Lynda Brooks
Inquiry Officer

THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF A PATIENT KNOWN AS 'D'

Incorporating an Inclusive Root Cause Analysis-type Process

A report commissioned by:

South West Peninsula Strategic Health Authority

Published March 2005

PANEL MEMBERSHIP

Independent Chair: **Mr W Hayes**

1976 Qualified RMN, 1982 BA, 1995 Fellow Chartered Institute Management, 1997 Fellow Institute of Directors. Former NHS Chief Executive and Chief Nurse, with specialist Mental Health expertise in: Organizational, General and Clinical Management, Managing Complexity and Change, Systems Failure Analysis, Independent Inquiries into Homicide, Suicide, Unexplained Deaths and Serious Untoward Incidents.

Role: Chair the Inquiry Panel; provide independent expertise and advice; write the Inquiry Report.

Independent Member: **Dr P Aitken**

MB, ChB, MRCGP, MRCPsych, DCH, DRCOG, ILTM, Consultant Liaison Psychiatrist. Acting Director of Research and Development, Devon Partnership NHS Trust. Qualified University of Glasgow 1987. Qualified in General Practice 1993, appointed Consultant Liaison Psychiatrist, St Georges Hospital, London, in 1999.

Role: Provide independent medical expertise and advice.

Local Panel Member: **Mr I Hope**

Chairman of West Cornwall Magistrates Family Court Panel.
Local Provider Trust Non Executive lay member, local magistrate.

Role: Provide lay perspective based on experience; ensure Trust Board ownership and commitment to outcome of Inquiry.

Local Panel Member: **Mr T Jones**

MA RGN, RMN. Local Provider Trust Manager and internal review Panel member.

Role: Provide clinical and managerial expertise based of experience and knowledge gained from internal review; contribute to ownership and learning of the inquiry outcome within the Provider Trust.

Local Panel Member: **Mrs P Melhuish**

MSc (Risk Management), DpSM, RM, RGN. Local Provider Trust Risk Manager.

Role: Provide expert risk management expertise based on experience and knowledge; contribute to ownership and learning of the inquiry outcome within the Provider Trust.

Local Panel Member: **Ms L Watt**

S.R.O.T. (Edinburgh)

Local Primary Care Trust member, with Mental Health service commissioning responsibility.

Role: Provide commissioning perspective and ensure commissioners' ownership and commitment to outcome of Inquiry.

Support to the Panel:

Ms Lynda Brooks	Personal Assistant to Chair and Inquiry Officer.
Mrs Susan Benjamin	Policy Manager (MH/LD). South West Peninsula Strategic Health Authority.
Mrs Hazel Crook	Patient Safety Manager, National Patient Safety Agency (NPSA), facilitated the Root Cause Analysis Process.

ACKNOWLEDGEMENTS

It is difficult to comprehend the full effect that two such dreadful tragic deaths have had on the family, friends and those providing support to them. Those most affected must be supported and reassured in every possible way. On behalf of the Panel and myself, I offer my deepest sympathy and condolences to the surviving family and friends of the deceased.

I was aware and conscious of the family's wish for this Inquiry not to take place, and also of the family's informed choice not to contribute directly to this Inquiry. Family members, the Police and a family solicitor conveyed this decision to me.

I offer my sincere apologies to family members for any distress or upset this Inquiry process may have caused. I hope that this report will in some way help to conclude matters and allow those affected to grieve as needed. In these distressing circumstances I sincerely hope individuals can be helped to move on with their lives as best as they can.

I offer my sympathy to those staff members who were affected at the time, and those who continue to suffer from the effect of this and previous Inquiries. I apologise for any added difficulties that this Inquiry process may have caused. I encourage those still affected to access the support that is available, and hope they can resume their full duties and contribute to the best of their ability to providing services.

The Inquiry's work was helped greatly by the amount of support and goodwill from a number of local individuals and organisations. I wish to offer my grateful thanks to all those who contributed to the Inquiry and helped with its work. All individuals and organisations that contributed in any way are listed in Appendix 2.

I offer my grateful thanks to my fellow Inquiry Panel members: Peter Aitken, Ian Hope, Lorna Watt, Tim Jones and Pauline Melhuish. My thanks also go to those who supported the Panel throughout the Inquiry process, especially the Inquiry Officer, Lynda Brooks. Also my thanks for their support go to Hazel Crook, from the National Patient Safety Agency, and Sue Benjamin, from the South West Peninsula Strategic Health Authority.

William Hayes
Inquiry Panel Chair
Independent

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INTRODUCTION AND OVERVIEW

The South West Peninsula Strategic Health Authority commissioned this Inquiry. The full Terms of Reference are included in Appendix 1. The main remit of the Inquiry was to examine the unlawful killing of Mrs D and suicide of D while the balance of his mind was disturbed. These deaths occurred in May 2003. The Inquiry was asked to examine the circumstances of the treatment and care of D by the Mental Health Services provided by Cornwall Partnership NHS Trust.

Introduction to Inquiry

D was a retired dentist who killed his wife and then took his own life in 2003. D graduated in dentistry in London and moved to Cornwall. D and Mrs D married soon afterwards and they had two children. D and Mrs D were in contact with NHS Services from November 2002 to March 2003. During this time D and Mrs D were experiencing significant relationship difficulties. Also during this time D was involved in several incidents that required Police action and hospital treatment. He was arrested and cautioned on one occasion and was admitted to hospital for treatment on three occasions. Mrs D also received support from NHS services during this time.

In undertaking this remit, it was also the Inquiry Panel's task to consider the care of Mrs D, and the involvement of others in both cases. The Panel was appointed in August 2004 and commenced its work in September 2004. In the course of its work the Panel heard evidence and received submissions from a wide range of professional witnesses. Information from the Coroner's Inquests, advocates, other appropriate individuals and organisations was also submitted. Expert legal advice was obtained. A local part time Inquiry Officer, the South West Peninsula Strategic Health Authority and the National Patient Safety Agency supported the Panel.

The Strategic Health Authority agreed two changes to established procedure. Firstly, the Panel was required to engage in a process of Root Cause Analysis as a basis for the Inquiry's work; secondly, four local Panel members were appointed for this purpose. The Independent perspective and responsibility was invested in, and maintained by, the Independent Inquiry Chair and the Independent Consultant Psychiatrist. The NPSA was asked to facilitate the Root Cause Analysis process. However, they took no active role in the decision making.

The Inquiry report is arranged into eight chapters (supported by a number of Appendices) as shown below:

Chapter 1 describes the Inquiry process, procedure and approach, and explains the processes of obtaining relevant information and documentation. It also summarises the use of the Root Cause Analysis approach, a relatively new tool for investigations of this nature.

Chapter 2 describes the relevant family history and background in factual terms, based on the available information. Due to the family's express wish not to be directly involved, it is acknowledged that this is based on records submitted to the Panel and not necessarily on evidence corroborated by immediate family members.

