers and the children's deaths.

8. To consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence.

9. To prepare an independent report by HASCAS, for Ealing Primary Care Trust, and any other relevant bodies.

10. Use *root cause analysis* as appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.

11. To ensure that any action plan and recommendations take full account of the progress that both NHS Trusts have made since the completion of the internal investigation report.

7. The Investigation Team

This Investigation was undertaken by the following Independent Investigation Team of professionals who are independent of the healthcare services provided by the West London Mental Health Trust and the Ealing Primary Care Trust.

Helen Waldock, Investigation Project Lead, Director of Nursing HASCAS
Dr Elizabeth McDonald, Consultant Psychiatrist
Jasvinder Sanghera, Karma Nirvana
Sally Gooch, Independent Health Visitor Consultant

Independent Advice to Independent Investigation Team
Ashley Irons, Solicitor, Capsticks
Janet Mountford Children's Health Service Manager
Alan Watson, Independent Social Worker Consultant

Support to the Investigation
Christopher Welton Investigation Manager HASCAS

8. Investigation Methodology

NHS London commissioned this Independent Investigation under the Terms of Reference set out in Section Seven of this Report. This Investigation was led by a project manager from the Health and Social Care Advisory Service (HASCAS). In July 2008 a meeting was held with the PCT and later NHS London and HASCAS to discuss and confirm the terms of reference.

On the 23 July 2008 a meeting was held with the Trust Director of Nursing and the Associate Director for Service Development & Partnerships to discuss how the process would be undertaken. At this stage a preliminary identification was made regarding further documentary evidence that the Investigation Team would require

On the 1 August 2008 a letter was sent to the last known address of Mrs. S's uncle, as the closest family relative, informing him of the forthcoming role of HASCAS in leading the Independent Investigation into the care and treatment of Mrs. S. There was no reply to this letter and a further letter was sent on 14 August 2008, again there was no response.

Written consent from the Caldecott Guardians from the Mental Health Trust and the PCT was received on 18 August 2008 and 20 August 2008 respectively.

All witnesses were written to four weeks in advance of their interviews detailing the Terms of Reference of the Investigation, the areas that the Investigation Team would be questioning them about and the operational process of the Investigation. All witnesses from the Mental Health Trust and the PCT were invited to attend an informal meeting on 26 September 2008 to meet the Investigation Project Lead, the CEO from HASCAS and the HASCAS solicitor from Capsticks. During this meeting the process was explained and a question and answer session conducted.

A further briefing session was undertaken by the Investigation Project Lead with the clinical staff from the PCT on 29 September 2008.

In October 2008 the Investigation Project Lead obtained access to the Investigation conducted in 2005 by the British Transport Polices. Notes were taken from the interviews conducted by the British Transport Police.

In November 2008 the recording of the inquest into the deaths of Mrs. S, Child 1 and Child 2 was transcribed and made available to the Independent Investigation Independent Investigation Team.

All documentation received by the Independent Investigation Team was indexed and paginated.

Witnesses called by the Investigation Team

Evidence was received from a total of 25 individual witnesses over a period of five days between November 2008 and January 2009. Ten of these witnesses had been involved directly in the clinical care offered to Mrs. S between 1999 and 2005 the other fifteen witnesses undertook managerial responsibility for the services or had been involved with the internal investigation processes. All witnesses were encouraged to bring either a colleague or a trade union representative to their interviews for support. All witnesses were offered the opportunity to speak to the Investigation Team Leader for any further clarification that they may have required prior to their interview taking place.

Date	Interviewee	Interviewers
3rd November 2008	Consultant Psychiatrist WLMHT Staff Grade Psychiatrist WLMHT Social Worker CMHT (Care Coordinator) Named Nurse Child Protection WLMHT Sector Manager WLMHT CBT Therapist Ealing PCT	Dr McDonald, Sally Gooch, Jasvinder Sanghera Helen Waldock
14th November 2008	Service Manager WLMHT Associate Director Local Services Consultant Child Psychiatrist Head of Ealing Adult Health Services Consultant Psychiatrist and Clinical Director (Ealing)	Dr McDonald, Sally Gooch, Helen Waldock

	Deputy Chief Executive Responsible for Ealing Service Development Unit Medical Director WLMHT	
18th November 2008	Associate Director, Learning and Development WLMHT Health Visitor 2 Community Staff Nurse Health Visitor 1 Named Nurse safe guarding children EPCT Health Visitor Managers General Practitioner	Dr McDonald, Janet Mountford, JasvinderSanghera, Helen Waldock
2nd December 2009	Executive Director of Clinical Governance Director - Children & Families. Ealing Council Consultant Paediatrician Social Work Assistant CBT Therapist	Dr McDonald, Sally Gooch, Helen Waldock
9th January 2009	PCT Executive Director of Governance and Integrated Commissioning Manager	Sally Gooch, Helen Waldock

Root Cause Analysis

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

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organizational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is

evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.
RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this potential causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone. (Details of the Decision Tree and the Fish Bone can be accessed from the National Patient Safety Agency website).
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. This is set out below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Information and Evidence Gathered

During the course of this Investigation over 7,000 pages of documentation were received by the Investigation Team. The documentation received was used to collect evidence and formulate conclusions. It comprised the following:

Series 1: West London Mental Health Trust

Series 1A : West London Mental Health Trust Serious Untoward Incident Report

Series 1B; West London Mental Health Trust Investigation archive

Series 1C : West London Mental Health Trust Clinical records

Series 2: Ealing PCT

Series 2A General Practitioner Clinical Records

Series 2B Ealing PCT Time line and SCRP records

Series 2C Health Visiting Records (including family health needs, child 1 and 2 health needs)

Series 3: Ealing PCT Policies and Procedures

Riverside Community Health Care NHS Trust Child Protection policy and Procedures 2001

Ealing PCT Child Protection Policy 2005

Overarching protocol for information sharing in Ealing 2007

Perinatal Depression Protocol for Primary Care

Interim Guidance for staff failed access visits (undated)

RCHC Record Keeping Standards1999

RCHC Immunisation Standards 2001

RCHC New birth standards 1998

RCHC Movement in and no access contact of families with children under five years 2000

RCHC Respond to crying baby referral 1999

London Child Protection Procedures 2003 (NB there are 299 pages in this document)

Ealing agreement for the reporting and reviewing of serious, death and significant no harm Patient safety incidents across health organisation 2005

Ealing PCT Suicide Prevention Strategy 2005 and 2009

Ealing PCT Staff Competencies
Interim Guidance for staff on Failed access visits
Ealing PCT Health and Wellbeing Referral Form
Ealing Mental Health and Wellbeing Service-Service Specification

Series 4: West London MHT Policies and Procedures

Ealing Mental Health Single Line Management Structure 2008 (Section 31 Agreement)
Ealing Mental Health Single Line Management Structure 2004 (Section 31 Agreement)
List of policies 2002-2008
CPA Interim Arrangements July 2008
Care Programme Approach Policy C2-RIO 2008
CPA (Care Management) 2003 (ref C2)
Strategy for the Meaningful Involvement of People Caring for someone with a Mental Health Problem 2005/8
Local Services Procedure for Point of Discharge Summary, 'To Take Away' Medication and 7-Day Follow-Up
Choosing talking therapies
Contacts for Child Protection Revised October 2006
Child Protection Policy 2004 Ref C18(Current)
Child Protection Policy 2003 Ref C18
Safeguarding Children-all Trust Services; draft for consultation August 2008
Allegations of child abuse 2005 (Ref C18B)
Visits to psychiatric inpatient by Children 2006
Interim Guidance for staff on Failed access visits
Agreement for Reporting and Reviewing of SUI's 2005
Ealing CBT referrals protocol
Medicines Ref (M2) August 2006 (Current)
Medicines policy April 2006
Medicines policy 2004
Medicines policy 1998

Series 5: WLMHT Supporting Documents

Clinical Governance Support Structure 2008
WLMHT SUI Monitoring data base

Research and Governance Annual Report 2007-8
Integrated Risk Reduction Service 2008
Safe Guarding Children Governance Structure 2008
Reporting Relationships for safeguarding children
Statutory and Mandatory Training Guidelines
Safeguarding Report 2009
Cultural Competency Tool Kit
WLMHT Annual Report-Safeguarding Children 2008-09 A Report from the Medical Director
Seven Steps to Patient Safety
Strategy for RiO implementation
The rates of completion and accuracy of RiO core assessment documentation in a home treatment setting
Clinical Improvement Groups (CIGs) Terms of Reference 2005
Clinical Audit report 2005
Clinical Research and Governance Annual Report 2007/08

Series 6: Ealing Social Services
Case Notes

Series 7
Inquest Transcript
British Transport Police (notes taken from the investigation archive)
Crimes of the Community Honour Based Violence in the UK 2008 Centre for Social Inclusion

10. Profile of the Mental Health Services (Past and Present and Transition)

West London Mental Health Trust was created in 2001 by the merger of Ealing, Hammersmith & Fulham Mental Health Trust, and Broadmoor Hospital Authority.

It was further enlarged by the absorption of the Hounslow Mental Health Services following the dissolution of the Hounslow & Spelthorne Mental Health and Community Trust in 2002. In 2003, the remainder of the Hounslow services for adults and older people previously based at Ashford Hospital was also absorbed into the Trust.

The Trust's services span four broad service areas:

i) High Security Services at Broadmoor Hospital. This has a catchment area of London & the south of England and provides for male patients only.

ii) Forensic Services commissioned by a consortium of PCTs across the old north west sector of London. This includes the Women's Enhanced Medium Secure Unit (The Orchard), The Regional Secure Unit (The Three Bridges), the Adolescent Forensic Service (The Wells Unit) and low secure rehabilitation services.

iii) Local mental health services in the three London Boroughs of Ealing, Hammersmith & Fulham and Hounslow. Each borough provides CAMH services, adult and older people's services. Each borough has fully integrated NHS and Local Authority Social Care services for adults and older people. The services in Ealing and Hammersmith & Fulham are supported by Section 75 legal agreements. (Section 75 of the NHS Act 2006 provides an enabling framework to allow for improved joint working between local authorities and NHS partners)

iv) Specialist services with a national catchment area. This includes the Gender Identity Service and the Cassel Hospital Psychotherapy Service.

Ealing, the Borough in which this incident occurred, is the eleventh largest London Borough in area and the tenth least densely populated of the boroughs. There were 305,658 Ealing residents in mid-2005. Ealing is the third most populous London Borough. Ealing's population growth of 6% between 1991 and 2001 was above the growth in London (5%) and England (2.6%). Projections suggest that by 2028 the population could be 320,000.

The three Boroughs are all ethnically diverse. Ealing has Black or minority ethnic communities of about 40%, with 25% describing their ethnicity as Asian or Asian British. At electoral ward level, ethnic diversity varies from over 80% Black or minority ethnic residents in Southall to less than 20% in Southfield. Ealing also has the largest Sikh community in London and large Muslim and Polish communities.

The Trust aims to meet the diverse needs of a local population of nearly 700,000 people across the three local Boroughs. The Trust employs around 4,000 staff across 32 sites in four London Boroughs and Bracknell Forest.

Profile WLMHT 2004-2005

The West London Mental Heath NHS Trust is a complex organisation providing a spectrum of mental health services for patients with differing levels of need. Their vision in 2004/05 was to provide continual service improvement and to be a leader in the provision of high quality mental health services through being innovative and responsive to patient needs, and inclusive of staff, users and carers in developing and delivering their services. Within the Trust there are '*many viewpoints but one vision'* to develop and improve the service and care offered to patients.

In "Looking Forward" the Trust aimed to work with its partners, to develop better:

- Community understanding and acceptance of mental health issues
- Care and maintenance of patients in the community without the need for hospital admission
- Access and choice for patients to appropriate treatments and mental health professionals
- Access to housing, employment, debt counselling, training, voluntary services, supportive friendships and leisure activities

Profile 2007/8

This time saw a marked improvement in the Trust annual health check results from the Healthcare Commission. At the time of the interviews by the Independent Investigation Independent Investigation Team the Trust were rated 'excellent' for quality of care and 'good' for use of resources, improving on ratings of 'good' and 'fair' in 2006/7. These

ratings placed the Trust among the best performing Mental Health Trusts in London and the best performing of the three trusts which are responsible for high secure services.

The Trust approach to care is based on promoting recovery for all service users, aiming to help the people who come into contact with the Trust to lead a more fulfilling life. The approach to this is holistic and goes beyond simply treating symptoms.

On the 1st October 2008 the Trust was reorganised with the creation of five Service Delivery Units (SDUs) to replace the 13 previous clinical directorates. The five SDUs are:

- Ealing
- Hammersmith & Fulham (including gender identity clinic)
- High secure services
- Hounslow (including the Cassel Service based in LB Richmond)
- West London forensic services

In 2008, the Trust produced a Clinical Strategy, which, building on past aims and achievements, but within the context of the new organisational structure, sets the direction for clinical and care delivery services over a five year period. It was, and continues to be, driven by one overarching concern: to deliver the best possible service to patients.

This is to be achieved through five key, trust-wide principles: safeguarding and improving safety and clinical quality, ensuring services are built around individuals' needs, working closely with partner organisations, playing a part in wider networks of care and to be responsive and accountable to those that services are provided for.

Based upon these principles, the strategy identifies the following service developments over the next five years:

i) Services provided according to need, not age
ii) Recovery-based care pathways
iii) Improved access to psychological therapies
iv) Team working for effective delivery of clinical services
v) Closer working with primary care

vi) Shorter lengths of stay where clinically appropriate
vii) Better patient experience in inpatient care

Each of the five Service Delivery Units in turn developed three-five year Service Development Plans which outline in detail the delivery of the Clinical Strategy, the service developments listed above and the Trust Annual Corporate Objectives. The plans are refreshed and reviewed annually, and progress against them monitored routinely through the year.

The Trust Corporate Objectives for 2009/10 are as follows:

i) To further develop high quality care
ii) To modernise local secondary mental health services
iii) To improve interfaces with primary care
iv) To deliver psychological therapies
v) To further develop specialist services for personality disorder and gender dysphoria
vi) To redevelop Broadmoor Hospital
vii) To further develop medium and low secure services
viii) To redevelop St Bernard's Hospital site
ix) To achieve Foundation Trust equivalent status (as defined by the Department of Health)
x) To maintain financial stability

Ealing Mental Health Promotion Strategy

The inter-agency Mental Health Promotion Strategy for Ealing (2005-2008) included interventions designed to promote self-esteem, increase social inclusion and develop skills such as communicating, negotiating, relationship and parenting skills and reduce structural barriers to mental health. The following actions have been undertaken or are planned to promote mental health:

- Mental health awareness training targeting at a variety of audiences including front line staff, health educators and health visitors.
- Publishing a series of articles aimed at reducing stigma and discrimination

- Organise local activities and campaign in support of World Mental Health Day with a particular focus on addressing stigma and discrimination associated with mental ill health.
- Promote the emotional health and well-being of children and young people, with a specific focus on interventions in early years.
- Use creative ways to engage. CMHTs routinely invite local faith leaders into their teams and the 'cultural competency toolkit' designed to help clinicians understand patients' cultural needs, won two national awards.
- Closer coordination of mental health actions with borough-wide stakeholders to provide an improved service offering.
- Ensuring that Mental Health Action Plan and the Suicide Action Plan are complimentary in their actions.
- Appropriate mental health resources within the re-designed Public Health Library.

Ealing Primary Mental Health Care Developments

- A new integrated service is also being delivered through primary care called the Well Being Mental Health Service. A holistic approach, which supports a patient-led service embracing the diverse communities and the complex set of needs within Ealing. The new service will provide a quick and easy access for patients, clear pathway for patients, one point of access for GPs, a clinically cost effective service, ensuring professional development for the teams as well as proactive patient participation. The multi-disciplinary team includes:
  - Gateway Workers - working with moderate to severe patients with mental health problems providing in depth assessments and referring/supporting patients on to other agencies working closely with secondary care and the voluntary sector. Frequently seen patients who fall through the gap of services currently being provided with very complex needs.
  - Graduate Workers - working with mild to moderate mental health problems (depression, anxiety issues and panic disorders) using self-help workbooks, with one to one and telephone support (CBT based).
  - Cognitive Behavioural Therapy (CBT) Therapists (employed by West London Mental Health Trust) working within primary care, supporting patients for a short term intervention for 6 to 8 sessions or for a longer term intervention.

- Counsellors - offering brief psychological interventions usually up to 6 sessions for issues such as relationship difficulties, complex bereavement.
- Beating the Blues - self-help computer package recommended by NICE, based within surgeries for patients suffering from depression using a computer software package, the graduate workers support patients.
- Community Development Workers – using well-being as a tool to intervene and strengthen the black and minority ethnic communities within Ealing.
- Twining (social enterprise) Vocational Worker – working with mental health patients wanting to return or needing support to continue to work.
- Ealing PCT have also been successful in securing funding for 'Improving Access to Psychological Therapies', Department of Health funding in order to increase Cognitive Behaviour Therapies to support people getting back into work.

11. Chronology of Events

Mrs. S was a married Asian lady born in 1977 in the United Kingdom. She was an only child who was brought up by her mother in the presence of her maternal grandmother as her parents separated when she approximately two years of age. It would seem that Mrs. S had numerous consultations with her GP and was frequently taken by her mother to Accident & Emergency when she was a child for minor ailments. This in some respects laid down a pattern of behaviour for later life. Mrs. S grew up in a caring environment with an extended family network with whom she had close contact especially her cousins. Mrs. S attended school until the age of eighteen completing a Certificate in Business Administration and a Computer Course at college. She worked as a receptionist at a local radio station.

Mrs. S met her husband while visiting India in 1995 and they married a year later in 1996. Mr. and Mrs. S were both from a Sikh background and the marriage was mutually arranged and agreed through their families. Mrs. S sponsored her husband who joined her in the United Kingdom in 1997.They had two children, Child 1 born in 1999, and Child 2 born in 2003. Child 1 was female and Mrs. S was disappointed as she had hoped that their first child would have been male, she felt that she had failed her husband. Mr. S is reported as being less concerned with this matter and happy at having a healthy daughter[4].

Mrs. S was first referred to mental health services in April 2002 by her GP as she was experiencing thoughts preoccupied with germs and the concern that her husband and Child 1 may become ill. Mrs. S was cleaning at home several times a day, washing Child 1's hands excessively, checking doors and windows prior to leaving the house and constantly seeking reassurance from her husband. Her symptoms were restrictive and prevented her from leaving her home. A diagnosis of Obsessional Compulsive Disorder was made and Mrs. S was successfully treated with a Cognitive Behavioural Approach from a therapist and Sertraline, an antidepressant, from her GP. At this time Mrs. S felt that her problems were related to her childhood when her parents separated. Mrs. S referred to some difficulties in the relationship with her husband which in her view were due to him coming from India and her being born and brought up in the United Kingdom.

[4] GP Records pg 32

Mrs. S also described having a loving relationship with her husband. Mrs. S had approximately twelve sessions of Cognitive Behavioural Therapy at fortnightly intervals including joint sessions with her husband who played a supportive role in her therapy and educational sessions. When seen for a follow up session in 2003 Mrs. S was working part time and enjoying a good social life.

In March 2003 Mrs. S was referred to the Children and Families Social Services whilst pregnant with Child 2 by the Health Visiting Service who had noted Mrs. S's history of depression and Obsessive Compulsive Disorder and requested an assessment in the post natal period. A plan was made to visit Mrs. S after the delivery of Child 2 and to liaise with all agencies and arrange a network meeting if necessary. The assessment was to consider Mrs. S's support networks, previous child care history, preparation for the birth of her baby and a possible psychiatric assessment prior to discharge from hospital.

Mrs. S gave birth to Child 2 in October 2003 and was visited by a social worker whilst on the ante natal ward at Ealing Hospital. The hospital staff did not have any concerns reporting that Mr. S was supportive, washing and changing the baby. Mrs. S informed the social worker that she was having problems with her husband as he did not tell her that he loved her enough and sent money home to his family in India. Mr. S is noted to have "adored his daughter" but did not have a good relationship with his mother in law. Mrs. S felt positive about the recent birth especially as it was a boy and no further action was deemed necessary.

Child 2 was taken to A&E twice in the first two weeks after birth, once for a high temperature and the other time as Mrs. S reported episodes of 2nd and 3rd right toes turning purple. No abnormality was noted.

On the 20 October 2003 Mrs. S consulted Health Visitor 2 (HV2) and confided that she had suffered from postnatal depression for two years following the birth of Child 1. Mrs. S stated that she was helped to feel better by going back to work and commented that she may do this again when Child 2 was six months old. Mrs. S's current problems were documented as she appeared to be getting everything out of proportion. She also reported feeling tired and slowed down. She was worried about:
(1) Husband didn't give her enough support. Doesn't praise her enough.

(2) Difficulty with waking in the night and morning to care for baby.
(3) Naming baby has caused conflict. She wants X and he wants Y.
(4) She couldn't cope with his cousin coming to stay.
(5) She doesn't like him sending money back home to his family.
(6) At the birth of Child 1 she was very disappointed with the gender.
Plans for the immediate future included her husband's mother coming to stay for six months and that she was expecting a visit from a Social Worker. HV2 contacted social services about their involvement, noting that there were no concerns about Child 2 and that she felt that Mrs. S had a childlike expectation and made demands of her husband.

A follow up visit was made by Social Services on 19 November 2003. No concerns were noted in the red book (child health record). Mrs. S was very nervous about the paternal grandparents coming as they were going to discuss her relationship with her husband. Mrs. S reiterated her concerns about her husband stating that he did not listen and that they argued about little things. Mrs. S did not believe that Mr. S was putting his family first as she claimed that he sent a lot of money to India. No safety issues were identified and a sense of stability was noted in the family as they were committed to working things out. The social worker also noted that it appeared that Mrs. S had unrealistic expectations of her husband.

On the 23 November 2003 Child 1 was diagnosed with asthma. Mrs. S continued to take the children to A&E every two weeks and made frequent contact with the Health Visiting Service to discuss her concerns about the children.

By 15 January 2004 social services had closed Mrs. S's case as there had been no further contact with her and there were no child protection issues.

On 20 April 2004 A Community Staff Nurse (CSN1) was allocated by the HV2 to work with Mrs. S, at her request, as she wanted to be seen by a Registered General Nurse.

21.April 2004 CSN1 began visiting Mrs. S at home to discuss home management, food preparation and to encourage Mrs. S to use local facilities where a crèche was available. CSN1 also discussed with Mrs. S her anxieties about her relationship with her husband and suggested that they might want to consider seeing a counsellor. At the second visit on the 28 April 2004 CSN1 demonstrated baby massage. This was noted as a positive

experience for both mother and child. The visit on 5 May 2004 focused on relaxation technique and addressed concerns in relation to managing daily chores. The following day Mrs. S attended a child and toddler group where she was noted to be chatting to other mothers and enjoying her time there.

On the 9 May 2004 both children were seen at A&E as they were unwell. Child 1 was admitted to hospital for observation. This was followed up by CSN 2 on 11 May 2004 when she contacted Mrs. S to arrange a home visit. This visit was cancelled due to the CSN1 being unwell.

On 14 May 2004 Child 2 was taken to hospital where antibiotics were prescribed for an infection.

The next planned contact by CSN2 with Mrs. S was on the 20 May 2004 with the plan that the CSN would meet with Mr. S. Mr. S was helping with children and discussed the family difficulties. Mrs. S was to attend her GP in the afternoon to ask for antidepressants. The CSN1 encouraged Mrs. and Mr. S to make time to go out together. Mr. S was willing but informed CSN1 that Mrs. S found it incredibly difficult to leave the home, especially when she had lot of chores to complete. The following day a further visit was recorded where Mrs. S was advised about routines for the children. Mrs. S's mother was present at this visit helping to prepare the lunch. Mrs. S informed CSN2 that she had decided not to take the antidepressants prescribed by the GP on the advise of the pharmacist as at that time she was still breast feeding.

Child 2 was taken to A&E on 22 May 2004 as Mrs. S was concerned. The Senior House Officer (SHO) recorded Mrs. S as being depressed as she was finding it hard to cope at home claiming that her husband was unsupportive. The SHO noted: fleeting suicidal thoughts, no thoughts of harming children, would never harm them and that Mrs. S has been waiting longer than six months to see a counsellor. In terms of risk assessment the SHO recorded that Mrs. S had not made any previous suicide attempts, nor harmed herself and that she did not use drugs or alcohol. The SHO advised against taking antidepressants as Mrs. S was breast feeding. Mrs. S was reassured about the health of Child 2 and the SHO was to write to the GP for an early psychiatric or counselling appointment.

Mrs. S was seen at home by CSN1 on 24 May 2004. Mrs. S was described having had a better week end and that she had been feeling more positive as she had joined a gym and had discussed her difficulties with her husband.

Child 2 was taken to A&E on 26 May 2004 and diagnosed with an Inguinal Hernia. The following day CSN1 recorded a telephone call from Mrs. S who was very stressed and visited her later in the day. CSN1 recorded that Child 1 had attended A & E with tonsillitis and had been prescribed antibiotics and referred to a Consultant. Child 2 had also attended A & E and been referred to a Consultant. Both children had appeared very well, eating lunch and playing, Mrs. S was reassured. CSN1 discussed Mrs. S's relationship difficulties with her and Mrs. S exploring the possibility of going out as a couple and leaving children with Mrs. S's mother.

Further contact was made by Mrs. S with CSN1 on 1 June 2004 as she was feeling very down following a heated discussion with her husband. The CSN1 visited Mrs. S on 3 June 2004 at her mother's house and gave weaning advice for Child 2 who was going to hospital to have a hernia repair on the 7 June 2004. Mrs. S was continuing to feel anxious and was given information about Rishul an Asian counselling organisation.

On 7 June 2004 Child 2 was taken to A&E as he had been crying excessively. Child 2 was scheduled for surgery the following day but Mr. and Mrs. S did not wait to be seen The Sister from A&E contacted Mrs. S later and reassured and advised her about the forthcoming surgery. The following day Mrs. S was seen at home by CSN1 who advised Mrs. S to get up and change Child 2's nappy to prevent dressing from becoming soiled. Mrs. S reported that she and her husband had a row and it was suggested the couple needed to see a counsellor together. Mrs. S agreed to discuss this with Mr. S.

On 9 June 2004 Mrs. S took Child 2 to A&E to have the dressing from the hernia repair changed and again on 11 June 2004 when a diagnosis of tonsillitis was made and antibiotics prescribed. It is also recorded that Child 1 had a chest infection. On 13 June 2004, Child 1 returned to A&E where a diagnosis of acute tonsillitis with an evolving viral infection was made. Mr. and Mrs. S were reassured, advised to encourage oral fluids and return or see the GP if they had any further concerns. The following day the Liaison Nurse at A&E contacted CSN1 raising concerns about the level of attendance. CSN 1 discussed this concern with HV 3 who advised discussion with a Community Psychiatric

Nurse. A couple of days after this CSN 1 was contacted by Mrs. S and they discussed a potential referral to mental health services and it was noted that Mrs. S did not want to pursue the option of Asian Counselling. Later that day the CSN1 discussed her concerns with the GP who asked the CSN1 to write to him requesting a referral.

CSN1 made a home visit to take Mrs. S to the supermarket on 21 June 2004. However Mrs. S stated that she was too tired and that she would like to go on another day. Mrs. S informed CSN1 that she had stopped breast feeding and was that she was considering taking antidepressants and that she had an appointment booked to see the GP that evening.

On 23 June 2004 the CMHT received a referral letter from the GP, this was replied to on 30 June 2004 following a screening process asking Mrs. S to make an appointment. Mrs. S was also sent a letter offering her an appointment for 16 September 2004.

On 1 July 2004 there was further contact with the Liaison Nurse who was updated on the progress with the mental health referral. On 5 July 2004 CSN 1 had three telephone contacts with Mrs. S. Initially Mrs. S reported that she was feeling more positive and confident and that she had found the book about distracting her negative thoughts very helpful. Mrs. S stated that she had decided not to take the antidepressants. Later in the day Mrs. S contacted CSN1 stating that she felt as though she had hit rock bottom and that she would take antidepressants. Forty minutes after this there was further telephone contact with Mrs. S who was feeling very low, crying, and feeling panicky. CSN1 gave Mrs. S time to relax and talked her through relaxation techniques. CSN1 visited Mrs. S at home the following day, Mrs. S reported that she was still feeling low, and that she “cannot cope, doesn't want to do this anymore, doesn't want responsibility of children, husband not understanding". Mrs. S had contacted the CMHT and explained to them how she was feeling and requested an earlier appointment, she had been advised to come and see a duty worker. At the end of the visit with CSN1 Mrs. S stated that she was going to try and make an effort and would continue taking the antidepressants.

On 7 July 2004 CSN 1 discussed the case with HV2 highlighting the following concerns:
(1) Mother's perception of crystals in milk believing that it was contaminated.
(2) Won't let Child 2 crawl on kitchen floor as "dirty" although floor is clean.
(3) Not responding to baby's smiles.
(4) Force feeding Child 1 reported by mother.

(5) Unable to cope with day to day tasks e.g. cooking.
(6) Excessive A & E attendance.
The following plan was made:
(1) Discuss with father, grandmother and mother, where are we going from here?
(2) Discuss with GP
(3) Discuss with school

HV2 spoke to Mrs. S's mother who declined the invitation to attend the meeting stating that she believed that Mrs. S needed:
(a) More attention from her husband.
(b) To see the Psychiatrist before September.
(c) More practical help in the home.
(d) Would like HV2 to check that Mrs. S is taking her medication.

On 9 July 2004 the CMHT duty worker contacted Mrs. S who stated that she was not able to speak in detail on the phone and that she was worried about her children. Mrs. S was willing to come to duty as she wanted to talk to someone. The instructions written on the duty file were to organise a visit for assessment OR encourage client to visit to possibly see the locum psychiatrist and refer for child 1assessment if concerned. It was recorded that the case seemed urgent and that duty were to see Mrs. S. and arrange a short care plan prior to OPA in September.

Throughout July and August both children were ill with a variety of infections with Child 2 requiring admission for a short period of time. During this time there were several attempts to contact Mrs. S by the CMHT. Somebody from Duty contacted Mrs. S on 15 June 2004 who informed the duty worker that her mental health issue was not a priority at that time as she had other things to deal with but that she would contact the services when she was ready. The plan at that time was that no further action was required.

On 6 September 2004 the police referred the family to Ealing Housing and Social Services as the children had came to the attention of the domestic violence unit. It was reported that Mrs. S appeared to have had an argument with Mr. S about the children. Mr. S is alleged to have struck Mrs. S in the face and pushed her up against the wardrobe. Mr. S had been arrested. No evidence of violence towards the children was

recorded. Mrs. S had decided not to press charges and went to live with her mother and grandmother for one week. Mrs. S was very distressed at this time making several phone calls to the CSN2 for emotional support.

Mrs. S kept her appointment with the CMHT on 21 September 2004 and was seen by the Consultant Psychiatrist, in the presence of her maternal uncle who did not speak English. Consequently the Consultant spoke in Punjabi, where a full history was recorded. Mrs. S was distressed due to her relationship problems. Mrs. S. had an arranged marriage in India seven years previously and her husband had followed her to England one year after that. She stated she had always had difficulty in communicating with her husband and over the past year she had had additional problems as her parents-in-law had come over from India for five months. She had been feeling under their scrutiny as they had been "critical and unhelpful". In addition for several months there had been minor health problems with the children and she did not feel her husband had been very helpful. There had been several rows between her and her husband and he had left her one week before, "there had been the threat of separation from her husband for the past two to three months". Mrs. S. stated she felt she was helpless and unable to cope without her husband. She was very distressed. She had poor appetite but no weight loss. She had no sleep disturbance. She had suicidal thoughts but no intention as this would compromise her children. She had no psychotic symptoms.

Some months previously she had been prescribed Prozac by her GP but had not taken it. A few weeks previously she had been prescribed Diazepam also by her GP but had not taken that either. Her grandmother had a history of depression and was on anti-depressants.

Mrs. S's mother was 55 years old. Mrs. S had "felt the stigma attached to her mother's divorce". She had been born in the United Kingdom and had finished her education aged 18 years with a Certificate in Business Administration having also done a computer course at a local college. She worked as a receptionist at a local radio station for two years until Child 1 was born and then returned to work on a part-time basis from 2001 to 2003. She owned her home jointly with her husband. She complained that she had "communication problems with him and felt he was indifferent to the children". There had been "one episode of violence towards her from her husband some time before to

which the police had been called". She had decided "not to press charges". Mrs. S had been living with her mother and grandmother for the past week. She described her premorbid personality as someone who had always lacked confidence and was a 'worrier'. She did not smoke tobacco or drink alcohol. Her presentation was smart, calm and co-operative. Her speech was normal. The Consultant diagnosed an adjustment disorder due to relationship issues. The recommendation was that Mrs. S contact Relate and she was referred her back to her GP.

Between October and December 2004 there were several contacts with the CSN1. Mrs. S's mother informed the CSN1 that as the marriage had been arranged the family was trying to take some actions to sort out their differences. Mrs. S stayed with her mother until the middle of November 2004 and then returned to her own home. During this time Child 2 attended A&E on four occasions.

On the 21 January 2005 Mrs. S, a maternal aunt and the children went to India to "fetch her husband". By February 2005 Mr. and Mrs. S had returned from India and were living together with the children.

Child 2 attended A&E once in February and three times in March. At a routine child health clinic in April HV2 notes that Mrs. S had lost weight and that Mr. S had returned to the marital home. In April HV2 notes that Mrs. S anxiety levels were increasing and that she had been prescribed antidepressants by her GP. HV2 contacted the Asian Family Counselling Service to arrange some support for Mrs. S who had returned to live at her mothers' house as she felt she was not coping.

On 12 May 2005 Mrs. S contacted the CMHT where it is noted that she was very depressed and tearful. Two days later the GP made an urgent referral to the CMHT describing her as having been suicidal 2-3 months ago, having lost her appetite and weight noting her concerns about her children although they were both healthy. The GP had prescribed Cipralex 10 mgs on 15 April 2005. Mrs. S was seen on the same day by a locum staff grade psychiatrist in the presence of her maternal uncle. Mrs. S presented as "not being able to think straight, crying all the time, feeling useless with low energy"; her uncle and mother were looking after the children as she was withdrawn and requiring prompting to do anything (psychomotor retardation is recorded). It was recorded that

there were no thoughts of self harm or psychotic symptoms and a diagnosis of moderate depressive episode with a background of marital difficulties with emergence of OCD was made. The plan was to increase Cipralex to 15mgs and review in two weeks.

Mrs. S was reviewed by the permanent Staff Grade Psychiatrist, in the presence of her husband, as he had returned from leave on 26 May 2005. Mrs. S's anxiety had reduced although she remained tired and 'muddled up with low mood, poor concentration and appetite". No rituals or obsessions were noted. The Staff Grade was of the opinion that Mrs. S was over medicated and reduced the Cipralex to 10 mgs with the plan to review in four months and advised about access to the duty system and A&E. The Staff Grade also planned to make a referral to the Children in Need Team although this did not happen until 6 June 2005 stating that there were "severe interpersonal difficulties" between husband and wife and concerns with Child 1 who may be at risk of neglect.

Following this consultation on 7 June 2005 Mrs. S contacted the duty worker at the CMHT. She was distressed stating that she could not cope with the children. Contact was made about this with the Children's Service who in turn contacted Mrs. S. Mrs. S informed them that she needed help as things were out of control with the children and the house; she stated that she had been advised by the Staff Grade Psychiatrist to stop taking her medication for a week as it was not helping; Mrs. S's concerns were that Child 2 drank too much milk and Child 1 would only eat pasta. The social worker from the children's service spoke to Mr. S who stated that he helped as much as he could although Mrs. S still became distressed at times and agreed to take her and the children to her mother and grandmother's to stay.

On 8 June 2005 the case was allocated to a social worker within the Children's Service for an assessment.

On 9 June 2005 Mrs. S contacted the duty system and informed them that she did not wish to start the new medication (this was not new medication just a lower dose of the same medication) prescribed at her previous consultation with the Staff Grade Psychiatrist. The duty worker discussed this with the Staff Grade Psychiatrist who contacted the Children's Service. The Staff Grade Psychiatrist agreed to Mrs. S not taking medication as long as she remained in contact with services.

HV 2 contacted the CMHT on 14 June 2005 requesting information about their involvement with Mrs. S and was advised by a duty worker to contact the Staff Grade Psychiatrist directly. Later that day HV2 made an unannounced home visit to Mrs. S. Mrs. S presented as very strained and informed HV2 that she saw a psychiatrist at Southall Norwood Hospital and that she wasn't taking any medication as it did not help. The plan was that HV2 would contact the psychiatrist and try to get an earlier appointment for Mrs. S which she did but he was not available for discussion. A couple of days later CSN 2 contacted Mrs. S to arrange a visit and noted that Mrs. S was feeling very depressed and not able to speak for long.

There was further duty contact with the CMHT on 17 June 2005 when Mrs. S called very distressed again stating that she could not cope with the children. Mrs. S expressed that she was feeling low and had felt like this for a long time, anxious that she was not caring adequately for her children. The duty worker contacted HV2 who informed the duty worker that Mrs. S tended to be anxious about the children. The duty worker also spoke to the children's team and was advised that a social worker would be in touch on the following Monday. There were no concerns about Mrs. S over the weekend as Mr. S would be at home and available to help with the children.

The Children and Families Service visited Mrs. S at home on 21 June 2005 and reported that they did not have any concerns about the children. The social worker also contacted HV2 who reported that Mrs. S needed to engage with external resources to get herself out of her current situation and that they had explored play groups and the Asian Family Counselling service with her. The social worker noted that Mrs. S will try to get the children to eat more than they require. The social worker attempted to contact the GP and the psychiatrist although neither was available.

Over the next week CSN 2 made several attempts to contact Mrs. S by phone eventually arranging a home visit for 30 June 2005. At this visit the home was reported as being untidy with lots of toys in the hallway. Mrs. S had presented as being low in mood and stated how difficult she found preparing meals for the family. Child 2 was asleep on the lounge floor. Mrs. S expressed concerns about the children's diet. The children were up to date with their immunisations and had been physically well with no attendance at A & E. Mrs. S informed CSN2 that she had an appointment to see the Psychiatrist at

Norwood Hospital the following day and CSN2 suggested Mrs. S ask for a Community Psychiatric Nurse (CPN).

Mrs. S was seen for the second time by the permanent Staff Grade Psychiatrist on 1 July 2005 again in the presence of her maternal uncle. She was found to be experiencing "low mood, ideas of self-harm, with no specific plans but described as vague thoughts along with increased sleep and appetite, poor energy levels and concentration". Mrs. S described her "husband as being unsupportive and that interpersonal relations had been strained". A diagnosis of Recurrent Depressive Disorder was made noting that the current episode was a moderate depression with some somatic symptoms and was psychosocial in its origins. Her medication was changed to Sertraline 50mgs with a view to increasing this to 100mgs in two weeks and an urgent request was made to the CMHT manager for a CPN to be allocated. Mrs. S was to be reviewed after feedback from the allocated worker.

CSN2 followed up Mrs. S by phone on 7 July 2005 enquiring what happened in her appointment with the psychiatrist and arranged to see her on the following day at the toy library.

On 13 July 2005 Mrs. S was allocated to a social worker in the CMHT who was to take on the role of Care Coordinator. It was noted that Mrs. S was socially isolated and experiencing thoughts of self-harm. The Care Coordinator contacted Mrs. S who requested to meet her at her mother's address as she was feeling nervous and would like support. Mrs. S agreed to call back and arrange for a date and time for the visit.

The Care Coordinator made the first home visit on 18 July 2005 at her mother's home. It was noted Mrs. S was spending most of her time there. Mrs. S talked mostly about her children and expressed her concerns about their food intake. At one point she became tearful and requested that she be supported every day. She felt her medication needed reviewing and she remained very anxious. She had increased her Sertraline to 75mg per day as advised during her outpatient visit. It was also noted that her mother was actively involved in helping her look after the children. A plan was made to see Mrs. S on a weekly basis and she was advised to contact the Care Coordinator if she continued to feel the medication was not helping her.

On 19 July 2005 the children's service contacted the GP for background information and were informed that Mrs. S had suffered similar problems after Child 1 was born although not as severe and that she had made many visits to Ealing and Hammersmith Hospital but "they got fed up".

Mrs. S contacted the duty system on 22 July 2005 with concerns about her medication. This was brought to the attention of the Staff Grade Psychiatrist who noted the complaint of dizzy spells and decided that the dose of her medication could not be increased further. Mrs. S was advised to omit the Sertraline and advised to take Paroxetine 10mg daily and that a prescription would be left for her at the CMHT.

A second visit was made by the Care Coordinator on 27 July 2005. It was noted that Mrs. S was at her home address and appeared more "chatty". She was not taking any medication and was given a prescription for a new antidepressant. It was also noted that she appeared more willing to engage with other services and her Care Coordinator agreed to provide her with more information during the next visit.

Between 28 July 2005 and 2 August 2005 both CSN1 and the social worker from the children's service attempted to contact Mrs. S without success.

A third visit by the Care Coordinator occurred on 2 August 2005. Mrs. S reported that she had not been taking the medication and felt that she had nothing to look forward to, believing that she was a bad mother although she had attended to her children when ever they approached her and had taken them to the park that day. Mrs. S disclosed she had been through a difficult time when she gave birth to a baby girl rather than a baby boy. She had felt "rejected by her in-laws" and felt "guilty and upset" for disappointing them. She also felt she had been managing and maintaining her household well before her mother-in-law came over from India. Since then she had been struggling and had brought cooked meals from her mother's house. Mrs. S also discussed her relationship difficulties with her husband which had led to him leaving home for four to five months and that she had been to India to "bring him back". However the Care Coordinator noted that she thought Mrs. S was managing quite well and that she needed some educational input and reassurance in relation to the bringing up of her children.

CSN1 telephoned Mrs. S on 4 August 2005 and was informed that she had stopped her medication as it was making her feel drowsy, also that she had been prescribed an alternative which she was trying to avoid taking. CSN1 planned to call again the following week to plan a trip to Golf Link Toddlers. The children were noted to be well.

A further assessment visit by Children and Families Services was scheduled for 8 August 2005 but was subsequently cancelled due to staff illness.