Chapter 3 outlines the key events in chronological order. The period covered in this chapter is from the first significant event that involved statutory services on 19th November 2002, to the date of the Coroner's Inquests on 21 October 2003.

Chapter 4 summarises the significant critical events, and comments on the decisions that were made.

Chapter 5 summarises the general findings from relevant information obtained during witness interviews, meetings with relevant interested parties, and information obtained during visits to appropriate service areas. The individuals, organisations and areas involved are listed in Appendix 2. Research on Suicide/Homicide in Cornwall and analysis of education and training are also included in this chapter.

Chapter 6 deals with the Care and Service Delivery analysis and records the key outcome of this area of work.

Chapter 7 deals with the relevant research, and key guidance and sources of reference used by the Panel in its work. This section summarises the specific guidance that is relevant to this case, and the key issues to be addressed and considered for further action by relevant agencies. Further extracts from relevant guidance, a list of reference sources and other information used during the Inquiry's work is listed in Appendix 3.1.

Chapter 8 details the Inquiry Panel's overall conclusion and the main body of conclusions, recommendations and commendations from this Inquiry. The conclusions and recommendations are grouped under general headings. Commendations for notable practice identified by the Panel during the course of the Inquiry are listed in Chapter 8

Overview of Inquiry Findings

D was considered to have a dominant and over-controlling personality. He was considered to have an adjustment disorder with episodes of low mood and aggression, which were exacerbated by relationship problems and alcohol abuse. Both D and Mrs D appeared to have been significantly dependent on each other. Many professionals involved in this case were not aware of the degree, nature or significance of D and Mrs D's dependence on each other.

Prior to May 2003, D avoided prosecution in court and detention under the Mental Health Act on a number of occasions. He was charged and cautioned on one occasion. He was assessed on three separate occasions for detention under the Mental Health Act. He was not detained or sectioned under the Mental Health Act. The Mental Health Act assessments involved three different Consultant Psychiatrists, three different Mental Health Act approved second opinion doctors, and two different Mental Health Act approved Social Workers. He had no known psychiatric diagnosis, and no known psychiatric history.

It can be argued that the system either failed, or enabled D to avoid criminal prosecution and/or detention under the Mental Health Act. However, his behaviour and profile suggests he planned to avoid being detained or prosecuted. His behaviour and profile is consistent with similar cases, as evidenced in *Safety First*. (See Chapter 7).

It can also be argued that psychiatric diagnosis was made on a number of occasions during admission for assessment and treatment. However, there was no evidence of a properly classified psychiatric diagnosis in accordance with International Classified Diagnostic Codes. In particular, D was not classed as having a treatable mental illness or psychotic disorder.

National evidence (*Safety First*) suggests that patients who are in contact with Mental Health Services commit a relatively small proportion of homicides. In risk management terms, the

evidence suggests that young men with a dual diagnosis, usually Schizophrenia with a substance misuse problem, present the highest risk. In Cornwall evidence suggests a different trend; men over 45 years old committed three of the last four homicides by people in contact with Mental Health Services.

Evidence suggests (*Safety First*) that around 20 people per year were reported to have committed suicide after homicide and before conviction; only 7% of these were known to have been in contact with Mental Health Services. Although the number of cases is small (less than two per year nationally), D had similar characteristics to these perpetrators, the majority of whom are males over 45 years old.

Males over 45 are most likely to commit suicide. Individuals who abuse substances, and who are aggressive and self-harm, are likely to be in self-denial about the extent of their problems. They are also most likely to mislead and avoid treatment. In cases like this a lengthy period of specialist psychotherapy assessment and treatment is needed to form an appropriate diagnosis.

The Inquiry Panel concluded that it was highly likely that these tragic deaths could not have been prevented. D was a most unusual patient, as deaths in particular circumstances such as this are extremely rare. Nationally, an average of three people every two years commit homicide and suicide in circumstances similar to D. Both D and Mrs D were known to the Police and Health service for a relatively brief period of their lives. In both cases there was no evidence of a Mental Health diagnosis, and no Psychiatric history or history of Mental Health care before November 2002. With the agreement of clinicians, D and Mrs D had disengaged with NHS health care, and decided to pursue private therapy. D and Mrs D were not involved with statutory services at the time of their death and had not been significantly involved for the three months prior to this.

Inevitably in Inquiries such as this there are lessons to be learned and room for improvement is identified. It is most important that the Panel's conclusions are not read and considered in isolation from the main body of the report. They must be kept in perspective and considered in their proper context. The Inquiry found that during the period November 2002 to May 2003, all

the relevant information about both D and Mrs D was not available to the key decision makers of the agencies involved, in any one place at the same time. Knowledge and information held by the family, the Criminal Justice System, and various parts of the NHS, was not recorded in the same place or available in a timely fashion to those involved in making critical decisions.

In this case working practices, both within and between key agencies, inhibited the decision making process. Pressure of work, a lack of timely follow up, failure to refer back for review to referring personnel, and the absence of face-to-face debate during critical assessments, affected the quality of communication and robustness of decision-making.

The variety of locations used for assessments, in particular those carried out in response to a crisis, presents significant logistical problems. Having the right people and the relevant information available at critical times, in the same location where the patient is being assessed, is a significant issue.

A lack of clarity and understanding existed within disciplines, between disciplines and between agencies. In this case, there was extensive and high quality Health Service involvement from Community Psychiatric Nurses. The quality and level of medical input was high, although continuity of medical input was lacking on some occasions. The quality of input from Emergency Department and Ambulance staff was high, in particular in terms of care, risk management and record keeping. The Panel observed that, at the time, the involvement and input of psychology was limited to consultancy advice, and social work was limited to Mental Health Act assessments.

Considerable work has been undertaken to review and update policies in the Partnership Trust. Eight substantial Trust manuals of considerable weight were presented to the Panel for reference. Two manuals commonly appeared in ward areas, each one substantial in weight and volume. In crisis assessment locations, such as Custody Centres and Emergency Departments, no manuals or guidance was readily available.

There is evidence of training and education within the area, both between agencies and within the Partnership Trust. Despite this, the majority of those interviewed had not ensured that they had attended sufficient training on relevant policy and guidance. They did not have sufficient

relevant guidance readily available in the workplace and did not appear familiar with an appropriate amount of guidance and reference material that is relevant to services and staff who manage clinical cases in Mental Health care. All interviewees were clear about, and familiar with, their legal, statutory and professional responsibilities.

In the Partnership Trust clear evidence existed of services being structured and organised in a modern and multi-disciplinary way. The quality and quantity of multi-disciplinary input and attendance for team meetings, ward rounds, learning lessons meetings, and other critical meetings need review and improvement.

Evidence exists of appropriate Multi-agency working, in particular around Multi Agency Planning and Mentally Disordered Offenders meetings. No evidence of a Multi-agency case conference taking place existed for this case. Evidence exists of improved working relationships between key agencies, in particular the Police and Mental Health services. Evidence to support the existence of appropriate Multi-agency local operational forums exists. Attendance at certain established forums does not seem sufficiently representative of operational personnel.