The final visit by the Care Coordinator was on 17 August 2005. Mrs. S reported that she was feeling ok and that she was still not taking her medication. She was notably somewhat withdrawn and not expressing her concerns and worries to her mother. Her mother felt that Mrs. S would benefit from home help while Mrs. S wanted to do the household chores herself. Mrs. S said she would prefer not to receive visits from professionals including the Care Coordinator during the school holidays in case Child 1 started worrying that something was wrong. A plan was made to maintain contact over the telephone for the next few weeks.

At some point around this time Mr. and Mrs. S and the children had a short holiday in Blackpool.

The Children & Families Services assessment had been rescheduled for 22 August 2005 at home. However this occurred on 30 August 2005 and it was reported that there were no major concerns about the children. Mrs. S was reported to be in an elevated mood which was viewed as an improvement on her presentation at their first meeting. This was the final contact with any professional prior to the incident.

It was the following day 31 August 2005 that Mrs. S took her own life and those of her children at Southall Station.

On the 21st February 2006 Mrs. S's mother died after being hit by a train at Southall Station.

12. Timeline and Identification of the Critical Issues- RCA Second Stage

The Independent Investigation Team formulated a Timeline in table format (Appendix 1) and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. This represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

Areas of Concern Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified areas of concern that rose directly from the care and treatment that Mrs. S received from the West London Mental Health Trust, Ealing PCT and Ealing Children and Families Social Services. A total of 58 areas of concern were identified and four prominent themes identified

1. Medical management
    - Role of psychiatrist in CMHT
    - Medication
    - Diagnosis

2. CMHT intervention
    - Assessment, intervention, CPA
    - Medication management
    - Referral to talking therapies
    - Allocation
    - Record keeping
    - Risk assessment
    - Carers assessment

3. Health Visitor Involvement
    - Role of the community staff nurse
    - Action on the A&E referrals
    - Mental health assessment and action taken
    - Management and case load

4. Interagency working at a clinical level

- Mental health
- Health visiting
- A&E attendance
- GP care
- Children and Families Social Services
- Parents who have a mental illness

Critical Issues Arising from the Time Line and Review of other Data

The Independent Investigation Team identified critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below to reflect headings of the Independent Investigation Terms of Reference. These are examined in detail in Section 13 of this report.

1. Cultural Diversity. Mrs. S was of Asian background and the significance of this in relation to her then present circumstances did not appear to have been a consideration in the approach taken by any of the agencies with whom she had contact

2. Medical Management: Mrs. S was initially seen by members of medical staff within the Out Patient/ Community Mental Health Team mental health service; there appeared to be a lack of cohesion within the service structure. Five critical issues arose from the examination of all data related to these contacts:

- Medical consultations
- Diagnosis
- Medication
- Medical reviews
- Referrals to other services

3. Community Mental Health Team Intervention: there were weak operational systems within the CMHT in 2005 due in part to the lack of an operational policy and the absence of a nurse team leader leading to reduced multidisciplinary working. Four critical issues were identified:

- Management systems
- Referrals
- Duty system
- Allocation of care coordinators

4. Care Programme Approach. The Investigation Team were not able to identify an assessment or care plan within the CMHT records. There was no evidence to indicate that a CPA meeting was in the process of being organised. Further critical issues were identified as:

- Case loads
- Supervision

5. Risk Assessment. There was no evidence of a full and complete risk assessment having been completed

6. Documentation. There were date discrepancies within the clinical record, some entries were difficult to read having been made in shorthand, there was no clear audit trail as to what decisions were made and by whom

7. Health Visiting Services. The Independent Investigation Team identified seven areas for further investigation:

- The level of health visiting contact
- Assessment
- The role of the Community Staff nurse
- Care planning
- Supervision
- Maternal mental health assessment
- The level of attendance at A&E

8. Children and Families Social Services Involvement (Safeguarding Children)

9. Involvement of the General Practitioner

10. The level of Interagency Working

The above ten critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not necessarily have a direct causal bearing upon an incident.

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

RCA Third Stage

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

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

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

Key Causal Factor: The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon Mrs. S's mental state, which subsequently may have led to the suicide and homicides that occurred in August 2005. In the realm of mental health service provision it is never a simple or straight forward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent suicide or homicide perpetrated by them.

Contributory Factor: The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mrs, S's mental health and/or the failure to manage it effectively.

Service Issues: The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of August 2005, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

13.1 Critical Issue 1: Cultural Diversity

Introduction

The Independent Investigation Team has been in the privileged position of being able to review all the documentation that relates to this case and consult with a recognised expert on South Asian Culture. The Independent Investigation Team appreciates and accepts the notion of cultural sensitivity but also recognises that reports are often coy and overly politically sensitive in addressing these issues. However this case relates to an "honour system", izzat, which is not solely about individual men controlling individual women but about family dynamics, community norms and values, social policing and collective decisions. In the spirit of learning lessons and understanding the Independent Investigation Team believes that it is important to be bold and address the cultural issues of this case, where four people died, directly and initially in order for the care and treatment offered to Mrs. S to be seen in context.

Context

Britain is a multicultural society. Nearly 6.4 million people in England belong to ethnic minority communities'[5]. Ethnic minority communities in England share a number of features, disadvantage and discrimination often characterise their experiences in this country in almost every aspect of life. This is particularly prevalent in the area of health and healthcare. Those from minority ethnic groups tend to suffer from poorer health, have reduced life expectancy and have greater problems with accessing health care than the majority white indigenous population. However, there have been many policy and service initiatives within the National Health Service aimed at reducing ethnic variations in disease incidence, access to care and service experience by service users.[6]

[5] Office of National Statistics. United Kingdom National census 2001
[6] *The National Service Framework for Mental Health – Five Years On*. 2004 London: HMSO;

Mental health is an area of particular concern for the minority communities in this country. For years, the disparities and inequalities between black and minority ethnic groups (BME) and the indigenous white population in the rates of mental illness has been the focus of concern, debate and research. Of all the mental health issues, the significantly raised risk of suicide and attempted suicide among young women of South Asian origin is of particular concern. By the year 2010, reducing the suicide rate by 20% is a key national mental health target with emphasis on South Asian women.[7]

A history of a suicide attempt appears to be an important predictor of future suicide risk.[8] All studies apart from one have reported that the risks of self-harm and suicide attempts, as well as completed suicide, are higher in South Asian women as compared to the British indigenous population. Young women of South Asian origin are at a high-risk for suicide, even though they may not have a previous psychiatric history.[9]

Cooper et al, (2006) reviewed some of the literature about young South Asian women (16–24 years) who have a 1.5 fold increase in risk compared to indigenous white British women in the same age group. Underlying factors that have been identified through research indicate that gender role expectations, pressure for arranged marriage, individualisation and culture conflict, marital problems, and interpersonal disputes all contribute to the increased rates of suicide in this cultural group. All the studies mentioned indicate that rates of attempted and successful suicide are significantly higher among South Asian females particularly among the younger age group.[10]

One major precipitating factor in South Asian women who harm themselves is marital problems. In a study by Merrill and Owensin (1986) South Asian women reported marital problems more frequently and the majority of these problems were due to cultural conflicts. A few of the Asian women in the study reported that their husbands demanded that they behave in a less westernised fashion. Also, they reported that their mother in

[7] *The health of the nation: a strategy for health in England.* London: HMSO; 1992
[8] Pokorny AD. Prediction of suicide in psychiatric patients. Report of a prospective study. *Arch Gen Psychiatry.* 1983;**40**:249–257.].
[9] Cooper J, Husain N, Webb R, Waheed W, Kapur N, Guthrie E, Appleby L. 2006 Self-harm in the UK: differences between South Asians and Whites in rates, characteristics, provision of service and repetition. *Under review.*
[10] Bhugra D, Baldwin DS, Desai M, Jacob KS. Attempted Suicide in West London, II. Intergroup comparisons. *Psychological Medicine.* 1999;**29**:1131–1139

laws interfered with the way they ran their lives and marriages. Such factors, along with arranged marriages, rejections of arranged marriage proposals and other marital problems place pressure on South Asian women, and thus were reported as precipitating factors for self-harm and suicide.

Most South Asian communities maintain their traditional cultural identity and place great importance on academic and economic success, the stigma attached to failure, the overriding authority of elders and an unquestioning compliance from the younger members. Such cultural attitudes place hard-to-meet expectations on Asian youth leading to increased pressure and stress. A qualitative study of South Asian women in Manchester found that issues such as racism, stereotyping of Asian women, Asian communities, and the concept of *"izzat"* (honour) in Asian family life all led to increased mental distress.[11] The concept of *izzat* (i.e. honour/respect) is a major influence in Asian family life. According to the women in the study, *izzat* was pervasive and internalised and it prevented other community members from listening and getting involved.[12]

Furthermore, many Asian families are critical about the behaviour of women and it is very important whether this is seen as 'good' behaviour according to the community since it is essential in gaining status and prestige for the family. Within the community, women are subject to powerful traditional practices such as izzat and sharam (shame). Women are expected to uphold the honour of the family by conforming to certain prescribed roles, as the dutiful and obedient wife and daughter, who accepts or tolerates domestic violence rather than leave home. Failure to do so results in being treated as a social outcast by their extended family and wider community. The burden of izzat is unequally placed upon the women in South Asian families and as a result this creates hard-to-achieve high expectations of women as daughters, daughters-in-law, sisters, wives and mothers. Therefore, many women in the study felt as though they had nobody to trust and would not speak to anyone in the community. This led to an increased sense of isolation.

[11] Merril J, Owens J. Ethnic differences in self-poisoning: a comparison of Asian and white groups. *British Journal of Psychiatry.* 1986;**148**:708–712.
[12] Chew-Graham C, Bashir C, Chantler K, Burman E, Batsleer J. South Asian women, psychological distress and self-harm: lessons for primary care trusts. *Health and Social Care in the Community.* 2002;**10**:339–347

Background

Mrs. S's mother was born and brought up in India and moved with her parents to the United Kingdom around 1970. She married her husband in 1972 with Mrs. S being the only child from the union. It was reported that her father left immediately after her birth and never returned to the family home.[13] Mrs. S's parents divorced in 1977. Mrs. S was brought up by her mother and her grandmother attending local schools and college'. Mrs. S's mother is recorded as having reported that as a child Mrs. S was a "normal happy girl who enjoyed watching films and listening to music; she did have friends although she did not go out much".[14]

Mrs. S had an extended family (an uncle who was married with four children, an aunt who was married with two children) who lived in the locality and an aunt who resided in India. The family were of the Sikh faith.[15] They were described as a close family that "tried to compensate and reduce the stigma of her not having a father",[16] with lots of family involvement, and being close to her cousins. Mrs. S was described as a very nice child "like a doll". The uncle was regarded as the head of the family and generally if there were problems in the family this would be where advice would be sought.[17]

In 1995 Mrs. S went to India with her mother and maternal aunt staying with her other aunt who resides in India. Mr. S's family where known to the Aunt living in India who arranged an introduction to Mr. S. The families had arranged the meeting to ascertain if the couple was agreeable to a marriage. This visit lasted for three and a half weeks, and at the end of the stay in India there was a verbal agreement about their engagement.[18] Mrs. S's mother is recorded as reporting that if "Mrs. S did not want to marry she had the choice not to but that she had not been looking at anyone else for Mrs. S to marry at that time".[19] They corresponded for a year before Mrs. S her mother and a male cousin went to India for the wedding.

[13] BTP notes pg 4
[14] BTP notes pg 7
[15] Inquest transcript pg 5
[16] BTP notes pg 4
[17] BTP notes pg 6
[18] Inquest transcript pg5
[19] BTP notes pg 7

On return from the wedding Mrs. S continued to live with her mother and grandmother and after a year Mr. S joined the household.

Child 1 was born in 1999 and it is reported that Mrs. S was very upset that the baby was a girl. Mr. S was aware that Mrs. S was depressed and reported that 'she would get upset with me (Mr. S) and her family'. There is evidence to suggest that Mr. S actively participated in the care of Child 1 being aware that she was depressed "still having things inside her about not giving me a boy".[20] Mr. and Mrs. S moved to their own home in 2000. There are several references to Mrs. S complaining that Mr. S was more concerned about his family in India than he was about his wife who was concerned that he would send money to India to support his family. At some point prior to the birth of Child 2 the couple went to India and on their return Mrs. S confided in her mother that her mother in law had directed her to find a job to help with the financial burden of the mortgage and that Mr. S had changed as he had started shouting at her and bullying her.[21]

In 2003 Mrs. S became pregnant with Child 2. Mr. S was aware that Mrs. S was becoming depressed and easily agitated. It is reported that there was a disagreement about a cousin coming to stay as Mrs. S believed that she had enough to do with being at work, running the house and looking after child 1 and did not want the burden of "having another person to serve".[22] Around this time Mr. S went to India on his own for three months as "I (Mr. S) was angry and said that I would go this time". Mr. S returned to the UK at some point prior to the birth of Child 2.

In October 2003 Child 2 was born and the family temporarily moved to Mrs. S's mother's house. It is recorded that Mrs. S's mother reported that "Mr. S not only expected me to look after the baby but would tell Mrs. S to tell me to look after the baby; he would not consider it (the baby) as his responsibility".[23]

[20] BTP notes pg2
[21] BTP notes pg 7
[22] BTP notes pg 2
[23] BTP notes pg 7

After the birth of Child 2 Mrs. S was very happy as this child was a boy but Mr. S was aware that she was "really struggling; she had a chart (height and weight) from the doctor and she always wanted child 2 to be top of the chart; he wasn't and she would get very upset and cry because he wasn't doing well although the doctor and the nurse would tell her that he was fine; she would walk around with a spoon for hours trying to get the children to eat worrying that they did not have enough". [24]

When they returned to their own home Mr. S's parents came to stay as "there were problems looking after two children" Mrs. S's mother in law was described as a "typical Indian mother in law, domineering".[25] Mrs. S apparently informed her aunt they would criticise her cleaning, cooking and complain about how long she took in the bath and that she was not able to look after the children. It is also documented that Mrs. S confided in her mother about her mother in law's expectations of her in that that Mrs. S was expected to take on all the domestic responsibilities, cooking, cleaning, caring for the children and that when the men returned from work they should rest and that she was not to ask her husband for help. However when they left this increased the pressure on Mrs. S as she did not have any help with the domestic chores or the children.[26]

Mrs. S also confided in a friend that she had known from school that she was finding it difficult to cope with both children. The friend's observations were that when the mother in law was staying Mrs. S allowed her to do most of the work within the house as she struggled to keep the same standards.[27]

In August 2004 there was an incident of domestic violence where Mrs. S had called the police and Mr. S had been arrested. Mrs. S's cousin is noted as reporting that Mrs. S "was more concerned about having called the police than she was about the incident". [28] Mrs. S informed her aunt and said that she had called the police as Mr. S had hit her and pushed her and her aunt told her that she should have called us (the family) "as this would bring dishonour on the family". Mr. S then left the family home to visit his brother in America.

[24] BTP notes pg 2
[25] BTP notes pg 5
[26] BTP notes pg 8
[27] BTP notes pg 10
[28] BTP notes pg 6

Mrs. S was very upset about Mr. S leaving and tried to contact him on many occasions and it is reported that he would not answer her calls and that the mother in law refused to let her speak to Mr. S. The aunt recalled that at some point Mr. S did speak to Mrs. S and that she became extremely distressed "we could not control her, she was banging her head against the wall as she did not want her husband to leave her".[29] Mrs. S returned to live at her mother's house.

The friend was aware that Mr. S had left the marital home without telling Mrs. S due to the stress and strain of the relationship. The friend was also aware that Mrs. S had informed her mother that the friend was advising her about the marriage and believed that Mrs. S's mother tried to terminate their relationship as when she visited the mother would tell her that Mrs. S was not there although the friend could hear her. Mrs. S and her friend had "resorted to meeting on the street" where Mrs. S confided that "she felt so lonely that she felt like going somewhere to kill herself".[30]

Mrs. S's aunt in India went to see Mr. S's family; they were very upset that Mrs. S had called the police. They did not want Mrs. S to contact Mr. S and had agreed that they would discuss the matter as a family when their other son returned from abroad.

Mr. S returned to the United Kingdom but he did not contact Mrs. S.[31] They met by chance in the street. Mr. S informed Mrs. S that he could not go back to her as "there was family involved" Mrs. S's aunt reported that "Mrs. S had to go to India to talk about the matter and sort out the problems, we offered for Mr. S's family to come here (UK) but they declined they wanted their whole family at the meeting, uncles, aunties everyone; we wanted to speak to the family without all of them present but they refused".[32]

The maternal aunt went to India with Mrs. S and the children. Mr. S's family was reported as still being very angry with Mrs. S. The maternal aunt reported that about ten or twelve of Mrs. S's family came to see them stating that Mrs. S had brought shame and dishonour on the family by calling the police, everyone spoke at the same time, Mrs. S was very humiliated and did not get a chance to speak. Apparently Mrs. S would be

[29] BTP notes pg 5
[30] BTP notes pg 11
[31] BTP notes pg 6
[32] BTP notes pg 5

taken back into their family only if she agreed to move with Mr. S to America and that she was not allowed to call the police or talk to her family if there were problems or Mr. S would return to India immediately.[33] Mr. S apparently made it "very clear that if Mrs. S wanted to live with him (Mr. S) then things had to be different".[34]

On their return to the United Kingdom Mr. and Mrs. S appear to have been happy although the level of contact with her mother and maternal aunt had declined. On one occasion it is recorded that they went as a family to have dinner with a friend of Mrs. S and her respective family. After this occasion Mrs. S did not speak to this friend when passing in the street.[35] After a few months both Mrs. S's mother and the maternal aunt expressed their concerns as Mrs. S appeared to be depressed as "Mr. S spent most of his time with his friends leaving Mrs. S with the children……..she (Mrs. S) would cry all the time, daily, nothing would set her of".[36] Mrs. S went to live at her mothers' house for a month. Both the mother and the aunt took Mrs. S to see a doctor where Mrs. S was referred to mental health services. At some point Mrs. S confided in her aunt stating that "he has not changed, I regret going back to India".[37] Mrs. S would not allow her mother or her aunt to speak to Mr. S as she was frightened that he would leave her and after she came back from India she never spoke about her problems to her mother.[38] Mrs. S also confided in her friend about the problems she was experiencing in her marriage.

Mr. S was aware that Mrs. S was under the care of the CMHT as "she got letters" and that she worried all the time "that she was not doing enough for the children"[39]. It is documented that Mr. S reported that "Mrs. S would often ring me (Mr. S) at work being upset and crying saying that she could not cope with the children it was not unusual for her to cry on the phone. "She was very frightened of everything, even about crossing the road. Some days, though, she was very happy – taking the children to the park".
The week before the incident the family had been on holiday together, had made plans for Child 1's birthday party and were making plans for the garden.

[33] BTP notes pg 6
[34] BTP notes pg 2
[35] BTP notes pg 1
[36] BTP notes pg 8
[37] BTP notes pg 6
[38] BTP notes pg 8
[39] BTP notes pg2- 3

On Wednesday 31 August, Mr. S was just finishing work when he received a phone call from Mrs. S. Mr. S reported that Mrs. S stated "I am sorry. I am sorry for everything. Say sorry to everyone. I always loved you. I am going". Mr. S asked where the children were and Mrs. S informed him that they were with her. At this point the money in the pay telephone ran out and the contact was disconnected. [40]

Findings

Mrs. S was a British born subject of Sikh faith who attended mainstream school leading her on a path to further education and employment. Mrs. S participated in an arranged marriage in India via introduction from a family member resident in India. There was awareness that Mrs. S's mother was divorced, and that a certain cultural value was placed on the first child being male. All clinical witnesses were aware of the disharmony between Mr and Mrs. S.

The Independent Investigation Team asked the clinical witnesses who were called to interview why this aspect was not critically examined particularly with regard to family dynamics and the occurrence of domestic violence. The transcripts contain the suggested notion that Mrs. S behaviour, the supposed attitude of her husband and the involvement of the extended family were of a "norm" in Asian culture and did not warrant concern. For example "a lady whose interpersonal relationship difficulties had been picked up previously and she has presented again in the context of the same situation";[41] "it is maybe sometimes culture stuff or it is just marital problems";[42] "it was a socio-cultural set-up of an Asian family coming with their norms of sticking to a marriage, no matter how rocky it is".[43]

The clinicians from the MHT in regular contact with Mrs. S at the time of the incident were from an Asian background.

The MHT has a cultural competencies toolkit (2007). The purpose of the document is to ensure the provision of culturally appropriate and sensitive mental health care to

[40] Inquest transcript pg 12
[41] AT 5 pg 8
[42] AT 2 pg 15
[43] AT 7 pg 9

patients. The tool kit has not been designed as a one size fits all, but as a quick reference guide. Further to this it is also designed to summarise the key issues for each minority group relevant to mental health care. The section on the Sikh faith refers to language, diet, hygiene, religious observances, dress, modesty, birth, bereavement and death. On the subject of birth reference is made to "rejoicing especially if it is a boy"[44] with no explanation why this is significant or any potential impact this will have on the mother in terms of pressures she may face from various members of the family. There is no reference to izzat or any honour codes and how these can influence family dynamics or an individual's view of them selves.

Conclusions

Mrs. S was a British born subject of Sikh faith who attended mainstream school leading her on a path to further education which would imply that she had aspirations for the future. This is also an indicator that Mrs. S was able to embrace forms of independence and integration but does not mean that she had the ability to make free and independent choices without pressures from the family.

It is widely documented that Mrs. S's mother was a single parent. Women, who divorce, separate or even challenge their husbands or other male members of the family are treated as morally "loose" and punished with social ostracism. This would therefore have created a position of stigma, shame and even pity that may have led to various pressures for both. The stigma attached to her mother being divorced, which is an experience all children may face, would have, in the view of the Independent Investigation Team, constrained them, as both Mrs. S and her mother would have feared bringing 'shame' onto their family and community. The social stigma attached to women in this position has a negative impact on future generations, particularly daughters, who face lower marriage prospects. This position would have also presented real fears of being socially ostracised by immediate and extended family members.

The family, honour and pride system had been disrupted as a result of Mrs. S's mother's divorce and the family may have experienced levels of being ostracised by the community and additional pressures to conform to the honour codes that clearly existed

[44] Cultural competencies tool kit 2007 pg 46

for Mrs. S. The mother would have a duty to ensure that Mrs. S was safely married as part of preserving the 'family honour' thereby protecting her daughter's future. It is evidently clear that family members were involved in arranging the marriage of Mrs. S. This marriage followed the normal process of Mrs. S working in Britain to secure her husband's visa as she would have sponsored him as a foreign national subsequently followed by the application to make him a British Subject.

The uncle as head of the family would have had influence over any decisions made within the family including the marriage of Mrs. S. Mrs. S's life and her mental well being would have been heavily dominated by seeking the approval of her uncle who, as is shown in later text accompanies her to mental health consultations, and was supportive of her having done her best to maintain the marriage. Mrs. S's life was dominated by her role and responsibility to maintaining the 'izzat' honour of the family and any decision making would have revolved around her putting this concept first as ultimately it dictated her life through various forms and family members.

Mrs. S's life revolved around seeking the approval of not only her uncle but her husband and also her in-laws and other family members. The following examples indicate how she would have experienced anxiety due to these pressures the majority of which revolved around her responsibility to maintaining the honour systems within the family dynamic.

Firstly, Mrs. S experienced pressures of being the obedient and dutiful wife and the 'perfect' daughter-in-law that resulted in an undermining of her role as wife and mother. This is evidenced through Mrs. S's own documented feelings and recorded accounts from her family of how the presence of her in-laws coming to visit was one of scrutiny and not helpfulness. This led Mrs. S to feeling further anxiety and helplessness, as she took on all the responsibilities of the household, including caring for the children to fulfil their expectations. Many family members were aware of the pressures but were not in a position to deal with the underlying issues that were perpetuating the situation, as this would have meant challenging the in-laws, Mr. S and "izzat" itself. Hence the family dynamic was to medicalise the situation and offer reconciliation with outcomes that supported the honour based systems and kept the extended family content. Further to this Mrs. S's life would have been plagued with constant 'put downs' relating to her as a

person and the many responsibilities she carried. This is clearly evident in the number of references that she made to health care professionals regarding how she felt she was undermined through criticisms from her in-laws and that her husband was unhelpful. The fact that her husband did not challenge his family's behaviour demonstrates how they influenced him and also his experience of the pressures to abide by their ways, norms, values and beliefs.

Secondly, Mrs. S described her despair at various times to several practitioners and her family. One example is the around the birth of Child 1, which reinforced her experiences of not being 'good enough' and potentially leading to the internalisation of guilt and shame due to giving birth to a girl.

The family dynamics and the subsequent pressures this put Mrs. S under were reinforced as demonstrated through the significant example of her husband going to India in 2003 and in 2004 after Mrs. S called the police following the incident of domestic violence. The fact that Mr. S left the marital home on two occasions can be viewed as a form of punishment as in Asian culture the threat of divorce or separation can be used to control women and prevent them from challenging their husbands' power or behaviour. The threat of divorce or separation can become part of the abuse in itself because of the severe consequences this has for women.

It appeared Mrs. S became extremely distressed following the separation from her husband in 2004 after she had called the police. Her husband and the family were dishonoured through this act and needed the reassurance that this would not happen again. The arrangement for her to go to India for reconciliation could not have happened without the active involvement of her husband. Mrs. S's experience of the reconciliation trip to India is regarded by the Independent Investigation Team as highly significant as it is probable that she experienced the ultimate in humiliation and powerlessness. In all probability Mrs. S would have been accused of the breakdown of the marriage bringing shame and dishonour onto the family an have come under considerable family pressure to reconcile with her husband who would not have been expected to change his behaviour despite the act of physical violence. The Independent Investigation Team base this view on the evidence that Mr. S did not change his behaviour after the reconciliation spending most of his time with his friends. The reconciliation conditions

imposed on Mrs. S would have increased her sense of isolation, insecurity, anxiety, and hopelessness as she was in effect banned from seeking support or protection from her family and the authorities and therefore silenced from bringing further shame onto the family. This is evidenced through the decreased contact that Mrs. S. had with her mother and her aunt, with whom she had previously confided in, on her return to the United Kingdom and the cessation of contact with her friends.

Whilst it could be viewed as a transgression to seek help in this way there is also the view that Mrs. S. was trying to behave as a dutiful daughter-in-law hence she accepted the need for her in laws to present conditions before her husband was to return to the United Kingdom and her to avoid the shame and dishonour of being a single parent.

There is evidence of a degree of collusion with the honour based system and the imposition of silence through the actions of Mrs. S's mother as she tried to decrease the level of contact that Mrs. S had with another of her friends. This is not to imply that she did not care about her daughter but to emphasise the power of the honour system and the level of fear she may have been experiencing should Mrs. S not adhere to the conditions of the reconciliation agreement.

In 2005, near the time of her death Mrs. S indicated her regret at having gone to India for the reconciliation and that the situation at home was worse suggesting that her husband had become less supportive and possibly more abusive.

Mrs. S's final day and the last words she communicated to her husband were indicative of her experience within the honour systems/environment she lived in. The fact that her last words were "I am sorry, I am sorry for everything, say sorry to everyone. I always loved you and I am going" communicated the level of responsibility she had assumed under the honour code that had governed her life. Over and above all of this Mrs. S never felt that she was good enough which was reinforced by many and led to her becoming silent. Mrs. S had internalised much of the guilt that izzat bestows on women and therefore in the view of the Independent Investigation Team Mrs. S felt that she was in-fact to blame and was even the initiator of a potentially failed marriage.

Mrs. S's fears of hardship, social stigma, and castigation supported by religious and cultural notions of shame and family honour which confine women would have been based on her childhood experiences of her mother's divorce and struggle as a lone parent. It is likely that she would have feared a similar future for her children who would have been twice affected by social disgrace through their mother and their grandmother. Mrs. S. lived with the fear of dishonouring her husband and family in which the collusion had become apparent as she was forced into silence.

Some Asian women who commit suicide can perceive this to be a selfless act. An act of suicide is to protect the family from divorce, separation and therefore dishonour and shame. Some women may, in these circumstances, be driven to commit suicide because of the pressures and the need to preserve 'family honour' although families often silence themselves when such suicides occur reinforcing the silence and systems.

It is relatively rare for women to kill their children[45] and the independent Investigation Team can only speculate as to what was in Mrs. S thoughts at this time. What is clear is that the power, fear and control factors that operate within the honour system to the detriment of women played a significant part in the lives and deaths of Mrs. S and the children.

There is no evidence to support the cultural competencies tool kit being used in practice and it is the view of the independent Investigation Team that this tool would not have helped Mrs. S as it did not consider her experiences and the challenges she may have experienced on various levels. Additionally many of the references related to women act to reinforce honour codified behaviours within families that use culture to oppress women. For example references in the tool kit are made to how 'men prefer' without regard for what women may wish or want. It must be acknowledged that some minority ethnic patients may not wish to be seen by minority practitioners given their fears of being judged, breaking the silence to a member of the same community and real fears about breeches in confidentiality. When working with BME communities in mental health contexts research literature usually states that western medicine often offers an unacceptable service to patients. It is understood that 'white middle class' doctors can

[45] Friedman S, Horwitz S, Resnick P, M.D. 2005 Child Murder by Mothers: A Critical Analysis of the Current State of Knowledge and a Research Agenda American Journal of Psychiatry 162:1578-1587

inadvertently provide culturally insensitive care.[46] Conversely the Independent Investigation Team would like to offer, for consideration, the issue that practitioners from BME communities may be at risk of colluding with oppressive honour systems, which may be part of the practitioner's own belief and value system.

It is the Independent Investigation Team's conclusion that to a certain degree Mrs. S was driven to commit suicide and there is a need to acknowledge this over and above the suicide being committed as a result of the depression brought on by marital problems. The Independent Investigation Team further conclude that the staff, although from an Asian background, were unable to relate to the more traditional values and beliefs held by Mrs. S.

Contributory factor 1: There was a lack of understanding of the significance of the cultural aspects of Mrs. S's background.

Recommendation 1: The Cultural Competencies Toolkit needs a separate section to address the cultural issues that are clearly significant to experiences as there needs to be reference to honour codes and 'izzat' both of which are fundamental to the experiences of South Asian communities. In highlighting these experiences examples can be given about help-seeking behaviour, births, practices, customs and other areas that are relevant to the communities being addressed including sources of help.

Recommendation 2: Learning from the cultural issues raised in this report need to be incorporated into the clinical leadership programmes offered by the Trusts.

[46]Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett,* (2005)

13.2 Critical issue 2: Medical Management of Mrs. S: Diagnosis medication and medical Intervention

Context

There was no operational policy for the Community Mental Health Team in 2005 however the following context was ascertained at interview with clinicians and managers.

In 2005 Ealing was divided into five sectors and there were two sector Consultant Psychiatrists who looked after inpatients and community (CMHT) patients equating to 1.6 WTE across both areas. The inpatient service comprised seventeen beds that were shared between the two consultants according to the address of the patient. Consultant 1 who is involved in this case covered two thirds of the sector (catchment area 36,000) and provided cover for a colleague accounting for three sessions a week.[47]The catchment areas for this sector was over the Royal College of Psychiatrists guidance which stipulates that the catchment area should be around 25,000 per head of population where as the catchment area for this team was around 54,000. [48]

A Staff Grade Psychiatrist worked full time within the CMHT with a caseload of approximately 450 patients.[49] The Staff Grade Psychiatrist offered six outpatient clinics a week where patients would be booked in for assessment and follow up. Each of the clinic sessions kept a slot free for emergencies so that where necessary a patient could be seen on the same day as they were referred. The clinics were organised so that an hour was allocated to see a new patient[50] and thirty minutes to a regular or routine follow up.[51]

The Staff Grade Psychiatrist also offered a 'phone in' clinic on a Friday afternoon between 2pm and 5 pm for any patients that had already been seen to discuss any concerns they may have.[52] The Staff Grade Psychiatrist was based within the CMHT being highly visible and available to all team members and participating in the morning

[47] AT 5 pg 4
[48] AT 5 pg 4
[49] AT 7 pg 5
[50] AT 2 pg 6
[51] AT 7 pg 16
[52] AT 2 pg 10

meeting and attending the weekly multi disciplinary team meeting. The Staff Grade Psychiatrist was supervised by the Consultant Psychiatrist on a weekly basis.

Referrals for a psychiatrist assessment are initially reviewed by the lead practitioners and/or manager within the CMHT who make decisions as to the nature and urgency of the referral. If it is decided that a person needs to be seen urgently they are first assessed through the duty system. If an urgent assessment is then required by a psychiatrist the patient is seen in the urgent appointment time that is kept free within each outpatient clinic.

The main reception is responsible for booking people into the Staff Grade Psychiatrists clinic. Case files would be collected by the administration team prior to a clinic. These would be written in by the Staff Grade Psychiatrist at the time of the appointment and then returned to central administration for filing so that they would be available to the rest of the team.

The Independent Investigation Team was informed that the waiting time for a non urgent first appointment is around three to four months. The routine follow up for all patients is also around three to four months. All patients are advised that if they need to see the psychiatrist before their next appointment then they can present to reception and ask to see the duty worker within the CMHT. The duty worker will then assess the person and decide if it is appropriate to use the reserved urgent session in the clinic schedule for that day. If the urgent session has already been booked then it was custom and practice for the person to be added onto the end of the clinic schedule.[53]

In the wider context the Home Treatment Team was expanding to cover all areas of the Borough. The Early Intervention Team were small and at full capacity, and the Assertive Outreach Team was embryonic.[54] The services were undergoing change in order to implement the Assertive Outreach Team development. The Borough had to be reorganised by reducing the number of sectors from five to four. In effect this brought this sector in line with the other sectors in terms of catchment area numbers.

[53] AT 5 pg8
[54] AT 6 pg 1

Description of events

Mrs. S was referred by her GP to mental health services in 2002. Her GP had started her on Sertraline 50mg daily. She was seen and treated by a Cognitive Behavioural Therapist for obsessive compulsive disorder. Her symptoms included rituals associated with obsessional ideas that Child 1 would become ill and that her husband was becoming ill because of contact with germs. Mrs. S stopped taking Sertraline in August 2002. She responded well to the cognitive behavioural psychotherapy. At the end of treatment she reported that she was 97% improved. She no longer asked her husband for reassurance and she was able to allow Child 1 to eat food without first washing her hands. She was able to leave her flat. She was not depressed though at times felt low in mood due to problems related to everyday life. She was able to maintain a part-time job and was discharged from the Cognitive Behavioural Psychotherapist's clinic in February 2003.[55]

Child 2 was born following an elective lower segment caesarean section on 3 October 2003.

Mrs. S was referred to the Community Mental Health Team by her GP on 23 June 2004. She presented with anxiety and depression following the birth of Child 2. She felt unable to cope and was anxious / obsessional about her children's health. Her concerns led her to make frequent visits to Hammersmith Hospital. The referral stated that she had deep-rooted childhood problems as a result of difficulties between her parents, and she had been seen by the in-house psychotherapist in the week of the referral. She had been prescribed antidepressants by her General Practitioner but she had not taken these.[56] On receipt of the referral a decision was made for a full psychiatric assessment by the psychiatrist to be followed by a multidisciplinary team care plan.[57] A letter was sent to Mrs. S on 30 June 2004 inviting her to call and make an appointment. A copy of this letter had a handwritten note saying 16 September 2004 at the top.[58]

[55] Series 3 pg 69
[56] Series 3 pg61
[57] Series 3 pg64
[58] Series 3 pg 59

Mrs. S contacted the Duty Worker on 9 July 2004 stating that she could not wait for September and needed support soon. She stated that she was worried about her children and felt that she could not attend to them properly. She was advised to come and see the Duty Worker. She was agreeable to this as she said she wanted to speak with someone and agreed to call the following week. The recorded plan was for a duty visit to be made for an assessment or to continue to encourage Mrs. S to visit duty as soon as possible to see the Locum Psychiatrist. The plan was also to include making a referral to the Children's Assessment Team if there were any concerns about the children. It was noted that the case appeared to be urgent and further duty contact was offered.[59] (see CMHT working)

Mrs. S attended her appointment on 16 September 2004 and was seen by the Consultant Psychiatrist in the presence of her maternal uncle. She was recorded as having a history of anxiety and depression. She felt unable to cope with the children and was distressed due to relationship problems. She had decreased appetite though there was no weight loss or sleep disturbance. Suicidal thoughts were present though she stated that she had no intention of acting on these. There were no psychotic symptoms. She appeared to be smartly dressed, calm and cooperative and her speech was normal. She seemed to be preoccupied with her marital problems. The notes stated that Mrs. S "realised that she was not mentally ill and has relationship problems". At this assessment interview the Consultant Psychiatrist's impression was "that her anxiety and preoccupation at the time was realistic and appropriate to some of the illnesses with the children" and that enough information had been obtained to make the diagnosis of an adjustment disorder. He felt that Mrs. S was not depressed.[60] A diagnosis of adjustment disorder was made in response to relationship problems. The decision was that the CMHT would not be able to offer a service at present as Mrs. S did not want to take medication. She was advised to contact her GP if she changed her mind about medication. Diazepam had been prescribed by her GP for symptoms of distress. She was advised about Relate as a means of addressing the marital tension and she was also advised to contact her GP to access counselling. The case was closed and referred back to primary care.

[59] Series 3 pg 67
[60] AT 5 pg 7

On 15 April 2005 the GP commenced Mrs. S on Citalopram (antidepressant) 10mg daily. Mrs. S self-referred to the Community Mental Health Team on 10 May 2005 as she was feeling very depressed and tearful. The Duty Worker referred her to the Psychiatrist.

The GP for Mrs. S made an urgent referral to the Community Mental Health Team on 12 May 2005 describing her as having been suicidal two to three months earlier. The GP stated that there were no concerns about Mrs. S's children who were described as being healthy and being looked after by family members. Mrs. S had lost her appetite and 3kgs in weight. She was seen on the day of referral by a Locum Staff Grade Psychiatrist in the presence of her maternal uncle. She described being unable to think straight, crying all the time, feeling useless, having low energy, and having a re-emergence of her symptoms of obsessive-compulsive disorder. There were no thoughts of self-harm, nor were there any symptoms of psychosis. She was observed to be withdrawn and required prompting to answer questions with poor eye contact and psychomotor retardation. The diagnosis of a recurrent depressive disorder (moderate severity) with obsessional symptoms with a background of marital difficulties was made. Her Citalopram was increased to 15mgs for two weeks and then an increase to 20mgs advised. It was noted that she had been non-concordant with medication. The notes stated "a lot of the problems are sociocultural and we can only continue to advise the couple to seek marital counselling. A follow-up appointment was made for 26 May 2005.[61]

Mrs. S was reviewed by the permanent Staff Grade Psychiatrist on 26 May 2005. Her anxiety was reduced though she was tired and muddled up with low mood. She had significantly reduced energy, concentration, and had a poor appetite. No rituals, obsessional ideas or ideas of self-harm were elicited. The impression was that she was over-medicated. A plan was made to reduce her Citalopram to 10mg daily and to review her in four months' time. She was advised about the duty system and A&E if she needed to see someone in the intervening time. At this appointment the Staff Grade Psychiatrist decided to refer the family to the Children and Families Team.[62]

[61] Series 3 pg 24-25
[62] Series 3 pg 26

On 6 June 2005 the Staff Grade Psychiatrist referred Mrs. S to the Children and Families team citing severe inter personal differences between Mr. and Mrs. S and his concerns about child 1 who might have been at risk of neglect. An assessment was requested.[63]

On 9 June 2005 Mrs. S contacted a duty worker and said that she did not want to start new medication now would rather wait a week. This was discussed with and agreed by the Staff Grade Psychiatrist.[64]

Mrs. S was reviewed by the Staff Grade Psychiatrist on 1 July 2005. No change in her mental state was recorded and she was described as being generally low and having vague thoughts of self-harm with no specific plans. Her sleep had increased as had her appetite. She complained of tiredness and forgetfulness. A plan was made to change her medication from Citalopram to Sertraline 50mg daily. The plan was that the Sertraline would then be increased to 100mg and that she should be reviewed in the Clinic in four weeks' time. An urgent referral was made requesting that a CPN be allocated by the Community Mental Health Team. The recorded impression of the Staff Grade Psychiatrist was that Mrs. S's problems were mostly psychosocial.[65] The referral for allocation recorded a diagnosis of depressive disorder with Obsessive Compulsive Disorder.[66] Following this consultation a letter was sent to the GP with a diagnosis of a moderate depressive episode with somatic symptoms stating that she would be reviewed in four months. Mrs. S was given a standard protocol for self-harm. She was advised to go to A&E if her distress increased and community monitoring was requested. [67]

Error! Not a valid link. Duty records contact with Mrs. S regarding her medication on 22 JULY 2005. She complained of experiencing dizzy spells. This was discussed by the duty worker with the Staff Grade Psychiatrist who advised omitting the Sertraline and starting Paroxetine. A prescription for Paroxetine was left at reception for Mrs. S to collect.

There was no further contact with a psychiatrist after this date.

[63] Series 3 pg 46
[64] Series 3 pg 12
[65] Series 3 pg 14
[66] Series 3 pg 45
[67] Series 3 pg 38-39

Note to reader: The term 'psychosocial' is used to emphasise the close connection between psychological aspects of experience (thoughts, emotions and behaviour) and the wider social experience (relationships, traditions and culture).

13.2.1 Medical Consultations

Findings

Mrs. S was seen by three different psychiatrists on four different occasions over a period of ten months. The Staff Grade Psychiatrist was the only person to have seen Mrs. S on more than one occasion.

The information available in the CMHT file at the point of her second referral was the summary from the Cognitive Behaviour Therapist who highlighted Mrs. S's main fears as her husband and Child 1 dying through food poisoning although this is disputed by the consultant. The GP referral on 22 June 2004 made reference to the multiple attendances at Hammersmith and Ealing Hospitals and that she was obsessional about the children's health".[68] During this consultation there was no evidence that obsessional ideas and ruminations were considered to account for her thoughts. There was no evidence that the Consultant Psychiatrist discussed or corroborated Mrs. S's accounts of her children's health with the family GP or the Health Visitor. He remained unaware of the extent that Mrs. S was seeking reassurance about the children's health through health services. At interview the Consultant Psychiatrist's impression was that her anxiety and pre-occupation at that time was realistic and appropriate to some of the illnesses with the children and that enough information had been obtained to make the diagnosis of an adjustment disorder and that Mrs. S was not depressed.[69]

During the Consultant Psychiatrist's assessment he recorded that Mrs. S was born and brought up in the United Kingdom. He noted that she had had an arranged marriage with a man who was born and brought up in India and that they had chosen to make their home in the United Kingdom. She was an only child and her father left the family home when she was very young and that she did not want her children to suffer the same fate. She reported that she felt her childhood had been very unhappy. She also reported an

[68] Series 3 pg 61
[69] AT 5 pg 7

episode of domestic violence where the police were called after which her husband left her.[70] There is no evidence that the potential cultural impact of these events contributed to the evaluation of Mrs. S mental state.