Most local organisations appear more risk adverse than risk aware. There appears to be a lack of joint agency review and appraisal of critical incidents and 'near misses' for this case. The threshold and tolerance levels for coping with risk seem high in all agencies.

Evidence of stigma and prejudice exist locally. This affects people with Mental Health problems, their families and the quality of service provision. It is accepted that this is a 'national disease' and a major political and social problem throughout society.

Chapter 1

The Inquiry Process and Procedure

The Inquiry was established under Department of Health Statutory Guidance (*HSG 94(27)*). The South West Peninsula Strategic Health Authority decided to include an additional approach using the Root Cause Analysis process. To maximise the potential benefits of this work it was decided to appoint local providers and commissioners, as well as independent members.

The context for this decision was as follows:

1. There had been three recent Independent Inquiries in the area. There is a limit to the value of holding a fourth inquiry that would report in twelve to eighteen months.
2. The Partnership Trust had completed a thorough internal review and was actively working through the recommendations of that review.
3. The Department of Health intends to change the Inquiry process to include the use of Root Cause Analysis. This is a multi-disciplinary appraisal approach, and with expert support will produce the same type of report as an Independent Inquiry.
4. The benefits are that the providers and the commissioners will be actively involved. This should enhance learning, gain better ownership of the process and outcomes, and enable key stakeholders to have more direct input into the implementation of the action plan.
5. The process would be supported and facilitated by the National Patient Safety Agency.
6. It could be demonstrated that the process would be independently led, and the Partnership Trust and Strategic Health Authority will be publicly accountable for implementing an action plan based on the conclusions and recommendations of the Inquiry Report.

Briefings, Meetings and Interviews

These were conducted in a range of appropriate locations convenient for those involved (Appendix 2). There were essentially three types of approach used:

1. The Chair conducted briefings on an individual and group basis throughout the process. Where individuals were unable to avail themselves of a briefing prior to the interview date, a briefing was given before the interview commenced.
2. Key stakeholders who were not witnesses (Appendix 2) were appropriately briefed on an individual basis and offered the opportunity to make a submission to the Panel.
3. Meetings with relevant Partnership Trust Directors were arranged to discuss emerging issues, advise on progress and discuss incidental findings. Where managers were able to demonstrate awareness, and prepared to accept incidental findings and act on the same, these were excluded from the final report. This was beneficial as it helped avoid the critical findings being subsumed by a variety of relevant but incidental information. The Panel received notes and feedback on all meetings.

The Inquiry Panel Independent Chair opened each session using a standard pro forma as follows:

1. Introductions: all individuals present introduced themselves and clarified their role and responsibility as appropriate. It was emphasised that the Inquiry's work was strictly private and confidential.
2. The background to the case was outlined.
3. The reason for an Inquiry was explained.
4. The Statutory Guidance, Inquiry Terms of Reference and the Root Cause Analysis process were explained.
5. The membership and roles of Panel members were explained.
6. How the Inquiry would be conducted was explained, in particular that it is not a legal process, that a non-adversarial approach would be used, and that the report would be anonymous. Discussions were summarised or recorded as appropriate.
7. Those involved in the internal review were offered the opportunity to read and comment on their transcripts and the internal report.
8. The range of reference material used by the Panel was highlighted, and questionnaires related to these were requested to be filled in if appropriate.
9. The time scale and programme for the Panel work was clarified.
10. Individuals were invited to make a further submission to the Panel based on previous statements and the outcome of the current interview and discussion.

Root Cause Analysis

The Root Cause Analysis process is a structured investigation that aims to identify the true causes(s) of a problem, and the actions necessary to eliminate it. The rationale for its use in this case is because it is widely accepted that there is a need to learn from patient safety incidents. It is acknowledged that system failures can lead to human errors. Evidence from 'high reliability' industries demonstrates that systematic investigations can expose system failures. This helps to identify notable practice, and highlights care delivery and service problems. Contributory factors are also considered and root causes identified.

The stages of a Root Cause Analysis are fact-finding, analysis and conclusions.

1. Gathering information is seen as the lifeblood of investigation. It is suggested that 60% of time should be spent on data gathering. Information tends to be in four categories, people, documentation, sites and equipment.
2. The next stage of the process is to map the information collected into tabular timeline, narrative chronology, and simple timeline.
3. This is followed by a process to identify care and service delivery problems.
4. Causes, effects, barriers and root causes are identified.
5. Considered conclusions, recommendations and commendations are drawn.

Chapter 2

Factual Family History and Background

D and Mrs D Summary Biography

D was born on 16th March 1952 in Warwick. His childhood is described as normal with normal schooling.

He studied and graduated in dentistry in London and practised there for a year after graduation. He moved to Cornwall, where he lived and worked for some 25 years prior to his death.

D was married on two occasions; he parted from his first wife some 27 years prior to his death. They had two children.

Mrs D was born on 23rd December 1952 in Middlesex. She married D after they moved to Cornwall in the 1970s; they had two children.

D's lifestyle was supported through income gained over a number of years from two dental practices and property transactions.

In an accident in 1998 he lost part of two fingers on his right hand. This injury required emergency hospital treatment and surgery. As a result of this accident he was unable to continue practising as a dentist, and subsequently retired. Due to conditions in his pension agreement, he was prohibited from resuming any form of paid employment.

Mental illness and services.

Prior to the period November 2002 to March 2003, D and Mrs D had no known psychiatric history.

Over the period November 2002 to March 2003 D had three informal admissions; these lasted approximately three days over a weekend on each occasion.

Throughout the rest of this period a local Community Mental Health Team supported D. Throughout the same period Mrs D was supported by Primary Care Mental Health Services

provided by the same team. D and Mrs D were discharged from NHS services in March 2003.

Following discharge from public services, ongoing therapy was provided through private psychotherapy. During the period November 2002 to May 2003, three private therapists were involved with both D and Mrs D at various stages.

Chapter 3

Chronology of events

This chapter is a factual chronology of events, based on extracts from records kept at the time and statements supplied by people in contact with D.

19th November 2002 at 20.30hrs:

D was admitted to the Emergency Department in Treliske Hospital in an alcohol-intoxicated state. He denied having taken an overdose and he denied having suicidal thoughts. He was monitored overnight in the Emergency Department. At 10.30am on the morning of 20th November 2002 when he was sober, he was assessed by a psychiatric liaison nurse and was discharged home. It appears that the Casualty nurse was not informed that D had left the department. D went to his boat and not his home. The Casualty nurse informed D's relatives of his discharge at 12 noon.

20th November 2002 at 16.30hrs:

He was admitted to the same Emergency Department in an unconscious state. He was intoxicated with alcohol and had taken an overdose of tablets. He was treated in the Emergency Department and subsequently stabilised on the high dependency unit.