No contact was made with the "in-house" psychotherapist that was mentioned in the GP's referral letter.

There appeared to be an inference from the management plan formulated in 2004 following Mrs. S's consultation that if she had agreed to take medication then she may have been eligible for support from the Community Mental Health Team. There was no evidence that consideration was given to the welfare (ability to care for, or safeguarding concerns) of the children of Mrs. S if she had a diagnosis of an adjustment disorder. This consultation did not appear to have been discussed within the Community Mental Health Team and the case was referred back to the GP and no evidence was presented to the Independent Investigation Team to the contrary.

Following the assessment by a Locum Staff Grade Psychiatrist in May 2005 a diagnosis of moderate depression was made and that there was an emergence of her OCD. Again the case did not appear to have been discussed with the Community Mental Health Team or Duty Worker who had arranged for Mrs. S to be seen urgently. The suggestion (within the clinic letter to the General Practitioner) was that Mrs. S continued to be advised to seek marital counselling for her and her husband regarding their current problems.[71] There was no evidence that a full multidisciplinary assessment was thought about or recommended.

Mrs. S was seen two weeks following this assessment by the Staff Grade Psychiatrist. The written entry in the case file is extremely brief. It was noted that she was accompanied by her husband though there did not seem to be any evidence that a corroborative history was obtained about the state of her mental health, how she was coping with the children, or of the marital relationship. There was no evidence that Mrs. S was offered an opportunity to be seen alone, despite the earlier documentation of domestic violence. The Staff Grade Psychiatrist's view was that he would see the couple

[70] Series 3 pg 21
[71] Series 3 pg 49

together in the first interview in order to show that they are working together and that the team is trying to help. He stated at interview that on the next occasion he was planning to see the patient alone although this did not happen[64]. At this appointment the Staff Grade Psychiatrist however was sufficiently concerned to initiate a referral to the Children and Families Team but did not discuss or refer the case to the Community Mental Health Team.

An appointment was arranged for 1 July 2005 following a duty contact on 17 June 2005. During this appointment Mrs. S was seen for the second time by the Staff Grade Psychiatrist in the company of her maternal uncle. It was recorded that there was no change.[72] She reported the same symptoms of depression. The Staff Grade Psychiatrist noted that she needed practical activities and noted that her problems were mostly psychosocial. He requested that a CPN be allocated to Mrs. S. The clinic letter to the General Practitioner described Mrs. S as having a recurrent depressive episode of moderate severity with somatic symptoms. The hand-written records indicated that the problems were regarded as being mostly psychosocial.[73] The Staff Grade Psychiatrist, when interviewed by the Independent Investigation Team, recognised the difficulty of the situation Mrs. S was in and that "that it was a sociocultural set-up of an Asian family coming from their norms, sticking to a marriage, no matter how rocky it was".[74]

There was no evidence that Mrs. S was offered an opportunity to be seen alone within the clinic appointments.

Conclusions

During Mrs. S's contact with mental health services she was experiencing changes in her domestic circumstances which were influenced by her culture. These changes, including her marriage to a husband who was brought up in India, her in-laws coming to stay with her, and the change of role that she as a daughter-in-law would have experienced as a consequence of this and her husband leaving her following her report of domestic violence which was reported to the police were very important events from both a personal and sociocultural view and were not given due weight in the formulation of Mrs. S's case.

[72] Series 3 pg 13
[73] Series 3 pg 14
[74] AT 7 pg 9

Mrs. S was not seen by a psychiatrist on her own at any of her appointments. At three appointments she was with her maternal uncle and once in the presence of her husband. There are two possible ways of looking at this: one that she was being supported by her family; two, Asian women being chaperoned by a male member of the family as a means of maintaining their silence. On review of the evidence in Critical Issue 1 (Cultural Diversity) of this report the Independent Investigation Team conclude that there were elements of both support and possibly control as evidenced through Mrs. S taking longer to respond to questions when in the presence of her husband. However it is poor practice to consult with any patient, who by the fact that they are a patient is a vulnerable person, in the presence of someone who is known to have abused them whether that is through domestic violence or any other kind of abuse. The onus lies on the professional to understand the family dynamics and collusion in such cases. A consultation in private is sometimes the only opportunity for individuals to disclose the reality of their experience.

The Independent Investigation Team had concerns as to the appropriateness of suggesting to Mrs. S and/or her husband that they consult Relate with regard to their marital difficulties. The suggestion may have been made following an assessment of Mrs. S as being an integrated, confident woman who had been born and brought up in the United Kingdom and who would have held mainstream health beliefs[75]. However, it was felt that this was an assumption and that due consideration was not given to her status as the wife of an individual who was born and brought up outside of the United Kingdom and the change in her perceived status (by herself, her extended family and husband) following her marriage. It is evident through the examples in part 13.1 that Mrs. S's family had views on dealing with marital problems internally and the suggestion of Relate may have put Mrs. S under further pressure through the shame and dishonour attributed to such a referral. The same dilemmas would have been applied to specific Asian Support services but compounded by the fact that they were within her own community.

[75] AT 5 pg 6

***Contributory Factor 2*: Mrs. S was not interviewed on her own at any of the medical consultations so there were missed opportunities for her to freely express herself if she had wished to do so.**

Recommendation 3: All service users must be offered the opportunity to be interviewed on their own. When there are specific cultural or gender issues where this is not appropriate a chaperone should be considered. When there are known instances of abuse or coercion the service user must not be seen with the perpetrator.

13.2.2 Diagnosis

Findings

During her contact with Mental Health Services Mrs. S received four diagnoses

- Obsessional Compulsive Disorder 2002
- Adjustment Disorder 2004 Consultant Psychiatrist [76]
- Moderate Depressive Episode, 2005, Locum Staff Grade Psychiatrist[77]
- Recurrent Depressive Disorder with Somatic Symptoms, 2005, Staff Grade Psychiatrist[78]

The diagnosis of adjustment disorder appears to have been made on the basis that Mrs. S acknowledged that she had relationship problems. Adjustment disorders sit uneasily between what are regarded as normal or just problematic difficulties and the major psychiatric diagnosis. They must occur within one month (ICD 10) or three months (DSM-IV) of a particular psychosocial stressor and should not persist for longer than six months after the stressor is removed. [79] Mrs. S was referred in June 2004 for anxiety and depression following the birth of child 2 (October 2003) and seen for assessment in September 2004. Post natal depression was not considered.

There also appeared to be some confusion following the consultation with the Staff Grade Psychiatrist on 1 July 2005 as there is conflicting information concerning

[76] Series 3 pg23
[77] Series 3 pg 25
[78] Series 3 pg 38
[79] Semple et al 2005 Oxford Handbook of Psychiatry pg 364 OUP

diagnosis with what is recorded in the case file "mostly psychosocial", the letter to the GP cites "recurrent depressive disorder, moderate with somatic symptoms [80] and the referral to the CMHT indicates a depressive disorder with OCD.[81]

Conclusions

The referral in 2002 by the General Practitioner to mental health services resulted in the identification of OCD and subsequent effective treatment. This is considered to be a completed episode of care and represented a good example of an uncomplicated care pathway.

Although it is common for a psychiatrist to make a diagnosis at a first appointment it is uncommon for any mental health worker not to review someone who presents with suicidal thoughts.

Following the assessment by a Locum Staff Grade Psychiatrist in May 2005 a diagnosis of moderate depression was made and it was noted that there was an emergence of her OCD. Mrs. S then had two appointments with the Staff Grade Psychiatrist where she presented with the same symptoms of depression.

The view of the Independent Investigation Team is that there was some therapeutic pessimism with regard to the marital difficulties (sociocultural factors)and this had an effect on the treating psychiatrists' acknowledgement and adequate appraisal of the severity of her depressive symptomatology. The Independent Investigation Team felt that Mrs. S's depression was of moderate severity given her presenting symptoms of thoughts of self-harm, psychomotor retardation, hypersomnia, feelings of hopelessness and worthlessness, and feeling a failure as a mother. The symptoms are recorded in the clinical notes.

Contributory Factor 3: The formulation that Mrs. S was depressed because of her marital problems rather than vice versa was a contributory factor in the psychiatric assessment of Mrs. S.

[80] Series 3 pg 38
[81] Series 3 pg 45

13.2.3 Medication

Findings

The General Practitioner initiated the antidepressant Citalopram 10 mg. There was no evidence in the General Practitioner records that the patient was reviewed in a timely fashion following the initial prescription of Citalopram in order to assess whether there were any side-effects, whether the patient was concordant with the prescribed medication or whether consideration should be given to increasing the dose.

The Locum Staff Grade Psychiatrist decided to increase the dose of Citalopram to 15mg daily in the light of non-response. Mrs. S was noted to be non compliant with medication at this assessment in May 2005.[82]

The decision to reduce the Citalopram during the first review with the Staff Grade Psychiatrist on 20 June 2005 appeared to be based on his interpretation that her reported symptoms indicated that she was over-sedated from the increased dose of Citalopram. The excessive sleepiness she reported and her slowness in response that was observed were not interpreted as psychomotor retardation as had been reported in the previous assessment by the Locum Staff Grade Psychiatrist. There was little evidence that consideration was given to the excessive sleepiness being a symptom of her depression rather than a side-effect of the medication. Consideration did not appear to be given as to whether or not her reported symptoms were indicative of her depression being unresponsive to this medication or that she was not concordant with the medication as prescribed. The Staff Grade psychiatrist reflected that there could have been an alternative explanation for her symptoms other than over-sedation as a side-effect and also recognised that the fact that her husband was present and that this may have contributed to her responding in a measured way"[83].

There is no description available in the records with regard to discussions that may or may not have taken place between the Staff Grade Psychiatrist and Mrs. S with regard to the side-effect profile of medications, the anticipated duration of treatment, using

[82] Series 3 pg 24
[83] AT 7 pg 12

prescribed medication, the potential effects of medication, and the time that it would take to see a response. The Staff Grade Psychiatrist's consultations did not record any discussion with regard to concordance.

During her contact with the mental health services in 2005 Mrs. S had three changes in medication.

Chronology of medication changes

Medication			
Date	**Prescriber**	**Medication**	**Comment**
25/01/02	GP	Sertraline 50 mg	Recognised OCD
22/02/02	GP	Sertraline 50 mg	
5/3/2002	GP	Sertraline 50 mg	
3/4/2002	GP	Sertraline 50 mg	
01/08/02			Stopped Sertraline
22/06/04			Reference made to having been prescribed antidepressants but was not taking them
15/04/05	GP	Citalopram 10mg	Depressed
14/5/2005	Locum psychiatrist	Citalopram increased to 15mg	Non responsive to 10 mg, review 2 weeks
26/05/05	Staff Grade Psychiatrist	Citalopram reduced to 10mg	Over sedated; follow up 4 months
01/07/05	Staff Grade Psychiatrist	Sertraline 50 increasing to 100 mg in two weeks	Follow up appointment 4 weeks in records, 4 months in GP letter
22/07/05	Staff Grade Psychiatrist	Stop Sertraline start Paroxetine 10 mg	Patient complained of feeling dizzy. Patient not seen. To review in one week

During the consultation on 26/05/05 Mrs. S presented as less anxious and sleeping excessively. The Staff Grade Psychiatrist was of the opinion that she was over sedated and reduced the Citalopram to 10 mg.

At the consultation on 1/07/05, five weeks and not four months later, there was no change in Mrs. S's presentation and the Staff Grade Psychiatrist changed her medication to Sertraline 50 mgs with the advice that she increased this to 100mg in two weeks time. [84]

Three weeks later Mrs. S contacted a duty worker complaining of dizzy spells which she felt were a side-effect of her medication following the prescription of Sertraline. Dizziness is a common side-effect in the initial stages of treatment with an SSRI. The Staff Grade Psychiatrist spoke to Mrs. S on the telephone and advised her to stop taking the Sertraline and prescribed Paroxetine 10mg daily instead. Confirmation of this practice was obtained from the allocated worker "had a telephone conversation with her (Mrs. S) and changed the medication".[85] Mrs. S had her medication changed without a clinical review.[86] However, there is evidence to support the notion that if Mrs. S had attended with these concerns in person then the Staff Grade would have seen her prior to implementing any change as "he always sees anyone who turns up".[87]

The Staff Grade Psychiatrist recorded in the clinical record that Mrs. S should be reviewed in one week. This did not happen.

Conclusions

The General Practitioner initiated the antidepressant Citalopram which is an appropriate first-line antidepressant in an adult presenting with depression and anxiety. The patient was given a starting dose of 10mg which would minimise the risk of potential adverse effects. This would be in keeping with good practice. However, this should have been reviewed within one week (NICE Guidelines for the Management of Depression in Primary Care 2004) and if there were no side effects the dose increased to 20 mg. There

[84] Series 3 pg 13
[85] TA 1 pg 9
[86] Series 3 pg16
[87] AT 2 pg 16

are no records in the GP notes submitted to the Independent Investigation Team that this occurred.

The Locum Staff Grade Psychiatrist's decision to increase the dose of Citalopram to 15mg daily in the light of non-response was deemed to be appropriate.

The decision to reduce the Citalopram at the review with the Staff Grade Psychiatrist on 26 May 2005 was based on his interpretation of her symptoms concluding that she was over sedated. The excessive sleepiness she reported and the slowness in response that was observed were not interpreted as psychomotor retardation as reported in the previous assessment by the Locum Psychiatrist. Citalopram is one of the "modern" antidepressant medications with a low side effect profile. At the time of the reduction on 26 May 2005 it would be unlikely that Mrs. S would have been experiencing excessive sleepiness from the increased dose as she had reportedly been taking this for the past six weeks and that the symptoms she was reporting were actually indicative of her depression being either unresponsive to this medication or that she was not taking the medication as required. On reflection and with hind sight the Staff Grade Psychiatrist recognised that this could have been the case.[88]

The plan for Mrs. S to start Sertraline 50mg and increase the dose to 100mg two weeks later is not reflective of good practice, as there was no plan in place to review the patient with regard to side-effects, response to treatment and concordance. However the context in which this decision was made was that the average wait for a routine appointment was cited as being about four months. [89]

The decision to stop Sertraline and prescribe Paroxetine without seeing Mrs. S reflected a very superficial assessment and response to the patient's contact with the team about her concerns. In this instance the Independent Investigation Team concluded that while changing medication without seeing the patient is far from good practice the Staff Grade Psychiatrist was aware of the medication history and that there had been no previous adverse reactions to this group of medications when taken at the equivalent dose in the past. Whilst the Independent Investigation Team do not wish to condone this practice it

[88] AT 7 pg 12
[89] AT 7 pg 2

has to be seen in the context of over booked clinics and the Staff Grade Psychiatrists' commitment to see any patient who attended the team base with medical concerns.

Adherence to NICE Guidelines

The Independent Investigation Team discussed adherence to NICE guidelines (2004) for depression when considering the frequent changes in medication. It could be argued that the treatment of Mrs. S was fully compliant with the guidelines with the critical recommendation (1.5.2.1) that "in moderate depression, antidepressant medication should be routinely offered to all patients before psychological interventions". Mrs. S was diagnosed with a moderate depression. The issue of this depression being recurrent is not pertinent as the previous episodes were not clear cut depression with the axis 1 diagnoses being OCD and Adjustment Disorder.[90]

At the assessment on 1 July 2005 the prescribed medication of Citalopram was not felt to be effective. It was not appropriate to increase the dose as this had previously resulted in the opinion that it led to over sedation consequently an alternative antidepressant was prescribed. Again this is in keeping with the guidance recommendation 1.5.2.22. The medication was again changed on 22 July 2005 due to Mrs. S reporting side effects. There is a crossed through reference in the clinical file initially suggesting the use of Venlafaxine but this was changed to Paroxetine the significance being the guidelines in 2004 did not recommend Venlafaxine as a treatment of choice and indicates that the guidelines were being followed. If, accepting that all the decisions had been correct, then it would be fair to say that the NICE guidelines in 2004 had been followed in regard to medication. However what the Independent Investigation Team questioned was the accuracy of the clinical assessment.

Service Issue 1: Medication was changed based on a brief assessment over the phone and without the patient being seen.

[90] AT 6 pg 5-6

13.2.4 Medical Reviews

Findings

Following the appointment 16 September 2004 with the Consultant Psychiatrist no follow up was offered by the mental health service and Mrs. S was referred back to primary care services.[91]

Following the review by the locum Staff Grade Psychiatrist on 12 May 2005 a review was planed for two weeks and an appointment was requested for July.[92]

Mrs. S was in fact reviewed within two weeks by the Staff Grade Psychiatrist.[93] At the consultation on 26 May 2005 a plan was made for a review in four months however Mrs. S was seen again seven weeks later following a duty contact on 1 July 2005 which was her final contact with a psychiatrist[87]. A plan was made to review her again in four weeks but this did not occur.

The Staff Grade Psychiatrist was expected to see any patients who came to duty with a concern about their medication even if the clinic appointments were fully booked. Provision was made to keep an appointment free in each clinic session to see emergency cases but often these slots were filled in advance. The Staff Grade Psychiatrist stated that there was a standard routine follow-up for which the waiting list for most doctors was three months or longer. When interviewed he stated that the urgent appointments were placed in overbooked clinics either at the start or at the end of the clinic session.[94]

Conclusions

The Independent Investigation Team were concerned about the lack of flexibility in offering an unwell woman, possibly non-concordant with medication, with ongoing symptoms, the opportunity for timely reviews and assessments within the medical outpatient service. Routine four monthly appointments were offered with the fall back

[91] Series 3 pg 23
[92] Series 3 pg 25
[93] Series 3 pg 26
[94] AT 5 pg 5

position being that the Staff Grade Psychiatrist would advise people to use the duty system so that they would be seen by a duty worker who would then assess them with a view to determining some level of urgency as to medical review. This system appeared to work in the case of Mrs. S on one occasion, when she had an appointment for review brought forward following her contact with a duty worker on 17 June 2005.[59] However, this does not compensate for routine and regular reviews especially where medication has been changed or a patient is not responding as expected. The system at the time contributed to a self perpetuating situation where clinics were over booked.

The Staff Grade Psychiatrist was aware that Mrs. S might have benefited from more regular reviews as indicated by his entries suggesting a review in four weeks at the appointment in May and within one week following the final change in medication in July. However there was no capacity to see any patient in a planned manner within those time frames with the Staff Grade Psychiatrists case load at that time. There appeared to have been insufficient resources available within the team or that the team was not functioning adequately to enable the provision of an appropriate follow-up service for new cases and those patients whose mental state was not yet stabilised. This lack of capacity would also have impacted on the Staff Grade Psychiatrists' ability to liaise with other agencies including GPs who were directed to prescribe repeat prescriptions and monitor mental states in between outpatient appointments.

Following the death of Mrs. S and her children there has been a review of the medical structure within the CMHT. This has given greater flexibility as there are now dedicated sessions for home visits and emergency visits outside of clinic times. The Consultant Psychiatrist informed the Independent Investigation Team when interviewed that if somebody is started on antidepressants they can be followed up within a week outside of the clinic time[95] although this view conflicted with that of the Staff Grade Psychiatrist in that he commented that his appointment schedule had not changed and that his clinics remained over booked and his caseload remains around 400.[96]

[95] AT 5 pg 5
[96] AT 7 pg 5

The Independent Investigation Team concluded that it was neither possible nor reasonable to provide an outpatient review function and a duty function within the same role and timeframe. It was felt that this leads to inevitable shortcomings in assessments and a lack of responsiveness in terms of follow-up, leaving patients and the team vulnerable to a lack of timely medical reviews.

Systems management

An impression was formed by the Independent Investigation Team that there were parallel systems in operation at the time of the incident. The medical activity in this case appears to have been conducted primarily on an outpatient system basis with the doctors working in isolation from the Community Mental Health Team and within a medical model apart from at times of crisis.

The evidence for this is:

- The referral in 2004 came through the referral system within the CMHT but did not return to the CMHT for discussion prior to being referred back to primary care.
- There was no consideration or request for a full needs assessment by the medical staff from the CMHT
- There was no liaison with the CMHT or duty system following referral to Children and Families Social Services
- The Staff Grade Psychiatrist had to formally refer Mrs. S to the CMHT requesting the allocation of a care coordinator

The Independent Investigation Team does not wish to imply that there were poor working relationships within the team, rather that the systems in operation at the time were not as integrated as they could have been.

Contributory factor 4: There was a lack of capacity within the Out Patient System/ CMHT to medically review people in a timely manner.

Recommendation 4: The Independent Investigation Team recognise that the Mental Health Trust has taken action to address the medical capacity within the CMHT and would like to support the Trust further by recommending that the Trust works with the Commissioners in Primary Care to develop a protocol to transfer those patients who are well and stable within their "mental illness" to primary care services and thereby more effectively use specialist mental health services to treat and monitor those who are unstable or unwell.

13.2.5 Referrals to other services

There were three areas of referral that the Independent Investigation Team considered.

1. Referral to the Children and Families Team.
2. Referral to Psychological Therapies.
3. Referral to the Community Mental Health Team for allocation

1. *Referral to the Children and Families Team***.**

The Staff Grade Psychiatrist made a referral to the Children and Families Team following the consultation on 26 May 2005 though this was not faxed until 6 June 2005. He expressed the concern that Child 1 might be at risk of neglect.[97] Child 2 was referred to as being aged 18 years rather than 18 months. [98] This referral occurred at the first time the Staff Grade Psychiatrist met Mrs. S. There are no documented reasons in the clinical records as to why he was concerned about possible neglect. During his interview with the Independent Investigation Team he stated his rationale as being "when a mother of two is suffering from a depressive illness and there are interpersonal relationships issues I am always concerned about what impact this is having at home and on the kids… I wanted some feedback there".[99] An undated entry in the clinical records (thought to be 9 June 2005[100]) indicates that the Staff Grade Psychiatrist followed up a concern raised by the Duty Worker by calling the Children and Families Team to confirm their involvement. There was no evidence of further follow-up or discussion between the Staff Grade

[97] Series 3 pg 46
[98] Series 3 pg 46
[99] AT& pg 3
[100] Series a pg 12

Psychiatrist and the Children and Families Team, and the involvement of the team was not considered in future management plans.

2. Referral to Psychological Therapies.

Mrs. S responded well to psychological intervention following her first presentation to services in 2002. In 2004 it was recommended that Mrs. S seek counselling in primary care. Psychological therapy was not considered to be a viable option during 2005.

At the time of the assessment in 2004 with the Consultant Psychiatrist, he had been in post for 16 days and was therefore new to the Community Mental Health Team. He recalled that they had their local Psychotherapy Department criteria pinned on the wall. His understanding at the time was that they had a waiting list of several months and that the team did not take people on who had relationship problems. He stated that his focus was therefore on primary care counselling and Mrs. S attending Relate.[101] On reflection, and having reviewed the case notes, the Consultant Psychiatrist thought that Mrs. S may have met the criteria for a psychotherapy referral by the time she was seen by the Staff Grade Psychiatrist because he thought that she was clearly depressed by then.[102] The Staff Grade Psychiatrist described the criteria regarding referral to Psychological Therapies as having an exclusion criterion that patients are not suitable for CBT if the patient has interpersonal relationship difficulties.[103]

The referral protocol available at the time[68] was written in line with the *National Service Framework* (2000), *Treatment of Choice in Psychological Therapies* (2001), and the *NICE Guidelines for the Treatment of Panic Disorder, General Anxiety and Depression.* The acceptance criteria refer to depression as not confined to a relationship difficulty, with one of the exclusion criteria stated as (we do not accept referrals with a diagnosis of) “stress due to current life situation for example work / relationships”. It was advised that these individuals be referred to primary care counselling.

[101] AT 5 pg 2
[102] AT 5 pg 4
[103] AT 7 pg 6

3. Referral to the CMHT for allocation

At the review consultation in July 2005 as a consequence of there being no change in Mrs. S's presentation, the Staff Grade Psychiatrist made an urgent request for the allocation of a CPN in order to obtain collateral information about Mrs. S's home situation and to provide support and monitoring.[104] The Staff Grade Psychiatrist did not phone other agencies involved such as health visiting and primary care. The plan noted on the referral to the CMHT for allocation was that the Staff Grade Psychiatrist should receive feedback from the allocation meeting and that consideration should be given to review the case for enhanced care under the Care Programme Approach.

There was no evidence that the Staff Grade Psychiatrist followed up the referral.

Conclusions

1. Referral to Children and Families Social Services

The error in the recording of Child 2's age did not appear to affect the response of the Children and Families Team. The delay in sending the referral to the Children and Families team could not be accounted for and was a concern addressed by the Internal Investigation.

2. Referral to talking therapies

Although having responded well to previous psychological intervention before this was not considered as a viable option during the time Mrs. S was depressed.

In terms of adherence to NICE Guidelines for Depression (2004) they are flexible and endorse a degree of judgement on the part of the professional. However, the guidance is about specific, structured interventions being offered in the case of moderate depression where pharmacological treatment has not worked or for patients "who do not take or who refuse antidepressant medication". In terms of Mrs. S there were references to her ambivalence about compliance with medication from her contact with the locum psychiatrist.

[104] AT 5 pg 9

The view of the Independent Investigation Team is that the criteria used within the Trust were open to interpretation and that if someone had an illness and interpersonal problems they could be referred. However the interpretation by those involved at the time was if a patient had an illness and interpersonal problems then they could not be referred. The Independent Investigation Teams view was that given Mrs. S's previous good response to cognitive behavioural psychotherapy a referral could and should have been made. However, direct causality cannot be attached to this omission as the previous referral and good response to CBT were in association with a diagnosis of OCD as opposed to depression and it would be an assumption to assume that Mrs. S would have had a positive response.

Contributory factor 5. Not referring Mrs. S for psychological therapies was a missed opportunity in the light of her previous positive response.

Comment: The Independent Investigation Team is not making a recommendation at this point as it is aware of the developments within Ealing PCT IAPT programme and are of the view that access to psychological therapy is comparatively straight forward and timely within Primary Care. It is unlikely with the configuration of the current services that a similar case presenting today would be classed as being of a nature or degree to warrant referral to Specialist Mental Health Services.

3. Referral to the CMHT for allocation

The referral was deemed to be appropriate in 2005.

13.3 Critical Issue 3: Community Mental Health Team Intervention

Context for CMHT Involvement

No operational policy is available for the CMHT for 2005 hence National and Local Policy coupled with interviews were used to identify the structure, function and standards that would have been expected to be in operation at the time.

Community Mental Health Teams Policy Implementation Guide (2002 DoH) outlined the *functions* a CMHT needed to perform. The policy states:

The CMHT performs functions for two groups of people:

1. Most patients treated by the CMHT will have time limited disorders and be referred back to their GPs after a period of weeks or months when their condition has improved.

2. A substantial minority, however, will remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include people needing ongoing specialist care:

Three distinct functions are required:

1. Giving advice on the management of mental health problems by other professionals – in particular advice to primary care and a triage function enabling appropriate referral.

2. Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions.

3. Providing treatment and care for those with more complex and enduring needs.[105]

Key components of a CMHT:

- Working with Primary Care: for pre referral discussion and the development of a single point of entry

[105] Community Mental Health Teams Policy Implementation Guide (2002) DoH) pg 4-5

- Assessment Routine: assessments should be prompt 4 week's maximum but working towards 1 week. If medical staff still conduct outpatient clinics, the relationship between this clinic and the CMHT needs to be clear. Those with common mental health problems may more appropriately be assessed by other team members
- Social Services assessment: usually takes place within the CPA framework
  It is essential to work towards an integrated approach across health and social care. There should be:
    - A single point of referral
    - A unified health and social care assessment process
    - Co-ordination of the respective roles and responsibilities of each agency in the system
    - Access, through a single process to the support and resources of both health and social care
- Team Approach: each user to be assigned a care co-ordinator with overall CPA responsibility for ensuring appropriate assessment, care and review by themselves and others in the team
- Regular review: Weekly team meetings should include the consultant psychiatrist where actions are agreed and changes in treatment discussed by the whole team. This should include users and carers where possible
    - Appropriate structured assessments should be used to monitor progress
    - Risk assessment should be a routinely recorded component
- Note keeping: Records should be kept of all contacts with the user and with significant others in relation to the care that the patient receives There should be a single written record for each service user

Interventions

Primarily, but not exclusively, for those with short-term needs

- Psychological therapies should be routinely considered as an option when assessing mental health problems

Primarily, but not exclusively, for those with severe and enduring illness

- Continuity of care: contact and communication should be maintained with primary care, so that the GP is informed of significant changes in mental health, medication etc, whilst remaining in the care of the CMHT
- Medication: the team should be responsible for prescribing, administering and monitoring medication as indicated by clinical need, with blood tests as necessary to monitor therapeutic levels or side effects
- Basics of daily living
- Help in accessing local opportunities in work and education
- Support
- Family and carer support & help: assessment on a routine basis of the overall well-being of dependent children whose needs may be compromised by parental illness. Involvement of the appropriate children and families team if indicated; adult CMHT staff are not trained in assessing parenting ability but can recognise when a patient's illness or problems pose a significant burden or risk for a child. They should try and meet with dependent family members and, if concerned, discuss it with the user. The child's needs must take priority

WLMHT CPA policy 2003

The above directives are acknowledged in the local CPA policy which was jointly developed, owned, and managed by the London Boroughs of Ealing, Hammersmith and Hounslow.

The policy states:

All patients should be assessed for the possibility of non-compliance with treatment and/or medication as a part of the CPA risk assessment process. In the event of "Treatment Non-compliance" or "Failure to attend", all appropriate and relevant people should be informed and previously agreed plans should be implemented without delay.[106] The standard CPA flow chart indicates that if the service user is not complying with the care plan then a review needs to be scheduled

[106] WLMHT CPA policy 2005 pg 8

Standard and Enhanced care pathways are noted as flow charts. The standard CPA flow chart indicates that this is appropriate for patients accepted via the out patient service and further indicates that when a referral is accepted through OPD and there is a need for a person to see more than one professional then the service user becomes part of the enhanced CPA process.

In both the standard and the enhanced CPA flow charts there are directions for carers assessment.[107]

Structure of CMHT 2005

Management

A service manager held the overall responsibility for the CMHT in conjunction with responsibilities for another CMHT, the development of the Assertive Outreach Team, the approved social work service for the Borough and the management of two acute inpatient wards and the community rehabilitation service.

In 2005 Ealing was divided into five sectors with each sector manager being responsible for the management of a CMHT. Within the CMHT there were two lead practitioners, one from a nursing background and the other from a social work background, who were responsible for the day to day running of the team with the sector manager having more of an "overview".[108] The sector manager was the line manager for the lead practitioners and the administration team leaders. In turn the lead practitioners would manage the Community Psychiatric Nurses and the Social Workers within the team.

The whole team met every morning to discuss the day's work and at weekly MDT meetings for in-depth discussion. A reflective practice group was held twice a month although this was not mandatory and some staff attended more that others.[109]

[107] WLMHT CPA policy pg 13-14
[108] AT 2 pg 2
[109] AT 2 pg 10

Referrals

The CMHT acted as a single point of referral to mental health services. All referrals were screened by the lead practitioners and passed to where they felt was the most appropriate part of the service. If there was an urgent referral this would go through the duty system and they would be screened by the duty manager which would be one of the lead practitioners or the sector manager. Routine referrals were left for the lead practitioners to screen and then decide whether they are referred back to the GP, primary care team or needs to be seen by a psychiatrist or an MDT assessment.[110]

Duty system 2004/5

The purpose of a duty system is to ensure that a member of staff is available to respond to queries, referral, crisis and individuals as they present to the service. During 2004/5 there were always two members of staff on duty one of whom was a qualified mental health professional the other was a care organiser. Qualified staff rotated onto duty on a daily basis whereas the care organiser had a more permanent role within the duty system. The duty system was overseen by the duty manger which was usually one of the lead practitioners. In essence a duty system acted as the front line within a CMHT. The urgent referrals were seen and processed by the duty system. They received the referral and made a judgement as to whether a person needed to be seen now or later. If a decision was made to see them straightaway, it's was usually a non-medical duty person who made the contact, and then they made a judgement as to whether that person needed to be reviewed by a medic there and then. In those cases, two staff members could share the responsibility.[111]

Telephone calls and self presentations were also passed onto the duty worker via an administrator where initial information was gathered i.e. who the client was and what the concern was and this would be followed up by a duty worker.

[110] AT 2 pg19
[111] AT 5 pg 8

Allocation

Written requests were made for the allocation of a care coordinator, where the requests remained unclear it was discussed at the morning meeting.[112] Cases were allocated by the lead practitioners sometimes in conjunction with the manager. Most often referrals would come through the doctors that worked within the team. Considerations for allocation were-: availability of care coordinators in terms of caseload and professional background. Other considerations were the person's gender, language and culture as well as an individual practitioner's personality and preferences. There was no formal protocol for the allocation of patients.[113]

Case loads

Case loads in 2005 were reported as being at 35-40 all of which would be enhanced cases by virtue of the fact that they were allocated.[114]

Assessment

There was a standard assessment interview form where a worker was expected to document the patients presenting problems, past psychiatric history, family and personal history, mental state at time of interview, outcome of assessment/interview, date discussed at the Multi Disciplinary Team (MDT), action taken and future plans.[115]

Description of events

In 2003 Mrs. S had her first contact with mental health services when she was successfully treated by a CBT therapist for OCD.

The next contact with mental health services was on 22 June 2004 when her GP referred Mrs. S to the CMHT, citing: multiple contacts with A&E and surgery; deep rooted childhood problems and obsessions about the children's health. Antidepressants had been prescribed but not taken as Mrs. S was breast feeding.[116]

[112] AT 2 pg 4, 13
[113] AT 2 pg 4
[114] AT 2 pg11
[115] Series 3 pg 42-43
[116] Series 3 pg 61

The referral was screened the following day and it was decided that a psychiatric assessment by a doctor was required, followed by MDT care plan. An appointment was sent for 16 September 2004. Mrs. S telephoned the CMHT stating that she "can't wait for September, needs support soon"; and was advised to come and see duty worker.[117]

The referral was followed up through the duty system on 9 July 2004 with a phone call to Mrs. S who was not able to speak in detail on the phone; she was worried about her children although willing to come to the CMHT to see a duty worker, as she wanted to talk to someone; and stated that she would come on Tuesday. A duty worker was to see Mrs. S and arrange a short term care plan prior to the OPA in September. The team leader's plan was for a duty worker to visit for an assessment OR to encourage the client to visit the CMHT; possibly see the locum psychiatrist and refer for a child assessment if there was concern; it was noted that the "case seems urgent if you need support just ask".[118]

A duty worker followed up the case on 14 July 2004 with two phone calls to try to arrange an urgent meeting, but there was no response and no message was left. On the second occasion the duty worker spoke to Mr. S who informed them that Mrs. S had been in hospital with her sick child. A further call was made the following day when Mrs. S informed the worker that she had "other priorities and that she would contact the service when she was ready". The plan was for no further action.[119]

Mrs. S kept her OPA on 16 September 2004 when she was seen by the Consultant Psychiatrist . The impression was that Mrs. S was experiencing an adjustment disorder due to relationship problems. The outcome of the assessment was that "we (CMHT) cannot offer service at present especially as she (Mrs. S) does not want to take medication and for Mrs. S to contact her GP if she changed her mind about medication"; Diazepam had been prescribed for her distress by GP. The consultant advised about Relate and advised Mrs. S to contact her GP to access counseling. The case was in effect closed by the Consultant Psychiatrist.

[117] Series 3 pg 65
[118] Series 3 pg 67
[119] Series 3 pg 11

In the following year on 10 May 2005 Mrs. S self referred to the CMHT as she was very depressed and tearful. The duty worker referred her to the locum psychiatrist.[120]

Mrs. S's GP also made an urgent referral to the CMHT on 12 May 2005, the same day that Mrs. S was seen by a locum Staff Grade Psychiatrist. The impression formed was that Mrs. S had a recurrent depressive disorder with obsessional symptoms against a background of marital difficulties. The plan was to increase the Citalopram, which had been started by her GP, to 15 mg for two weeks and then to 20 mg. If there was no improvement the plan was to consider Venlafaxine. Compliance with medication was discussed. "A lot of the problems are socio-cultural and we (the CMHT) can only continue to advise the couple to seek marital counseling."[121]

On the 26 May 2005 Mrs. S was reviewed by the Staff Grade Psychiatrist whose impression was that Mrs. S was over medicated. The plan was to reduce the Citalopram to 10 mg and review her again in four months. Mrs. S was advised about the duty system and A&E should her situation deteriorate and was referred to the Children and Families Social Services.

On 9 June 2005 (date not recorded in CMHT file but information correlates with Social Services file) Mrs. S contacted the duty worker and said that she did not want to start new medication now and would rather wait a week. This was discussed with the Staff Grade Psychiatrist who contacted the Children and Families Social Services to ascertain their involvement. The plan was to see how Mrs. S coped over the next week.

The Health Visitor contacted the duty worker on 16 June 2005 asking about the involvement of the Staff Grade Psychiatrist. The Health Visitor was advised to speak to the psychiatrist.

On 17 June 2005 (this is undated on the CMHT clinical history sheets but is dated on mental health screening form[122] and the information correlates with the Children and Families Social Services case file) Mrs. S contacted the duty worker stating that she was very distressed and not able to cope with the children. The plan was to follow up the

[120] Series 3 pg 53
[121] Series 3 pg 45
[122] Series 3 pg 7-8

referral to the Children and Families Social Services and Mrs. S was asked to call back within the hour if she had not heard anything. Further duty contact the same day documents that Mrs. S reported that she was feeling worse, there had been no change since starting new medication and that her "mind was not working loss of concentration, poor memory, no harm ideation". The duty worker contacted Health Visitor 2 and was informed that Mrs. S tends to be anxious about feeding the children; then contacted Children and Families Social Services and was informed that a social worker had been allocated. The Children and Families manager contacted Mrs. S. The feedback to the duty worker was that following discussion Mrs. S had agreed to spend the weekend at her mother's.[123]

Mrs. S was reviewed by the Staff Grade Psychiatrist on 1 July 2005 who noted that Mrs. S was socially isolated and had difficulty engaging; deliberate self harm ideation present, generally low; self harm ideation described as "vague thoughts", no specific plans; no DSH attempts; increased sleep and appetite; poor energy and concentration. Impression: mostly psychosocial. The plan was to try Sertraline 50 mg increasing to 100 mg and to review in four weeks. An urgent referral for allocation to a CPN was requested from the CMHT to be "reviewed after first feedback to possibly enhanced CPA".

On 13 July 2005 (the date appears to have been altered to 19 and the year is recorded as 2006) the case was received by the care coordinator. The plan was for the care coordinator to assess Mrs. S's needs, to discuss with the Staff Grade Psychiatrist to get an update of any presenting concerns and to liaise with the Children and Families Team.[124]

The following day, 14 July 2005 (date in the file is recorded as 20 June) the Care Coordinator contacted Mrs. S by telephone to arrange a visit. Mrs. S requested that this initial contact was at her mother's house. Mrs. S was to call back to confirm a day for the visit. The Care Coordinator also contacted the Children and Families team to check that they had received the referral and confirmed that the referral had been received.[125]

[123] Series 3 pg 12-13
[124] Series 3 pg 14
[125] Series 3 pg 15

On 15 July 2005 (the date records the year as being 2006). The Care Coordinator contacted Mrs. S by telephone but was unable to arrange a visit. The Care Coordinator noted that Mrs. S was very quiet, not knowing what she had planned for the following days. The arrangement was that the Care Coordinator would call again on the following Monday.

On the Monday, 18 July 2005 (the notes record the year as being 2006) the Care Coordinator called Mrs. S and arranged to meet her later that day at her mother's address. It is recorded that Mrs. S was initially very quiet, talking about her concerns for her children and how she did not believe that they ate enough. It was noted that Child 2 had a throat infection at this time and that this would account for his decreased ability to eat. It was also noted that Mrs. S's mother was very involved in looking after her and the children. Medication was discussed as Mrs. S felt that it was not working. The Care Coordinator recorded that Mrs. S had been advised by the Staff Grade Psychiatrist to increase her medication weekly and that she had increased her dose to 75mg. The Care Coordinator advised Mrs. S to contact her the following week if she still felt that the medication was not helping. The impression formed by the care coordinator was that Mrs. S "felt trapped looking after the children every day" and the plan was to see Mrs. S on a weekly basis to explore her hobbies and interests to get her involved in activities.[126]

On 21 July 2005 Mrs. S contacted duty about her medication. This message was conveyed to the Staff Grade Psychiatrist who phoned Mrs. S the following day and changed her medication as she was experiencing side effects.[127] The Staff Grade Psychiatrist noted that Mrs. S should be reviewed during the following week.