22nd November 2002:

Following psychiatric assessment he was admitted informally. The medical recommendations for detention under the Mental Health Act were made. This attempt to detain D under the Mental Health Act was not completed, as he agreed to be admitted informally. He was admitted to a psychiatric ward in Bodmin Hospital.

At interview in hospital he stated:

He would not attempt to kill himself and wanted to live to see his grand children.
He denied any homicidal intentions towards his wife.
He loved her to bits and could only harm her in the heat of the moment.
He accepted the fact his marriage was effectively over.
He blamed his wife for destroying his marriage and the family.
He believed his wife had planned this break up over the last 10 years.
He had plans for the future: to sell off his property and spend more time with his children.

He had plans to travel and carry out voluntary work abroad.

He felt strongly that being in hospital was doing him more harm than good.

25th November 2002:

Following a settled and unremarkable period in a psychiatric acute admission ward, he was reassessed and discharged home at his request. He was supported by the family, with follow up by the Community Mental Health Team.

25th November 2002:

D was referred to Community Mental Health Team.

27th November 2002:

D was visited at home by the Community Psychiatric Nurse. An assessment was carried out.

29th November 2002:

A home visit was attempted. There was no reply. Phone calls to D were made with no reply. Several phone calls to various relatives were made. There was one answer-phone response, and one confirmed he had improved, and that they had removed all tablets and weapons from him.

2nd December 2002:

A relative was contacted and confirmed that D had been to his GP and had been prescribed antidepressants. The Community Psychiatric Nurse contacted D on his mobile phone; he was travelling and planning to visit various family members in London and elsewhere.

4th December 2002:

The Community Psychiatric Nurse contacted D on his mobile phone; he confirmed he was visiting family in Oxford. A home visit was agreed for the next day.

5th December 2002:

D was seen by a Community Psychiatric Nurse at home, and appeared calm but tearful. Lifeboat training plans had failed because of his age and disability. He planned to get a dog for company. He was advised to keep active and spend time with supportive people. He denied thoughts of suicide.

6th December 2002:

D was seen by the Consultant Psychiatrist in the outpatients department in Truro. He expressed suicidal ideation but denied any intent. His antidepressants were changed for safety reasons. Hospital admission was offered but refused.

10th December 2002:

The Community Psychiatric Nurse phoned D and left a message on his mobile. D phoned Consultant Psychiatrist's secretary to say he was going to Antigua for a few weeks. He was advised to contact his GP for medication.

11th December 2002:

The Community Psychiatric Nurse contacted D and he informed her he was no longer going on a trip.

13th December 2002:

D was contacted by the Community Psychiatric Nurse. He confirmed he was taking his medication, but felt disorientated as his life was disrupted.

16th December 2002:

D phoned the Community Psychiatric Nurse. He said he had had a bad night with negative thoughts, but felt better as he was going to be with Mrs D for Christmas. He asked for sleeping tablets, which were arranged with the GP. D said he had an 'AK47' (automatic rifle), and he was advised to give it to his relatives/Police, but he refused to do so. The Community Psychiatric Nurse also discussed concerns about D's access to weapons with her line manager. D was contacted and asked to give the gun to someone in authority; he refused and said he would get rid of it at sea. The Community Psychiatric Nurse phoned a third time and D said he was much better, he had collected his medication and he had disposed of the weapon. The Consultant Psychiatrist was informed and an urgent appointment to see D was made for 18th December 2002. Mrs D was contacted by the line manager and advised of events. Mrs D could only recall a weapon that was left in Malta.

17th December 2002:

The Community Psychiatric Nurse contacted D and an appointment to see him was made for the following day. He subsequently cancelled this and the appointment with the Consultant. He stated he would prefer telephone contact and that was all that was required.

18th December 2002:

D phoned the Community Psychiatric Nurse; D said Mrs D had been advised about the threat of Carbon Monoxide poisoning and D's dangerous driving. D stated that Mrs D had been advised by staff to stay away. This concerned D, and he was advised to keep his appointment and see the Consultant that day.

21st December 2002:

D was admitted informally to the acute psychiatric admission ward in Truro. This followed threats of self-harm by Carbon Monoxide poisoning and dangerous driving. There was evidence of alcohol intoxication in the period leading up to admission.

22nd December 2002:

D was requesting to leave hospital but was persuaded to stay.

23rd December 2002:

D was demanding his discharge. The Consultant Psychiatrist made the first recommendation for detention under the Mental Health Act, as he considered D a high risk of harm to himself and his wife. The second medical recommendation was not made. This was considered by an Approved Doctor (D's GP for a number of years) and he decided D could not be sectioned.

Later on 23rd December 2002 D was reviewed by the psychiatric team at the ward round and was advised to stay in hospital. The team concluded they were no longer able to legally detain him. D subsequently took his own discharge against medical advice. The family was advised of the risks and appropriate Community Mental Health Team support was put in place.

28th December 2002:

D phoned the Out of Hours service, spoke to the Duty Community Psychiatric Nurse and said he was feeling alone and vulnerable. D agreed he was not suffering from Mental Health problems.

29th December 2002:

D phoned the Out of Hours service and spoke to the Duty Community Psychiatric Nurse who in turn spoke to Mrs D. The details of the contact were faxed to the GP and the Community Psychiatric Nurse.

2nd January 2003:

D was seen by the Community Psychiatric Nurse. He was feeling low and hated being alone. He was drinking alcohol heavily and was angry about Mrs D's intentions.

9th January 2003:

D was seen by the Community Psychiatric Nurse; the risk of excessive alcohol consumption was discussed, and occupational advice given. An appointment to see the Consultant Psychiatrist was made.

15th January 2003:

D was seen by the Consultant Psychiatrist. His mood was low and he admitted to excessive alcohol consumption. An arrangement to see a private Psychotherapist, which D wanted, was to be organised by the team Clinical Psychologist. He confirmed he and Mrs D had not made any efforts to seek marriage guidance.

24th January 2003:

D was seen by the Clinical Psychologist for initial assessment.

28th January 2003:

D was seen by the Community Psychiatric Nurse and requested to see the Psychologist again to see what form of therapy he and Mrs D could have. He requested phone contact only with the Community Psychiatric Nurse.

31st January 2003:

D and Mrs D were seen by the Clinical Psychologist, requested private psychotherapy, and a suitably qualified private Psychotherapist was suggested. This was confirmed to the Community Psychiatric Nurse.

13th February 2003:

D phoned the Community Psychiatric Nurse. Mrs D had told him it was a critical time regarding their future. He had seen two private Psychotherapists. He did not want further visits from the nurse and preferred phone contact as and when needed.

Later the nurse got a phone call from the GP surgery expressing concern about D's Mental Health. She phoned D who was tearful, but noted no change in his mental state. He was advised to keep occupied.

14th February 2003:

D was taken into custody at Newquay Police station, where he was arrested and cautioned. This followed a series of phone calls with threats to use a gun, and an armed siege that lasted throughout most of the previous night. He was not charged or referred to the Crown Prosecution Service and did not appear in Court. He was referred for Psychiatric assessment.

The Consultant Psychiatrist, who felt he was a danger to himself and his wife, made the first medical recommendation for detention under the Mental Health Act. The second recommendation was not made as the second Doctor (Police surgeon and Section 12 approved Doctor) decided D could not be sectioned; she was not aware of any risk to Mrs D. He agreed to be admitted informally to the admission ward in Truro, but on arrival he refused to stay, was not properly admitted and took his own discharge against medical advice.

He was persuaded to return to hospital and was taken to the Psychiatric Intensive Care Unit in Bodmin, where he was admitted informally. He had some periods of restlessness and pestered his relatives with phone calls. Other than this, his stay on this locked facility was relatively unremarkable.

17th February 2003:

D was requesting to leave hospital. Two Consultant Psychiatrists and the ward team reviewed him. He was considered a risk to himself and his wife. He did not show signs of mood disorder or psychosis. He was considered as not being detainable under the Mental Health Act and not requiring hospital treatment. His wife was advised of the risks and advised to obtain legal advice and to call the Police if threatened. The Police confirmed there were no outstanding

charges against him. His GP was informed of his discharge and Community Mental Health Team Support was put in place. He was discharged home later that day.

21st February 2003:

A letter was received by the Trust Clinical Psychologist confirming D was seen by his private Psychotherapist for an extended assessment.

11th March 2003:

D attended a discharge-planning meeting with the Consultant Psychiatrist, Clinical Psychologist, Community Mental Health Team Manager and Community Psychiatric Nurse/Care Co-ordinator. His mental state was noted to be stable and he was not clinically depressed. He had abstained from alcohol for over three weeks, he felt the worst of his crisis was over, and he was moving on. He was happy with his medication and agreed the commitment of his new private therapist made the Community Mental Health Team role redundant. He was happy to be discharged back to the care of his GP.

16th April 2003:

D's discharge letter was sent to his GP.

20th May 2003:

Mrs D found dead in London.

21st May 2003:

D found dead in Cornwall.

28th May 2003:

Coroner's Inquest into the death of Mrs D opened and adjourned at Southwark Coroner's Court in London.

29th May 2003:

Coroner's Inquest into the death of D opened and adjourned at Southwark Coroner's Court in London.

June 2003:

Internal Review commissioned by the Cornwall Partnership Trust.

21st October 2003:

Inquests into both deaths were held in London, at Southwark Coroner's Court. The findings were that between 20.30hrs on 19th May 2003 and 06.40hrs on the 20th May 2003, Mrs D was unlawfully killed at her home, following which, sometime late on 20th May 2003 or early on 21st May 2003, at his own home in Cornwall, D took his own life whilst the balance of his mind was disturbed.

Chapter 4

Summary of significant critical events:

This chapter outlines the Panel's assessment and judgement of key decisions made by others for the critical events.

1. On 19th November 2002 D was admitted to the Emergency Department in Treliske Hospital. He was in an alcohol-intoxicated state, he denied having taken an overdose and he denied having suicidal thoughts. He was monitored overnight in the Emergency Department. On the morning of 20th November 2002, when he was sober, he was assessed by a psychiatric liaison nurse and was discharged home.

   Comments:

   When the history and information that was available at the time is taken into account, this decision seemed appropriate. The decision-making process could have been enhanced by better communication and record keeping of the discharge arrangements.

2. Late in the afternoon of 20th November 2002, he was admitted to the same Emergency Department in an unconscious state. He was intoxicated with alcohol and had taken an overdose of tablets. He was treated in the Emergency Department and subsequently stabilised on the high dependency unit.

   On 22nd November 2002, following psychiatric assessment, he was admitted informally. The two medical recommendations for detention under the Mental Health Act were made, but the application was not made. Therefore D could not be legally detained under the Mental Health Act. This attempt to detain D under the Mental Health Act was not completed because he agreed to be admitted informally. He was admitted to a psychiatric admission ward in Bodmin Hospital.

   Comments:

   Given the particular circumstances, available history and information, the decision to admit informally was appropriate. The decision-making process could have been enhanced by a joint Mental Health Act team assessment, and an independent review of this incomplete Mental Health Act section attempt.

3. On 25th November 2002, following a settled and unremarkable period in a psychiatric acute admission ward, D was reassessed and discharged home at his request. He was supported by the family, with follow-up by the Community Mental Health Team.

Comments:

Based on the available history and information, the decision to discharge was appropriate on this occasion, and adequate support arrangements were put in place.

4. On 21st December 2002 D was admitted informally to the acute psychiatric admission ward in Truro. This followed threats of self-harm by Carbon Monoxide poisoning and dangerous driving. There was evidence of alcohol intoxication in the period leading up to admission. On 22nd December 2002 he was requesting to leave hospital, but was persuaded to stay.

On 23rd December 2002 he was demanding his discharge. The Consultant Psychiatrist made the first recommendation for detention under the Mental Health Act, as he considered D a high risk of harm to himself and his wife. The second medical recommendation was not made. This was considered by a Section 12 Approved Doctor (D's GP for a number of years) and he decided D could not be sectioned.

Later on 23rd December 2002 D was reviewed by the psychiatric team at the ward round and was advised to stay in hospital. However, the team concluded they were no longer able to legally detain him under the Mental Health Act. Subsequently D, against medical advice, took his own discharge. The family was advised of the risks, and appropriate Community Mental Health Team support was put in place.

Comments:

Based on the available history and information, the decision not to section and detain under the Mental Health Act, and D's subsequent discharge against medical advice, were appropriate on this occasion. The decision-making process could have benefited from a joint Mental Health Act team assessment, and an independent review of this incomplete Mental Health Act section attempt.

5. On 14th February 2003 D was taken into custody at Newquay Police station, he was arrested and cautioned. This followed a series of phone calls, which involved threats to use a gun. There was also an armed siege at his home that lasted throughout most of the previous night. He was not charged or referred to the Crown Prosecution Service and did not appear in Court. He was referred for psychiatric assessment.

The Consultant Psychiatrist, who felt D was a danger to himself and his wife, made the first medical recommendation. The second recommendation was not made, as the second Doctor (Police surgeon and Section 12 approved Doctor) decided he could not be sectioned; she was not aware of any risk to Mrs D. D agreed to be admitted informally to the psychiatric admission ward in Truro.

On arrival he refused to stay, was not properly admitted and took his own discharge against medical advice. He was persuaded to return to hospital and was taken to the Psychiatric Intensive Care Unit in Bodmin, where he was admitted informally. He had some periods of restlessness and pestered his relatives with phone calls. Other than this, his stay on this locked facility was relatively unremarkable.