The Care Coordinator contacted Mrs. S on 27 July 2005 (the date recorded in the notes is 27 June 2006) and arranged to see her later in the day as the prescription had not been collected. Mrs. S was seen in her own home where she presented as "more chatty" and was busy feeding Child 2, stating that she had not been on any medication and was trying to cope without any. The Care Coordinator gave Mrs. S her prescription "if she wished to take it". The opinion of the Care Coordinator was that Mrs. S seemed more

[126] Series 3 pg 16
[127] Series 3 pg 16

willing to engage with services and that she would provide her with some information when she next saw her. An arrangement was made that the care coordinator would call and arrange a day for the next visit.[128]

The following week on 2 August 2005 the Care Coordinator visited Mrs. S and recorded that Mrs. S "is still choosing not to take her medication as she wants to try and cope without it". Mrs. S had talked about her family and identified when she started to find things difficult at home. Mrs. S disclosed that that she had a period of separation from her husband and that she went to India and had "brought him back". Mrs. S stated that she felt that she has nothing to look forward to and that she was a bad mother. The opinion of the Care Coordinator was that Mrs. S was "managing quite well" and noted that she was attentive to the needs of her children having taken them to the park earlier in the day. The following day 3 August 2005 (the month is illegible in the notes and assumed to be the eighth month) the Care Coordinator contacted the Children and Families Social Services team, identified the allocated worker, recording that the assessment would be carried out on 8 October 2005.[129]

Two weeks later on 17 August 2005 the Care Coordinator visited Mrs. S in the presence of her mother and noted that she continued to be non concordant with her medication and that Mrs. S was withdrawn. Mrs. S's mother informed the Care Coordinator that Mrs. S did not talk about her concerns with her and that she might benefit from a home help although Mrs. S felt that she would like to cope on her own. The Care Coordinator was informed that the allocated social worker had rescheduled the visit for assessment to 22 August 2005. Mrs. S requested that the Care Coordinator did not visit her again whilst Child 1 was on holiday from school. The Care Coordinator recorded "in terms of respecting her wishes and taking into consideration her level of anxiety I will keep in contact by phone unless Mrs. S says otherwise or if in crisis".[130]

This was the final contact the CMHT had with Mrs. S prior to the incident on 31 August 2005

[128] Series 3 pg 17
[129] Series 3 pg 17-18
[130] Series 3 pg 19

13.3.1 Clinical Management Systems

Findings

The management structure within the team indicated that it was the lead practitioner's responsibility to oversee the duty system. In this team the functions of the lead practitioners had been divided in that the nurse lead practitioner (known as the Lead Nurse) was responsible for overseeing the referrals and the social worker lead practitioner was responsible for overseeing the duty system.[131] The lead nurse post was newly appointed to June 2005. The Sector Manger was from a nursing background. The lead practitioners were expected to be in charge of the day-to-day running of the referrals and the patients and the Sector Manger had overall responsibility with an overview, but no in-depth knowledge. The Sector Manger line managed the two lead practitioners. [132]

There are some clear management directions on the case file although it is not clear who people are when they complete the CMHT screening form, or who reviews the decisions that are made on duty e.g. when the case was deemed NFA (no further action) on 15 July 2004 by the duty worker when there were instructions to complete an assessment.

There is no indication that the case was discussed in supervision, the morning meetings or the Multi Disciplinary Team (MDT) meetings as there are no entries to that effect in the file.

Conclusions

As well as providing clear professional leads the lead practitioners need to be working together when decisions are made, pooling their professional knowledge and experience to the benefit of patients. There is also greater safety in having two different professions reviewing the same case files as they have different views which is the fundamental principle underpinning multi disciplinary work. The Independent Investigation Team regard failure to do this as a weakness in the system.

The original plan for an assessment on a case that seemed urgent was changed to "no further action". The case appears to have been closed to the duty system without

[131] AT 3 pg 8
[132] AT 2 pg 3

adequate information, further consultation with the lead practitioners or the Consultant Psychiatrist. It is the view of the Independent Investigation Team that all decisions, plans and instructions need to be clearly documented in the clinical records whether these are paper or electronic records. The accepted and standard format for recording in case notes is that practitioners and managers record their name and position after an entry so that there is a clear audit trail as to what decisions were made, and when and what the rationale for the said decisions are. It could be argued that this approach would be too time consuming for a team that is already reported as being overstretched however this is a basic standard for all professionals. However the view of the Independent Investigation Team is that this is further evidence of weak leadership as these are issues that could and should have been addressed.

The Independent Investigation Team conclude that the management systems in place at the time were weak and there was a lack of inter disciplinary working, case formulation and management by the lead practitioner. This was not noted and therefore not addressed by the Sector Manager.

Comment: The Independent Investigation Team are highlighting this area as they are aware that at the time of interview this post had been vacant for long periods of time and was regarded as a “hard to recruit to” post.

Contributory Factor 6: There was a lack of inter disciplinary working and nurse clinical leadership within the CMHT.

Recommendation 5: The Nurse Lead Practitioner plays an integral and important role in the day to day running of a CMHT and greater efforts must be made to ensure the post is covered whether this is through enabling a suitable team member to act up or offering the post as a development opportunity to the wider Trust. Consideration also needs to be given to how this post is professionally supported to reduce attrition rates.

13.3.2 Referrals into the CMHT

Findings

There were two referrals into the CMHT by the GP.

The GP initially referred Mrs. S as a non-urgent referral on 22 June 2004. This was screened the following day and a decision made that a routine out patient appointment was appropriate and that this should be followed by a MDT action care plan. The appointment was arranged for 16 September 2004 as the waiting time for non urgent referral was around three to four months. Mrs. S was seen by the Consultant Psychiatrist but not by a CMHT worker.

Mrs. S self referred to the CMHT on 11 May 2005 and an urgent appointment was booked for her to see the locum psychiatrist the following day.

The GP made a second and urgent referral on 12 May 2005 noting that she had a "community nurse visiting her at home".[133] The Community Nurse was not contacted to ascertain her involvement with Mrs. S. The concern Mrs. S expressed about being worried about her children did not trigger any further intervention at the time. Mrs. S was not seen by any other member of the MDT on this day.

Since the development of the Primary Mental Health Care Team the referral rate to the CMHT has dropped to approximately ten per week it was reported as being around 30 a week in 2005.[134]

Conclusions

There is one point of entry into the CMHT, and OPA mental health service through referral to the CMHT after which it appears that there are two separate systems in operation and these systems do not communicate unless there is a crisis.

[133] Series 3 pg 67
[134] AT 2 pg 20

While the Independent Investigation Team recognise that having access to a psychiatrist at short notice is positive there is the possibility that this can lead to an over reliance on this service and potential subsequent de skilling or under utilisation of other clinical staff, who rather than complete an assessment themselves hand it over to the psychiatrist.

Contributory factor 7: There was a lack of communication between OPA system and the duty system resulting in referrals not being followed through and full needs assessments being offered.

13.3.3 Duty System

Findings

All CPN's and Social Worker's are on a rota to the duty system on a daily basis. There were two people on duty, one of whom was a care organiser. The Independent Investigation Team was not familiar with this role. It transpired that this role was employed through the London Borough of Ealing as a training/development post for a social worker, although the Team noted that there could be a qualified person in this role. The post was predominantly designed to cover duty contacts with post holders often going on to complete a formal qualification. The post was described as "an old social worker post so they can assess people on duty and see what their needs are and if they need anything further then they will bring them back, they do have on the job training and an induction".[135].

At no point was Mrs. S offered an assessment of her needs by the duty system. It was reported to the Independent Investigation Team "it is not often that we do an MDT assessment on duty as all the practitioners are busy managing their case loads".[136]

Mrs. S had five contacts with the duty system at times of crisis. Various duty workers had contact with Mrs. S and for the purposes of this report they will be referred to collaboratively as "the duty worker".

[135] AT 2 pg 17
[136] AT 2 pg 19

Episode 1

Mrs. S contacted the duty system on 9 July 2004 in a very distressed state informing them that she was not able to wait until September for her appointment noting that she was worried about her children.

A plan was recorded on the file:

- A duty visit be made for assessment OR
- Encourage client to turn up (has not yet turned up)
- Possibly to see the locum psychiatrist
- Make a referral to children and families if there are any concerns
- Case seems urgent[137]

Duty followed up this plan by contacting Mrs. S on 14 July 2004 and spoke to Mr. S who explained that Child 2 had been in hospital. A further duty call was made on 15 July 2004 where Mrs. S informed the duty worker that she had other priorities at that time. It is recorded that no further action was required at this point.

Episode 2

Mrs. S self referred to the CMHT on 11 May 2005 as very depressed and tearful. She was referred urgently to the locum psychiatrist and an appointment made to see her the following day. It is unclear from the clinical record whether Mrs. S attended the CMHT in person or referred herself over the telephone. An urgent referral from the GP was received on 12 May 2005. Mrs. S was seen by the locum psychiatrist on 12 May 2005. Mrs. S was not seen by a duty worker at this visit to the CMHT. Nor was the case passed back to the duty system for follow up and a full assessment after the consultation.

Episode 3

A month later Mrs. S contacted the duty system on 9 June 2005 as she was very distressed feeling that she couldn't cope with the children. By this time she had been assessed by the Staff Grade Psychiatrist who had made a referral to the Children and Families team. The duty worker noted Mrs. S's mental state and the fact that she didn't want to start the new medication that had been prescribed and discussed the situation

[137] Series 3 pg 67

with the Staff Grade Psychiatrist[138] .This contact did not initiate a full needs assessment for Mrs. S.

Episode 4

A Health Visitor contacted duty on 16 June 2005 and spoke to a duty worker requesting information about their involvement. The Health Visitor was advised to contact the Staff Grade Psychiatrist. The duty worker did not use this opportunity to obtain further information about the role or involvement of the Health Visitor or use this as a trigger to contact the children and families team.

Mrs. S contacted the duty system in a very distressed state on 17 June 2005. The duty worker contacted the Health Visitor and Social Services to obtain further information and inform them of Mrs. S's concerns about her ability to cope with the children. Social Services informed the duty worker that the case had been allocated for assessment. The duty worker ensured that Mrs. S had support from family members over the weekend and fed this back to the Health Visitor. This contact was not followed up until Mrs. S's scheduled appointment with the Staff Grade Psychiatrist.[139]

Episode 5

A final duty contact was made by Mrs. S on 21 July 2005 concerning her medication and this information was passed to the Staff Grade Psychiatrist.[140] This information did not appear to have been highlighted for the attention of the allocated worker.

Conclusions

The Independent Investigation Team considered four issues within the duty system

1) Information gathering

Information gathering serves several purposes, primarily to assess the level of risk involved in a case, whether this is to the individual, their family, the public or the professionals involved. It is also to aid the professionals to further understand the

[138] Series 3 pg 12
[139] Series 3 pg 13
[140] Series 3 pg 16

situation and make informed decisions. There were several missed opportunities to gather further information.

Although there had been relatively detailed referrals from the GP's there was no contact with these services to obtain further information. For example what was meant by deep rooted childhood problems and what was the outcome of the appointment with the in-house psychotherapist at the GP practice; Mrs. S's reference to a community staff nurse visiting her at home (2004); why was the GP referring Mrs. S at this particular point when the records show that she had been suicidal two to three months previously and was partially responding to treatment (2005). It is good practice to talk to the referrer as they often have detailed information that they have not included in the referral and to clarify points raised in the referral. The community staff nurse was playing an integral role in the psychological support of Mrs. S and would have been a valuable source of information had she been contacted.

The contact from the Health Visitor was also regarded as a missed opportunity to gather further information about that service's involvement and their perception of Mrs. S and the family. The Independent Investigation Team discussed the notion of awareness within the CMHT about the role of the Health Visitor and School Nurse as the potential significance of this contact appears to have been overlooked. At interview some clinicians from the CMHT reported they "wouldn't know at what age a health visitor would be involved". It does not appear to be known that every family with children under five has a named health visitor.

Contributory Factor 8. Part of the role of the duty system is to gather further information and this did not occur in this case in 2004 or 2005. Throughout this time there was intensive involvement with the Health Visiting team and potentially vital information (for example frequency of contact and interventions) was not fed into the decision making process This may have altered the decision to take no further action and potentially the diagnosis made by the psychiatrists. The Independent Investigation Team regard this as a contributory factor and a fundamental flaw in the care pathway within the CMHT at that time.

2) Assessment on duty

The self referral on 11 May 2005 by Mrs. S and the subsequent urgent referral by the GP on 12 May 2005 when Mrs. S was seen on the same day by the locum psychiatrist, was an opportunity for Mrs. S to have be seen by a duty worker as again the referral made mention of the fact that there were children and that Mrs. S was continuing to express suicidal feelings. There is the basic expectation that anyone referred to a CMHT will have a multidisciplinary assessment as was suggested in the policy implementation guide. Whereas the reality of this, in 2005, was that this may not have been possible as the CMHT was receiving a high number of referrals as primary mental health care was under developed. Logic would dictate that if someone was "ill" enough to warrant a psychiatric opinion they would also be eligible to have their needs assessed. The Independent Investigation Team recognise that duty work is often stressful and busy within CMHT's, however conducting needs assessment is a core function of qualified CMHT professionals and should be completed within a duty system prior to case discussion and decision making.

Furthermore when a new and urgent case has been booked to be seen by a psychiatrist it is not returned to the lead practitioners or duty for follow up or discussion with a view to a needs assessment. This finding supports the notion that two separate systems were in operation at the time, the outpatient appointment system and the CMHT's system.

Contributory Factor 9. There were missed opportunities to offer Mrs. S a full and timely needs assessment via the duty system which may have contributed to a better understanding of her situation.

3) Crisis management

Duty contacts do appear to have been followed through by the duty workers in times of crisis. As a point of good practice on 9 June 2005 when Mrs. S contacted the duty system the duty worker contacted and liaised with the Children and Families Assessment team to follow up the Staff Grade Psychiatrist's referral. A brief mental state was taken and they ensured that Mrs. S was going to be supported in the immediate future. A further example of good practice within the duty system was on 17

June 2005 when Mrs. S was feeling low. There was liaison with the Children and Families service and the Health Visiting service and a clear plan was made to ensure that Mrs. S was supported. There was also further discussion with the Staff Grade Psychiatrist enabling Mrs. S to receive an earlier review appointment. The strength in the system comes from individual practitioners who are clear about their role in terms of managing duty cases and crisis. There was clear capability in some practitioners to assess situations and effectively manage them at an interagency level ensuring that clients were well supported.

The Independent Investigation Team concludes that there was no clear system in place for the function and management of the duty system and as a consequence it functioned as a crisis service.

4) Staffing

The Independent Investigation Team discussed the justification for having an unqualified member of staff acting in a duty capacity as this raised many issues, not least of which is the recognition that duty is the absolute front line when it comes to dealing with crisis, making assessments, and making instant decisions in the absence of a duty manager and so on. It was also the system through which enquiries were made, and advice sought and dealt with whether from service users and carers or other professionals. The Independent Investigation Team also considered issues of accountability not only for the individual but also for the managers within the team and the Trust. The view of the Independent Investigation Team is that the nature of the work undertaken by a duty system requires the depth of knowledge and skill that can only be offered via professional training and qualification and that having a front line position staffed by some one with “on the job” training is an unnecessary risk. That is not to say that there is not a role for the other practitioners within the team but recognises that duty work is often highly complex and requires a high degree of skill and knowledge to be effective and efficient

Comment: Although there is no evidence that this role contributed to this case the Trust understood and accepted the concerns raised by the Independent Investigation Team and immediately reviewed the situation as it was recognised as a potential vulnerability for the service users and the team.

13.3.4 Allocation

Findings

The case was placed for allocation to a CPN after the consultation with the Staff Grade Psychiatrist on 1 July 2005.[141] The Staff Grade Psychiatrist stated on the referral form that Mrs. S was in need of short term allocation as she was socially isolated and experiencing difficulty engaging as lethargy confined her at home. The diagnosis was stated as a depressive disorder with OCD.

Allocation was based on discussion with the sector manager and the lead practitioners and based on identified need at the time although an assessment had not been completed. It is unclear who allocated the case as this was not recorded on the case file.

The case was allocated to a Care Coordinator with a social work background. The Care Coordinator accepted the case on 13 July 2005. The sector manager was clear that "if a mental state needs close monitoring, if they are quite ill we would think of allocating a nurse"[142] When questioned whether the professional background was of any significance in this case the response was that it would not have made any difference as Mrs. S's presentation was not of a nature or a degree to warrant more stringent intervention such as consideration under the Mental Health Act (1983).[143]

Referral from the outpatient system to the CMHT system and allocation is the trigger point for assessment under the CPA process

[141] Series three pg 45
[142] AT 2 pg 4
[143] AT 3 pg 9

Conclusions

The case was nominated for allocation on 1 July 2005. Allocation decisions were not recorded on the case files, so it remains unclear when the case was allocated, however the first entry by the allocated worker was 13 July 2005 (seven weeks prior to the incident) indicating that it took two weeks to allocate the case. In the context of a busy CMHT in 2005 that would have dealt with all kinds of mental health referrals and constantly changing priorities the allocation time frame is considered timely. The impression from the case notes is that the case was discussed with the Care Coordinator as this is acknowledged on the case file.

The clinical record stated that Mrs. S's needs were mainly psychosocial and that she was socially isolated which in some respects may have led the discussion about allocation and a social worker being identified. It is unclear if the more medically orientated GP letter was considered at allocation and whether or not this would have influenced the decision to allocate. The Independent Investigation Team recognise that there was a broad continuum of mental health need and whilst Mrs. S clearly did not meet the threshold for assessment under the Mental Health Act (1983) there was evidence to suggest that her mental state was not stable and that she was not concordant with her medication. Case allocation within a CMHT is a complex process with consideration being given to "best match" in terms of need to skill base, age, cultural sensitivities, gender, and the capacity of individual practitioners and needs of the service user. The Independent Investigation Team considered at length the allocation of a social worker as a Care Coordinator in this case and whether the allocation of a CPN would have made any difference. Although the opinion of those interviewed was that the allocation of a CPN would not have led to a different treatment plan being offered, the Independent Investigation Team disagreed with this based on the findings from the interview with the Care Coordinator (see part 13.4.3) and that there was conflicting information in the clinical record about what the potential needs were as highlighted in 13.2.2

Contributory factor 10: Mrs. S's needs might have been better met through the allocation of a CPN who would have been more focused on monitoring and trying to stabilise Mrs. S's mental state prior to social engagement.

Comment: The Independent Investigation Team is aware that the Trust has taken immediate steps to develop an Operational Policy for the CMHT and would like to support them in this work.

Recommendation 6: The Mental Health Trust need to review the CMHT operational policy to ensure that all the contributory factors noted in this report have been addressed in particular the role and function of duty workers and the interface between the OPA and duty systems.

Recommendation 7: Priority needs to be given to the development of the CMHT practitioners to ensure that the operational policy and the changes therein are implemented. Further, practitioners must be given the opportunity to develop as advanced practitioners through non medical prescribing, Adult Mental Health Practitioners, coaching, and mentoring etc to ensure their full development to meet patient needs and the challenges of the future.

13.4 Critical Issue 4: Care Programme Approach

Context

Care Programme Approach (CPA)

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

The Care Programme Approach is the corner stone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services (Building Bridges DoH 1995). This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where there is more than one agency involved but to all patients.

The essential elements or any care programme are:

- Systematic assessment of health and social care needs both immediate and long term
- The formulation of a care plan agreed between the relevant professionals, the patient and their carer, this should be recorded in writing
- The allocation of a key worker/care coordinator whose job it is:
    - To keep in close contact with he patient
    - To monitor that the agreed programme of care remains relevant
    - To take immediate action if it does not
- Ensure regular reviews of the patients progress and of their health and social care needs

Two Tiers of CPA were defined:

- Standard for people who will be likely to:
    - Require the support or intervention of one agency or discipline or
    - Require low key support from more than one agency or mental health worker
    - Be more able to mange their mental health problems
    - Have an informal support network
    - Pose little danger to themselves and others
    - Be more likely to maintain contact with services
- Enhanced for people who are likely to:
    - Fulfil the criteria for Section 117 aftercare (i.e. service users who have been detained in hospital under Section 3,37, 37/41, 47/49, 48/49 of the Mental Health Act 1983)
    - A diagnosis of severe or persistent mental illness
    - A requirement for multi-agency involvement and co-ordination
- Plus any of the following:
    - A history of repeated relapse of their illness due to a breakdown in their medical or social care in the community
    - Individuals with severe social dysfunction or major housing difficulties as a consequence of their illness
    - A history of suicide risk, self harm, self neglect, violence or dangerousness to others as a consequence of their illness

The success of CPA is upon decisions and actions being systematically recorded and arrangements being in place for communication between members of the care team, the patient and their carers.

WLMHT CPA policy 2003

The above directives are acknowledged in the local CPA policy which was jointly developed, owned, and managed by the London Boroughs of Ealing, Hammersmith and Hounslow.

The policy states:

All patients should be assessed for their Mental Health, Social and Psychological needs on initial contact with Mental Health Services. An initial assessment should be completed within 48 hours, and a comprehensive assessment within 4 weeks of initial contact. Pg4

Wherever possible the patient and relevant professionals should be consulted in the assessment process. If the patient agrees, his/her next of kin and/or significant others should be asked to contribute to the assessment.[144]

A Plan of Care based on the patients identified needs should be formulated to address his/her needs.

The Trust policy defines the role of the role of the Care Coordinator as:

Care Coordinators are responsible for the organisation and planning of CPA meetings and for the circulation and documentation of information following CPA meetings.

The Responsible Medical Officer (RMO) should not act as the Care Coordinator for people who have been admitted to hospital, but the Community Responsible Medical Officer (CRMO) may act as the Care Coordinator for community-based patients if appropriate. [145]

[144] WLMHT CPA Policy pg 45
[145] WLMHT CPA policy 2005 pg 6

The Care Coordinator should be a professional or carer who is acceptable to the patient and/or to the care team. It is critical that the care Coordinator can understand and respond to the specific needs of the service user that may relate to their cultural or ethnic background. If for any reason the service user is unable to get on with the Care Coordinator as well as they would like, they can request their MDT to consider a change.

The Care Coordinator will be responsible for the co-ordination of assessments, planning and delivery of care to the patient. [146]

13.4.1 Assessment

Findings

Although the CPA policy indicates that an assessment should be completed within four weeks there "are no average times for completing assessments as each individual is different".[147] The Care Coordinator visited Mrs. S on four occasions over the seven weeks that she had been allocated the case. The Care Coordinator indicated at interview that she "usually spent about two hours with Mrs. S".[148]

A comprehensive assessment had not been completed by the time of the incident seven weeks after the case was accepted by the Care Coordinator.

However, the Care Coordinator had gained some significant information about Mrs. S and was able to identify some of the cultural factors that may have influenced the assessment process and outcome. The Care Coordinator was aware of how concepts of shame and fear of bringing shame on a family can be problematic but these issues were not explored nor were they used to inform the assessment process.

There is no reference to a carer's assessment for either Mr. S or Mrs. S's mother both of whom were reported as offering a substantial amount of support to Mrs. S.

[146] WLMHT CPA policy 2005 pg 6
[147] AT 1 pg 15
[148] AT 1 pg 4

At the time of allocation the case had already been referred to the Children and Families Social Services Team for assessment.

Conclusions

The Independent Investigation Team recognises that engagement with new patients can often be a slow and sensitive process, however if each visit was approximately two hours then the Care Coordinator would have spent eight hours with Mrs. S. The Independent Investigation Team consider this an ample amount of time to have completed a full assessment including the formulation of a care plan. There were also several opportunities to speak with other family members about how Mrs. S and the family were coping and to inform the assessment but these were not utilised.

As with the duty work there were missed opportunities to contact and liaise with other professionals who were involved with the case at this time to inform the assessment process.

The standard assessment form in use at the time whilst not all encompassing was available as a guide as to what information should be gathered to inform an assessment but also a guide to the process, this was not followed.

The Independent Investigation Team accept that assessment is an ongoing process and that some degree of assessment occurs at every contact. However the expectation of the Trust was that a comprehensive assessment should be completed within four weeks of initial contact and this did not occur. It is accepted by the Independent Investigation Team that not all aspects of an individual's life can be ascertained by health care professionals and the Care Coordinator did manage to identify some relevant and useful information. In terms of causality there was a clear breach in terms of Trust policy but the view of the Independent Investigation Team is that they were unable to establish a direct causal relationship between the lack of a comprehensive assessment and the events in August 2005 however it is clear that the omission to complete a formal assessment and understand the significance of some of the information obtained contributed to the lack of understanding about Mrs. S's situation.

Contributory factor 11: As a consequence of the lack of formal assessment there was no case formulation or care plan to address Mrs. S needs.

Recommendation 8: The Trust needs to introduce and develop the concept of case formulation to underpin and promote robust clinical practice and to embed policy within practice.

13.4.2 CPA process

Findings

Care Coordinators are responsible for the organisation and planning of CPA meetings and for the circulation and documentation of information following CPA meetings. By virtue of having an allocated Care Coordinator and being involved with multiple services Mrs. S was in receipt of an enhanced level of CPA.

There is no indication in the case file that a CPA had occurred after the case had been allocated or that a CPA was being planned. The Care Coordinator had agreed to disengage from the case at the time of the incident although at interview the Care Coordinator did state that once a CPA was raised she would be able to involve the Children and Families worker and the other professionals involved.[149] The sector manager was of the opinion that there would have been a care plan and that it wasn't written down properly in the proper format.[150]

Conclusions

According to Local and National guidelines Mrs. S was on enhanced CPA as there was multiagency involvement and an allocated Care Coordinator. The Care Coordinator did not complete an assessment or organise a CPA meeting with all noted professionals and family. There is no evidence on the case file to indicate that the Care Coordinator was considering this process when she agreed to disengage from Mrs. S. Consequently there was no overview of the case from a multi professional perspective and options around interventions such as CBT were not considered. In conclusion the Independent Investigation Team regards the failure to organise a CPA meeting as a contributory

[149] AT 1 pg 6
[150] AT 2 pg 6

factor in the death of Mrs. S and her children. The Team was unable to establish direct causality with what can be viewed as a fundamental basic within mental health practice as the reality of getting the right people to attend a CPA requires considerable notice unless there is a need for an urgent review e.g. the Staff Grade Psychiatrist was booked three months in advance. There was nothing in Mrs. S's presentation that gave rise to immediate concern.

Contributory factor 12: There was a failure to adhere to National and Local CPA standards and policy.

13.4.3 Care Coordination

Findings

The Care Coordinator allocated to Mrs. S had been working with the team for approximately eight months and received supervision every six weeks. The Care Coordinator had spent several months as a locum duty worker prior to taking on a permanent post.

From interview it became apparent that the Care Coordinator had some conflict in her mind about her role as a social worker and her role as a Care Coordinator consequently focusing predominantly on social engagement with Mrs. S. This was supported through the Care Coordinator's statement of "when I took on the permanent job I then took on more of a role as a social worker"[151] with case load responsibility. There is further confusion within the social worker's mind about what her role is, as she refers to Mrs. S as not having a care coordinator and was under the impression that she just had to assess her social need in the community.[152]

The remit of the care coordinator was clearly documented at the point of allocation by the Care Coordinator[153] stating the role was to assess Mrs. S's needs, support and liaise with the Children and Families Team and to discuss the case with the Staff Grade

[151] AT 1 pg 2
[152] AT 1 pg 9
[153] Series 3 pg14

Psychiatrist updating him if there were any concerns. There is no reference to monitoring Mrs. S's mental state or medication.[154]

The Care Coordinator did attempt to contact Mrs. S on the day after she records acceptance of the case.

The Care Coordinator did not familiarise herself with the case prior to starting to engage with Mrs. S believing that this was something that would be done in parallel with the case work "No I did not read the whole file"[155] and was therefore not aware of the incident of domestic violence or Mr. S having left her following this incident.

The Care Coordinator had four contacts with Mrs. S:

Contact 1. 18/07/05

The Care Coordinator visited Mrs. S at her mothers' house. Mrs. S informed the Care Coordinator that she is increasing her dose of her medication weekly as directed by the Staff Grade and requested a medication review as she did not feel that it was helping as she remained anxious and was advised to wait a further week. Mrs. S and the Care Coordinator discussed Mrs. S concerns about the children's diet and it was noted that Mrs. S's mother was very involved. The Care Coordinator recorded that Mrs. S became more tearful as she began to open up[156]The impression formed by the Care Coordinator was that Mrs. S "felt trapped looking after the children every day" and the plan was to see Mrs. S on a weekly basis to explore her hobbies and interests to get her involved in activities. There is no record of Mrs. S's mental state or risk assessment. The Care Coordinator considered referring Mrs. S to a project to help with her confidence and motivation.[157]

Contact 2. 27 July 2005

The Care Coordinator visited Mrs. S at her own home. Mrs. S presented as more "chatty" and busy with Child 2. Mrs. S informed the Care Coordinator that she was not taking any medication as she was trying to cope without it. The Care Coordinator

[154] Series 3 pg 14
[155] AT 1 pg 7
[156] Series 3 pg 16
[157] Series 3 pg 15

provided Mrs. S with a new prescription for medication should she "wish to take it". There was no reference to Mrs. S's mental state or how she was coping. The Care Coordinator noted that Mrs. S was more willing to engage with other services and that she would provide her with some information.[158]

Contact 3. 2 August 2005

It is unclear from the records if this contact was at Mrs. S's home or her mothers' home. Mrs. S informed the Care Coordinator that she was continuing to try and cope without medication. Mrs. S disclosed the difficulties she had experienced when her parents in law had come to stay "taking control of her home" and how she felt that she had lost her confidence. She had "felt rejected and guilty and thought that she had disappointed them when she gave birth to a girl". Mrs. S also disclosed that she fell out with her husband and that he had left her for four to five months and that she had been to India and "brought him back". It is documented that Mrs. S described how she was feeling: when "she wakes up everyday she has nothing to look forward to believing that she is a bad mother". The opinion of the Care Coordinator was that Mrs. S was managing quite well and that "she needed some education and reassurance in relation to bringing up her children". There is no clinical record of Mrs. S having any of the statements she made about her cultural background, her feelings of worthlessness and lack of future being followed through. There is no reference to a mental state being completed or discussion about the potential value of medication. There is no record that the Care Coordinator provided Mrs. S with the information she referred to in her previous visit.[159]

Contact 4. 17 August 2005

The Care Coordinator visited Mrs. S at her mother's house. It is recorded that Mrs. S stated that she felt Ok although the Care Coordinator recorded that Mrs. S was "withdrawn and that she was not expressing her worries or concerns to her mother". Mrs. S was continuing not to take medication. Discussion centred on Mrs. S having help in the home with Mrs. S's mother feeing that a home help would be beneficial and Mrs. S stating that she would like to do her housework herself. The Care Coordinator offered to help Mrs. S with the housework prior to considering a home help. The Care Coordinator established that Social Services had not yet done an assessment. Mrs. S requested that

[158] Series 3 pg 17
[159] Series 4 pg 18

there were no further visits whilst Child 1 was on holiday from school. The Care Coordinator agreed to keep in touch with Mrs. S by telephone "respecting her wishes and taking into consideration her levels of anxiety". There is no record of a mental state or discussion about medication.

The Care Coordinator did contact the Children and Families Social Services team to find out the date of the assessment that they were going to conduct, although there is no record to indicate that this opportunity was used for information sharing or to arrange a joint assessment.

There is no evidence to support the notion of the Care Coordinator contacting the Health Visitor, although there is evidence that she was aware that a Health Visitor was involved, as this was specified on the consent to share information form[160] and there had been earlier contact on a duty basis. There are no records to indicate that the Care Coordinator attempted to contact any of the other professions that had been noted on the case file, namely the community staff nurse and the GP.

The Care Coordinator understood that Mrs. S was "depressed to some degree because she was using services"[161]: "I understand that she had a severe depression but my role was to support the social factors in her life, looking at her social circumstances, how these were having an impact on her depression and working to change these".[162] I always felt that she lacked self esteem and confidence: the main things I picked up was that she was getting a bit bored with her daily routine which was what she was struggling to manage".[163]

Mrs. S did talk to the Care Coordinator about her medication as she didn't feel that it was helping but it was reported that this is something "she (Mrs. S) needed to speak to the Psychiatrist about as this is not my (Care Coordinator) speciality".[164] There is no evidence in the clinical record that the Care Coordinator attempted to make an appointment for Mrs. S to discuss her medication with the Psychiatrist or that she sought advice about this matter from her supervisor or colleague. In fact the only intervention

[160] Series 3 pg 42
[161] AT 1 pg 4
[162] AT 1 pg 10
[163] At1 pg 4
[164] AT 1 pg 6

about medication was completed through the duty system when Mrs. S's medication was changed. The expectation is clear from the CMHT manager "the only thing that I can't expect social workers to do, is to give medication, and that's about it, really. As far as we're concerned, that's where the boundaries are, it's a generic role".[165]

At interview there was some recognition by the Care Coordinator that she was acting in a mental health capacity "I am monitoring her mental state: is she eating ok? Or sleeping ok? Does she have any suicidal tendencies? I was fairly confident of picking that up".[166] However although stating this at interview there was no evidence in the clinical record to support this and no mental state was documented after 1 July 2005. Furthermore, at the final visit, when Mrs. S did present as withdrawn and the Care Coordinator was informed by Mrs. S's mother that she was also concerned "the mother being very, very worried about her (daughter) and aware that she was withholding information from me (mother)"[167]" this did not trigger a change in approach, the frequency of visits or a review.

There is no evidence on the clinical record that this case was discussed by the Care Coordinator in supervision.

The Care Coordinator at interview demonstrated some understanding of the value of CBT as an evidenced based intervention for depression but did not appear to have considered referral to this service as an option.

The Care Coordinator was able to identify some of the cultural factors for example "they (husband's family) feel it is shame if their family found out they were getting help from the girl's side of the family when the wife should be able to do the chores herself"; "I understood why she said her husband was not willing to have help in the home and why she first gave birth to a girl and not a boy"[168]

[165] AT 3 pg 13
[166] At 1 pg 10
[167] At 1 pg 5
[168] At 1 pg 12-13

In terms of work load the Care Coordinator reported that “at the time I felt it my case load was containable” [169] This is in conflict with the managers’ view who reported “all the Care Coordinators felt overwhelmed all the time”.[170]

Conclusion

The Care Coordinator did understand that Mrs. S had a moderate depression that was ongoing and was aware of the basic symptoms, however there was no evidence in the case notes to support this knowledge being applied to practice, guiding care or interventions. Indeed there was evidence to the contrary as what can be gleaned form the clinical record is that Mrs. S was feeling hopeless about the future focusing on what she perceived to be her failings around her marriage and as a mother and that she had become withdrawn and was not confiding in anyone at the final contact on 17 August 2005.The Care Coordinator continued to focus on Mrs. S’s concerns for her children rather than the changes in her mental health.

The Independent Investigation Team appreciates that there is a balance between the need for a formal mental state assessment and the need to engage with patients on a personal level but believe that in the time allocated to the visits that both would have been achievable. Whilst it can be argued that monitoring a mental state is a medical approach to mental healthcare, an individual’s diagnosis and presentation are used to implement evidenced based care and give direction to care pathways. Mental state examination is a core function of all qualified members of a CMHT. The depth of an MSE will vary according the level of experience and knowledge of individual practitioners however all CMHT practitioners should be able to complete a basic assessment according to the provisional diagnosis of the patient. The fact that Mrs. S did not have a mental state assessment after her appointment with the Staff Grade Psychiatrist on the 1 July 2005 is regarded as a major omission, especially in the light of the changes in the prescribed medication and her known history of non concordance. As a consequence Mrs. S’s mental state was not known at the time of the incident.

[169] At 1 pg 14
[170] At 2 pg 15

The failure to liaise with other agencies that were known to be involved with Mrs. S and the missed opportunities for joint visits and the lack of consideration of a carer's assessment are all indicative of poor practice. However there is evidence to support the Care Coordinator engaging well with Mrs. S on two occasions and building a trusting relationship from the level of disclosure about some of the relationship issues discussed (although there was no exploration of these issues and their impact on Mrs. S, or how they may have influenced her life choices). It also has to be noted that the Care Coordinator had been allocated only seven weeks prior to the incident.

It is generally accepted in mental health that the history of a service user is of importance as history informs the present and the future. It became clear at interview that the Care Coordinator had not read the case history and was therefore unaware of significant events such as domestic violence. Furthermore the prevailing attitude of the Care Coordinator, when questioned about this aspect of care, gave the Independent Investigation Team cause for concern. The Team were concerned that the Care Coordinator lacked insight into any potential shortcomings. In her current practice she continues not to read case files although she would "probably read the last letters". The rationale offered being that "some of the files are quite bulky and take time to read". The Care Coordinator raised specific issues about the use of electronic files, in particular, "health and safety considerations limiting the electronic reading to sessions of one hour with breaks" and that "reading the electronic file requires an understanding of locations and storage of information and documentation and almost certainly requires more time" implying that there was a lack of familiarity with the system.[171] While this is certainly true in many cases Mrs. S's case file contained less than 60 pages.

The Independent Investigation Team recognises that social workers are not the only profession to adhere to particular aspects of their discipline and training and that it is the task at senior practitioner level to supervise the work within the context of the CMHT, then to bring this together as an MDT. The Team also notes that the Care Coordinator was junior, inexperienced and receiving little supervision in 2005. Supervision on a six weekly basis was regarded as inadequate for a relatively newly qualified social worker or nurse although it is acknowledged that this CMHT did have access to a reflective

[171] AT 1 pg

practice session with an experienced psychotherapist, however there was no obligation to attend.

Contributory factor 13: The Independent Investigation Team found that the Care Coordinator failed to understand the significance of her own observations or apply her knowledge of mental health and culture. The Care Coordinator had a poor understanding of the role and function of a Care Coordinator as outlined in the CPA policy and consequently failed to meet the requirements of this role working within the confines of a generic social worker rather than the role of a social worker within a specialist mental health team.

Recommendation 9: The CPA policy was reviewed in 2008. The Trust should undertake a full audit to ensure that the revised policy has been implemented effectively and that practitioners are operating smoothly.

Recommendation 10: Consideration needs to be given to the development of core competencies for duty workers, team leaders and managers that are in keeping with the Knowledge and Skills Framework and the National Occupational Standards to support the implementation of the Operational Policy. Core competencies should be completed with Care Coordinators as part of their annual appraisal process.

Recommendation 11: The Trust needs to revisit the supervision policy with a view to enhancing integrated practice and not limiting this to professional groups.

13.5 Critical Issue 5: Risk assessment

WLMHT CPA policy 2003

The policy states:

All Service Users must be assessed for risk to themselves and/or others on initial contact with the service. All assessments must be fully documented and filed in the appropriate clinical file (CNST Standard: 8.1.1). Risk assessments should be based on the use of appropriate and recognised "Assessment Tools", at the discretion of the relevant Multi Disciplinary Team.[172]

Risks to be assessed should include:

- Risk of harm to others
- Risk of harm to themselves
- Risk of significant deterioration
- Risk of non-compliance with treatment
- Risk of harm from others

Findings

There were three references in the clinical records to Mrs. S experiencing suicidal thoughts (16 September 2004, 15 May 2005, and 1 July 2005).

The assessment on 16 September 2004 noted that Mrs. S had suicidal thoughts "but no intention to act on these as she loves her children too much".[173] There was no reference during the other consultations as to what would prevent her from acting on suicidal thoughts and impulses.

The suicidal thoughts noted in the GP referral had abated after the introduction of Citalopram and when seen on 12 May 205 by the Locum Psychiatrist.[174]

[172] WLMHT CPA policy 2005 pg 5
[173] Series 3 pg 20
[174] Series 3 pg 24

By the 26 May 2005 it was recorded that there were no thoughts of self harm but that Mrs. S took a long time to reply to the question.[175]

By 1 July 2005 it was reported that there was no change and that Mrs. S was occasionally experiencing some self harm ideation in the form of "vague thoughts" where the thoughts just came into her head although there were no plans to act on these. [176] There was no evidence that these "vague thoughts" were explored further with Mrs. S.

There was no written evidence at the consultations that consideration was given to other risk areas such as:

- Risk of significant deterioration
- Risk of non-compliance with treatment
- Risk to children
- Risk of harm from others[177]

Where Mrs. S did admit to feeling suicidal there was no evidence to support this being followed through in a timely manner with outpatient consultations being three to four months apart. There was no evidence to support Mrs. S being advised as to how to cope with these distressing thoughts or what to do if they became more frequent or overwhelming. In essence there was no crisis plan beyond the use of A&E or the duty system. No consideration was given to self management of symptoms or the use of third sector agencies such as the Samaritans.

There was no reference outside the medical entries concerning risk assessment.
The Care Coordinator was not aware that there had been a previous incident of domestic violence which had been recorded on the case file; it transpired that the Care Coordinator had not read the case notes.

[175] Series 3 pg 26
[176] Series 3 pg 13
[177] CPA policy 2003 pg 5

Conclusions

Mrs. S's reported lack of concordance does not appear to have been robustly addressed.

Medication management is part of the role of the Care Coordinator. Non-compliance with treatment and/or prescribed medication is addressed in the CPA policy which recognises that it may lead to a deterioration of the patient's condition and an increase in the risks associated with that condition. All patients should be assessed for the possibility of non-compliance with treatment and/or medication as a part of the CPA risk assessment process. In the event of "Treatment Non-compliance" or "Failure to attend", all appropriate and relevant people should be informed and previously agreed plans should be implemented without delay. The standard and enhanced CPA flow chart indicates that if the service user is not complying with the care plan, then a review needs to be scheduled. Information about possible compliance issues were first raised when Mrs. S saw the Locum Psychiatrist on 12 May 2005. Although able to recognise that medication management was outside her area of expertise the Care Coordinator did not recognise that not taking medication gives rise to a cause for concern and did not appear to have discussed this with colleagues, Mrs. S, or the Staff Grade Psychiatrist.

It was of concern that despite a history of domestic violence this was not addressed on an ongoing basis. It was also felt by the Independent Investigation Team that risk factors related to the socio-cultural environment in which Mrs. S lived was not assessed adequately in terms of risk.

The view of the Independent Investigation Team was that the risk assessment completed by the Staff Grade Psychiatrist was limited in its approach focusing on self harm ideation. The fact that there was no history of previous self harm was noted as history generally predicts the future in these matters. However there was no real or immediate risk ascertained at any of the consultations that would have warranted more immediate intervention.

The risk management plan was also limited to the use of the duty system and A&E which were not always the most appropriate avenues. Consideration could have been given to the use of other organisations that are able to provide a supportive listening service on a

24 hour basis that may have been more accessible to Mrs. S as a young mother for when she was feeling vulnerable.

However at no time did Mrs. S admit, to any of the professionals involved in her care to feeling actively suicidal, or present with any active risks to her children, or to harm herself or others.

Contributory factor 14: There was a failure to adhere to the local risk assessment policy.

Recommendation: as for recommendations 8, 9 and 10.

13.6 Critical Issue: WLMHT Documentation

Context

In 2005 WLMHT electronic record systems were being introduced in a graded manner across the Trust. The CMHT under scrutiny were continuing to use multidisciplinary integrated paper records i.e. one file for each patient that would be written in a cotemporaneous manner by all professionals, including duty workers, who had contact with a particular patient.

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

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off[178]

[178] http://www.medicalprotection.org/uk/factsheets/records

Findings

A psychiatric assessment was completed by the Consultant Psychiatrist with a follow up letter and proposed management plan being sent to the GP.[179] A psychiatric assessment was completed by the Locum Psychiatrist and a letter sent to the GP stressing the importance of compliance with medication. [180] There is no record of communication with the GP following the change of medication on 22 July 2005.

The handwritten entries in the case file by the Staff Grade Psychiatrist are in part illegible, brief, difficult to follow, and do not give adequate evidence for the rationale for decisions made. It is understood that this was an issue that was raised by the Trust's own Internal Investigation. The Staff Grade demonstrated awareness in the shortcomings of his record keeping when interviewed.[181]

Following the consultation with the Staff Grade psychiatrist on 26 May 2005 there was no communication with the GP. However following the consultation on 1 July 2005 a detailed letter was sent to the GP outlining the management plan although there was conflicting information concerning diagnosis with what was recorded in the case file which cited "mostly psychosocial", the letter to the GP cited "recurrent depressive disorder, moderate with somatic symptoms [182] and the referral to the CMHT indicated a depressive disorder with OCD.[183]

There is no clear audit trail in the clinical record as to what decisions or plans were made and by whom.

Mrs. S's clinical record did not contain complete CPA documentation, risk assessment documentation or care planning documentation. The record contains what can at best be described a simple chronological running record based upon clinical contacts and interventions. This kind of system is usually devoid of care planning and practical case management.

[179] Series 3 pg 49
[180] Series 3 pg23-25
[181] AT 7 pg 3
[182] Series 3 pg 38
[183] Series 3 pg 45

The Independent Investigation Team was told by clinical witnesses that some discussions did in fact take place regarding Mrs. S's care and treatment. However these discussions were described as having been informal rather than formal, and did not appear to have been recorded anywhere in such a manner that would meet professional regulatory standards.

As a finding of fact it is important in terms of quality and accuracy of the documentation to highlight the errors in the recording of dates within the clinical records:

- The date the case was received by the Care Coordinator is initially recorded as 13 July 2006. This appears to have been over written with the date 19 although the year remains inaccurately recorded as 2006.[184]
- The following four entries are also dated with the year 2006 instead of 2005: 14 July 2006, 14 July 2006, 15 July 2006 and 18 July 2006[185]
- There appears to be further inaccurate recordings of the date where the entry reads 27 June 05 when it should be 27 July 2005, with the following entry having an illegible month presumed to be August.
- There is a duty entry where the date has not been recorded however the Independent Investigation Team has been able to cross reference this with entry with the health visiting records and social services records to ascertain an accurate date.[186]

Conclusions

The standard of documentation indicates poor levels of communication with the Primary Care Services. Clinicians have a responsibility to compile full and complete case notes, documenting the rationale for decisions taken and correspondence to other agencies. The omission of clinic letters to GP's is of importance as they are charged with repeat prescribing following specialist consultation. Like wise GP's have responsibility to inform specialist services if they have concerns about a patient.

[184] Series 3 pg 14
[185] Series 3 pg 14 &15 respectively
[186] Series 3 pg 12

The lack of coherent documentation meant that the Independent Investigation Team could find no evidence to support the notion of the existence of a coherent Care Programme Approach, risk assessment or care planning process.

There was a lack of consistency in the documentation and correspondence about the diagnosis and it is the Independent Investigation Team's view that the focus on Mrs. S's problems being mostly psychosocial was felt to be misleading given the severity of her depression and the need for her to be enabled and supported to receive the most appropriate treatment for that in the first instance.

All decisions, plans and instructions need to be clearly documented in the clinical records whether these are paper or electronic. The accepted and standard format for recording in case notes is that practitioners and managers record their name and position after an entry so that there is a clear audit trail as to what decisions were made, and when and what the rationale for the said decisions is. It could be suggested that this approach would be too time consuming for a team that is already reported as being overstretched however this is a basic standard for all professionals.

The Independent Investigation Team considered the significance of the date errors:

The Internal Investigation noted the date for the allocation being received by the Care Coordinator as being 13 July 2005. The records indicate that the date was overwritten. The further four entries with the 2006 date were also not noted as an area for concern by the Internal Investigation. This leaves the Independent Investigation Team to speculate that either that the date was changed after the Internal Investigation and prior to the Independent Investigation or that it was something that was not noted by the Internal Investigation.

The Independent Investigation Team, having reviewed the notes in their entirety, does not believe that the notes were made after the event as the content is reflective of other professionals' entries, and in the middle of other entries i.e. not on a separate page but came to the conclusion that they were not contemporaneous, albeit over a period of six days and that the standard of record keeping was poor.

Service Issue 3: Individual clinicians did not produce and maintain Mrs. S's clinical records to a professional standard. Local team management systems failed to detect these shortcomings.

Recommendation 12: Whilst some of the record keeping issues have been negated through the introduction of the electronic record system (RiO) i.e. dates and names, clinical files should be scrutinised as a matter of course during supervision to ensure they are up to date and that Trust policy is being followed especially in relation to the CPA process. Managerial supervision notes should be recorded in the clinical file.

Recommendation 13: Clinical files should be scrutinised as a matter of course during supervision not only for accuracy but also quality and appropriateness of mental health interventions.

13.7 Health Visiting Service Involvement

National Context

Since the publication of the *Laming Enquiry* (2003) the Government has produced a raft of documents to identify how services should work together especially around inter-agency communication.

The key drivers have been

- NICE Guidelines for Ante Natal Care 2003
- Every Child Matters 2004
- National Service Framework 2004
- NICE Guidelines for Depression Primary and Secondary Care 2004
- Chief Nursing Officers Report 2004
- Core Standards 2005
- Choosing Health 2005
- Young Peoples White Paper 2005/6
- Working Together to Safeguard Children Inter Agency Approach 2006
- NICE Guidelines for Post Natal Care 2006

The Hall report (2003) Hall E, Elliman D, (Ed) (2003), *Health for all Children,* Oxford University Press, Oxford, is a report providing good practice guidance on screening and health promotion for children in the light of the Government's commitment to reduce inequalities in health. The core pre-school health visiting programme has resulted from these discussions and a broad consultation process involving key stakeholders and members of the public.

Health Visitors had previously followed the Universal Pre-school Screening and Surveillance programme in which all families were offered a developmental assessment for their child at eight/nine months and 18 months to two years of age. The core programme is based on the following principles.

Principles underpinning the core programme

- Health visiting practice is underpinned by a public health approach, tackling health inequalities through promotion of good health and prevention of ill-health on an individual, group and population basis.
- In order to achieve this, a core *minimum* programme is required for the pre-school service. The previous child health-screening programme is no longer appropriate universally (Hall, 2003).
- Every child and parent should have access to a universal child health promotion programme; however this does not imply that all families must receive the same service (Hall, 2003).
- All families will receive a health needs assessment. Any aspect of this may be reviewed at any time *if indicated* e.g. 'removal' in visits, family crisis, accident and emergency follow-ups.
- More effective use of Health Visitor's resources will enable Health Visitors to increase their public health role, reducing inequalities and targeting their services to the most vulnerable.

"Professional judgement is valid for decisions about where to target home visiting resources" (Elkan et al, 2000) Elkan R, Kendrick D, Hewitt M, Robinson JJA, Tolley K, Blair M, et al. (2000). The effectiveness of domiciliary health visiting: a systematic review

of international studies and a selective review of the British Literature. *Health Technol Assess* **4:** (13).

- This minimum programme is proposed for families where there are no identified needs – this may include families who have at least one child and are not disadvantaged by residence or circumstances (Hall, 2003).
- Communication between members of the primary health care team is essential to ensure families receive appropriate levels of support.

Family Health Needs Assessment.

When a new family is referred to the health visiting service an assessment would be made. Currently Health Visitors undertake this in a variety of ways and the proposal is to adopt the framework for assessment currently used for children in need (DOH 2000). This relates to three areas: family and environmental factors, parenting capacity and a child's developmental needs. It offers an opportunity for the whole family's health needs to be reviewed and a plan negotiated between the family and Health Visitor to meet identified needs. It is envisaged that this tool will ultimately be utilised by all persons working with children. Review of maternal mood is part of a Family Health Needs Assessment.

At each stage of the core programme the Health Visitor will make an assessment whether more than the core minimum programme is necessary. If this is the case, the Health Visitor will offer an enhanced service based on negotiated objectives identified in partnership with the family as appropriate.

Following the Family Health Needs Assessment further review may be indicated at a later date. New information may indicate that further telephone or face-to-face contact is indicated.

Local Context

As an operational policy for 2005 was not available to the Independent investigation the local context has been established through interviews.

There were two key management posts within the PCT Community Nursing Services the Neighbourhood Manager and the Neighbourhood Nurse Lead. The role of the manager was to develop services in response to local need and to take operational responsibility for the community nursing teams within that neighbourhood. The Neighbourhood Nurse Lead role was to provide the day to day operational management to a group of nurses which included the district nurses, specialist nurses and the school health team. Initially there were seven neighbourhoods although this changed to four localities. The management structure has remained unchanged

Between 2004 and 2006 the Health Visiting Service in Ealing was undergoing a service redesign from a practice attachment system to a corporate team approach working with practice liaison roles with nursery nurses, health visitor assistants and community staff nurses'. Within the corporate model a team of health visitors and other health staff would work with a number of practices within a defined geographical area with a GP link for liaison work. GP attachment is where the Health Visitor only sees families who are registered at a particular GP practice and residing within the London Borough of Ealing. There are 83 GP practices within the London Borough of Ealing.

At the time of the incident HV1 was part of a team of Health Visitors in Southall. HV2 was working full time as a Senior Public Health Nurse in Southall, the role was split equally between working as a clinical lead for the Neighbourhood Renewal Project and, as a member of the Health Visiting Team in Southall North. HV 2 was the GP attached Health Visitor to the GP's practice. The community staff nurse was a member of the health visiting team working under the supervision of HV 2 and other Health Visitors within the team.

The Health Visitor service included routine new birth visits, eight month developmental checks and child health clinics.[187]

Allocation of work within the corporate team structure: all children on the child protection register would have an allocated Health Visitor who would work with a colleague to cover

[187] AT 12 pg 5

leave enabling a family to have two Health Visitor contacts rather than having to work with a team.

The Health Visiting service offers a core and enhanced service although the language used in 2004/5 was different referring to "families with additional needs" [188] the enhanced service included baby massage. Baby massage is offered to enhanced families as a way of enabling mothers to bond with their babies; mostly people are offered five sessions within a group framework although individual circumstances are taken into consideration and the service is also offered on a one to one basis at the family residence.

The Health Visitor is responsible for the assessment, listening to the family and establishing what their needs are then making a plan that will, where appropriate involve other support workers. This plan would be discussed with the support worker (this could be a Community Staff Nurse (Registered General Nurse), Health Visitor assistant or nursery nurse). The Health Visitor would receive regular verbal feedback about the plan from virtually every visit as they had a shared office.[189]

In 2005 the Health Visiting service operated with a paper record system for individual children and a separate record for "family health". Parent-held child health records (red book) should have been used by all health professionals whenever the child was seen or discussed with a professional.[190]

In 2005 there were difficulties in recruiting health visitors and Ealing were carrying significant vacancies. The services were undergoing a process of transition from the GP attachment system to the team (corporate) approach.[191]

Every time a child attends A&E the Health Visitor is informed as they receive a notification slip.[192] It would be expected that the Health Visitor would make contact with the family by telephone or a visit and that if the family were not well known then the Health Visitor would be expected to find out about them. It was reported that at the time

[188] AT 11 pg 2
[189] AT 11 pg 11
[190] AT 11 pg 11
[191] AT 15 pg 5
[192] AT 14 pg 12

there was probably more concern with non accidental injury which would warrant a telephone call to the Health Visitor.[193]

Clinical supervision was in a group setting with specific staff groups e.g. Health Visitor Community Staff Nurses or Nursery Nurses.[194] where staff discussed issues affecting practice every six weeks. Group supervision was used for child protection cases with the Health Visitors. There was the facility to bring families that were causing high levels of concern to the child protection supervision arena.[195] Supervision for all staff was mandatory.

Description of events

The GP records for Mrs. S indicate that she was taken to see her GP on numerous occasions when she was a child and teenager for a variety of ailments and this was a pattern that was continued into adulthood.[196]

HV 1 visited Mrs. S following the birth of her first child on 22 September 1999 at her mother's house where she and her husband had resided since their marriage. The visit was a routine new birth visit.

On 27 September 1999 HV 1 was informed that a locum GP had referred Mrs. S to Southall Norwood Hospital (Community Mental Health Team) for post natal depression. The GP made the referral following the advice of the Consultant Obstetrician who "had a long conversation with her" noting that "she was scared that she would not be able to look after Child 1 when her husband returned to work and that she was disappointed that she had a daughter rather than a son although her husband was happy".[197]

The Health Visitor was able to visit later the same day and Mrs. S discussed her feelings of sadness and tiredness; Mrs. S confided that she was worried about "coping with her baby alone when her husband returned to work".[198] After this HV 1 saw Mrs. S and Child 1 each week or fortnight at home or at clinic visits often accompanied by Mr. S. Mrs. S

[193] AT 11 pg 15
[194] AT 14 pg 6
[195] AT 11 pg 13
[196] GP clinical records
[197] Series 2C pg 105
[198] AT 11 pg 2

remained well and the contacts became monthly and then less frequently as Child 1 grew older and Mrs. S returned to work. There was very occasional telephone contact with the Health Visiting service and Mrs. S attended for all Child 1 routine checks.

On 26 March 2003 HV 1 was informed by the community midwife that Mrs. S was expecting Child 2 and that she had a history of post natal depression and OCD. HV 1 contacted Mrs. S who informed her that she did not have any current problems and that she would contact her as needed. The community midwife also referred Mrs. S to Social Services due to the history of mental health problems.[199]

Mrs. S and family moved into their own home in 2003 prior to the birth of Child 2 they changed GP and therefore health visitor HV1 ended her involvement with the family.[200] Prior to the birth of Child 2 Child 1 was referred to hospital by the GP in 1999 and 2001 and attended the A&E department on ten occasions.

Mrs. S was admitted between 4 October 2003 - 8 October 2003 for an elective Caesarean Section, it was noted that she had a history of depression prior to the birth of her first baby and this became worse in the postnatal period, also that she had previously been on medication. Mrs. S was to be followed up by Social Services on discharge from hospital. Ealing Hospital sent notification of the birth of Child 2 on 7 October 2003 to Health Visitor 2 (although this was sent to the wrong GP practice as the GP records had not been updated)[201]. On discharge from hospital Mrs. S went to stay at her mothers' house returning to her own house on 3 November 2003.

Mrs. S first took Child 2 to A&E on 16 October 2003. The 13 day old baby presented with a history of three episodes of the 2nd and 3rd toes on the right foot turning purple since the previous night. The parents were reassured and the child discharged home.

HV 2 visited Mrs. S on 20 October 2003 at her mother's house. H.V.2 recorded Mrs. S reporting that she suffered from postnatal depression for two years following the birth of Child 1. She was helped to feel better by going to work and was considering returning to work when Child 2 was six months old. The problem appeared to present as getting

[199] Series 6 pg 15
[200] AT 11 pg 3
[201] Series 6 pg 104

everything out of proportion, tiredness and slowness. At that time Mrs. S reported being worried about:

(1) Husband didn't give her enough support. Doesn't praise her enough.
(2) Difficulty with waking in the night and morning to care for baby.
(3) Naming baby has caused conflict. She wants A and he wants I.
(4) She couldn't cope with his cousin coming to stay.
(5) She did not like him sending money back home to his family.
(6) At the birth of her daughter she was very disappointed with the sex.
HV2 records that Mrs. S's mother coming to stay for six months and that she is expecting a visit from a Social Worker.

Later in October 2003 HV2 contacted Social Services who gave feedback that they did not have any concerns about Child 2.

Mrs. S and Child 2 were seen regularly in the GP child health clinic for routine checks and immunisations. Child 2 had a series of ailments including a cough, a sticky eye (conjunctivitis), and blood in stools. In March 2004 HV 2 noted increased contact from Mrs. S and her requests for increased reassurance on a range of issues. HV 2 arranged for Mrs. S to have further support from a Community Staff Nurse (CSN).[202]

The CSN first visited Mrs. S at her home on 21 April 2004 and discussed home management, recreational activities and Mrs. S's relationship with her husband. The CSN visited Mrs. S regularly demonstrating baby massage and helping Mrs. S problem solve around the practical issues of having two young children, a house to manage and a husband who worked unsocial hours. Although relationship problems were hinted at they were not discussed in detail.[203]

On one occasion in May 2004 the CSN facilitated a discussion between Mr and Mrs. S suggesting that they might like to go out as a couple. Mr. S was apparently in agreement with this idea and stated that "when they did go out Mrs. S always wanted to go home as

[202] AT 12 pg 2
[203] AT 13 pg 3

she was worried about the children".[204] The CSN suggested that Mr and Mrs. S might benefit form attending some counselling together and suggested a local culturally sensitive agency.

In June 2004 the CSN visited Mrs. S at her mothers' house as she was staying there as Child 2 was to be admitted for a hernia repair and Mrs. S required extra support. Mrs. S returned to the marital home shortly afterwards. Child 2 was taken to A&E three times during this month and Child 1 once.

On 14 June 2004 the CSN received a phone call from the Child Protection Liaison Nurse at Hammersmith Hospital who was concerned about the high number of A&E attendances made by Mrs. S with Child 2. The CSN discussed this issue with HV 3 who advised that the increased anxiety levels be discussed with a CPN and the GP. Child 2 had been taken to A&E five times. The CSN contacted a CPN who advised that the case be discussed with the GP with a view to making a referral. Mrs. S fed back to the CSN that Mr. S did not wish to attend a counselling service. The CSN discussed the case with the GP highlighting her concerns about Mrs. S's mental health and the impact this was having on her ability to parent the children, who referred Mrs. S to the CMHT on 22 June 2004.[205]

At the beginning of July there was further contact from the Child Protection Liaison Nurse at Hammersmith Hospital as Child 2 had attended A&E 5 times in July. The CSN was able to update about the current referral to the CMHT and that she would discuss a referral to Social Services in view of Mrs. S increasing anxiety.[206]

At the home visit on 6 July 2004 the CSN recorded that Mrs. S was "still feeling low and that she had informed the CMHT of how she was feeling and that they have offered her an appointment for 16 of September". The CSN recorded that Mrs. S stated "she cannot cope, doesn't want to do this anymore and doesn't want responsibility of children, husband not understanding". However at the end of the visit Mrs. S stood up and said: "I'm really going to try and make an effort and to continue taking antidepressants".[207]

[204] AT 13 pg 4
[205] Series 3 pg 60, Series 2C pg 21
[206] Series 2 C pg 11
[207] Series 2C pg 13

The CSN discussed with Mrs. S about her ability to cope and informed her that she would discuss it with H.V.2 with maybe a referral to Social Services.

The following day the CSN discusses the case with HV 2 noting the concerns as:
(1) Mother's perception of crystals in milk, milk contaminated.
(2) Won't let baby crawl on kitchen floor as "dirty" although floor is clean.
(3) Not responding to baby's smiles.
(4) Force feeding Child 1 reported by mother.
(5) Unable to cope with day to day task e.g. cooking.
(6) Excessive A & E attendance.
HV 2 made the following plan
(1) Discuss with father, grandmother and mother, where are we going from here?
(2) Discuss with GP
(3) Discuss with school[208]

HV 2 contacted Mrs. S's mother by telephone as she had declined to attend a meeting. Mrs. S mother informed HV 2 that she felt that Mrs. S needed:
(a) More attention from her husband.
(b) To see the Psychiatrist before September.
(c) More practical help in the home.
(d) HV2 to check that Mrs. S was taking her medication.

HV 2 contacted the family on 12 July 2004 and was informed that Child 2 had been admitted to hospital. There were two further A&E contacts in July.

There were two A&E attendances and a routine eight month check, by HV 2 for child 2 in August 2004.

On 10 September 2004 it was recorded in the family health record that there had been various telephone calls from Mrs. S who was described as "frantic" as her husband had left her. HV 2 telephoned on 22 September 2004. Mrs. S had gone to stay at her mothers house, and Mrs. S informed HV 2 that her marriage had been arranged and that the family were trying to make some arrangements and that she was trying to "keep

[208] Series 2C pg 14

things as normal as possible".[209] The CSN phoned Mrs. S on 27 September 2004 and was informed that Mrs. S felt fine now and was happy to contact the clinic should she need to.

Child 2 was taken to A&E on two occasions in October and November 2004. There was no recorded contact with any primary care or acute service during December 04 and January 05. In February 2005 Child 2 was taken to A&E on one occasion and twice in March. There was no contact with the Health Visiting service during this time.

The next contact with the Health Visiting service was on 6 April 2005 when Child 2 attended the clinic for a routine check. It was noted that Mrs. S had lost weight and that Mr. S had returned from India, also that they were living back in the family home.

By 18 April 2005 Mrs. S contacted HV 2 stating that she was not able to cope and that her mother was having to come to her home to help her. It was suggested to Mrs. S that she see the local Asian Counselling service and HV 2 phoned them to arrange contact. On 19 April 2005 CSN 1 spoke to Mr. S about the frequent attendance at A&E suggesting that if there were concerns about Child 2 that he was brought to a clinic rather than attend A&E (it was unclear from the records if this was a face to face contact or a telephone contact it was however the final contact in the Child 2 health record).[210]

There was no recorded contact with Mrs. S during May 2005.

HV 2 made an unannounced home visit on 14 June 2005 when Mrs. S presented as "very strained". [211] Mrs. S informed HV 2 that she was seeing a Staff Grade Psychiatrist at the CMHT. This was the final contact made by HV 2.

Two days later CSN 2 telephoned Mrs. S who was not able to stay on the phone long "as her husband was at home" she reported that she was feeling very depressed.[212] The CSN attempted to contact Mrs. S on the phone to arrange an appointment on three

[209] Series 1 C pg 15
[210] Series "C pg 184
[211] Series 2C pg 16
[212] Series 2 C pg 16

separate dates and managed to get through on 30 June 2005 and visited later the same day.

The CSN recorded that the home was untidy with lots of toys in the hallway, kitchen untidy. Mrs. S was low in mood and stated how difficult she was finding it preparing meals for the family. Mrs. S informed the CSN that she had an appointment to see the Psychiatrist at Norwood Hospital the following day and the CSN suggested that Mrs. S ask for a CPN.

The CSN made a plan to:
1.Discuss with Nursery Nurse the possibility of planning and preparing meals, time management food routine, timetable left for mother to think about.
2. To telephone on 7 July 2005 to make arrangements to go to the toy library
3. Liaise with Nursery Nurse i.e. behaviour management for Child 1.
4. For Mrs. S to ask for CPN to visit her at home. [213]

The CSN contacted Mrs. S on the telephone on 7 July 2005 and arranged a visit to the toy library for the following day. At the visit Mrs. S informed the CSN that she had been seen by the psychiatrist and had started taking some medication.

This was the last face to face contact that Mrs. S had with the Health Visiting service.

There were further telephone contacts on 17 July 2005, 28 July 2005 and 4 August 2005 when Mrs. S reported that the children were well and that she had stopped her medication as it was making her feel drowsy and that she was avoiding taking the alternative that had been prescribed by the psychiatrist. The CSN arranged to telephone Mrs. S the following week to arrange a trip to a toddlers group.

This was the final contact with Mrs. S.[214]

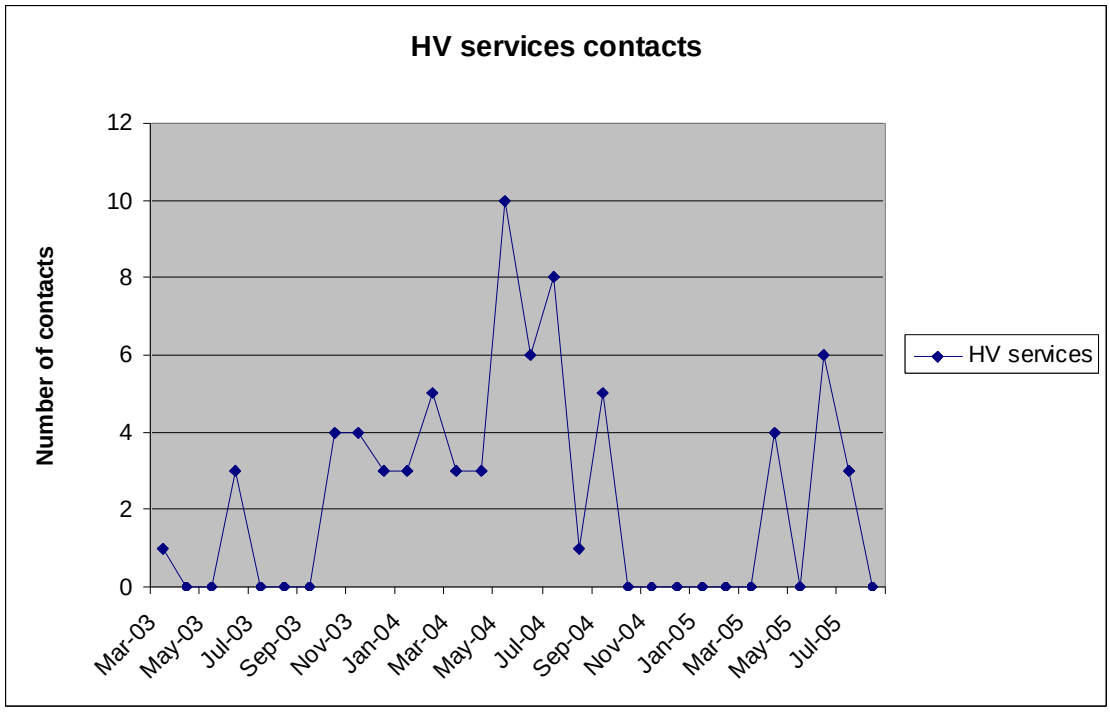
[213] Series 2C pg 18
[214] Series 2C pg 19

13.7.1 Health Visiting Service Contacts

Findings

HV 2 saw Mrs. S at a clinic 13 times, at home seven times and there are records of six telephone calls.[215] There are records indicating that the CSN made 13 home visits and had 21 telephone contacts with Mrs. S. There were clear increases in contact with the Health Visiting service after the birth of Child 2 in October 2003 as would be expected, and in June/ July 2004 when, Mrs. S's mental health deteriorated culminating in a referral to the CMHT. Following the episode of domestic violence resulting in her husband leaving and Mrs. S returning to live with her mother there was a six month gap where Mrs. S did not have any contact with the Health Visiting service, (October 2004 until April 2005).

The CSN had taken extended leave from November 2004 to June 2005. There was no review or evaluation of the case at this point rather Mrs. S indicated that she was feeling well and that she would contact the clinic if she felt it was necessary.



[215] AT 12 pg

Conclusions

There are clear indications that the service was in transition and that at the time individuals were unclear regarding their roles and responsibilities. The Independent Investigation Team recognises that reconfiguration and reorganisation can be factors that destabilise clinical delivery however that should not detract from the delivery of some of the fundamental aspects of care.

13.7.2 Assessment

Findings

It is the responsibility of the Health Visitor to conduct an assessment and formulate a care plan. From the first contact with Mrs. S HV 2 assessed the family's need as being "enhanced" as there had been a referral from the maternity unit stating that Mrs. S had suffered from depression and OCD. [216] There was no record of this assessment in the clinical records.

HV2 felt that Mrs. S was quite a needy person requiring reassurance and was very critical of things that her husband did e.g. gave Child 1 toast and marmalade prior to cereal "tiny things like that became an issue in the family".[217] HV 2 was of the opinion that Mr. S "always responded very considerately to her (Mrs. S) and tried to be helpful…… he left her as she was quite critical of the things he did". HV 2 was aware that Mrs. S maintained a close relationship with her mother and spent much of her time at her mother's house.

Mental health awareness is part of basic training for all registered nurses. HV 2 had not had any training regarding the medication used for depression although was aware that many patients complain of unpleasant side effects and that they need to be taken for a couple of weeks prior to feeling any benefit.[218]

There was no record of a reassessment of what Mrs. S's needs where when she re-presented to services in April 2005 and was re-referred to the CSN.

[216] AT 11 pg 12
[217] AT 11 pg 5
[218] AT 11 pg 4

HV 2 did attempt to contact the Staff Grade Psychiatrist on one occasion.[219] There was no record of any feed back being received by the Health Visiting service about the referral to the CMHT, nor was there any record of HV 2 having discussed the referral outcome with the GP.

There was no record of the Health Visiting team being notified of the incident of domestic violence in September 2004.

Conclusions

HV 2 was clear that it was her responsibility to assess, care plan and delegate work to other team members, principally in this case the CSN. The assessment should have addressed: family and environmental factors, parenting capacity and child's developmental needs.

HV 2 was not aware that Mrs. S had been taken to see her GP on numerous occasions when she was a child. Whilst it would not have been practical for the Health Visitor to have read all Mrs. S's childhood records she should have initiated a discussion with the GP about Mrs. S's history and her parenting ability. Although several home visits were undertaken by HV2 there was no evidence that she made her own assessment of Mrs. S's mood, ability to parent effectively, assess any risk to children of significant harm because of their mother's mental ill health, nor identified any health needs for Mr. S.

HV 2's view of Mr. S was that he was pleasant and appeared to have good relationships within the family. This view appears to have been taken at face value and whilst HV2 was aware of the comments and criticisms Mrs. S had of her husband her view erred on the side of this being within normal (western) marital patterns. HV 2 did not understand the cultural complexities of this family and treated Mrs. S as a western woman as she had fluent English and an outwardly western appearance, however as a professional practitioner it would have been expected for her to have had a greater understanding and awareness of potential cultural complexities even if she did not know what they might all be. Whilst HV2 was able to form an opinion about Mr. S she neglected to consider the role that Mrs. S's mother was playing in supporting the family or any issues this may have raised in relation to the dynamics within the family.

[219] Series 2C pg 17

The Health Visitor realised Mrs. S's anxieties were not grounded in reality and attributed them to her Mental Health problem but thought that this was being addressed by the CMHT/medication. Even although she expressed these anxieties in relation to child health and parenting the Health Visiting Team judgement was that she was parenting well enough. That assessment, although not documented properly, was correct.

Service issue 4: **HV 2 failed to document the assessment of the family's health and needs.**

13.7.3 Community Staff Nurse

Findings

The CSN is a Registered Nurse (Child) and had previously worked in a Sure Start Health Visiting Team so was experienced in working intensively with families over a prolonged period of time. The CSN had also attend baby massage training, Brief Encounters for health professionals' which is a client focused problem solving strategies programme (Developed by One plus One, Marriage and Partnership Research) and The Impact of Mental Health on Parenting Capacity and Children in Need and Child Protection Work' training.[220]

When requiring advice or guidance the CSN actively sought assistance and supervision from a senior colleague and documented this.

Conclusions

The Community Staff Nurse visited diligently, made relevant observations, and provided appropriate interventions that were in keeping with her training during her visits. Her record-keeping was good and she ensured that she kept a Health Visitor informed when there were concerns.

[220] AT 13 pg 2

13.7.4 Care Plan

Findings

There is no record of a plan being made following the initial visit in 2003 although it was clear to HV2 that Mrs. S needed further support.[221] The family was therefore deemed to be in need of an 'enhanced' level of service. Mrs. S did not have a Care Plan developed by her HV 2 in conjunction with the Community Staff Nurse deployed to provide intensive home support in 2005. Feedback from visits was not formal but ad hoc and not clearly documented. There was no evidence of review, re-evaluation and updating of care planning.

HV 2 did attempt to involve the family in a joint discussion about how to support Mrs. S in July 2004 but did not follow this through after Mrs. S's mother declined to attend a meeting.

At the time it was not common practice to arrange professional meetings unless there was a need for a child protection plan and this was usually arranged by social services.[222]

Conclusions

Corporate caseloads were being introduced, but in 2005 there were no explicit definitions of universal and enhanced health visiting services. There was no clear identification of goals of intervention. Health Visitor 2 should have ensured that, in the absence of clarity about the role of the Community Staff Nurse that the Community Staff Nurse appraised herself fully with the involvement of the CMHT staff members and that either she or the Community Staff Nurse undertook a joint visit or attended a professionals' meeting with the Care Co-ordinator. At the very least a Care Plan should have been developed to set out the objectives to be achieved through further CSN intervention with the family and over what time scale. Accepting that the role of the community staff nurse was undeveloped the Health Visitor should have used her skill and experience to guide practice through the formulation of a care plan.

[221] AT 12 pg 2
[222] At 11 pg 8

Contributory factor 15. The Independent Investigation Team regard the omission to formulate a care plan as a failure on the part of the HV to fulfil her role.

Comment: the Independent Investigation Team will not be making a recommendation at this point as this was an issue raised and addressed by the internal investigation team.

13.7.5. Supervision

Findings

There are three recordings of the CSN seeking advice and supervision from a Health Visitor in the clinical record on 14 June 2004, 5 July 2004, and 7 July 2004, although direct supervision with HV2 was described as "ad hoc".[223]

There was no record on the clinical file that HV 2 discussed this case in supervision. Child protection supervision would look at those who are on the register and those who are designated children in need as it was recognised that they "may cause greater anxiety as they do not always have a range of professionals involved". HV 2 only took child protection families to supervision, not cause for concern or above core families.[224]

The CSN was aware that the Health Visitor had supervision with the child protection nurse but this was not available to the CSN at the time although supervision was always available on a more informal basis resulting in the CSN feeling "guided and supervised".[225]

Conclusions

The Health Visiting Service had introduced Community Staff Nurses, but had not yet fully identified and implemented arrangements for their effective management and supervision by Health Visitors. The CSN records in the clinical notes where she has consulted a senior about the case and this is noted as good practice. The Health Visitor always had freedom to seek supervision on any case but did not do this with regard to Mrs. S..

[223] At 13 pg 2
[224] AT 14 pg 7
[225] At 13 pg 2

Contributory factor 16: Reflective practice was under developed in HV 2.

Recommendation 14: The PCT should actively take responsibility for developing reflective practitioners and where there are staff who fail to engage with this or show evidence of continuous learning, their capability for the job should be reviewed in the context of performance appraisal.

13.7.6 Mental Health Assessment

Findings

Whilst being aware of the indications of post natal depression HV 2 did not have any understanding of obsessive compulsive disorder.[226] When describing a situation that cased Mrs. S anxiety HV 2 reported that "it was the little things that caused disagreement in the family e.g. on one occasion Mr. S gave child 2 toast and marmalade prior to cereal and milk. I was never sure if it was anxiety or depression…..felt she needed to control for some reason by trying to control these little things".

In 2005 the Health Visiting service had not had training in the use of the Maternal Mood Assessment (MMA) or the EPNDS (Edinburgh Post Natal Depression Scale) although some practitioners did have experience of this coming from other areas. However HV 2 was able to describe how she would recognise that someone might be depressed "by their demeanour, ability to sleep, ability to concentrate and is aware of the impact a mother's negative mood can have on her children. [227]

The CSN had participated in some mental health training prior to taking up the post and was aware that Mrs. S's mental health problems were beginning to affect her parenting abilities as she was lacking emotional warmth and not providing basic care to the children.[228]

In 2005 there were no local services offering a post natal depression group.[229]

[226] AT 11 pg 5
[227] AT 11 pg 10
[228] AT 13 pg 3
[229] AT 11 pg 12

Conclusions

Whilst the Independent Investigation Team would expect HV2 and the CSN to be familiar and even conversant with depression, especially post natal depression, they would not expect them to be familiar with OCD although it is a very common anxiety-based disorder. However where there are known to be mental health issues it would be expected that any practitioner would enable themselves to have some understanding of the manifestations of the disorder so they would know when to seek help from an appropriate service. There are clear markers in the case notes of a deterioration in Mrs. S's mental state in 2004 and 2005 that are documented and it is perhaps only with mental health workers reading the case notes that the potential significance of what is recorded has been given any consideration highlighting the need for interagency communication and mental health training.

The CSN diligently recorded details about Mrs. S's limitations but did not relate these to an emergence of her OCD although was aware that what she presented with was not "normal" and so sought advice.

Comment: the Independent Investigation Team is aware of the developments that have taken place within the PCT regarding the introduction of mental health awareness training and the introduction of the EPNDS (Edinburgh Post Natal Depression Scale).

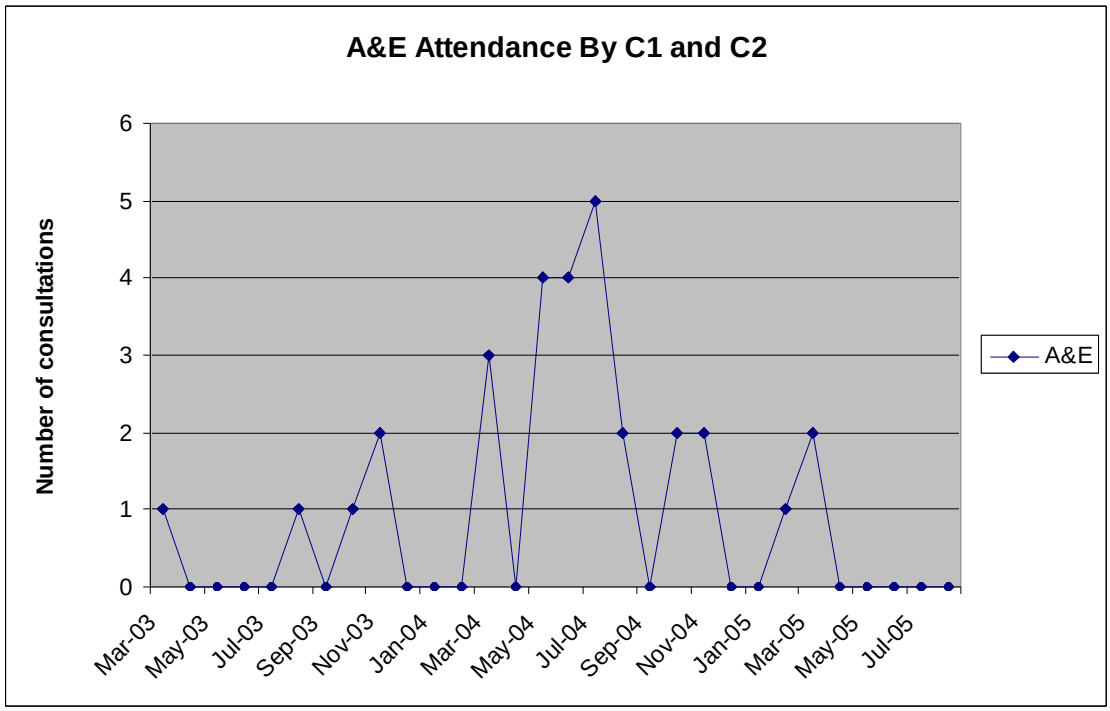
13.7.7 A&E attendance

Findings

A&E send attendance slips for all children less than five years of age to the relevant Health Visiting service they are in turn given to the case holder for assessment.[230] It was reported that it was "part and parcel of practice that you follow up A&E attendance it has always been a marker and is sometimes indicative of not having access to a responsive GP service".[231]. There was no record in the clinical notes that the A&E slips were considered by HV 2 although at interview HV 2's interpretation of the A&E slips was

[230] At 11 pg 12
[231] AT 14 pg 21

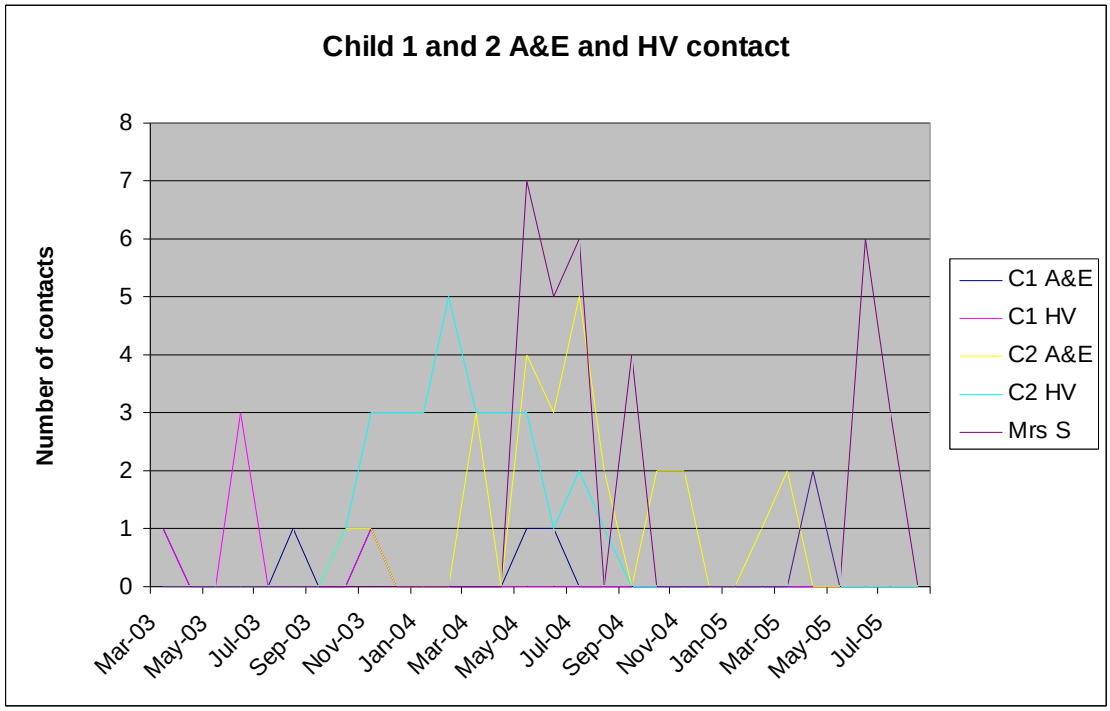
"from my reading of the notes and the A&E slips the children were genuinely ill there were fevers and problems with them.[232]



The Independent Investigation Team explored the contacts with A&E and the Health Visiting service in detail by breaking down the attendances at A&E and with the Health Visiting service for Child 1 and Child 2. The team also identified the level of contact with Mrs. S.