On the 17th February 2003 D was requesting to leave hospital. Two Consultant psychiatrists and the ward team reviewed him. Although he was considered a risk to himself and his wife, he did not show signs of mood disorder or psychosis. He was not considered detainable under the Mental Health Act, and did not require hospital treatment. Mrs D was advised of the risks, and was advised to obtain legal advice and to call the Police if threatened.

The Police confirmed there were no outstanding charges against him. His GP was informed of his discharge and Community Mental Health Team Support was put in place. He was discharged home later that day.

Comments:

Based on the available history and information, the decision not to section and detain under the Mental Health Act, and D's subsequent discharge, were appropriate on this occasion. The decision-making process could have been enhanced by D being

charged and put before the courts. The decision-making could have benefited from a joint Mental Health Act team assessment and an independent review of this incomplete Mental Health Act section attempt.

6. **Discharge Meeting**

The discharge-planning meeting between D and the Community Mental Health Trust was held on 11th March 2003. D, Consultant Psychiatrist, Clinical Psychologist, Community Mental Health Trust Manager and the Community Psychiatric Nurse/Care Co-ordinator attended this meeting. The team noted and recorded that D's mental state was stable and he was not considered to be clinically depressed. D had abstained from alcohol for over three weeks, and stated that he felt the worst of his crisis was over and that he was moving on. D was happy with his medication and agreed that the commitment of his new private therapist made the Community Mental Health Trust role redundant. He was happy to be discharged back to the care of his GP. The Community Psychiatric Nurse completed the discharge letter to the GP one month after the meeting.

Comments:

Based on the available history and information, and D's presentation at the meeting, the decision to discharge back to the care of the GP, with the provision of support by 'private therapist', was appropriate. The decision-making process could have been enhanced by the Consultant Psychiatrist completing the discharge letter, and the letter being sent to the GP within a shorter timescale.

7. **Deaths**

On 20th May 2003 Mrs D was found dead in her apartment in London. She had been unlawfully killed. On 21st May 2003 D was found dead in the barn at his home. He had taken his own life whilst the balance of his mind was disturbed.

Comments:

Both of these deaths occurred within a relatively short period of time and without any warning. They could not have been predicted or prevented at the time. All reasonable efforts to trace, contact and protect others were made.

Chapter 5

General Findings Summary Analysis

The content of this chapter reflects the views and comments that were made to the Panel. These findings do not reflect the Panel's considered opinion. They were, however, used by the Panel as key evidence, which was subject to analysis and debate. The considered opinion of the Panel is outlined in Chapter 8.

This chapter captures the key points from the relevant body of evidence that was submitted to the Panel. This was obtained from a range of interviews, meetings, briefings, questionnaires and visits. The complete list of these activities is outlined in Appendix 2. Some points are contradictory and reflect different views of interviewees.

The key points in this chapter are supplementary and complementary to the analysis of NHS clinical files (5), Police records (44), Coroner's records (2), and the Internal Review.

In addition, this chapter contains summaries of key information and research on suicide and homicide in Cornwall, and on education and training in the Cornwall Partnership Trust.

Key Point Summary:

The key points below are listed to reflect the majority of views captured, and are not reproduced in any priority order. They are based on the expressed views of individuals who were seen and on submissions that were received by the Inquiry Panel. They reflect how certain people regarded D and services at different times. They are not definitive and not conclusive.

To avoid repetition the number in brackets at the end of each point represents the number of individuals who expressed this or a distinctly similar view. The percentages have been rounded up or down to the nearest 0.5%.

There were over 60 (100%) individual contributions to the Inquiry process.

1. Training, awareness and access to key guidance need review. (26) (43%)
2. Interviewees did not see the internal review report. (23) (38%)

3. The transcripts and statements produced were not seen and commented on by interviewees. (23) (38%)
4. Quality of content and input to meetings varies. (16) (26%)
5. Interdisciplinary communication in the Partnership Trust could be improved. (16) (26%)
6. Access to notes and record-keeping is a problem. (14) (23%)
7. Policy manuals are not practical. (14) (23%)
8. D was not detainable under the Mental Health Act. (14) (23%)
9. Inter-agency communication in Cornwall could be improved. (13) (21.5%)
10. D had significant levels of Health and Police Service support. (12) (20%)
11. Team assessments would be safer and better. (12) (20%)
12. Resources are a problem. (11) (18.5%)
13. D was a risk to himself and his wife. (11) (18.5%)
14. D should have gone to court and been prosecuted for threats and weapons. (11) (18.5%)
15. There is confusion about the roles of certain service areas. (10) (17%)
16. Most D incidents were manipulative; he was very resourceful. (9) (15.5%)
17. D had no psychiatric history. (9) (15.5%)
18. The deaths were not preventable. (9) (15.5%)
19. Criminal Justice System should be more involved. (8) (14%)
20. Hospitalisation was not conducive to a therapeutic relationship with D. (8) (14%)
21. Stigma and prejudice about mentally ill people affects decisions. (8) (14%)
22. Risk threshold, for managing escalating risk, was high in the area. (8) (14%)
23. D's professional status and social background influenced decision-makers. (8) (14%)
24. Heads of profession should be more involved in practice and policy. (8) (14%)
25. D had an Attachment Disorder, had a superior attitude and was hostile. (7) (11.5%)
26. Responsibility for D was shared, and authority to act was delegated. (7) (11.5%)
27. Alcohol intake affected his mood and behaviour. (6) (10%)
28. Clinicians are demoralised and disempowered. (6) (10%)
29. D had a personality disorder. (5) (8.5%)
30. People, certain women in particular, felt unsafe around him. (5) (8.5%)
31. The first D episode was alcohol intoxication not an overdose. (4) (6%)
32. Escorting D by car ambulance from casualty to the acute admission psychiatric ward was good practice. (4) (6%)
33. History of domestic violence in this case was not significant. (4) (6%)
34. D was detainable under the Mental Health Act. (3) (4.5%)

Suicide & Homicide in Cornwall Research Summary:

In producing this report it was considered important to use national (*Safety First*) and local (this report) research data, and relate the same to this case. It is essential that the reader put this case in its proper context and perspective.

At the request of the Inquiry Panel Chair a report was commissioned by the South West Peninsula Strategic Health Authority, and draws on data from Cornwall Partnership Trust's 'Suicide Database', the National Confidential Inquiry Report '*Safety First*' (2001), and the Office of National Statistics. This summary highlights some of the key differences between data specific to Cornwall and the Isles of Scilly, and corresponding national data. The full report, summarised in this section, will be disseminated by the Strategic Health Authority to all appropriate statutory organisations.