The Independent Investigation Team found that Child 1 had attended A&E 15 times for a variety of ailments ranging from an accidental head injury, otitis media (acute inner ear infection), high temperatures not responding to anti pyretic and acute viral infections and pneumonia compounded by asthma. It could be argued that for the majority of A&E attendances it would have been more appropriate to attend the GP however all but one of these attendances was out of hours or following referral from the GP.[233]

[232] AT 12 pg 14
[233] Series 2C Child 1 Health Records



Child 2 had attended A&E 21 times again for a variety of physical complaints similar to Child 1. In May 2004 Child 2 was diagnosed with an Inguinal Hernia that required surgery and as a consequence of this the attendance at A&E increased post surgery. Again most contacts were out of hours or at weekends.[234]

On further exploration of the contacts that were made by the Health Visiting service a considerable amount of emotional support was given to Mrs. S either on the telephone or face to face. The records of these contacts have Mrs. S's mental well being as their focus namely her anxieties about being able to cope with the children.

The opinion of the managers of the service was "the attendances should have been looked at very carefully and that there should have been discussion with other services to identify any potential child protection concerns" [235] there was also the notion that this is what South Asian Women do.

[234] Series 2C Child 2 Health Records
[235] At 14 pg 14

Hammersmith Hospital contacted the Health Visiting service on two occasions to increase awareness about the level of Child 2 attendance at A&E. This was not followed up with the family by either HV2 or the CSN involved in the care but by a chance encounter with Mr. S through CSN 2.[236] However CSN 2 did respond to the increased contact and asked the GP to refer to Mental Health Services.

Conclusions

The high attendance at A&E would not have necessarily flagged up child protection considerations but the expectation would have been that the attendances would have been reviewed. Had the Health Visitor or GP reviewed Mrs. S's childhood GP records an abnormal pattern of excessive consultations with doctors throughout her childhood and adolescence would have been observed. This may have had a bearing on their understanding of the relevance of her frequent consultations with health care services in respect of her own children.

Mrs. S took the children to hospital and to her GP more frequently than most parents of healthy children. This was interpreted by Health Visiting services as a normal pattern of Accident and Emergency Department usage by South Asian mothers like Mrs. S given their access to high quality GP services. Although the overuse of A&E services was discussed with her husband, there was no appreciation by the GP or Health Visitor, or by Ealing Hospital that Mrs. S's frequent consultations were related to her own mental ill health. When looking at the pattern of increased A&E attendance it matches the increase in Health Visiting contact due to Mrs. S increased anxiety levels. When this is matched to the content of the clinical records there is a clear escalation in Mrs. S anxiety in that, she is clearly stating that she cannot cope and there are clear records that she is responding to her obsessional compulsive thinking as indicated by the entries made by the CSN. There was no evidence that HV2 knew that high A&E attendance is a vulnerability factor as identified in Framework for Assessment of Children in Need and their Families (DoH 2000) and the Independent Investigation Team regard this as a missed opportunity to reflect on the care offered to Mrs. S.

[236] Series 2C pg 184

The possible cultural issues were not identified or considered in that Mrs. S would have found it difficult to seek help in her own right and that the referral to the Asian Women's Counselling Service may have put Mrs. S under further pressure as she had stated that the "family were trying to make arrangements". The fact that Mr. S was informed about the frequent A&E attendances, after which they ceased, may have contributed to an increase in Mrs. S's anxieties and her sense of isolation.

In some respects the role of the Health Visitor is similar to that of a Care Coordinator in Mental Health as both roles carry the responsibility for the assessment and care planning for service users. They also have the responsibility for organising and overseeing care when it is provided by others in the same team or from other teams. This is an aspect of the role that was inadequate and under developed in this case.

Contributory factor 17: There were further missed opportunities by the Health Visiting services to reflect on the case in relation to the high A&E attendance.

Recommendation 15: Ealing Primary Care Trust should require both GPs and Health Visiting staff to consider whether inappropriate anxiety in a parent as exhibited by one who takes the children too frequently to the doctor, hospital or health visitor clinic may be pathological and share that information with the CMHT if they are involved.

Comment: Not as a result of this incident but as a planned programme of development the following changes have been implemented across the PCT:

- A protocol so that health visitors can refer directly to Mental Health Services
- A training programme was rolled out underpinned by the NICE guidelines 2006
- The EPNDS is included in the birth pack that is give to expectant mothers
- There is greater notification of frequent A&E attendance; a traffic light system operating alongside RiO has been developed so if there are more than three attendances within a short space of time, even if they are relatively minor ones a review is triggered
- Much work has been undertaken in the development of clinical competencies for all staff and how to perform competency based assessment

- Post natal depression and mood assessment training has been completed and there appears to be a greater degree of confidence in asking some of the more difficult questions about harm to self through using the MMA (Maternal Mood Assessment)
- The PCT have developed a separate team looking at mental health and well being in primary care
- Clinical supervision has developed and is now inclusive of all Staff Grades for safeguarding children; Data is collected about attendance and themes that emerge

13.8 Children and Families Social Services Involvement

Children and families Social Services Assessment Process

The initial assessment is a brief assessment of each child referred to Children's Social Care Services where it is necessary to determine whether the child is in need, the nature of any services required, and whether a further, more detailed core assessment should be undertaken (paragraph 3.9 of the Framework for the Assessment of Children in Need and their Families (2000). The initial assessment using the framework set out in the Framework for the Assessment of Children in Need and their Families must be completed within a maximum of seven working days of the date of the referral.

A core assessment, using the Framework for the Assessment of Children in Need and their Families must be completed within a maximum of 35 working days. Children's Social Care staff are responsible for the co-ordination and completion of the assessment, drawing upon information provided by partner agencies.

Description of events

Mrs. S was referred to social services by the community midwife when she was expecting Child 2 as she had a history of post natal depression. Mrs. S was visited in hospital on 7 October 2003 after the birth of Child 2. No concerns were reported by the hospital staff although they reported that Mrs. S was "asking lots of questions being very demanding and attention seeking. Mrs. S had reported to hospital staff that she was having problems with her husband as he did not tell her that he loved her often enough

and that he sent money back to his home in India". Mrs. S was recorded as being as being supportive washing and changing the baby. The family dynamics were noted as Mr. S not having a good relationship with Mrs. S's mother and that when Mrs. S was seven months pregnant he went on holiday to India.[237]

On 19 November 2003 a home visit took place, no concerns were noted in the red book (parent held child records); the paternal grandparents arrived on 5 November 2003 and were due to stay until April 2004. It was recorded that Mrs. S was very nervous about their coming as they were going to discuss her relationship with her husband. Mrs. S informed the social worker that her husband did not listen, they argued about little things and that he was not putting his family first as he sent a lot of money to India. No safety issues were identified and the social worker concluded that there was a sense of stability in the family as they are committed to working things out although it appeared that Mrs. S had unrealistic expectations regarding her husband.[238]

The case was held in Social Services until 15 January 2004, as there was no further contact the case was closed.[239]

On 6 September 2004 the family came to the attention of Social Services as "the father appears to have had an argument with the mother over the children; the father struck the mother in the face and pushed her up against the wardrobe". The police had been called and the father arrested. There was no evidence of violence towards the children. Social Services responded to the notification by writing to Mr and Mrs. S advising them about the effects of domestic violence on children and closed the case.[240]

There was no further contact with Social Services until a referral was received from the Staff Grade Psychiatrist at the CMHT on 6 June 2005 requesting an assessment of child 1 stating "severe interpersonal difficulties with the husband and wife and concerns that child 1 may be at risk of neglect". Social Services noted that there were many family members who could offer support and planned to liaise with the parents, the extended

[237] Series 6 pg 104
[238] Series 6 pg 91
[239] Series 6 pg 38
[240] Series 6 pg 69

family and other agencies as to how Mrs. S could be supported to look after the children.[241]

The following day there is duty contact between Social Services and the CMHT as Mrs. S had contacted the CMHT in a distressed state stating that she was unable to cope with the children. The duty worker at the CMHT informed Social Services that Mrs. S had suffered from post natal depression and an adjustment disorder due to relationship problems. A social worker contacted Mrs. S who informed her that she "I (Mrs. S) cannot think straight I need help as things are out of control with the children and the house, that child 2 drinks too much milk and that child 1 only eats pasta". Mrs. S also informed the social worker that she had been advised by the psychiatrist to stop her medication as it had not been helping her. The social worker spoke to Mr. S and was informed that he helps as much as he can but that his wife still becomes distressed at times. It was agreed that Mr. S would take Mrs. S to her mothers' house.[242]

On 8 June 2005 the children were allocated to a social worker for assessment.[243]

The allocated social worker contacted Mrs. S on 20 June 2005 and arranged a visit for the following day.

At the visit on 21 June 2005 Mr. and Mrs. S were at home and Child 1 was asleep. The social worker arranged to visit again when Child 2 was at home. The social worker discussed the case with HV2 who stated that she had no health concerns about the children but that Mrs. S needed to engage with external resources to get herself out of her current situation and that Mrs. S would try to get the children to eat more than they required. HV2 informed the social worker that they had explored play groups and an Asian Family Counselling service. HV2 did not inform the social worker of the enhanced care plan that was being delivered to Mrs. S or the significance of this.[244] The social worker also tried to contact the GP and the Staff Grade Psychiatrist although neither was available. [245]

[241] Series 6 pg 7 and 24
[242] Series 6 pg 90
[243] Series 6 pg 2
[244] AT 19 pg 5
[245] Series 6 pg 86

Further phone calls to medical staff were made on 24 June 2005.

On 4 July 2005 the social worker contacted the Staff Grade Psychiatrist and was informed that Mrs. S had been advised to gradually stop her medication due to side effects and that he wanted an assessment of the children.[246]

On 30 August 2005 the allocated social worker made a further visit to complete the assessment. The assessment concluded that there was nothing to support the Staff Grade Psychiatrist's concerns regarding neglect and that none of the professionals consulted had indicated any concerns regarding the children. The social worker's own observations led him to believe that both of the children were well looked after and happy. All professionals consulted had various concerns about Mrs. S and the expectation was that with increased input from the CMHT, such as from the Care Coordinator whom the social worker understood from Mrs. S would be working with her, would address these. There was no evidence that would indicate possible harm to Child 1 or Child 2 or that they were children in need. It would seem that there were difficulties in Mr. and Mrs. S's relationship but this was not impacting on the children's development and that the parents needed to be encouraged to address their issues through an appropriate counselling service. The social worker had agreed to refer Mrs. S to the Family Welfare Association to request support in the morning as this is when she found things most difficult.[247]

The social worker was clear that the role was to assess the needs of the children and reported that at each of the visits the children appeared to be well cared for and healthy.[248]

Findings

There were three discreet episodes of care with social services.

[246] Series 6 pg 87
[247] Series 6 pg 48
[248] AT 18 pg1

1) Assessment after the birth of Child 2

Mrs. S was visited in hospital and at home following the birth of child 2. No concerns were raised about the children although the disharmony between Mr and Mrs. S was noted.

2) Domestic Violence

The Health Visiting services were not notified of the incident of domestic violence by either the police or social services.

3) Core assessment for the children

The social worker did contact the school that Child 1 attended, the Staff Grade psychiatrist, the GP and the health visiting service although no contact was made with the Care Coordinator to establish the plan of care for Mrs. S.

The social worker did interview Mr. S but did not interview Mrs. S's mother although he was aware that she had provided an "extensive" amount of support to Mrs. S and that this was currently not as readily available as her own mother for whom she was a carer was unwell. [249]

Cultural issues are alluded to in the assessment completed by the social worker "there was an occasion in the past year where Mr. S returned to India for an extended period of time. Whilst Mr. S was abroad Mrs. S resided with her mother and I (social worker) felt that issues around this may also contribute to the relationship issues that they are experiencing. [250] Mrs. S did not want to attend the Asian Counselling service for some reason although they have child care available there".[251]

The social worker visited Mrs. S at home on two occasions once in the presence Mr. S and once on her own. At the second visit, when visited on her own, Mrs. S was described as being more alert and energetic.[252]

[249] Series 6 pg 45
[250] Series 6 pg 47
[251] At 19 pg 2
[252] AT 19 pg 14

The social worker was clear that his role was to assess the children and Mrs. S's ability to parent. [253] However there were gaps in the assessment as Mrs. S's mother and the Care Coordinator had not been consulted.

The social worker had not had the opportunity to share the completed assessment with the other agencies involved as the incident occurred on the day after the final visit.

The social worker received supervision on 14 June 2005, 6 July 2005, and 16 August 2005.[254]

Conclusions

Most parents with a mental health problem parent their children effectively,[255] and few children suffer as a result of their parents mental health problems.[256] However parental mental health problems can have a range of negative effects for children such as developmental delays, failure of parent/child bonding (with adverse effects in functioning for younger children), and even an increased risk of child abuse. [257] Generally, maternal mental health problems have been identified as a risk factor for children, affecting the bonding process and the ability of the mother to cope with her parenting responsibilities.[258] The conclusion of the social workers assessment concurred with the opinion of the health visitor in that Mrs. S was adequately parenting her children with the added identified need being that she needed some support in the mornings as her mother was no longer able to help her. There was no indication that the children were at risk or that Mrs. S had any intention of harming them. No safeguarding children issues were identified.

Whilst instinctively picking up that the prolonged stay in India of Mr. S may have somehow contributed to Mrs. S's current position and the disharmony between Mr and

[253] AT 19 pg 1
[254] Series 6 pg 83-85
[255] *Mancini, A. and Bonamo, G. (2006) 'Resilience in the Face of Potential Trauma: Clinical Practices and Illustrations', Journal of Clinical Psychology: In Session 62(8), pp971-985, quoted in SCIE Research briefing 23*
[256] *Sanford, C.B. (1998) 'Maternal depressive symptoms and homeless children's mental health: risk and resiliency', Archives of Psychiatric Nursing XII(1), pp50-58, quoted in SCIE Research briefing 23*
[257] *Herring, M. and Kaslow, N.J. (2002) 'Depression and attachment in families: a child-focused perspective', Family Process 41(3), p494*
[258] *To, T. and others (2004) 'Risk markers for poor developmental attainment in young children', Archives of Pediatric and Adolescent Medicine 158, pp643–649*

Mrs. S, the social worker did not follow the potential cultural implications of this and this was not something that was raised in supervision or with the team.

The social worker completed the assessment the day before Mrs. S died and therefore there was no opportunity to share the report with the other professionals involved.

Contributory factor 18: The Children and Families social worker did not liaise with the care coordinator about the impact that Mrs. S's mental health problems were having or could have, if her condition deteriorated, on the children not just on her physical ability to care for them but also in her emotional ability to care for them.

Recommendation 16: Where it is known that a parent is in receipt of mental health services the assessment of the children must incorporate the views of the care coordinator.

13.9 General Practitioner Involvement

Description of events

Mrs. S was a frequent attendee at the GP practice (GP clinical records) having an average of 17 consultations a year for various physical complaints, anti natal and post natal care.

On 22 June 2004 the GP referred Mrs. S to the CMHT following referral from the CSN pg139 as she was generally depressed and feeing that she could not cope with looking after her young children and referred to deep rooted childhood problems.[259]

On 30 June 2004 the GP was copied into a letter to Mrs. S inviting her to contact the CMHT for an appointment. The GP did not receive a copy of the Consultant Psychiatrist's assessment until 30 August 2004 [260] as it had been sent to the wrong GP practice.

[259] Series 2A pg 141
[260] Series 2a pg 143

On 15 September 2004 Mrs. S attended the GP practice with her aunt in a distressed state and was given an urgent consultation as her husband had left her. Having assessed her Diazepam was offered by the GP. Mrs. S refused the Diazepam stating that she wanted her husband back.

On 15 April 2005 the GP diagnosed depression as Mrs. S admitted to suicidal thoughts and prescribed Citalopram 10 mg. There was regular follow up but by 12 May 2005 there had only been a partial response to treatment in that the suicidal thoughts were less but Mrs. S remained very depressed and the GP made an urgent referral to the CMHT.

On 25 May 2005 and 26 July 2005 the GP received feedback from the assessments conducted by the locum psychiatrist and the Staff Grade psychiatrist.[261]

Findings

The GP was female and of Asian origin and had a high degree of awareness and understanding of the cultural influences in Mrs. S's life.

The GP was able to corroborate, at interview, Mrs. S's history and the influence of "izzat" in that Mrs. S would have felt that she was responsible for everything and that when things went wrong that it would be all her fault as this was the way that some traditional South Asian women are brought up to think.

The GP was able to recall memories rather than specific events:

- Mrs. S had been insecure as a child and felt the stigma associated with having been brought up without the presence of a father
- Mrs. S was worried that "her husband might leave her and that she would be left on her own with the children"
- Mrs. S had different expectations to her husband about his role as a father
- Mrs. S had admitted that on "one occasion she had felt threatened by Mr. S"
- Mrs. S had struggled with the criticism from her mother in law and that this had undermined her confidence

[261] Series 2A pg152-158

- The GP was able to recall that Mrs. S had informed her that she “was going to India to get on her knees and beg her husband to come back regardless of any conditions that might be imposed on her” as she wanted him back at any cost.

The GP had discussed the concerns about the relationship with HV 2 who had reported that Mr. S had always been “pleasant” when she had any contact with him and came to the conclusion that Mrs. S was anxious and insecure.

There were no records to indicate that Mrs. S contacted the GP service during the time that she had an allocated Care Coordinator.

Conclusions

The GP made timely and appropriate referrals to the CMHT in 2004 and 2005. However what became apparent at interview was that the GP had a clear understanding of the dynamics and cultural influences that were affecting Mrs. S. These were not recorded in the clinical record as it was the general flow of conversation and not what was perceived to be the essence of the problem that Mrs. S was presenting with. It was only with hindsight that the significance of the cultural implications became apparent to the GP.

The interview with the GP served to support the Independent Investigation Team’s view that the cultural factors in this case were of significance.

13.10 Interagency Working

Context

Since the late 1980's there has been a wealth of legislation aimed at increased interagency working. This has been focused on different agencies, at different levels, both strategic and operational, and different age groups.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone.[262] The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[263] The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. This level of expectation was firmly in place during the time that Mrs. S first came to the attention of mental health services in Ealing.

Interagency or joined up working is a dominant characteristic of policy and practice across the range of health and social care settings. The purpose of an interagency meeting is to exchange information as appropriate on individual cases, organise care planning when two or more agencies are involved, and ensure overall that relevant information is shared. It is a common principle across all policy directives from CPA to Every Child Matters and a basic principle that underpins positive practice in mental health.

Description of events

At the time of the incident there were four organisations involved in the care and treatment of Mrs. S:

- Health Visiting Services: Mrs. S had a named Health Visitor and an allocated Community Staff Nurse

[262] Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). Pg 144.

[263] Ritchie et al Report of the Inquiry into the Care and Treatment of Christopher Clunis (1994)

- Mental Health Services: a social worker had been allocated as the care coordinator to provide on going support
- Social Services: a social worker had been allocated to assess the needs of the children following referral from mental health services
- Primary Care General Practitioner

The Individual agencies, context, contact and involvement have been documented in previous chapters and will not be repeated here.

Findings

It has already been established:

- that there were missed opportunities within the CMHT duty system for liaising with other agencies as to their involvement and perception of Mrs. S and her family and that an assessment was not completed on a duty basis
- the Care Coordinator did not liaise with the health visiting service i.e. HV2, the CSN or the GP, complete an assessment or coordinate a CPA meeting
- the Health Visiting service did not liaise with the CMHT, document an assessment or organise a professional meeting
- the Health Visiting service were not notified of the incident of domestic violence
- the Staff Grade psychiatrist did not liaise with the health visiting service and intermittently communicated with the GP
- the Children and Families social worker did not consult with the CMHT
- the GP had a good understanding of Mrs. S cultural circumstances

Chart documenting the contact across agencies following the urgent referral on 12 May 2005 until the time of the incident.

Date	C&F Social Services	CMHT	Health Visiting	Psychiatrist	GP
12/05/05				Urgent referral Seen by locum psychiatrist	
26/05/05				OPA Staff Grade	
06/06/05				Urgent referral	
07/06/05	Duty	Duty			
09/06/05	Duty	Duty		Staff Grade	
13/06/05		Duty phone call social services			
14/06/05		Duty	CSN2 visit		
17/06/05	Manager	Duty	HV1	Staff Grade	
21/06/05	SW visit Phone call GP, Staff Grade				Fax to social services
27/06/05	SW visit Phone call GP, Staff Grade				
30/06/05			CSN2 visit		
01/07/05 04/07/05	P/C Staff Grade			OPA Staff Grade	Letter
14/07/05		Allocated worker phone call social services			
18/07/05	Phone call to school	Home visit by allocated worker			
22/07/05		Duty contact			
03/08/05		Allocated worker Phone call			
02/08/05	Duty	Home visit by allocated worker			
17/08/05		Home visit by allocated worker			
30/08/05	SW visit				
31/08/05	Incident				

Conclusions

The Independent Investigation Team considered the information that was available to each of the practitioners involved and whether an interagency meeting would have assisted in the overall assessment and care planning that was offered to Mrs. S.

What was known?

Psychiatrist

It had been established that Mrs. S had experienced several episodes of suicidal ideation and that she had a recurrent depressive disorder. Mrs. S had previously responded well to a combination of antidepressants and CBT. There was no known history of previous suicide attempts or of Mrs. S harming herself. The Staff Grade Psychiatrist was concerned enough about Mrs. S to refer her to Social Services and the CMHT for assessments. Mrs. S was not taking any medication for her mental health problems at the time of the incident. Mrs. S was last seen by a psychiatrist on 1 July 2005 when her mental state was noted to be “socially isolated having increased sleep and appetite with poor energy and concentration”.

Care Coordinator

It has been established that the Care Coordinator had not completed an assessment although she had identified that Mrs. S was socially isolated and was attempting to engage Mrs. S in social activities. The Care Coordinator had some understanding of Mrs. S’s culture and was aware of the significant events that may have been contributing to Mrs. S’s current circumstances. Mrs. S had a low self esteem and had expressed some hopelessness about the future. The Care Coordinator had not completed a risk or CPA assessment or care plan but noted that the children seemed to be well cared for.

Health Visiting Service

It has been established that Mrs. S was very anxious about her children’s health and her ability to feed and parent them correctly. The Health Visitor did not have any concerns about Mrs. S’s ability to effectively look after her children. A CSN had been very involved with trying to support Mrs. S emotionally whilst encouraging her to attend activities out side of the house. The CSN had on one occasion raised concerns about Mrs. S withdrawing from her children and recorded that Mrs. S responded to obsessional

thoughts about dirt that she had reported to HV2. The Health Visitor was aware of the multiple attendances at A&E and the high levels of anxiety that Mrs. S experienced.

Social Services

The social worker was the only professional to have completed an assessment of Mrs. S and her family although there were gaps in the assessment as Mrs. S's mother and the Care Coordinator had not been consulted. No risks were identified with Child 1 or Child 2.

GP

It has been established that the GP had the overview of Mrs. S in the context of her life history and culture with access to her childhood clinical records and identified what were considered long standing psychological problems as noted in the first referral to the CMHT. The GP was aware of the frequent attendances at the surgery and A&E services and had referred Mrs. S to the CMHT on two occasions for depression and suicidal ideation.

All agencies were aware that there were problems within the marriage of Mr and Mrs. S.

None of the agencies involved in this case considered a joint assessment or a case conference/ professional meeting/ CPA meeting. The psychiatrist was clear that he was expecting feedback from the Care Coordinators assessment and was considering reviewing the case formally to an enhanced CPA status although in effect Mrs. S had already reached the criteria in 2005. From the health visiting perspective, whilst a professional's meeting was the method in use where there were concerns about safeguarding, or in primary care/social services around care for children with disabilities/complex needs the children were not classified in this way. The GP being in possession of all the information did not play an active role in following through the referral to the CMHT. The Care Co-ordinator was in the position to arrange a CPA to which the GP, HV/Staff Nurse and Social Services Children & Families could be invited with the subsequent opportunity for information sharing. (Refer to 13.4)

Contributory factor 19: The professionals involved did not liaise sufficiently, share and collate all the information available, reflect and plan on the care that could have been offered to Mrs. S. This had a direct influence on how she was perceived and is a significant contributory factor in the care and treatment offered to Mrs. S.

Recommendations as for 8, 9, 10, 11 and 12.

13.11 Safe Guarding Children

Context

One in four adults will experience mental health problems. Many of these people will be parents, parents-to-be, grandparents, other family members, or will have regular access to children. Parental mental illness in particular can have a detrimental effect on the health and well being of a child. The Department of Health and the Royal College of Psychiatry advise that systems should be in place to ensure timely assessment, review and support.[264].

There is a significant legislative framework in place to both protect and safeguard children. There is also a significant series of Inquiry recommendations and Department of Health Guidance relating to both the protection and safeguarding of children. In 2004 the Mental Health Trust had in place a Child Protection Policy and associated training based on Working Together 1999. The policy defined emotional abuse as:

"*the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation of corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur alone"*

[264] Royal College of Psychiatrists, *Patients as Parents* (2002)

And neglect as

"*the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs."*

Findings

Concern about Mrs. S's ability to parent the children effectively was raised by CNN2 on 7 July 2004 as she would not let Child 2 crawl on the floor as it "was dirty" although the floor was reported as clean, she was not responding to the baby's smiles and claimed that she was force feeding Child 1. This information was not known to the mental health services. Mrs. S was receiving an enhanced care package from the Health Visiting Service and had been referred to the Mental Health Services for an assessment where she was diagnosed as having an adjustment disorder. There was no further reference to these concerns.

At the assessment from the Children and Families Social Worker in August 2005 it was recorded that both the children's emotional and behavioural development was consistent with their ages[265] and that they were close to their mother. The children were described as happy with Mrs. S paying attention to them both.[266] In the conclusion the Social Worker recorded "there was no evidence that would indicate possible harm to the children at this time or that they are children in need by virtue of their normal development being impaired in any identifiable way".[267]

At no point were any of the professionals involved in the assessment and care of Mrs. S concerned to the degree that Child Protection considerations were instigated. In fact all professionals who were in a position to offer an opinion on Mrs. S's parenting abilities concurred that she was adequately able to look after them and that she had been supported by her mother and her husband.

[265] Series 6 pg 45
[266] Series 6 pg 46
[267] Series 3 pg 48

Conclusions

The Independent Investigation Team conclude that there is no evidence to support the children meeting the threshold that would have triggered the child protection processes of 2005.

13.12 Adherence to National and Local Policy

Context

Evidence-based practice has been defined as '*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*[223]' National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.[268]

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible,

[268] Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

Findings

The Independent Investigation Team examined a list of Mental Health Trust policies and procedures. The policies and procedures most pertinent to this investigation were those pertaining to CPA, Medicines Policy 2004, Psychological Therapy Referrals and Child Protection. It was the view of the Independent Investigation Team that these policies and procedures reflected both national guidelines and best practice.

What was noted by its absence was any operational policy for the CMHT.

Conclusions

The implementation of policy and procedure presents a challenge to all healthcare providers. Implementation requires clear dissemination, training, audit and clearly defined clinical supervision arrangements.

It has already been established that:

- The clinical supervision within the CMHT was weak with six weekly supervision being inadequate (the supervision policy recommends supervision to be every four weeks)
- The CPA policy time frame and process was not adhered to
- The referral criteria to psychological therapies was open to differing interpretations
- The standard of record keeping was poor
- Clinical leadership was weak within the CMHT
- There was poor practice around the prescribing of medication without a face to face contact with the service user

During the period that Mrs. S received her care and treatment from the Trust it was evident that several systems failed to work effectively, particularly with regard to CPA and the operational systems within the CMHT. CPA, clinical supervision and record keeping are all key systems that ensure a safety net is placed under the service user

and the practitioner. These safety nets were not deployed effectively nor did they appear to have been detected within the locality.

Contributory factor 19: Clinical practice within the Mental Health Trust did not conform to internal policies and procedures.

14. Summary of Findings

Root Cause Analysis

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

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the mental state of Mrs. S and thereby her suicide and the homicides that occurred in August 2005. In the realm of mental health service provision it is never a simple or straight forward task to identify a direct causal relationship between the care and treatment that a service user receives and any subsequent suicide or homicide perpetrated by them.

2. **Contributory Factor.** The term is used in this report to denote a process or a system that that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mrs. S's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of August 2005, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Key Causal Factors

The Independent Investigation Team did not find any key causal factors relating to the care and treatment of Mrs. S and the subsequent events of August 2000. Whilst there are a significant number of contributory factors highlighting some failures, omissions and missed opportunities there is insufficient evidence to state that any one of these would have unconditionally had a direct causal relationship to the occurrences in August 2005.

Contributory Factors

The Independent Investigation Team found 20 factors that contributed to the less than effective care and treatment package that Mrs. S received.

Contributory Factor 1: There was a lack of understanding of the significance of the cultural aspects of Mrs. S's background. This was found to be a repetitive finding throughout the Investigation.

Contributory Factor 2: Mrs. S was not interviewed on her own at any of the medical consultations so there were missed opportunities for her to freely express herself if she had wished to do so.

Contributory Factor 3: The formulation that Mrs. S was depressed because of her marital problems rather than vice versa was a contributory factor in the care and treatment of Mrs. S.

Contributory Factor 4: There was a lack of capacity within the Outpatient/ Community Mental Health Team to medically review people in a timely manner.

Contributory Factor 5: Not referring Mrs. S for psychological therapies was a missed opportunity in the light of her previous positive response.

Contributory Factor 6: There was a lack of interdisciplinary working and nurse clinical leadership within the CMHT.

Contributory Factor 7: There was a lack of communication between OPA system and the duty system resulting in referrals not being followed through and full needs assessments being offered.

Contributory Factor 8: Part of the role of the duty system is to gather further information and this did not occur in this case in 2004 or 2005. Throughout this time there was intensive involvement with the Health Visiting team and potentially vital information was not fed into the decision making process This may have altered the decision to take no further action in 2004 and potentially the diagnosis made by the psychiatrists. The

Independent Investigation Team regards this as a contributory factor and a fundamental flaw in the care pathway within the CMHT at that time.

Contributory Factor 9: There were missed opportunities to offer Mrs. S a full and timely needs assessment via the duty system which may have contributed to a better understanding of her situation.

Contributory Factor 10: Mrs. S's needs might have been better met through the allocation of a CPN who would have been more focused on monitoring and trying to stabilise Mrs. S's mental state prior to social engagement.

Contributory Factor 11: As a consequence of the lack of formal assessment there was no case formulation or care plan to address Mrs S's needs.

Contributory Factor 12: There was a failure to adhere to National and local CPA standards and policy.

Contributory Factor 13: The Independent Investigation Team found that the Care Coordinator failed to understand the significance of her own observations or apply her knowledge of mental health and culture. The Care Coordinator had a poor understanding of the role and function of a care coordinator as outlined in the CPA policy and consequently failed to meet the requirements of this role working within the confines of a generic social worker rather than the role of a social worker within a specialist mental health team.

Contributory Factor 14: There was a failure to adhere to the local risk assessment policy.

Contributory Factor 15: The Independent Investigation Team regards the omission to formulate a care plan as a failure on the part of the Health Visitor to fulfil her role.

Contributory Factor 16: Reflective practice was under developed in HV2.

Contributory factor17: There were further missed opportunities for the Health Visiting services to reflect on the case in relation to the high A&E attendance.

Contributory Factor 18: The Children and Families social worker did not liaise with the Care Coordinator about the impact that Mrs. S's mental health problems were having or could have, if her condition deteriorated, on the children not just on her physical ability to care for them but also in her emotional ability to care for them.

Contributory Factor 19: The professionals involved did not liaise sufficiently, share and collate all the information available, reflect and plan on the care that could have been offered to Mrs. S. This had a direct influence on how she was perceived and is a significant contributory factor in the care and treatment offered to Mrs. S.

Contributory Factor20: Clinical practice within the Trust did not conform to internal policies and procedures.

Service Issues

The Independent Investigation found three service issues:

Service Issue1: Medication was changed by the CMHT based on a brief assessment over the phone and without the patient being seen.

Service Issue 2: Individual clinicians within the CMHT did not produce and maintain Mrs. S's clinical records to a professional standard. Local team management systems failed to detect these shortcomings.

Service issue 3: HV 2 failed to document the assessment of the family's health and needs.

Conclusion

There were three distinctive episodes of care with the Mental Health Trust between 2002 and 2005. It is the final episode of care from 11 May 2005 until 31 August 2005 that has been the main focus of this report.

Both The Mental Health Trust and the PCT staff interviewed were of the belief that there was nothing in Mrs. S's history or presentations whether known or not known at the time

that would have made any difference to the events in August 2005. Whilst it is impossible to say that the events of August 2005 could have been foreseen, it is possible to say that Mrs. S's care and treatment plan could have been managed more effectively and that her mental illness could have been assessed and monitored more robustly.

Whilst it is probably only with hindsight and a great deal of reflection that there is some clarity about what may have led to the events that occurred on 31/08/05 there are lessons that can be learnt across all services that may contribute to the approach taken in the mental health care of South Asian Women.

As stated during the discussion and analysis in casual factor 1:

It is extremely rare for women to kill their children and the Independent Investigation Team can only speculate as to what was in Mrs. S thoughts at this time. What is clear is that the power, fear and control factors that operate within the honour system to the detriment of women played a significant part in the lives and deaths of Mrs. S and the children. It is the Independent Investigation Team's conclusion that to a certain degree Mrs. S was driven to commit suicide and there is a need to acknowledge this over and above the suicide being committed as a result of the depression brought on by the marital problems. However it would be wrong to stereotype all Asian women in this way and clearly state that the importance of living and working in a multi cultural society cannot be relegated to second place and the onus has to be on those who provide the services to be aware of these factors and ask the right questions.

15. Services Response to the Incident and Internal Investigation

The chronology of Investigations following the deaths of Mrs. S, Child 1 and Child 2 is available as Appendix 2.

For ease of reading and to reflect the process of events that took place at the time this chapter has been divided into three sections:

1. Child Protection-Serious Case Review Independent Investigation Team (including Social Services)
2. EPCT Internal Investigation
3. Mental Health Trust Internal Investigation

15.1 Child Protection-Serious Case Review Independent Investigation Team

Working Together to Safeguard Children (Working Together to Safeguard Children, DH, HO & DfEE 1999) required each PCT to appoint a designated doctor and nurse whose role is to provide the strategic lead in relation to all aspects of the health service contribution to safeguarding children. By 2005 Ealing had a well established Area Child Protection Committee (ACPC) with a designated doctor and a designated nurse. Social Services Departments have lead responsibility for the establishment and effective working of each ACPC. (London Child Protection Procedures 2003 pg 244)

When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children at risk of harm who need safeguarding (e.g. siblings, other children in an institution where abuse is alleged). Thereafter, agencies should consider whether there are any lessons to be learned from the tragedy about the ways in which they work together to safeguard children. Consequently, when a child dies in such circumstances, the ACPC should always conduct a review into the involvement with the child and family of agencies and professionals. Additionally, ACPCs should always consider whether a review should be conducted where a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development, or has been subjected to particularly serious sexual abuse; and the case gives rise to concerns about inter-agency working to protect children.

The following questions were designed to help in deciding whether or not a case should be the subject of a case review in circumstances other than when a child dies – a 'yes' answer to several of these questions is likely to indicate that a review will yield useful lessons:

- Was there clear evidence of a risk of significant harm to a child, which was:
- Not recognised by agencies or professional in contact with the child or perpetrator
- *Or* not shared with others
- *Or* not acted upon appropriately?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre)?
- Was the child abused while being looked after by the local authority?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal child protection procedures, which go beyond the handling of this case?
- Was the child's name on the child protection register or had it been previously on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the ACPC may need to change its local protocols or procedures, or that protocols and procedures are not adequately being promulgated, understood or acted upon? Pg 96

The Chair of the ACPC has ultimate responsibility for deciding whether or not to conduct a case review.

Description of Events

A meeting of the Area Child Protection Committee (ACPC) Serious Case Review Panel (SCRP) was held on 13 September 2005 chaired by the Designated Doctor for Child Protection and attended by the Service Manger from the Mental Health Trust.

Records of the discussion at this meeting showed that the family was known to the police with respect to one Form 78 for domestic violence. The deaths were being investigated by British Transport Police. Both children were known to Ealing Hospital Trust, mainly for a number of A&E attendances. The family was known to both Children's and Adult Mental Health Social Services. The elder child was attending school and there were no particular concerns. A reasonably intensive package of care had been initiated being delivered by a Community Nurse within the Health Visiting Services. Initial analysis indicated this family, in terms of the mother's mental health, was considered low risk. The Management Report indicated this conclusion was appropriate. The family was known to Children's Social Services in terms of vulnerable children/children in need. There were no child protection concerns.

The Committee considered the eight guidance questions to be considered under such circumstances and noted five negative responses. The committee remained unclear about the involvement of the Health Visiting Service and the significance of the A&E attendance and therefore decided to review those two aspects of involvement prior to taking any further decision. The Ealing PCT Director with responsibility for Child Protection directed that a chronology be constructed.[269] The next meeting was to be scheduled for when the reports were available.

The Mental Health Trust questioned the decision not to have a serious case review as they had also reviewed the criteria and believed that they were met.[270] There is no response to this query in the archive submitted to the Independent Investigation Team.

On 26 September 2005 the Coroner recorded a verdict of unlawful killing of Child 1 and Child 2.

In May 2006 (date not noted) the Chair of the SCRP wrote a conclusion of the case review. This was a limited Case Review examining the professional services' input for this family. Participants in the review were the West London Mental Healthcare Trust, Ealing Hospital Trust and Ealing Primary Care Trust. It was argued that if the Mental

[269] Series 1b pg 50
[270] Series 1B pg 43

Health Trust concluded the events could not have been foreseen then no other agency could realistically been expected to foresee the outcome.[271]

It was acknowledged that the mother's Obsessive Compulsive Disorder was likely to have been significant in driving hospital attendance of the children to A&E, but it was a familiar pattern to use A&E as a GP service in any case in that area.

It noted that the mother presented her depression to A&E and action to notify the GP was identified. She expressed some suicidal ideation. It stated there was no evidence that the identified action was carried out. The note concluded that as this was in May 2004 and she subsequently had mental health input this did not affect the final outcome.

It concluded the vast majority of A&E attendances were dealt with appropriately.

It was noted that the Health Visiting and Community Staff Nurse services had a significant number of contacts in a generally supportive role and that this also acted as a monitor for her mental state. There was not an initial assessment which would have been required to define the package of care and its remit. However, the family did seem to benefit. The Community Staff Nurse acted as an ear and helped with advice for family functioning.

A meeting of the Serious Case Review Panel(SCRP) on 23 May 2006 concluded that the events were not foreseeable but that there were areas where practice could be improved both in the specific area of providing services to a family where there is depression and in the more general areas of record keeping. Also, given that the Mental Health Trust had the expertise on mental health leading to suicide; it followed that no other agency could have realistically been expected to foresee the outcome. The local Safeguarding Children Board expected that each participating agency would act on its own recommendations and would provide feedback on completion to the SCRP.[272]

Each participating organisation will be taking forward their own recommendations. The main issue for SCB would be to take forward the NICE Depression guidelines (2004).

[271] Series 2B pg 22
[272] Series 1B pg 47

On 19 June 2006 the Designated Doctor and the Named Nurse met with the CSN and HV2 to give then feedback from their review.

Findings

The Serious Case Review conducted a preliminary investigation and had access to the PCT timeline yet they did not consider any of the information held at the Mental Health Trust. However at interview with the Independent Investigation Team corporate witnesses from the PCT stated that they "felt confident that we'd captured all the issues".[273]

There is reference to the eight key questions being considered by the Serious Case Review Panel and reference to their thinking that five of these key questions were not met although there is no record of the rationale underpinning the decisions. The Serious Case Review Panel did not revisit the key questions following the Coroner's verdict of unlawful killing of the children.

The focus of the discussion at interviews with the Chair of the Serious Case Review and the Director of Children and Families by this Investigation was on their understanding from their reading of the PCT case files and "abuse or neglect being known or suspected to be a factor in the deaths".

"the difficulty always was that if the only known abusive episode was the terminal one, is actually whether you should then do a serious case review, because the implication is there's not a lot of track history of abuse to look at."[274]

The decision not to hold a serious case review was not unanimous. All those who attended the SCRP who were not permanent members of the SCRP believed that a Chapter 8 review would and should have taken place.[275]

[273] AT 2 pg 6
[274] AT 20 pg 4
[275] At 15 pg 11; AT 3 pg 3; AT 4 pg 3

The Mental Health Trust remained unaware of the details of the PCT investigation apart from the serious case review discussion which was attended by representatives from the Mental Health Services.

The Mental Health Trust representatives reported to the Independent Investigation Team that they had little involvement with the decision making process in that they attended a couple of meetings and were asked a couple of questions.

There was no formal report from Social Services. At interview it was reported that they had looked at the case file and the social workers assessment and thought that this was appropriate given the circumstances as the children were not on the Child Protection Register as no risks had been identified.[276]

Conclusion

It appears the Serious Case Review Panel based their decision not to have a serious case review on the basis of an initial analysis; they already appeared to have come to the conclusion that this event was unpredictable without full knowledge of all the facts. There is a difference between 'not predictable' and 'not preventable' that does not appear to have been considered by the Serious Case Review Panel in terms of their judgment about the case where two children have lost their lives through unlawful killing. It can be argued that even at the meeting of the serious case review in May 2006 they were not in full possession of the facts as there had not been an interagency review and the facts had not been pieced together or shared as there was no formal report from the PCT, Social Services, or the Acute Trust. Part of the SCRP consideration was to consider whether there were any lessons that could be learnt from such an event and by not conducting the Serious Case Review they have indicated that they do not feel that there was anything that they could have done differently which may have changed the direction this case took.

The Independent Investigation Team considered at length the decision of the SCRP not to have a serious case review and the rationale for this. It recognises that the climate has changed recently in relation to society's views on safeguarding and the responsibilities of the safeguarding agencies.

[276] At 17 pg 13

However, it considers that a Serious Case Review should have been undertaken as those involved in the decision making were in a position to recognise two children had died at the hands of a parent in circumstances where the ACPC could not know whether their deaths could have been prevented. It was in a position to know, because of its membership, that without a Serious Case Review, thorough internal reviews in the PCT and in Social Services may not be conducted and that there was no other vehicle either for an inquiry focused on the children or for an interagency inquiry. The ACPC relied upon a generally held but not, at that stage, evidence-based view among the agencies involved that Mrs. S was not seriously mentally ill and that there was no history of abuse in the family.

In making this decision, which, as reported at interview, was not unanimous, the ACPC was sticking closely to its narrow understanding at the time of the threshold to be reached before a Serious Case Review was initiated. The PCT and the Mental Health Trust were surprised by the decision, and the latter expressed its view to the ACPC at the time. Neither the PCT nor the Mental Health Trust appreciated that, in addition to losing the opportunity to acquire and share the learning from a Serious Case Review, any opportunity for a joint investigation between the agencies was lost. Moreover, any incident investigation that focused on the outcome for the children was precluded by this decision.

15.2 Ealing PCT Internal Investigation

Local Policy

Investigation and Root Cause Analysis Policy and Guidance Ealing PCT 2004

This Policy outlines the management procedures for those staff either involved in or required to undertake an investigation within Ealing Primary Care Trust. In order for an investigation to be open and transparent it is essential that all investigations are undertaken in the spirit of fair blame and openness. Central to the investigation is the need to identify lessons to be learnt and areas of good practice.[277]

[277] Investigation and Root Cause Analysis Policy and Guidance Ealing PCT 2004 pg 3

Local Investigation

A local investigation refers to those investigations that are managed and undertaken locally. They may be initiated through a complaint, adverse incident or claim that has been categorised In terms of its impact and future potential to the organisation and/or to the individual involved.

This investigation will be undertaken and managed by the local service managers and members of the staff involved. It is good practice for the investigation to be undertaken by more than one person. This helps guard against the superimposition of the individuals' perspective on the investigation outcome. It also guards against avenues of inquiry, which may not be explored because of the investigators knowledge, or experience of the area under investigation.

Organisational Investigation

Investigations of category Red Incidents may be commissioned both **internally** i.e. by the relevant Service Director, the Chief Executive or Chairman and **externally** by the relevant Strategic Health Authority or National Patient Safety Agency. This is the highest level of investigation within the organisation and is initiated when the complaint, adverse incidents or claim has been categorised as red/orange (major /catastrophic harm), or where they have been categorised yellow/green with the future potential being a red (high risk).

This investigation will include the service managers and individuals involved but the investigation will be chaired by an individual trained in the root cause analysis approach and external to the service .The investigation team should also consider an expert guest and a representative from patient and public involvement.

Based on the risk-grading matrix the Director of Quality, Clinical Governance and Clinical Practice together with the Service Director/lead will make the decision as to whether a full root cause analysis or reactive controls analysis will take place.

Description of events

At the ACPC SCRP on 13 September 2005 the Ealing PCT Director of Clinical Governance and responsible Director for Child Protection directed that a chronology be constructed.[278]

A detailed time line was constructed recording the contact between the Health Visiting Service and Mrs. S, Child 1 and Child 2 with all aspects of the Health Visiting Service i.e. immunization clinics, developmental checks Health Visitor and Community Staff Nurse Contacts by the Designated Nurse for Child Protection.

In February 2006 the Director of Clinical Governance and the Designated Nurse for child protection analysed the time line in detail and identified areas of good practice as the work completed by the community staff nurse and areas for practice improvement being around record keeping, assessment of the family, supervision and professional's meetings.[279]

This discussion was used to inform the case review compiled by the Chair of the SCRP.

Findings

A complete Internal Investigation was not completed in line with PCT policy. It was reported at interview by the Director for Clinical Governance that there were particular and unique circumstances surrounding the PCT's non completion of their Internal Investigation. At the time the Designated Nurse for Child Protection was diagnosed as being terminally ill and the Named Nurse post was vacant. The Director for Clinical Governance is an experienced nurse and was able to draw some conclusions from discussion with the designated nurse and use this information to conclude the investigation on behalf of the PCT.

The neighbourhood manager and the neighbourhood lead nurse were not involved in any part of the investigation nor was there any involvement with the Health Visitors or the Community Staff Nurse delivering the care.

[278] Series 1B pg 49
[279] Series 2B pg 21

It does not appear that this case was taken to the Trust Board of the PCT as there was no formal report from the PCT nor a formal action plan that was going to be monitored.

Conclusion

There appears to have been some confusion between the two options available within the PCT i.e. the Serious Case Review process and the PCT's Internal Investigation process. Whilst The SCRP decided not to do a Serious Case Review they did highlight areas for further investigation. This should have then triggered the PCT's Internal Investigation Procedure but this did not happen in a formal manner as would have been expected. What appears to have happened is that the chair of the SCRP directed the Designated Nurse to pursue further enquiries rather than report to the Director of Clinical Governance to commission an investigation.

Because the PCT was most affected by the decision not to investigate using a Serious Case Review process, the Director of Clinical Governance should have been more assertive in trying to get the decision changed. Alternatively, she should have understood the implications for her own organisation and then initiated a full Internal Serious Incident Investigation to ensure lessons could be learned. Even had she not done this, she could and should have ensured that the Mental Health Trust's Internal Serious Incident Investigation had terms of reference and a process that would have included PCT staff directly in the investigation and the implementation of its findings. On reflection and with hindsight this has been acknowledged by the Director for Clinical Governance.[280]

The Independent Investigation Team appreciates and understands the difficulties surrounding the situation of the Designated Nurse but conclude that the PCT should have conducted a full and robust Internal Investigation.

[280] AT 15 pg 9

15.3 MHT Internal Investigation Process

Context

Mental Health Trust SUI Policy

A serious untoward incident is an adverse event where a patient, member of staff or the public suffers serious harm or unexpected death; where actions of Trust staff are likely to cause serious public concern; any event that might seriously impact upon the delivery of services and/or may attract media attention. WLMHT categorises incidents through the use of the National Patient Safety Agency (NPSA) terms and definitions for the grading of incidents:

- Death
- Severe: any incident that appears to have resulted in permanent harm to one or more people
- Moderate: any incident that resulted in a moderate increase in treatment and/or which caused significant but not permanent harm to one or more persons
- Low or no harm: an incident that required extra observation or minor treatment and/or caused minimal harm to one or more persons

Incident categories influence the type of review to be carried out. Levels of review:

- Level 1: this is the highest level of review undertaken within the trust. It is likely to involve a Non Executive Director and may involve members of the review team who are external to the Trust. It is often referred to locally as a Board Level Inquiry
- Level 2: is likely to involve members of the review team from another Directorate
- Level 3: the majority of the review team will be from the local Directorate

Description of Events

On 1 September 2005 a Serious Untoward Incident Notification Form was completed by the Service Manager with an appendix detailing the contact Mrs. S had had with the CMHT to the Director of Local Services and the PCT. The case notes were removed

from the CMHT and staff involved in the case was offered one to one and formal staff support on 01/09/05[281]

Following contact from the British Transport Police managers and medical staff were interviewed by them on 2 September 2005. A full copy of the clinical records was released to the BTP on 07/09/05.[282]

A serious Untoward Incident Manger's Report was completed by the service manager on 13 September 2005. The report recommended that the case should initially be reviewed by the care teams and their managers in Children's and Mental Health services and that this should be facilitated by a senior manager from one of the areas.
The issues identified to be explored further included:

- Chronology of events
- Multi agency working
- Ethnicity and cultural factors
- Risk assessment
- Medication management and administration
- Post natal depression
- Marital problems and domestic violence
- Informal and compulsory interventions[283]

In September 2005 the service manager met with the family members to discuss the Trusts involvement with Mrs. S. They were able to respond to specific queries they raised in regard to her care and treatment. It was agreed that family members would contact the Trust's again if they wanted any further meetings.[284]

Minutes of the SUI meeting on 11 October 2005.

- Terms of reference were drafted by the Director of Local Services:

(i) whether the relevant policies and procedures were followed
(ii) whether policy and practice was adequate and to a good standard

[281] Series 1B pg 326
[282] Series 1B pg 321
[283] Series 1B pg 322
[284] Series 1B pg 53

(iii) whether there is a need for standards of practice to be further considered at an appropriate forum
(iv) whether there is a need for revision of existing or new policy
(v) whether there are recommendations to be made to any other organisation.

- Multi-agency working: the incident had been reviewed by the ACPC in September 2005 and it had been decided not to make the case the subject of a Chapter 8 review. There was discussion concerning the roles and tasks of other agencies involved and it was agreed that although evidence of what occurred within the family would be used the operation of other services would be excluded.
- RCA approach would be used and practitioners would be seen collectively.
- Panel Membership was agreed as:
    - Associate Director of Local Services
    - Non Executive Director (chair)
    - AOT and EI Team Manager
    - Service Manager Ealing Adult Services
    - Business Manager Ealing Adult Services
    - Consultant Psychiatrist CAMHs in relation to Mrs. S race and ethnicity, also external to the Ealing services.[285]
- Information from other agencies was to be requested from Children and Families Social Services and Primary Care

Minutes of the SUI meeting on 4 November 2005.

- A comprehensive time line of the MHT involvement had been constructed from the time of Mrs. S's first contact with Mental Health Services in 2002
- Critical junctures and potential areas of good practice were highlighted
- Further areas for investigation were identified
- Staff were identified for interview[286]

[285] Series 1B pg 314-315
[286] Series 1B pg 302-303

On 24 November 2005 communication between the Service Manager and the Designated Nurse for Child Protection/Safeguarding informs the Panel that the PCT are doing a parallel investigation into their own services role in the incident and that notes would not be available until mid December 2006.[287]

Minutes of the SUI meeting on 24 November 2005.
The Panel met with the clinicians involved

- It was established that all staff had been offered some form of support around the incident and had attended a debriefing session
- The group analysed the time line to add further information and context[288]
- Of note it is recorded that:
    - Mrs. S's maternal uncle could not speak English so the Consultant had conversed with him in Punjabi
    - The Staff Grade explained about his risk management structure which was that he "stamped the file if a risk was greater than low and that the team were aware of his risk assessment methodology"
    - The care coordinator was the only person within the CMHT who had capacity at this time to take on another case and she was a similar age and background to Mrs. S [289]

Minutes of the SUI meeting on 5 December 2005.
Further consideration of questions that had been raised by the Internal Investigation Team members.

Following this meeting the Consultant e-mails the Independent Investigation Team Chair and raises the issue about NICE guidelines for depression and referral to talking therapies as being an option that was not considered.[290]

Minutes of the SUI meeting On 4 January 2006.
Further lines of enquiry were identified
Emerging issues were identified as:

[287] Series 1B pg 301
[288] Series 1B pg 280
[289] Series 1B pg280-281
[290] Series 1B pg260

- 2003 CBT therapy seen as a good constructive timely piece of work
- 2004 referral
    - A&E contact not followed through
    - Prompt contact for assessment
    - Referral to Relate raised the issue about medical staff on rotation being aware of local facilities and that local resource directories need to be included as part of the secondary induction process
    - Other referrals were not considered e.g. local voluntary support group
- 2005 referral
    - Quality of medical recordings
    - Use of personalised risk assessment
    - Referral to Children and Families
    - Allocation within the CMHT
    - Lack of rationale for allocation and case formulation
    - Medication
    - Supervision of allocated worker
    - Lack of case discussion
    - Lack of care plan
    - Lack of CPA
    - Lack of consultation with CBT therapist who was based in the office
    - Structure of MDT files.[291]

A copy of the Primary Care time line was available to the investigation team although it is unclear on what date this was received by the Internal Investigation Team.[292]

On 6 February 2006 a first draft report was discussed, amended and sent to the staff interviewed to check for factual accuracy checking.[293]

The Panel Chair contacted the Designated Doctor for Child Protection at the PCT on 27 February 2006 about sharing reports.[294] The agreement was that both WLMHT and

[291] Series 1B pg 242-245
[292] Series 1B pg 222
[293] Series 1B pg 103
[294] Series 1B pg94

Ealing ACPC would share final reports, and that the Designated Dr would coordinate this under the ACPC serious case review panel.

A second draft of the report was completed on 3 March 2006 and distributed to those interviewed for factual accuracy checking.

On 6 March 2006 the Staff Grade Psychiatrist replied to the draft report stating that his risk assessment was an evidenced based piece of work that he has been developing as part of his Masters' Thesis.

Minutes of the SUI Panel Meeting on 10 March 2006

- Considered and replied to the Staff Grades' concerns recommending that Trust procedures be followed and highlighting the clinical governance system as a way of implementing change[295]
- Final amendments to the report were made

The report was finalised and presented to the MHT Board by the Director of Local Services in March 2006.[296]

On 6 August 2006 the investigation findings were reported in the Local and National press and the Trust were contacted by a family member and responded to by the Panel Chair.[297]

Findings

The Trust completed an Initial Incident Report and this was supplemented by the Service Manager to form a 72 hour report although this did not occur within the 72 hours. This has to be seen in the context of the involvement of the British Transport Police and their interviewing of staff.

The Mental Health Trust did complete an Internal Investigation that was in adherence with their Serious Untoward Incident Policy.

[295] Series 1B pg99
[296] Series 1B pg 20
[297] Series 1B pg 53

Commissioning of the Internal Investigation

The Internal Investigation was commissioned by the Director of Local Services who also determined the internal investigation panel:

- Associate Director-Internal
- Service Manager-Internal and line manger for the CMHT under investigation
- Lead Nurse-Internal
- Business Manager-Business Manger to act as a lay person
- Non Executive Director-Chair
- Consultant Psychiatrist-CAMHS

Terms of reference

There are what the Independent Investigation Team considers to be two sets of terms of reference: the first set was outlined in the Manager's Report and the second set outlined at the first meeting of the SUI Independent Investigation Team. The Panel worked with the Terms of Reference as directed by the Service Director:

(vi) whether the relevant policies and procedures were followed

(vii) whether policy and practice was adequate and to a good standard

(viii) whether there is a need for standards of practice to be further considered at an appropriate forum

(ix) whether there is a need for revision of existing or new policy

(x) whether there are recommendations to be made to any other organisation.

Meetings of the Internal Review Panel and Attendance

The Panel met on six occasions although the full panel was only present on one occasion. There is evidence that the Panel were in communication with each other as issues arose via e-mail.

Dates of meetings						
	11/10	04/11	24/11	05/12	04/01	08/02
Independent Investigation Team Members						
Associate Director	a	a	a	a	a	?
Service Manager	a	a	a			?
Lead Nurse	a	a	a	a	a	?

Business Manager	a	a	a	a	a	?
Non Executive Director		a	a	a		?
Consultant Psychiatrist			a	a		?

Methodological Approach

The minutes of the SUI meetings do show that many pertinent matters were discussed.

There are no recordings of witness statements from the MHT and this is probably in breach of the Trusts Internal Policy; the 2008 policy indicates that it is a contractual requirement that staff involved in an SUI to provide a written statement of their involvement prior to going off duty".[298]

Although a time line was completed of the Mental Health Trust contact with Mrs. S this was not integrated with the time line produced by the PCT although this document had been requested by the Panel nor were potential critical junctures identified.

Reference was not made to local policy within the narrative of the investigation. Wider issues such as safeguarding children in the context of maternal mental illness, cultural context, corroborating evidence and involvement of the family were omitted form the Internal Investigation.

There is evidence that the Internal Investigation worked with fact as opposed to assumption but this evidence is limited in part to the interview process which was collective and the lack of consideration given to issues raised in the Management Report and suggested areas for further enquiry. The Care Coordinator was interviewed separately on her return to work. The Independent Investigation Team appreciate that this method of interviewing is sometimes a more sensitive and a less personal way for conducting investigations. It is also noted that the Internal Investigation Team were not in possession of all the facts due to the constraints of the investigation being uni-agency.

[298] Investigation and Root Cause Analysis Policy and Guidance Ealing PCT 2004 pg 11

There was adherence to Scott processes in that when the Internal Investigation was to be critical of individual practitioners they were given the opportunity to comment on the criticisms prior to the report being given to a wider audience. All personnel interviewed had the opportunity to view the report with regard to factual accuracy.

Members of the clinical team were interviewed collectively with the exception of the care coordinator who was unavailable on that date.

Key Findings-Strengths

- Following the contact in 2002 the service response represented a good piece of time limited work.
- Following the GP referral in 2004 the team made proactive attempts to contact Mrs. S.
- The quality of the case records was of an acceptable or good standard except in the case of the Staff Grade psychiatrist; the care coordinators documentation was cited as an area of good practice.
- There was a referral to the children and families service.

Key Findings-Areas of Concern

- There was no evidence to support the frequent contacts with A&E being followed up.
- A lack of awareness about local culturally appropriate services.
- There was a lack of adherence to the Trust wide Risk Assessment Policy.
- There was concern that at the consultation in May 2005 that the notes lacked a full history, were fairly illegible and were difficult to follow.
- There was a lack of communication following this consultation.
- Information regarding the family structure was difficult to locate within the case file.
- There was no rationale for allocation on the case file.
- The Care Coordinator did not complete an assessment or care plan.
- There was no rationale given for the changes in medication on the case file.
- There was a lack of supervision for the Care Coordinator as the supervisor only worked in term time.

- There was no formal case discussion within the CMHT, or discussion with other agencies.
- There was no case formulation of an initial assessment or care plan.
- There was no evidence that a CPA meeting had occurred or as being planned.

Presentation of Report

The report did not summarise all the information received although it is noted that this was difficult due to the confusion around the terms of reference and the initial assumption that there would be a Serious Case Review. When it became apparent that this was not going to occur the remit of the investigation narrowed so as not to include other services although the actual terms of reference were not changed. This makes it appear as though the terms of reference have not been met.

Conclusions

Commissioning the Internal Investigation

The Internal Investigation was appropriately and timely commissioned. It was not clear from the records of the Internal Review whether there had been consideration of how the report was to be published, nor when this was to be achieved by.

Terms of reference

The lack of change or further consideration given to the terms of reference was a weakness and a missed opportunity to explore some of the potential underlying issues of this case for example the recurring theme of marital problems and domestic violence in a cultural setting have not received due attention. However the Independent Investigation appreciate that the Internal Investigation Team attempted to be reflective of the cultural issues through the inclusion of this particular consultant psychiatrist however the Independent Investigation Team conclude that this was not brought sufficiently to the fore front of the investigation.

Panel membership

The Internal Investigation Team were chosen with care although were not used to their full potential especially in relation to exploring the family dynamics, the cultural context and wider issues around maternal mental health.

The Service Manager was a panel member and the Independent Investigation Team questioned his ability to be objective as he was one of the people that could have been held accountable should the report have identified major failings. Further it is often difficult to see flaws in a system in which one is embedded.

The Associate Director of Local Services was designated the lead officer for the Internal Investigation and assumed the role of chair in the Non Executives Directors absence. This was his first investigation at and at that time had not participated in any training. The Independent Investigation Team considers this a weakness within the Internal Investigation process as the Panel was not used to its full potential.

Meetings of the Internal Review Panel Team and Attendance
The meetings of the internal investigation team were timely and well organised.

Methodology
Although a time line was completed of the Mental Health Trust contact with Mrs. S this was not integrated with the time line neither produced by the PCT nor were potential critical junctures identified. Reference has not been made to local policy within the narrative of the investigation. Wider issues such as safeguarding children in the context of maternal mental illness, cultural context, corroborating evidence and involvement of the family were omitted form the Internal Investigation.

Members of the clinical team were interviewed collectively. The Independent Investigation Team accepts that there are pros and cons to seeing staff individually and collectively but are of the view that investigations of this level warrant individual interviews and transcriptions. This is especially important in homicide enquiries where there will be an automatic Independent Investigation and will become increasingly important for investigations of suicide where this has occurred in custodial care.

The Associate Director who inadvertently chaired the Panel was also tasked with the role of project manager. Although the report was not completed within the required 60 days it is noted that the Panel meetings were held in relatively quick succession with a first draft report being available by early February. The Independent Investigation Team acknowledges the Christmas period would have delayed due process due to staff leave and the inexperience in this area of work. The Associate Director has since completed RCA training.

15.4 Summary of Internal Investigations

There is a balance when conducting investigations between scapegoating and objectively weighing up findings of fact and for that a panel needs to be robust, inquisitive and on occasion critical in their questioning and findings. It became apparent at interview that the Internal Investigation Panel didn't feel that they were being deeply critical. The Internal Investigation appears to have followed the lead in the clinical records in that this was a "social case" by trying to build a picture of her in her social context and in part losing the focus of her mental health care and the Trusts core task of providing Mental Health Care. The Independent Investigation Team find that the internal investigation was appropriately critical of the Staff Grade Psychiatrist but less so about the involvement of the Care Coordinator who had also not adhered to Trust policy. Consequently a fundamental recommendation around her practice at the time was omitted.

However, the Mental Health Trust was the only organisation to follow their procedures regarding Internal Investigations. The Serious Case Review Panel had it within their gift to conduct a Chapter 8 Review to support all agencies in collectively learning lessons yet they decided against this. The Independent Investigation concludes that the failure of the ACPC SCRP to conduct a Chapter 8, multi agency review, was detrimental to learning from this event.

15.5 Support to the Family

Context

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[299]

Findings

Children and Families Social Services

The Deputy Team Manger from The Children and Families Social Work Team and the social worker allocated to undertake the assessment proactively visited Mr. S to express their condolences and offer support after the incident on 19 September 2005. They followed up the visit with a letter detailing agencies where he could access support in the future if he wished to do so.[300]

[299] National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005. pg4.

[300] Series 6 pg 71-73

The Independent Investigation Team recognised the timely contact with Mr. S by the Children and Families team as good practice.

There was no contact with Mrs. S's mother's side of the family.

PCT

There was no formal offer of support to Mr. S from the PCT. However support was given to Mr. S in the aftermath of the incident by HV2. She met with Mr. S on two occasions where they discussed the events of the day of the untoward incident. Mr. S was described as being in great emotional pain and was being supported by his own family who had arrived from India. It was suggested that bereavement counselling might be helpful to him and it is known to the Independent Investigation Independent Investigation Team that Mr. S did take up this offer prior to his return to India.

There was no contact with Mrs. S's mother's side of the family.

Mental Health Trust

There was no initial contact between the Mental Health Trust and the family, Mr. S or Mrs. S's mother in the aftermath of the incident.

At some point Mrs. S's mother was referred to the same CMHT as she had become depressed following the death of her daughter and grandchildren. There was no contact with Mrs. S's mother in terms of involvement with the Internal Investigation as she was at that point being seen as a service user.

In August 2006 the Mental Health Trust inadvertently released a copy of the Internal Investigation to the media. This was seen by Mrs. S's extended family who subsequently contacted the Trust and met with the Service Manger and a consultant psychiatrist to discuss the findings and recommendations.

On reflection all the Internal Investigation Panel members who were interviewed regarded the omission of involvement and support to the family as a gap in their investigation and with hindsight something that perhaps they should have given greater

consideration to. It was not possible for the Internal Investigation Panel to have offered support to Mr. S as he returned to his family in India shortly after the incident. However the maternal uncle who had escorted Mrs. S to her appointments remained local and although not the immediate next of kin/nearest relative may have been of assistance to the Investigation Panel and could have been more actively involved if he had been given the opportunity. At the time the report was finalised Mrs. S's mother had died as a result of suicide.

Summary

The Independent Investigation Team concluded that the Mental Health Trust did not communicate effectively with either side of the family of Mrs. S in the aftermath of the incident or about the process of the Internal Investigation. This has been recognised as an omission by the Trust and is an issue that the Mental Heath Trust have given greater priority to in the revised version of the SUI policy (2008).

15.6 Support to Staff

PCT

At interview the clinical and managerial staff from the PCT were unable to recall any involvement with the Investigation process. They were in effect unaware that an Investigation was being undertaken.

"My (staff) memory of the time is that this case was not discussed in a structured manner, that the staff concerned discussed it between themselves".[301]

CSN2 and HV2 first became aware that the SCRP when they were asked to attend a meeting with the Chair of the Serious Case Review Independent Investigation Team and the Named Nurse for Child Protection who wanted to meet with them to discuss the findings of the review. The Neighbourhood Manager had not been informed that staff were about to hear feedback from an investigation/review.

"I sat and listened and was given the conclusions on an A4 piece of paper". [302]

[301] AT 14 pg 2
[302] AT 13 pg 8

"There was no opportunity for discussion of the contents of the report". [303]

.A meeting then took place with HV1, HV2, the Designated Nurse for Child Protection and CSN2 on 5 July 2006 when they were given the opportunity to express any concerns about the incident, the handling of the Review and their involvement in the case.

The feedback given to the PCT staff was poorly handled. Neither the CSN2 nor HV2 had been kept informed of the process of the review for this case. They were asked to attend a meeting, without the support of a manager, which was critical of their practice. They were not given the opportunity to discuss the findings nor contextualise their actions at the time. Little consideration appears to have been given to their feelings bearing in mind this was a personal issue for them as they both knew Mrs. S as an individual.

Mental Health Trust

All staff interviewed stated that they had been well supported throughout the investigation process although the medical staff were distressed that they were mentioned by name in the media and had not been informed that the Internal Report was to be released into a public arena.

"*It was a very traumatic experience, and I think we heard it through local press, and I was first informed by the admin staff who had heard on the radio and looked on the patient's record, checked the name, so there was a lot of informal support".*

"I think when we had the inquiry, the internal review; I discovered that the review had been published by reading it in a paper on a tube journey. We weren't told. We had the internal review, we were given the draft and we had sent some comments back. After the event it was explained that there was some sort of miscommunication between the Trust Headquarters and one of the senior managers. Somebody had made a request for the report under the Freedom of Information Act, and somebody had misinterpreted it and sent it (the report) before informing us".

[303] AT 12 pg 5

As a point of good practice a neutral Independent Investigation Team member contacted the Care Coordinator who had taken leave to ensure that she was aware of the support services available from the Trust and to offer individual support if needed.

Summary

It is vital that from the initiation of a Serious Incident Investigation a communication strategy is agreed and followed that ensures that staff and others who may be affected by subsequent media coverage, even if as a result of an Inquest or other event not directly under the Trust's control, are informed ahead of time and supported throughout.

As a point of good practice, the Mental Health Trust has developed reflective feedback sessions for multi-agency teams following incidents or near misses.

15.7 Progress made against Internal Action Plans

Mental Health Trust

In 2005 the system for the review of reports was that once they have gone to the Trust Board the report would be returned to the team concerned first through the service Clinical Improvement Group then the Borough Clinical Governance group. An action plan was developed locally by the team and discussed in the Clinical Governance Forum; leads were identified to take the work forward. Action plans would be monitored through the Clinical Governance Forum and fed back to the Trust Board.

It was reported at interview that the systems have not always been as robust as they could have been and there are new structures to address this.

A total of twelve recommendations were made following the MHT Internal Investigation. In a paper to the Board from the Director of Local Services dated March 2007 in relation to the action plan most areas for change had been acted on and endorsed by the Local Services Management Structure.

1. All staff especially junior medical staff on rotations should be made aware of the range of local organisations within the local area. An up to date directory of local statutory and voluntary services should be available to all staff.

Action
The Ealing National Service Framework Local Implementation Group has developed a local website which is accessible to staff, voluntary sector providers, service users and carers via the internet. This contains information about all Mental Health Services in Ealing.

Implemented June2006

2. Ensure that all relevant and appropriate local authority and independent sector organisations are able to share and access information.

Action
As above.
Implemented June 2006.

3. When a decision is made that a case warrants referral to the Children and Families Services this should be made as speedily as possible in writing. Whilst the delay of almost two weeks was not felt to have been significant, the team felt that such a referral should have been made within 48 hours of the review.

Action
After discussion with local services and subject to capacity and priorities best practice would suggest: urgent referrals about risk of immediate harm should be made on the same day. Less urgent referrals should be made within 48 hours and both confirmed in writing.

Implemented August 2006.

4. A genogram should be completed and attached to the patient notes to clearly outline and identify family composition and as an initial step in gathering information about dependant children.

Action
Discussed at the clinical governance forum in October 2006, agreed not to apply in all cases but family history needed to be documented.

5. Specially developed or adapted approaches to risk assessment should only be used if there is common understanding of the usage throughout the Trust and an established process of local induction for new members of staff.

Action
The risk assessment highlighted was developed as an evidenced based research project to be presented via formal channels for ratification. A standard format is now in place.

Implemented October 2006.

6. Shorthand and idiosyncratic notation used to record the content of a consultation should be written up in the case file notes to ensure these are comprehensive and accessible to the whole team.

Action
All consultations should be followed with a typed letter to the GP. Periodic case file audits to be conducted by lead practitioners and senior medical staff via supervision.

Implemented August 2006. Audited March 2007.

7. Ensure that during case allocation meetings the rationale for allocation is clear to all relevant staff and recorded clearly in the case file.

Action
Periodic case file audits to be conducted by lead practitioners and senior medical staff via supervision.

Implemented August 2006 Audit to be undertaken March 2007.

8. Following allocation an initial assessment should have been formulated by the cars coordinator within the first four weeks, discussed in supervision and at the MDT and used as the basis for an initial CPA meeting within 4-6 weeks of allocation.

Action
Best practice would suggest that prior to such a meeting, given the involvement of Children's Social Services and Primary Care a structured discussion between professionals involved should take place.

Implemented September 2006.

9. For ease of reference the integrated patient care notes should contain a section for recording medication where variations in medication together with a rationale for such changes can be noted.

Action
With adequate training and careful use the RiO (electronic patient records) will address this.

Implementation on going.

10. Ensure that suitable levels of support and supervision are made available for staff when their usual supervisor is away for long periods of leave. This is especially important in the case of staff who supervise others but who work on "term only" contracts.

Action
Supervision standards are in place. People should be notified in writing of the supervision arrangements for periods of leave greater than 3 weeks.

Implemented October 2006.

11. Additional training should be made available for all members of the MDT on the use of medication dosages, side effects and the implications of non compliance etc.

Action
This is available for social workers as part of the 90 day Approved Social Worker Training, additional training to be delivered to all members of the MDT, After discussion with local services it was agreed: training arranged for November 2006 for all team members. Team doctors to provide training. Consider roll out across all areas.

Implemented November 2006

12. The NICE (National Institute for Clinical Excellence) guidance on Depression (December 2004) gives a clear stepped care model of management of depression in primary and secondary care settings. Adherence/reference to the guidance could have generated a care plan for Mrs. S that would have involved careful consideration of pharmacological and psychological treatment options taking into account patient preference and response to past treatment cognitive behaviour therapy in this instance.

Action
There is a need to review implementation plans of all the relevant NICE guidance in the CMHT context and address any training and recruitment issues. *Part of audit plan 2007/08.*

Findings

1. Range of local organisation
It was reported at interview that the current situation at this CMHT is that the administration team leader takes responsibility for ensuring that an information pack is available in all the consulting rooms and duty. In addition leaflets are displayed on notice boards in the waiting area, a CPN has responsibility to ensure that these leaflets are

updated and in good supply. The Trust has a National Service Framework link to their website, developed by service users and supported by staff. There is also an information resource centre within the inpatient unit that has packs for people which will include all information about local services and directorates, and forms part of the induction process for all new members of staff.

2. Equal access to resource information

Local voluntary and independent sector organisations are able to share and access information.

3. Timeliness of referral to children and families

The recommendation was discussed across a range of management groups including ASW group, Borough Clinical Governance and the Joint Management Group. It was agreed that there should be an immediate referral for urgent cases and two working days for non urgent cases. It was also reported that where an urgent referral has been made that this is reported to the clinical team leader within the CMHT.

4. Genograms

The implementation of genograms was discussed at board level where it was decided that this was not appropriate for all cases as the structure of the family was clear in the narrative of the medical assessments.

5. Risk assessment

Risk assessment is integral within the CPA policy and all staff are expected to adhere to this policy. Risk assessment can be monitored in supervision through the use of RiO (electronic record keeping system).

6. Record keeping

Record keeping can also be monitored through the use of RiO in supervision. It was reported that there had been a gap in the record keeping audit cycle when the electronic system was being introduced. Case file audits used to go to the service manager, and they would highlight any exceptions. All audit results now report into the Clinical Governance system. It was reported that the current focus is on care plans and quality of progress notes on RiO.

It was reported in the Clinical Governance and Research Annual Report 2007/8 that a standard format for letters from out patient clinics has been developed and implemented thus improving the quality of communication and ensuring that key data is gathered and allowing a care plan to be available and easily identified for all service users.

7. Rational for case allocation

It was reported that this remains an area for concern as there had been questions raised in the CMHT about the parity of allocation. At the time of interview this recommendation had not been audited although it was eluded to that this would be part of the future audit plans.

8. Assessment and CPA

With the implementation of the RiO system there is immediate access to data at a team level and at an individual practitioner level. The system is able to highlight those service users who have not had a CPA in the past six months and those who have not had a CPA started within the first four weeks.

9. Recording of medication changes

It remained unclear if this recommendation had been implemented within the RiO system.

10. Supervision

Supervision standards have been in place across the Trust and The Borough since 2003. It is expected that if an individual was experiencing difficulties then this would be raised through the line management structure.

All staff at the CMHT have had an annual appraisal in the past 12 months although it was reported that there is now a delay for the nursing staff as the lead practitioner for nursing post has been vacant for the past six months due to lack of applicants. The lead nurse vacancy also indicates that nursing staff within the CHMT are lacking in supervision.

11. Medication Training

Training about the use and side effects of medication is available on an informal basis within the team. Following the dissemination of the Internal Investigation Report the medical staff completed a number of presentations within the team although there are no records of who attended. Medication training sessions have also been provided by the chief pharmacist covering hypnotics and anxiolytics, pharmacokinetics, drugs used in psychosis and related disorders, and antidepressants. It was reported that these sessions had been well attended and received.

It was reported that all the social workers within the team had completed some form of medication training. However when the Independent Investigation Independent Investigation Team asked the care coordinator about training she stated that she had not attended any.[304]

12. Implementation of NICE Guidelines for Depression

The Mental Health Trust and the Primary Care Trust have worked collaboratively to implement a stepped care mode for the treatment and management of depression.

Summary

The Independent Investigation Team would concur with the verbal report at interview in that some of the recommendations were not implemented as robustly as they could have been. Also a heavy reliance appears to have been placed on the implementation of the RiO system as a means of monitoring individual practice. The Independent Investigation Team heard a fair amount of anecdotal evidence about auditing which was not supported with data reflective of a high degree of trust between people worked together but a weakness in terms of being able to demonstrate robust systems. It was of concern to the Independent Investigation that although training had been provided in order to meet a recommendation this had not been targeted at the individual professional concerned and that four years after the event the gap in knowledge and therefore practice may remain.

Recommendation 18: Where it has been identified that there is a gap in the skill or knowledge base of a practitioner this must be immediately incorporated into their

[304] AT 1 pg 11

Continuing Professional Development Plan and form part of their annual appraisal.

Update

In 2008 the Clinical Governance structure was reviewed along with the service structure. The Borough of Ealing is now referred to as a Service Development Unit (SDU) which is jointly managed by a Director and a Clinical Director both of whom are accountable to an Executive Director. Each SDU has responsibility for clinical governance and for monitoring and reviewing incidents. For example, where an SUI or a review is considered at CSSG, learning and action plans established, it would move across to the ODG from a governance point of view to ensure that that action plan is implemented. The SDU Clinical Director and the SDU Management Director attend both these meetings. The new structure has a Clinical Governance Support Service with a designated post that will ensure the timely presentation of reviews and investigations and will track the progress through the system and will agenda action for monitoring on a quarterly basis. It is expected that the new arrangements will provide a more robust governance system.

16. Notable Practice

The Independent Investigation Team were not able to discern any areas of notable practice rather that the Mental Health Trust is continuing to develop and refine their systems to ensure the development of clinical practice and more robust systems of governance.

17. Lessons Learnt

What was remarkable about this Investigation was the number of witnesses who stated that they had not learnt anything from this case or the Internal Review Report. This appeared to be based on the assertion that the death of Mrs. S and her children was unpredictable and therefore unpreventable. Whilst the nature of mental health care is that there is often a degree of unpredictability it almost goes without saying that there are always lessons to be learnt with the benefit of hindsight.

The Independent Investigation Team believes that there are three key lessons:

1. Cultural background, beliefs and values are of importance and need to be explored with individuals in order to gain a greater degree of insight into a person's thinking and behaviour.

2. Whilst the Independent Investigation Team notes that the findings within this report conform to those of most other Independent Investigations conducted in recent years such as issues raised regarding the Care Programme Approach, assessment, clinical supervision, the quality of documentation and so on these are the basic building blocks in an individual's care and the safety net in which practitioners practice. Systems and processes are in place for a reason and that is primarily to ensure that the best possible care is provided. Basics such as a comprehensive assessment and the CPA process cannot be omitted in any case and the onus is on the management and the governance structures within an organisation to ensure that this occurs. Complacency in this area is not acceptable.

3. The importance of interagency liaison cannot be underestimated by any organisation providing health and social care.

18. Recommendations

The Independent Investigation Team worked with the Mental Health Trust and the Primary Care Trust to formulate the recommendations arising from this inquiry process. The events of August 2005 occurred over four years ago. It is evident that the Trust has been able to develop processes and strategies since the dates on which the serious untoward incidents occurred that have either partially or fully addressed many of the issues identified by the Independent Investigation.

The recommendations that the Independent Investigation Team have developed in response to its inquiry are set out below under a brief synopsis of each finding. The progress that the Trust has already made has been taken into account. As a result the recommendations developed by the Independent Investigation Team are intended to support the Trust's strategic direction.

Recommendations

18.1 Cultural Diversity

Contributory Factor 1: There was a lack of understanding of the significance of the cultural aspects of Mrs. S's background. This was found to be a repetitive finding throughout the Investigation

Recommendation 1: The Cultural Competencies Toolkit needs a separate section to address the cultural issues that are clearly significant to experiences. Reference needs to be made to honour codes and 'izzat' both of which are fundamental to the experiences of South Asian communities. In highlighting these examples can be given about help-seeking behaviour, births, practices, customs and other areas that are relevant to the communities being addressed including sources of help.

Recommendation 2: Learning from the cultural issues raised in this report needs to be incorporated into the clinical leadership programmes offered by the Trusts.

18.2 Medical Management

Contributory Factor 2: Mrs. S was not interviewed on her own at any of the medical consultations so there were missed opportunities for her to freely express herself if she had wished to do so.

Contributory Factor 3: The formulation that Mrs. S was depressed because of her marital problems rather than vice versa was a contributory factor in the care and treatment of Mrs. S.

Contributory Factor 4: There was a lack of capacity within the Outpatient System/ CMHT to medically review people in a timely manner**.**

Contributory Factor 5: Not referring Mrs. S for psychological therapies was a missed opportunity in the light of her previous positive response.

Service Issue1: Medication was changed based on a brief assessment over the phone and without the patient being seen.

Recommendation 3: All service users must be offered the opportunity to be interviewed on their own. Where there are specific cultural or gender issues where this is not appropriate a chaperone should be considered. Where there are known instances of abuse or coercion the service user must not be seen with the perpetrator.

Recommendation 4: The Independent Investigation Team recognise that the Mental HealthTrust have taken action to address the medical capacity within the CMHT and would like to support the Trust further by recommending that the Trust work with the Commissioners in Primary Care to develop a protocol to transfer those patients who are well and stable within their "mental illness" to primary care services and thereby more effectively use specialist mental health services to treat and monitor those who are unstable or unwell.

18.3 CMHT Intervention

Contributory Factor 6: There was a lack of inter disciplinary working and nurse clinical leadership within the CMHT.

Contributory Factor 7: There was a lack of communication between the Out Patient Appointment system and the duty system resulting in referrals not being followed through and full needs assessments being offered

Contributory Factor 8: Part of the role of the duty system is to gather further information and this did not occur in this case in 2004 or 2005. Throughout this time there was intensive involvement with the Health Visiting team and potentially vital information was not fed into the decision making process This may have altered the decision to take no further action in 2004 and potentially the diagnosis made by the psychiatrists. The Independent Investigation Team regards this as a contributory factor and a fundamental flaw in the care pathway within the CMHT at that time.

Contributory Factor 9: There were missed opportunities to offer Mrs. S a full and timely needs assessment via the duty system which may have contributed to a better understanding of her situation**.**

Contributory Factor 10: Mrs. S's needs might have been better met through the allocation of a CPN who may have been more focused on monitoring and trying to stabilise Mrs. S's mental state prior to social engagement.

Recommendation 5: The Nurse Lead Practitioner plays integral and important role in the day to day running of a CMHT and greater efforts must be made to ensure the post is covered whether this is through enabling a suitable team member to act up or offering the post as a development opportunity to the wider Trust. Consideration also needs to be given to how this post is professionally supported to reduce attrition rates and to raise the nursing profile.

Recommendation 6: The Mental Health Trust needs to review the CMHT operational policy to ensure that all the contributory factors noted in this report

have been addressed in particular the role and function of duty workers and the interface between the OPA and duty systems.

Recommendation 7: Priority needs to be given to the development of the CMHT practitioners to ensure that the operational policy and the changes therein are implemented. Further, practitioners must be given the opportunity to develop as advanced practitioners through non medical prescribing, AMHP, coaching, and mentoring etc to ensure their full development to meet patient needs and the challenges of the future.

18.4 Care Programme Approach

Contributory Factor 11: There was a failure to adhere to National and local CPA standards and policy.

Contributory Factor 12: As a consequence of the lack of formal assessment there was no case formulation or care plan to address Mrs. S's needs.

Contributory Factor 13: The Independent Investigation Team found that the Care Coordinator failed to understand the significance of her own observations or apply her knowledge of mental health and culture. The care coordinator had a poor understanding of the role and function of a care coordinator as outlined in the CPA policy and consequently failed to meet the requirements of this role working within the confines of a generic social worker rather than the role of a social worker within a specialist mental health team.

Recommendation 8: The Trust needs to introduce and develop the concept of case formulation to underpin and promote robust clinical practice and to embed policy within practice.

Recommendation 9: The CPA policy was reviewed in 2008. The Trust should undertake a full audit to ensure that the revised policy had been implemented effectively and that practitioners are operating appropriately.

Recommendation 10: Consideration needs to be given to the development of core competencies for duty workers, team leaders, and managers that are in keeping with the knowledge and skills framework and the National Occupational Standards to support the implementation of the Operational Policy. Core competencies should be completed with care coordinators as part of their annual appraisal,

Recommendation 11: The Trust needs to revisit the supervision policy with a view to enhancing integrated practice and not limiting this to uni professional groups.

Recommendation 12: Whilst some of the record keeping issues have been negated through the introduction of the electronic record system (RiO) i.e. dates and names, clinical files should be scrutinised as a matter of course during supervision to ensure they are up to date and that Trust Policy is being followed especially in relation to the CPA process. Managerial supervision notes should be recorded in the clinical file.

18.5 Risk Assessment

Contributory Factor 14: There was a failure to adhere to the local risk assessment policy

As for recommendation 9 and 12.