Suicides

Data relating to 'Inquiry cases' for the initial Inquiry Period, April 1996 to March 2000, was compiled by Cornwall Partnership Trust's Audit Department in their Suicide Database, and national data was compiled by the *Safety First* Inquiry. A comparison of these sources reveals that there were a number of notable differences between Cornwall and the Isles of Scilly, and the remainder of England and Wales

Suicide was much more common amongst Cornish female 'Inquiry cases' than nationally, with women making up 45.83% of suicides who had been in contact with Mental Health Services in the year leading up to their death. Nationally the equivalent figure was just 34.17%. Put simply, women make up just over a third of all Inquiry suicides nationally, whereas in Cornwall and the Isles of Scilly, they make up nearly half.

The data shows a higher incidence of suicide amongst older female 'Inquiry cases' in Cornwall and the Isles of Scilly compared to England and Wales. The most marked difference was in the 65 – 74 age range, which made up 13.86% of total Inquiry suicides locally, compared to the national figure of 4.01%.

National data from both the Office of National Statistics and the *Safety First* Inquiry report shows that the national suicide rate peaks in younger men (6.66% of National Inquiry cases were aged under 25; 18.15% were aged between 25 – 34). However, in Cornwall and the Isles of Scilly the rate amongst younger male Inquiry cases is markedly lower than the national one (2.78% under 25; 12.5% between 25 – 34).

This trend is reversed in middle-aged male Inquiry cases aged 45 – 64, where the local suicide rate was higher than the national one. 15.28% of total local Inquiry suicides were males aged between 45 - 54, compared with 12.51% nationally. Locally, 9.72% were males aged between 55 – 64, compared with 6.81% nationally. Added together, local suicides of Inquiry cases between 45 – 64 make up 25%; exactly one quarter, of the total. This compares to 19.32% nationally.

Both these patterns can be seen consistently in the general population data released by the Office of National Statistics (Part 4 of the report).

The most common method of suicide in Cornwall and the Isles of Scilly amongst Inquiry cases was poisoning / overdose, whereas nationally hanging is the most common method.

Fewer suicides occurred amongst those who had been in contact with Mental Health Services in the last week of their life in Cornwall than nationally. In Cornwall and the Isles of Scilly 15% of suicides occurred within 24 hours of contact, compared to 19% nationally; and only 23% occurred within a week of contact, compared to 48% nationally.

Homicides

Based on date of conviction, there were four Inquiry homicide cases in the Cornwall Partnership Trust area between the years 1997 and 2001. The *Safety First* Inquiry team reports that the perpetrators were predominantly male.

However, more detailed information on the profiles of the four perpetrators was not available for release, due to the small size of the figure involved. The Inquiry's policy, in line with the Data Protection Act, is to release information only in aggregates, due to issues of potential patient indentifiability. The numbers for Cornwall did not make up a sufficiently large aggregate to allow the release of further information. Indeed any form of analysis done on figures so small

would not have been either statistically or clinically significant; no robust conclusions about trends could have been drawn from such figures.

According to figures from the Office of National Statistics, within the general population of Cornwall and the Isles of Scilly, there were 133 murders committed between the years 1997 and 2001. Of the victims, 73 were male and 60 were female.

Four of these 133 homicides were committed by 'Inquiry cases' (patients of Mental Health Services). This figure represents 3% of total homicides in Cornwall and the Isles of Scilly for the period 1997 – 2001. This compares favourably with the national figures. In England and Wales, 9% of all perpetrators had been in contact with Mental Health Services within the year prior to committing murder, and at least 18% had been in contact with Mental Health Services at some point in their lives.

Education and Training Summary Analysis

As required by the Terms of Reference (see Appendix 1), the Inquiry examined the level of education and training. This was completed through analysis of submissions and records. In addition, individuals were asked to complete a questionnaire (see Appendix 6). This was based on the relevant reference material (Appendix 3) that was used by the Panel.

Forty questionnaires were completed on the key guidance used by the Panel, in particular, those highlighted in Chapter 7 and Appendix 3. The summary analysis is listed below.

The majority of those interviewed, and others who completed questionnaires, had:

1. Insufficient training on policies and guidance.
2. Insufficient guidance and reference material available in the work place.
3. Insufficient level of awareness of, and familiarity with, guidance and reference material relevant to services and staff who manage clinical cases in Mental Health care.

All interviewees were clear and familiar with their legal, statutory and professional responsibilities.

CHAPTER 6

Care and Service Delivery Summary Analysis

These findings were produced from detailed analysis of NHS clinical files (5), Police Records (44), Coroners Records (2), and the Internal Review. As in chapter 5 these initial findings were considered in depth by the Panel and were the subject of considerable debate and further analysis.

The summary findings under each heading as listed below should not be taken as a set of given opinions or considered out of context from the rest of this report. As with chapter 5, the considered opinion and conclusions of the Panel's work is contained in chapter 8.

Service and Care Delivery Issues:

1. The transfer of client care between the Acute Hospital Trust and the Partnership Trust is currently managed through processes that have evolved out of custom and practice. Formal multi-agency guidelines on the safe management, transfer of care, and sharing of information is required to provide staff with clarity and guidance in line with best practice, safety and operational policy.
2. Working in partnership, the Partnership Trust, the Ambulance Trust and the Hospital Trust, should review the *Patient Transfer Policy* to provide clarity and consistency in the safe transportation of patients/clients between sites. See Appendix 4.
3. Managers and Clinicians of the Partnership Trust should familiarise themselves with, and act in accordance to, the content and guidance within the Partnership Trust's *Bed Management Policy.*

Risk Escalation

1. The Partnership Trust, Ambulance and Police need to ensure that their Serious Untoward Incident and Risk Escalation Policies are robust and implemented.
2. Within the Partnership Trust the Serious Untoward Incident policy has been revised, and provides a robust mechanism for reporting Serious Untoward Incidents and "near misses" to executive management. The policy clarifies the timescales for investigation and learning from experience. The awareness of all clinical staff needs to be raised in relation to the existence and execution of this policy, and lessons learned should be shared within and outside the organisation, as necessary.

3. Multidisciplinary Team meetings need to ensure that risk is assessed, recorded and the record scrutinised for patterns of risk escalation.
4. Risk assessment and management tools need to be developed with reference *to 'Safety First'* (DoH 2001). See Appendix 5.
5. The threshold of the Management of Risk needs to be reviewed to ensure that appropriate clinical, managerial and multi-agency sharing of risk takes place.

Rota Handover

1. The Care Co-ordination of patients during periods of leave and absence should ensure contact is provided for high-risk patients, and managed by the team.
2. The handover between medical, inpatient and out of hours services needs to be clarified.
3. Handover between Responsible Medical Officers, Locums and on-call Doctors needs review.

Emergency Department

1. Within the Emergency services of the Acute Trust, a formal process is required for identifying, documenting and communication of:
    - Roles and responsibilities of physicians, junior doctors, nursing staff and specialist staff within the emergency department, particularly in respect to decision making around discharge for patients presenting similar to D.
    - Assessment, and timing of assessments, of individual's risks arising from intoxication.
2. A review of understanding amongst staff within organisations with regard to clarity, consistency and duty of information sharing within and across organisations.