18.6 Documentation

Service Issue 2: Individual clinicians did not produce and maintain Mrs. S's clinical records to a professional standard. Local team management systems failed to detect these shortcomings.

Recommendation 13: Clinical files should be scrutinised as a matter of course during supervision not only for accuracy but also quality and appropriateness of mental health interventions.

18.7 Health Visiting Service

Contributory Factor 15: The Independent Investigation Team regards the omission to formulate a care plan as a failure on the part of the Health Visitor to fulfil her role.

Contributory Factor 16: Reflective practice is under developed in HV 2.

Contributory Factor 17: There were further missed opportunities for the Health Visiting services to reflect on the case in relation to the high A&E attendance.

Service Issue 3: HV 2 failed to document the assessment of the family's health and needs.

Recommendation 14: The PCT should actively take responsibility for developing reflective practitioners and where there are staff who fail to engage with this or show no evidence of continuous learning, their capability for the job should be reviewed in the context of performance appraisal.

Recommendation 15: Ealing Primary Care Trust should require both GPs and Health Visiting staff to consider whether inappropriate anxiety in a parent as exhibited by one who takes the children too frequently to the doctor, hospital or health visitor clinic may be pathological and share that information with CMHT if they are involved.

18.8 Children and Families Social Services

Contributory Factor 18: The Children and Families social worker did not liaise with the Care Coordinator about the impact that Mrs. S mental health problems were having or could have, if her condition deteriorated, on the children not just on her physical ability to care for then but also in her emotional ability to care for them

Recommendation 17: Where it is known that a parent is in receipt of mental health services the assessment of the children must incorporate the views of the Care Coordinator or the clinician working with the service user.

18.9 Interagency Working

Contributory Factor 19: The professionals involved did not liaise sufficiently, share and collate all the information available, reflect and plan on the care that could have been offered to Mrs. S. This had a direct influence on how she was perceived and is a significant contributory factor in the care and treatment offered to Mrs. S

As for recommendations 8, 9, 10, 11 and 12.

18.9 Adherence to National and Local Policy

Contributory factor 18: Clinical practice within the Mental Health Trust did not conform to internal policies and procedures.

As for previous recommendations.

Recommendation 17: The RiO system will assist in supporting local management ensure that policies are adhered to in a timely manner however it will not ensure the quality of what is recorded. It is therefore recommended that a protocol be developed through the clinical governance system in conjunction with the commissioners' to ensure that core assessments, risk assessment, crisis and contingency plans and care plans are completed to an acceptable standard.

18.10 Implementation of Action Plans

Recommendation 18: Where it has been identified that there is a gap in the skill or knowledge base of a practitioner this must be immediately incorporated into their Continuing Professional Development Plan and form part of their annual appraisal

19. Glossary of Terms

A&E	Accident and Emergency Department
ACPC	Area Child Protection Committee
AOT	Assertive Outreach Team
CBT	Cognitive Behaviour Therapy
CMHT	Community Mental Health team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSN	Community Staff Nurse working with the Health Visiting Service
CSW	Community Support Worker
EIT	Early Intervention Team
GP	General Practitioner
HV	Health Visitor
MHT	Mental Health Trust
MDT	Multidisciplinary Team
NN	Nursery Nurse
OCD	Obsessive Compulsive Disorder
OPA	Out Patient Appointment
PCT	Primary Care Trust
SRCP	Serious Case Review

APPENDIX ONE

Integrated Time Line

Mrs. S

Independent Investigation

Key
Black entries represent the Health Visiting Service
Blue entries represent the Mental Health Services
Green entries represent Social Services

Date	Source	Event
12.09.99		**Child 1 born**
27.09.99	File 2A pg 105	Refers Mrs. S to MHS for an assessment as she is experiencing anxiety and post natal depression. She is noted to be disappointed about having a female Child 1Mrs. S worried about how she will cope when her husband returns to work
13.10.99	File 2A pg116	Letter from MHS. Mrs. S feeling better and does not want to see any one from their service
08.02.02	File 2A pg 118	Referral to MHS for OCD, anxiety, notes previous history of PND
11.07.02	File 2A pg 119	Letter from CBT therapist: assessed on 03/04/02 and started fortnightly treatment sessions
03.02.03	File 2A pg 124	Discharge letter from CBT indicating a good recovery and discharging her back to primary care
03.03.03	Ealing Hospital Trust referral form .Family Health Record	Midwife 1 - Referral to HV with mother's consent. History of depression prior to last baby became worse in postnatal period. Obsessive compulsive disorder. Treated with

	File 3 pg 68 File 6 pg15	antidepressants. Now off them. Feeling better. Letter to GP from CBT therapist, follow up visit: ritualistic behaviour associated with daughter becoming ill, husband and daughter becoming sick with germs. Feels that she is 97% improved; no longer asks her husband for reassurance, lets daughter eat food without washing her hands, able to leave her flat, not depressed although at times feels down due to everyday life; part time job helps her cope. No suicidal or negative thoughts Also sent to Social Services Plan: check SSIMBA history; visit ANC; liaise all agencies- arrange network meeting; consider support networks, previous child care history, preparation for baby; psych assessment prior to discharge
11.09.03	File 6 pg40	Allocate case to SW1
18.03.03	A&E forms in Child 1 health record.	Seen at EHT, A&E. Raised temperature. Not reduced with Calpol. Amoxicillin from GP. On examination well, alert, eating and drinking. Viral URTI. Full blood count. Home to continue treatment.
07.08.03	A & E Slip in Records. Dated 13th August 2003 Ravenor Park Clinic	EHT A & E forms. Child 1 seen. Raised temperature, complaining of sore throat. Bacterial tonsillitis. Treated with Penicillin 7/7 and Junifen prn. Discharged.
03.10.03		**Child 2 born**
07.10.03	File 6 pg 104	Saw Mrs. S on ward: hospital staff no concerns although lots of questions, very demanding and attention seeking; father supportive, washed and changed baby,, She is having problems with her husband as he does not tell her that he loves her enough and sends money home to his family in India; husband adores daughter, not a good relationship with her mother; when 7/12 pregnant went to India for a holiday; they argue a lot over little things. Feels positive about the birth especially as it is a boy
24.10.03	Recorded by H.V.2 Family Health Record (2). Series 6pg 01	H.V.2 contacts S.W.1, who informs her that she plans to make one visit but doesn't feel they have the resources to support. No real child protection issues.
19.11.03	Health Visitors Pre-school review contact sheets in	SW 1 home visit, no concerns noted in the red book; paternal grand parents arrives on 05/11/03. Mrs. S very nervous about their coming as they are going to discuss her

	Child 1 Health Record. File 6 pg 91	relationship; stated that her husband does not listen and they argue about little things; he is not putting his family first as he sends a lot of money to India. Mrs. S nervous about in laws coming to stay as they are going to discuss her relationship with Mr. S; no safety issues identified, sense of stability in the family, they are committed to working things out. Appears that Mrs. S has unrealistic expectations from her husband
23.11.03	A & E forms in Child 1 Health Record.	EHT, A & E 20.09. Child 1 seen, still short of breath and wheezy. Diagnosed Asthma with acute viral infection. Treated, observed and discharged home.
30.11.03	A & E forms in Child 1 Health Record.	Child 1 seen at EHT, A & E, cough for 1/7 seen by G.P. Started on Orcipenaline. Wednesday and Friday blood in stool. Today more chesty. Diagnosed viral URTI. Anus normal. Stool specimen. Discharged.
15/01/04	File 6 pg 38	Social Services close case
21.01.04-25.02.04	Recorded in Child 1's Health Record.	Six contacts with HV service over concerns about the children
05.03.04	A & E sheet in Child 2's Health Record.	Child 2 seen at E.H.T. A & E. complaining of diarrhoea 2/7. Giving Calpol 4 hrly. Temp has been on and off. Baby alert, no dehydration. Few rashes on stomach blanching on pressure. ? Viral. GE Parents reassured. Advice given. For Paracetamol 15 mgm/kg tds - Nurofen 5 mg/kg tds.
07.03.04, 17.36	A & E sheet in Child 2's Health Record.	Child 2 seen E.H.T. A & E complaining of rash over body. Long waiting time. Baby looked well. Temp. 36.9, pulse 128. Parents decided not to wait. Will return later. Child 2 returned to E.H.T. A & E. Temp. 36.5. Pulse 104. Rash over body. Paediatric team busy. Parents informed.
08.03.04, 01.50	A & E sheet in Child 2's Health Record.	Child 2 returned to E.H.T. A & E. Temp for 3 days reduced by Paracetamol. Diarrhoea for 2 days. No blood, mucus or vomiting. No solids, having breast milk only. Rash over body. Seen by Paediatrician. On examination child looks well. L ear slightly inflamed R ear NAD. Throat slightly red. Blanching erythamous rash on abdomen and back. Diagnosed - viral gastroenteritis. Reassured. Parents to give dioralyte. Parents to bring

		sample.
		Potential key causal factor 1: Why were all these A&E attendances not followed up via health visiting?
16.03.04- 20.04.04	Contact sheet in Child 1's Health Record. Recording in Family Health Record.	Five further contacts with HV service CSN2 will contact family and work with mother. GP not yet done referral for counsellor. No Guthrie test result in office. CSN2 visited client at home. Discussed home management with regard to food preparation. Mother reassured. Encouraged to join Golf Links computer courses and make use of crèche facilities for Child 1. Discussed mother's anxieties about relationship with husband. Advised talking to him or maybe consider counselling.
28.04.04- 06.05.04	Recorded in Family and Child 1 Health Record.	3 visits recorded by CSN2 of home visit to family. Feeling slightly better. Not so panicky. Discussed putting Child 2 into cot and to stop night feed. Will try and put cot in Child 1's room. Demonstrated baby massage. Mother says she hasn't been able to talk to Child 2 like this during massage. Found the massage very enjoyable and will try to do every day. Given advice about the contra indications and benefits of massage.
		Potential key causal factor 2: How and why did a CSN get allocated? Potential key causal factor 3: Why is there no Health Visitors assessment? Potential key causal factor 4: Where is the referral for counselling?
09.05.04	A & E Sheet in Child 1's record.	Child 2 seen at EHT A & E. Temperature 37.2 and cough. Triage Nurse records unwell for 8/7. Dr records 5/7. Ear and throat mildly congested. Diagnosed - viral infection. Plan -(1)urine (2)Paracetamol (3)home Child 1 also seen at EHT A & E. Unwell for 2/7. Temperature 37.6 and cough. Known asthmatic on Becotide 2 puffs. Developed temperature yesterday. Admitted to 10 North.
11.05.04	Recorded by CSN2 in Family Health Records.	Telephone call for contact meeting at Golf Links Toddlers. Mrs. S had difficult weekend. Both children ill, rows with partner. Feels good to know she has achieved Child 1's bed routine. B into his cot. Eating around the table helping meal times. Child 1 eating more. Home visit arranged for Thursday 13th May with partner.

14.05.04	Hammersmith Hospital, Children's Ambulatory Unit record in Child 2's Health Record.	Child 1 seen at Hammersmith Hospital. 10 day history of raised temperature. Calpol given. Intermittent cough. Runny nose. No loss of appetite, feeding well. Temperature 38.3. Pharynx red, no exudate. Throat swab and blood culture. Probably viral infection. Calpol and Nurofen for temperature and course of Penicillin V.
19.05.04	Recorded by CSN2 in Family Health Record.	Partner present, helping with children and discussing family difficulties. Mrs. S is going to see G.P. this evening for antidepressant. Encouraged to make time to go out with husband. He's willing but states Mrs. S finds it incredibly difficult to leave the home, especially when having lot of chores to complete.
20.05.04	Recorded in Family Health Record by CSN2.	Home visit recorded by CSN2. Advised to put Child 2 in a cot and to organise breakfast routine. Prescribed antidepressant but decided not to take as pharmacy advised not to as breast-feeding. Mother present during visit, preparing lunch for sister-in-law. Feeling a little more positive today and will try to keep positive thoughts in her head during the day.
22.05.04, 13.27.	Record of A & E attendance in Child 2's Health Record.	Child 2 seen A & E, Ealing Hospital. Complaining of diarrhoea for 1/7. Born with weight 50th centile, now between 25th - 9th centile tailing off slowly. Height above 75th centile. Baby well, alert. Mild nappy rash. Discharged on Diarolyte. Reassured. SHO - Recorded mother depressed. Wants to know if she can take Prozac and breast feed. Finding it hard to cope at home, unsupportive husband. Fleeting suicidal thoughts. No thoughts of harming children would never harm them. Waiting to see counsellor. More than 6 months wait. No previous suicide attempt or deliberate self-harm, alcohol or drugs or physical abuse. To phone Monday regarding feeding and Prozac.
		Potential key causal factor 5: Why did the health visitor or CSN not refer to MHS at this point?
24.05.04, 10.15.	Recorded by CSN2 in Family Health Record.	CSN2 visits Mrs. S at home. Better weekend, went for a walk, and joined the Gym, feeling more positive. Able to discuss difficulties with husband Attended A & E with Child 2, who had diarrhoea. Discussed anti-depressant with Doctor there, who advised not to take antidepressant as breastfeeding.

25.05.04, 12.00.	Recorded in Family Health Record.	Telephone contact with Mrs. S recorded by CSN2. Reported to be feeling fine. Will telephone onThursday.
26.05.04, 15.58	A & E attendance record in Child 1's Health Record.	Child 1 seen at Ealing A & E. Lump in ® groin area. Descends down to upper R scrotum. Increases with crying. Decreases when child is quiet. Diagnosis: Inguinal Hernia. CSN2 recorded - telephone call from mother attended A & E Hammersmith with Child 1 and Chelsea & Westminster with Child 2. Mother very stressed, reassured.
27.05.04.	Recording by CSN2 in Child 2 and Child 1 and Family Health Record.	CSN2 records - Child 1 attended A & E with tonsillitis. Prescribed antibiotics and referred to Consultant. Child 2 attended A & E Hammersmith with hernia. Referred to Consultant. During home visit hernia not evident, playing and eating well. Both children very well, eating lunch and playing. Discussed with mother relationship difficulties. When father came home explored possibility of going out as a couple and leaving children with Mrs. S's mother. Will ring next week with plans for organising routines for both children.
		Potential key causal factor 6: Appears to be a lack of clarity over role of the CSN Potential key causal factor 7: Increase attendance at A&E
01.06.04. 03.06.04, 3 pm	Recording signed by CSN2 in Family Health Record.	Telephone support CNS2 records home visit at Grandmother's house - Child 2 going to hospital and mother still feeling anxious. Given information about Rishul Asian counselling organisation.
		Potential key causal factor 8: What are the cultural implications of referral to an Asian Counselling Service? Potential key causal factor 9: What has happened to the GP's referral for counselling?
07.06.04, 0.22 am- 13.06.04.	Record of Hammersmith Hospital Ambulatory Unit in Child's Health Record.	5 contacts with A&E. Child 2 seen at Hammersmith Ambulatory Unit. One day history of high temperature. A little off food. Temperature settles with Calpol and Ibuprofen. Child 1 has URTI. Hernia repair site clean and healing well. Alert child. Temperature normal on arrival. Spiked 38.3c whilst in A & E. Chest clear - right tonsil has some pus spots. Swabs taken. Given Amoxicillin for 5 days. Antipyretic for temperature. Child 2 seen at A & E Ealing. Had hernia repair Hammersmith. High temperature a few days afterwards. Seen at Hammersmith Ambulatory Service - Acute tonsillitis - evolving

		viral infection. Plan parents reassured, advice given, encourage oral fluids, continue abs, return SOS at G.P. or A &E.
08.06.04.	Recordings by CSN2 in Child 2's and Family Health Records.	Noted Child 2 has inguinal hernia repair. No complications. Dressing area urine soaked from previous night nappy. Child 1sleep on the floor. Mrs. S advised to get up and change the nappy to prevent dressing from becoming soiled CSN2 records visiting the family at home. Mrs. S and her husband have had a row. Her mother present. Suggested the couple need to see a counsellor together. Mrs. S will discuss with husband. Will ring to follow up outcome next week.
14.06.04.	CSN2 recording in Family Health Record.	CSN 1 records discussed with HV3. Will ring and speak to CPN for advice. Will speak to G.P.2 on Wednesday 16th at 2pm to discuss possible referral to Consultant Psychiatrist.
		Potential key causal factor 10: CSN2 has been with family for 2 months without Mrs. S being assessed by a health visitor.
14.06.04.	CSN2 recording in Family Health Record.	CSN2 records telephone call to C.P.N. who suggests speaking to G.P. and see if referral can be completed.
		Potential key causal factor 11: Why can't the CSN refer to mental health services?
16.06.04.	Information recorded in Family and Child 1 Health Records.	Telephone call from Mrs. S. Has seen G.P. and will go back on Monday with husband. Has also **seen Practice Counsellor.** Mrs. S has been informed that CSN2 will be discussing her mental health with the G.P. with possible referral to appropriate agency/psychiatrist. Her husband has refused to take up of Asian counselling. Home visit planned for 17.06.04 - 9.15 - 9.30. Mrs. S has been asked to write up a plan of daily events to add to planned programme we will write up at home visit to plan daily activities with the children. Discussion with GP2 highlighting concerns regarding Mrs. S mental health and the impact this is having on her parenting and relationship with partner. GP and CSN2 agreed referral to be made to psychiatric services for assessment. GP2 would like written agreement to send with referral.
		Potential key causal factor 12: Why does the GP need a referral agreement?

		Potential key causal factor 13: Why is there no feedback from the in house counsellor?
17.06.04, 9.30.	Recorded in Family's and Child 2's Health Records by CSN2.	Child 2 playing happily on the lounge floor and having breakfast. CSN2 recorded at home visits -informed Mrs. S about contact with G.P.2 and referral to psychiatrist, in agreement. Will visit on Monday 21st to go to supermarket and to discuss meals and nutrition.
21.06.04, 15.00 hours.	Recorded in Family and Child 2 and Child 1 Health Record by CSN2.	Child 2 has now stopped breastfeeding and Mrs. S encouraged to establish feeding routine, giving breakfast in the morning when Child 1 is having hers. Mother reported Child 1 was not keen to go to Nursery today, having tummy ache. Child 1 in kitchen eating lunch, refused drink offered by mother. Will discuss A's welfare with Health Visitor in relation to diet eating issue. CSN2 makes home visit to take Mrs. S to supermarket. Mrs. S decided she would like to go on another day as husband tired and GP appointment booked for this evening 6 pm. Mrs. S says she has stopped breastfeeding Child 2 and is considering taking antidepressant. Still finding daily routine difficult to manage. Father present today upstairs with Child 1 watching television.
		Potential key causal factor 14: Lack of clarity in the role of Potential key causal factor 15: Now visiting for over 2/12. Contact with family 1-3 times each week. Supervision with H.V. lacking. Potential key causal factor 16: Knowledge about antidepressant medication?
21.06.04.	Recorded in Family Record. Copy of letter in Family Health Record.	Letter written to G.P.2 as requesting referral to MHS
		Potential key causal factor 17: Potential delay in referring to MHS
22/06/04	Series 2C pg 140-141	GP refers to MHS: states no previous history of mental health problems although states that she has had previous anxiety. Multiple contacts with A&E and surgery noted; Deep rooted child hood problems and obsessions about the children's health. Seen by the in-house psychotherapist last week antidepressants prescribed but not taken as has been breast feeding.

		Potential key causal factor 18: Is the advice given by the GP about antidepressants and breast feeding correct?
23/06/04	3 pg 60-61 and 62-65	Result of screening at CMHT: full psychiatric assessment by doctor; follow on by MDT action plan care plan. Appointment sent for 16/09/04. Mrs. S rang "cant wait for September, needs support soon"; advised to come and see duty worker
		Potential key causal factor 19: Why is there such a long wait for an appointment? Potential key causal factor 20: Why was she not offered a full needs assessment?
01.07.04, 14.10.	Recorded in Child 1 and Family Health Record. Copy of faxed report and hard copy dated Mattock Lane H.C. 06.07.04.	Fax received from Hammersmith. Child 1 attended A & E with abdominal pains, discharged to return with stool sample. Fax received from C.P. Liaison Nurse 1. Child 1 attended A & E dated 01.07.2004. Telephone call to C.P. Liaison Nurse 1, updated on progress so far. Informed liaised with G.P.2 and Psychiatric referral in progress. Informed CSN2. Will discuss with HV2 Monday 04.07.04 in relation to Social Service referral.
05.07.04, 10 am	CSN2 recording in Family Health Record.	Telephone conversation with Mrs. S on 01.07.04, 16.40. stated that she feels much more positive and is taking control of her own life and family. She states that she has been listening during our meetings and has found the book very useful which has been given to her to distract her negative thoughts. Mrs. S is delighted the garden is nearly complete and Child 1 had a friend home for lunch. Is feeling more confident and has decided not to take antidepressant. Would like opportunity to go shopping for ideas for the children's meals. Will telephone on Wednesday 7th to find out how the family are and to arrange home visit. Discussed current events with H.V.2 to follow up telephone contacts to assess mother's status and coping strategies and to liaise with Health Visitor 2 following contact. <u>Telephone call</u> from Mrs. S. Says has hit rock bottom again and will take antidepressant. Tried to be intimate with husband and was rejected. Child 1 was having lunch at a friend's house. Mrs. S was finding feeding Child 2 difficult at her friend's home, no high chair and rang husband to collect and bring home to feed baby. Meeting arranged for Tuesday 6th July 10 - 10.30 to discuss and explore where we go from here. <u>Telephone contact</u>. Feeling very low, crying, and feeling panicky. Given time to relax and talk through relaxation technique. Both Child 1 and Child 2 mother reports are playing in the lounge. Husband asleep upstairs.

		Potential key causal factor 21: appropriateness of response of H.V.2.as CSN2 not qualified to undertake assessment of mothers mental health Potential key causal factor 22 Why didn't HV2 contact MHS?
06.07.04, 08.45.	C.S.N.2 Recording in Family Record.	Telephone call from S/N 1 at G.P.2 - apparently G.P.2 has made a referral to Social Services on 28.06.04 and to Mental Health Norwood Hospital team 22.06.04. Has had Social Services input after Child 1's birth when requested by previous G.P.1. Was seeing a counsellor and was discharged.
06.07.04, 11.55.		CSN2 visited at home. Still feeling low. Says she rang Southall Norwood Mental Health and stated how she's feeling. Will see her on 16th September 2004. Discussed with Mrs. S about her ability to cope and said I will be discussing it with H.V.2 with maybe referral to Social Services. Reassured that I wouldn't be doing anything without first discussing it with her. Mrs. S is saying her mother is concerned about Child 2 formula feed not mixing well, crystals being left in the bottle. Advised to return milk and purchase new box. Child 2 asleep on the floor. Mother preparing lunch at 11 am for Child 1 and two friends today. Mrs. S asked how much milk Child 1 should have. Advised to give small amount and offer more if wanted; Child 1 will only drink once Mum has tried first. "**She cannot cope, doesn't want to do this anymore, and doesn't want responsibility of children, husband not understanding".** After visit Mrs. S stood up and said: "I'm really going to try and make an effort and to continue taking antidepressant. Requested Child 2 to be weighed, and then decided not to as Child 1sleep. Will return 08.07.04, 2.30 pm to weigh.
		Potential key causal factor 23: Why was there no contact with the CMHT at this point Potential key causal factor 24: Two month wait for appointment if Mrs. S has correct information. Potential key causal factor 25: Why was advise not sought about her antidepressant medication
07.07.04.		Discussion H.V.2 with CSN2 the concerns: (1) Mother's perception of crystals in milk, milk contaminated. (2) Won't let baby crawl on kitchen floor as "dirty" although floor is clean. (3) Not responding to baby's smiles.

		(4) Force feeding Child S reported by mother. (5) Unable to cope with day to day task e.g. cooking. (6) Excessive A & E attendance. Plan: (1) Discuss with father, grandmother and mother, where are we going from here? (2) Discuss with GP (3) Discuss with school
		Potential key causal factor 26: Why has the Health Visitor only become involved now?
07-08.07.04.	H.V.2 recording in Family Health Record.	Telephone call from Mrs. S to say her mother does not want to come to the meeting on 12.07.04. Telephone call to Mrs. S mother who states Mrs. S needs: a) more attention from her husband. b) see the Psychiatrist before September. c) more practical help in the home. d) would like HV2 to check in Mrs. S is taking her medication.
09/07/04	File 3 pg 67	CMHT Duty Follow up: phone call to Mrs. NS; not able to speak in detail on the phone; worried about her children; willing to come to duty as wants to talk to someone; she will come on Tuesday; duty to see and arrange a short care plan prior to OPA in September Team leader plan: duty visit for assessment OR encourage client to visits; possibly see locum for Dr C; referral for Child 1ssessment if concerned; "case seems urgent if you need support just ask"
		Potential key causal factor 27: Why is there no liaison with other agencies at this point? Potential key causal factor 28: Why has it taken so long for duty to follow up?
10.07.04. 14/07/04 15/07/04	A & E liaison sheet in child health records.	Child 2 seen at Hammersmith Ambulatory Unit c/o fever. Swelling on soles of feet. Fever intermittently for past 10 days. 3 days of fever with cough and cold and then odd days since then. 38o highest. Well between times - Viral URTI. Mother advised re care of baby. Duty phone call to Mrs. S to arrange an urgent meeting; no response no message left; further call informed by Mr. S that Mrs. S had been in hospital with her son who was ill. Further duty contact: Mrs. S has other priorities and will contact the service when she is

		ready
12.07.04.	A & E Liaison Sheet and Health Visitor Liaison information in child's Health Record.	Child 2 admitted 12.07. - 14.07.04 to Ealing Hospital via A & E. Fever on and off. Chest X ray - NAD. Weight 8.3 kg. 9th centile. Height 25th centile. Slowed weight gain. Blood film consistent with infection. Diagnosed otitis media treated with Augmentin. Review 3 months.
22.07.04- 16.08.04,	A & E Liaison Sheet in Child's Health Record.	4 attendances at A&E for Child 2. Fell with spoon in his mouth. Grazed the roof of his mouth. Bled but now stopped. Mother reassured. Calpol - home. Complaining of cold/ chesty cough. Mother reassured. Raised temperature 39.3. Vasicular rash. Diagnosed chickenpox concerned regarding x 1 chickenpox spot on child's (L) upper arm. Mother said advised by NHS Direct and ambulance called. Mother informed that Doctors were busy. Happy to go home after advice.
22.07.04. 18.31.	File 3 pg 59	Letter from CMHT confirming an appointment for 16/09/04, 2pm with locum consultant psychiatrist
06/09/04	File 6 pg 7	Referral to Ealing Housing and Social Services: child came to attention of domestic violence; father appears to have had an argument with the mother over the children; father struck mother in the face and pushed her up against the wardrobe; father arrested. No evidence of violence towards the children
10.09.04.	Recording in Family Health Record.	Various phone messages from mother. Frantic because husband has left. Has gone to stay with her mother
16/09/04	File 3 pg 20-23 File 3 pg 55-57	Seen Consultant 1 Letter to GP from Consultant Psychiatrist 1: history of anxiety, depression, inability to cope with children; feels distressed due to relationship problems. MSE: ↓ appetite, no weight loss or sleep disturbance; suicidal thoughts although no intent to act; no psychotic phenomena; smartly dressed, calm cooperative; speech normal rate and flow; preoccupied with marital problems; no abnormal thoughts or perceptions; orientated in time place and person "realised that she was not mentally ill and has relationship problems Impression: adjustment disorder due to relationship problems. Plan cannot offer service at present especially as she does not want to take medication; to contact GP if she

		changes her mind about medication; diazepam prescribed for distress by GP; advised about relate and advised to contact GP to access counseling
		Potential key causal factor 29: Plan of 07.07.04 not completed.
21.09.04.	Recording in Family Health Record.	Liaison with G.P. G.P has prescribed Valium and referred to Southall Norwood Hospital. G.P. also prescribed antidepressant but knows she hasn't taken any.
		Potential key causal factor 30:Time lapse before response to information of 10.09.04
24.10.04. 27.03.05.	A & E Liaison Sheet in Child's Records.	7 contacts with A&E for Child 2
		Potential key causal factor 31: Why was this increase in attendance at A&E not responded to?
06.04.05.	Entries on contact sheet in Child' Record and written in Family Health Record.	Child 1 seen by HV2 at GP baby clinic. Recently on antibiotics. Speech - Mama, Dada, understands brushes teeth, running up and down stairs. Weight 10.40 kg, 25th centile. Height 80 cms, 25th centile. Mother has lost weight. Went to India. Father has come back and living with family.
18.04.05.	Recording in Family Health Record by HV2.	Telephone call from mother. Anxious - not coping. Mother in home helping out. Has been to GP, given antidepressant. Suggests Mrs. S goes to Asian Family Counsellor. Asian Family Counsellor contacted on 020 8571 3933. Holding regular meetings in Emmanuel Church. Worker will ring mother.
20.04.05.	Recording in Family Health Record.	Telephone call to mothers address. Mrs. S with her mother. Feels she wants to lie down and relax. Taking antidepressants. Discussed Asian Family Counselling attempted contact. Plan - Asian Family Counsellor to contact next week. Mrs. S to rest this week. Asian Family Counsellor telephoned. Discussed the plan. Both telephone numbers given.
10/05/05	File 3 pg 53-54	Self referred to CMHT: "very depressed and very tearful"
12/05/05	File 3 pg 51-52	Urgent referral from GP; described her as suicidal 2-3 months ago; started cipralex 10 mgs on 15/04/05; concerns about children-both healthy; , lost appetite and weight (3kg); Requested an urgent mental health assessment OPA at the request of Duty Worker: Consultant 2: Cant think straight; says that she is

		non compliant with medication, cries all the time, feels useless; uncle and mother looking after the children; low energy, OCD re-emerging, no self harm thoughts or psychotic symptoms; withdrawn; requires prompting,; no evidence of psychosis; compliant with Cipralex; some psychomotor retardation, minimal speech, no suicidal ideation, concentration poor, orientated Impression: recurrent depressive disorder with obsessional symptoms; moderate depressive episode on a background of marital difficulties. Plan: increase cipralex to 15 mgs for 2/52 and then to 20 mgs. If no improvement consider venlafaxine. Compliance discussed. "A lot of the problems are socio-cultural and we can only continue to advise the couple to seek marital counselling. OPA follow up 26/05/05
		Potential key causal factor 32: Why is her depression attributed to her marital problems? Potential key causal factor 33: Why was a referral to talking therapies not considered at this point?
26/05/05	File 3 pg 26	OPD review Staff Grade 1 Anxiety reduced, tired and muddled up, mood low, poor concentration and appetite; no rituals or obsessions Impression: over medicated, reduce cipralex to 10 mgs; review in 4/12. possibly advised duty system A&E and refer to children in need team
		Very poor MSE hand writing difficult to read Potential key causal factor 34: Why was she not seen by a CMHT worker for assessment? Potential key causal factor 35: Why think she was over sedated as opposed to depressed?
06/06/05	File 3 pg 46 File 6 pg7+24	Referral to children and families from Staff Grade 1: severe inter personal differences with Mr. and Mrs. S and my concerns are about the 5 year old child who might be at risk of neglect; requested an assessment by the children in need team Referral to Ealing Social Services by Staff Grade 1. Depressive illness, mother of two children "severe interpersonal difficulties with husband and wife concerns with the 5 year old who may be at risk of neglect; requests assessment Many family members who can offer support; please explore with the parents and the extended family how mother can be supported to look after children; liaise with other agencies. Most likely case will proceed to core assessment
		Age of children on the referral form is incorrect stating 18 years instead of 18 months
07/06/05	File 6 6pg 90	PC to Mrs. S during the conversation although baby screaming in the background;

		stated that she needs help as things are out of control with the children and the house; stated that she had been advised by Dr C to stop taking her meds for a week as it was not helping; baby drinks too muck milk and daughter only eats pasta; stated that she has good support from her husband. Spoke to Mr. S; he helps as much as he can, wife still becomes distressed at times, he will take her and the children to her mother and grandmothers to stay Duty Worker, care manager CMHT; Mrs. S distressed and cannot cope with the children; suffered from post natal psychiatric problems, adjustment disorder due to relationship problems and depression; CMHT notes indicate that Dr C recommended that she continue her medication Plan: advised to contact Dr C about her medication; contact HV re concerns over children's diet; she agreed for her husband to take her to her mothers house today; advised that SS would undertake an assessment
09/06/05	File 3 pg 27 and 12	DR C: discussed with Andrew duty worker as Mrs. S contacted and said that she dose not want to start new medication now would rather wait a week, Dr C discussed with children in need team involved, would like to see how she is over the next week; ok by us
		Good piece of duty work, contacted all concerned
14.06.05.	Recording in Family Health Record. Recorded in Family's Health Record by HV2	Unplanned visit. Both parents and Child 2 at home. Mrs. S very strained. Sees psychiatrist at Southall Norwood Hospital. Off all medication as it didn't help. Only medication that helped is what she took after Child 1 was born and then she went back to work. Plan - Ring Psych. Re earlier appointment.
16.06.05.	Recording in Family Health Record.	CSN2 recorded telephone call to Mrs. S. Feeling very depressed, not able to speak for long. Husband at home today. Will call on Monday 20th June 2005, 11 am to discuss if a visit if would be useful.
17.06.05.	Undated in MH records File 3 pg 12 File 6 pg 86	Duty contact PC from Mrs. S: very distressed, cant cope with the children; to follow up Staff Grade 1 referral; asked to call back within the hour if she has not heard anything. Further duty contact: feeling worse, no change since starting new medication "mind not working, loss of concentration, poor memory, no harm ideation. Does not want to start new medication now-wait a week and see how things go Contacted HV: tends to be anxious about feeding the children; contacted SS, has been allocated a worker S.W 1. Plan Social Services manager will contact Mrs. S, feed back from this was that "following discussion Mrs. S has agreed to spend the w/e at her

		mothers. To discuss with Staff Grade 1 on Monday from Mrs. S; low in mood, decreased energy difficulties in coping with the children; Contacted HV who informed that she tends to be anxious about feeding the children. Spoke to Social Services who will phone Mrs. S and feedback PC from Duty Worker: not coping with child, advised that extended family can do this. PC to Mrs. S expressed that she was feeling low and had felt like this for a long time, anxious that she was not caring adequately for her children; Advised to contact husband and tell him that she was not feeling well, will call back in 15 mins to see what he says; Advised by Mrs. S that he would be home within the hour and she has decided to go to her mothers house. Not able to do this as her grand mother has to go to hospital. Spoke to Mr. S advised that a social worker has been allocated and will make contact on Monday Telephone call from Duty Worker at Southall Norwood Hospital re phone calls they are getting from Mrs. S. requesting help with child care. States family referred to Children in Need Social Worker – Plan: - I will refer to Social Services as well re impact anxiety re feeding. No concerns for weekend as father and mother available to help with children. Outcome: Mrs. S has agreed to stay with her mother over all the w/e. Discuss with Staff Grade 1 on Monday
21/06/05	File 6 pg 87	Home Visit: Mr. and Mrs. S at home, Child 2 asleep said that I would visit again when Child 1 was home Phone call to HV2, no health concerns about the children; mother needs to engage with external recourses to get herself out of her current situation; had explored play groups and Asian Family Counselling service; will try to get the children to eat more than they require. Phone call C to GP and Staff Grade 1 neither available
23.06.05.	Recorded in Family Record by CSN2.	Telephone call to Mrs. S Planned to telephone next week to make arrangements for home visit and discuss going to the toy library.
24/06/05	File 6 pg 5	Home Visit by SW1 Calls to Staff Grade 1 and GP and Mrs. S requesting information and updates
28-30/06/08	Recorded by CSN2 in Family Health Record.	Several Telephone calls made . No reply. Message left.
30.06.05,	Recorded in Family Record	Child 2 asleep on the lounge floor. Concerns expressed: child diet, bottle of milk at 6.30

15.10.	by CSN1.	am, no breakfast, sleeping through lunch, not wanting lunch. Up to date with immunisation and has been physically well. No attendance at A & E. Child 1 - mother says she's talking back to her. Explored ways of managing and setting firm boundaries. Home visit by CSN2. Home untidy. Lots of toys in the hallway, kitchen untidy. Mrs. S low in mood and stated how difficult she finds preparing meals for the family. Chat - husband at home. Mrs. S has an appointment to see the Psychiatrist at Norwood Hospital tomorrow. Suggested Mrs. S ask for a CPN. - Discuss with Nursery Nurse possibility of planning and preparing meals, time management food routine, timetable left for mother to think about. - To telephone 07.07.05 to make arrangements for toy library meeting. - Liaise with Nursery Nurse i.e. behaviour management for Child 1. - Mrs. S to ask for CPN to visit her at home.
		Potential key causal factor 36: Why did this apparent change in her home circumstances not trigger contact with other agencies or referral to CMHT?
01/07/05	File 3 pg 45 and 13-14	OPA Staff Grade 1: Urgent referral for allocation at CMHT requesting short allocation for support and a point of contact; socially isolated and difficulty engaging; DSH ideation present "generally low; self harm ideation described as "vague thoughts", no specific plans; no DSH attempts; increased sleep and appetite; poor energy + concentration. Impression: mostly psychosocial. Try Sertraline 50 mgs increasing to 100 mgs, review 4/52 To be reviewed after 1st feedback to possibly enhanced Letter to GP2 from Dr Staff Grade 1, OPA review: Impression: Moderate depressive episode with somatic symptoms.
		Potential key causal factor 37: Why do they think that this is mostly psychosocial? Potential key causal factor 38: Quality of MSE Potential key causal factor 39: No referral for talking therapies Potential key causal factor 40: Why are two different impressions given one in GP letter and one in OPA notes Potential key causal factor 41:Why was a review set at four months when starting on new medication and getting patient to titrate
14/07/2006 should be 14/07/05	File 3 pg 15	CMHT allocate the case with a provisional plan to assess needs, support, liaise with children and families team and the Staff Grade Psychiatrist CMHT allocated worker-phone call to children in need to team to see if they have the referral Phone call to Mrs. S to arrange a first visit; Mrs. S will call back
15/07/2006 ? Should	File 3 pg 15	CMHT allocated worker Phone call to Mrs. S: unable to arrange a visit as she is not sure

be 15/07/05		when she is available. Quite over the phone, seems to know what she has planned, focused on the day; claimed her son has a temperature so I was unable to see her
18/07/2005/18/07/06 18/07/05 Dates are illegible	File 3 pg 42 File 6 pg 15	CMHT allocated worker: met at her mothers address; talked about her children and her concerns: do not eat enough and youngest has a throat infection. Mother is very involved in caring for Mrs. S and her grandmother; more tearful as she spoke; wants help every day, medication review as not working, currently Sertraline 75mgs daily Mrs. S signed a "consent to share information" sheet for the health visiting service. Impression: "she feels trapped in having to look after her children everyday. Plan: to see Mrs. S weekly and explore her hobbies and interests to get her involved in activities. May refer to the ?Link project to help with confidence and motivation. Still no response from GP; Phone call to Primary School Child 1 quite shy and reserved, not new behaviour, felt Mrs. S "was under the thumb of both her husband and her family
22/07/05	File 3 pg 16	Duty contact re medication Will speak to Staff Grade 1 and get back to her Staff Grade 1: c/o dizzy spells; cant increase dosage further Plan: omit sertraline; start paroxetine 10 mgs; review 1/52
		Potential key causal factor 42: Appears that there was a change in medication without the patient being seen Potential key causal factor 43:No mental state recorded Potential key causal factor 44: CMHT allocated worker has consent to share with health visitors but makes no contact with them Potential key causal factor 45: no consideration of the impact that parental mental illness has on the children
27/06/05 Incorrect date recorded in file should read 27/07/05	File 3 pg 17	CMHT allocated worker: phone call to Mrs. S, has not yet collected her prescription will take this along. Home visit: presented as more "chatty" busy feeding Child 2, not on meds trying to cope; gave prescription if she wants to take medication; more willing to engage with other services; husband home asleep
		Potential key causal factor 45: No formal CMHT assessment appears to have been started Potential key causal factor 46:No care plan Potential key causal factor 47: Why was the importance of medication not appear to have been discussed with Mrs. S as this was the treatment plan Potential key causal factor 48: Allocated worker recognisees that mother is providing a lot of support but does not appear to consider a carers assessment

02/08/05	File 3 pg 17 File 6 6pg88	Call to Mrs. S-no reply; letter sent for home visit on Monday Home visit CMHT allocated worker: not taking medication; feels that she has nothing to look forward to, believes that she is a bad mother; attended to her children when ever they approached her and had taken them to the park that day Opinion through observation: "managing quite well; requires education and reassurance about bringing up her children
		Potential key causal factor 49: There is incongruence between the behaviour that Mrs. S is presenting with and what she is saying Potential key causal factor 50: Why has the CMHT allocated worker not picked up the deterioration in her mental state? Potential key causal factor 51: No formal CMHT assessment Potential key causal factor 52:No care plan Potential key causal factor 53: No referral for talking therapies Potential key causal factor 54: Why has the CMHT allocated worker not liaised with the Health Visiting Service about Mrs. S's concerns about brining up her children? Potential key causal factor 55: Why have none of the agencies planned for a professionals meeting
04.08.05.	Recorded by CSN2 in Family Health Record.	Telephone call to Mrs. S. Stopped medication. Making mother feel drowsy. Said Doctor took her off, prescribed alternative which she is trying to avoid taking. Will ring next week beginning 08.08.05 to plan trip to Golf Link toddlers. Stated the children are well. Heard playing in the background.
17/08/05	File 3 pg 18-19	Home visits By CMHT allocated worker: feeling ok; still not taking her medication; does not express her concerns to her mother; mother feels that she would benefit from a home help. Mrs. S would prefer not to have any more visits from services such as mine whilst her 5 yr old daughter is at home on school holidays Plan: keep in contact by phone in order to respect NS wishes, unless Mrs. S states otherwise or if in crisis
		Potential key causal factor 56: assessments had not been completed and concerns about the children had not been discussed with the health visiting service Potential key causal factor 57: Why does there not appear to be any liaison between the allocated worker and the Staff Grade 1or anyone else about the disengagement Potential key causal factor 58: No medical review has taken place since 1st July
30/08/05	Series 6 pg 45	Home visit by SW 1 to complete assessment

31/08/05	INCIDENT	Assessment completed-refer to family welfare association to request support for Mrs. S in the am which she finds lonely and difficult