General Practitioner

1. The recording of locum and out of hours primary care contact should be improved.
2. GP records are a useful source of information.
3. All GPs should consider training themselves up to the level of Section 12 approved Doctors. Refresher training should be undertaken by current Section 12 approved Doctors who conduct Mental Health Assessments.
4. The development of a local programme for the additional training and availability of Section 12 General Practitioners.

Care Programme Approach

The Partnership Trust is implementing a range of recommendations that have been developed following an independent review of its policy and practice in relation to the Care Programme Approach. This process of implementation needs to include:

1. Clarity regarding the allocation of cases, including a clear rationale for the allocation decision, and in particular the importance of the Care Co-ordinator role being taken on by all members of the Community Mental Health Team. No professional groups should be able to exclude themselves from becoming Care Co-ordinators.
2. A continuous process of audit and supervision to provide assurance that Care Plans are reviewed and updated in the light of new information.

Record Keeping

1. The Partnership Trust's *Record Keeping Policy* provides clear standards for documentation within patient health care records, in line with the Nursing and Midwifery Council and the Medical Defence Union. Such standards should be consistent across all organisations within the National Health Service.
2. An individual practitioner's standard of record keeping/documentation should be reviewed and discussed at supervision sessions to ensure contemporaneous records are kept, and that each entry is dated, timed, signed and legible.
3. Contemporaneous record keeping should include verification of the sources of information recorded, to ensure consistency and accuracy of information gathering and sharing.
4. Where health care records are unavailable to provide Clinicians with the necessary information to make an informed decision/diagnosis, a 'near miss' event should be reported.
5. Guidance to the patient/client clinical risk assessments is available in the Partnership Trust's *Care Plan Approach.* Risk assessment should be conducted as described within the guidelines, and be a comprehensive account of the initial and subsequent assessments.
6. Clarity should be sought within agencies for the safe storage of any suicide letter/note that may be obtained during the course of care, treatment or review.
7. There should be a review within the Partnership Trust of the process for ensuring the unified healthcare records are available in a timely manner to staff within a multi-disciplinary team.

8. The Strategic Health Authority to provide guidance and policy for the sharing of information between healthcare professionals and private therapists.
9. A multi-agency policy between Cornwall Hospital Trust, Police, Ambulance Trust, Criminal Justice System, Primary Care Trusts, and General Practitioners should be developed for the sharing of information, particularly with regard to the escalation of identified clinical and non-clinical risks.

Inter-Agency

1. Active Learning and simulation exercises should be developed and run.
2. Roles and responsibilities of custody officers, crown prosecutors and Mental Health assessment staff need clarity.
3. Access to the Police log by the Mental Health assessment team would be helpful.
4. The Police and Crown Prosecution Service procedures for escalation following significant incidents involving Mental Health Service users should be reviewed.

Weapons

1. Description, ownership, and legal status of weapons should be recorded and verified.
2. Multi-agency policy for dealing with weapons and reporting on disposal should be developed between statutory agencies.
3. Multi-agency policy for removing firearm certificates should be developed.
4. Action is required when the possession of firearms and homicide risk are identified.

Audit

1. Senior Clinical Review of non-completed Mental Health Act Assessments should happen within 72 hours.
2. There should be a mechanism for reviewing Section papers not progressed, as there is for reviewing completed Section applications.

Mental Health Act

1. There should be a review process for Mental Health Act assessments that do not result in detention.
2. There is a sense of disempowerment of Consultant Psychiatrists when sections are not sustained.

3. Clarify role of Approved Social Worker in leading assessment.
4. Implement joint assessments as routine.

Team

1. All care providers, within and external to the multi-disciplinary team, must be accountable for their involvement, attendance and communication with regards to sharing information, problem solving and care planning of individual patients/clients.
2. Team meetings and multi-disciplinary meetings should have clear terms of reference and identified membership.
3. Ward rounds, team meetings and multi-disciplinary meetings should be recorded and minuted for monitoring, auditing and assurance purposes.
4. Team managers should ensure that team meetings, debriefing sessions and reflective practice meetings are seen as an essential part of team building, risk management and staff development; and that staff attendance and active participation is seen as a priority. Managers and leaders should attend clinical meetings on a regular basis, to provide support and input appropriately.

Leadership

1. Identify Clinical Leadership in Mental Health team meetings, ward rounds, and Community Mental Health Teams.
2. Identify responsible Consultant Psychiatrist for patients in service units e.g. ward, Community Mental Health teams, specialist teams.
3. Clarify who has the deciding opinion on diagnosis and care planning and review process for deciding this.
4. Clarify roles of clinical Professional Heads of Medicine, Nursing Psychology, and Social Work within Trust management structure.
5. Clarify clinical supervision arrangements, and time for review, reflection and management input within ward rounds, Multi Disciplinary teams and Community Mental Health Teams.

Planning

1. Identify Policy for conducting risk assessment for environmental safety.
2. Mandate clear contingency planning to be recorded after Risk Assessments.

3. Risk Assessment should be issue-specific and time bound.

Unusual Patient

1. The Partnership Trust needs to ensure that its policy and practice enables staff to identify when their decisions may be influenced by service user's social standing, wealth or professional status.
2. Consideration needs to be given to a process that enables an overview to be maintained of the 'unusual patient', through individual and team supervision, calling on expertise outside the immediate team.
3. The Commissioners of services, the Partnership Trust and the Health and Social Care community, need to address the issue of stigma associated with the use of Mental Health facilities and services, enabling service users to be comfortable with the services provided.
4. A logistical difficulty in the provision of the right bed, in the right place, at the right time needs to be regularly reviewed.
5. The Commissioners of services, the Partnership Trust and statutory services need to review the current provision for service users identified as having a personality disorder, and ensure that there is a range of appropriate services in place to meet needs.

Notable Practice

1. The level of Health and Police involvement demonstrated that agencies fulfilled their duty of care and showed a desire to be helpful to both D and Mrs D.
2. The standard of medical assessments, in the Emergency Department and in Mental Health Wards, was of high quality.
3. The Psychiatric Liaison Nurses' initiative in escorting the patient from Emergency Department to the Mental Health Unit was commendable.
4. The level of persistence of the Community Mental Health Team support to both D and Mrs D was praiseworthy and reflected a professional desire to be of service.
5. The contact of D via his mobile phone was insightful.
6. The use of GP electronic records by the Community Mental Health Team is to be complimented.
7. The practice of staff in the Mental Health unit checking with the Police for outstanding charges was good practice.

8. The advice given to Mrs D by a range of individuals in respect to risk was clear and is commended.
9. The quality of report and expertise of the Internal Review team was of a high standard. This expertise needs to be harnessed and disseminated accordingly.
10. The projects to develop unified and electronic patient records, electronic Care Programming, and electronic dissemination systems for learning from experience, are commendable and need to be supported as a priority.
11. The weekly executive Serious Incident meetings are commendable.

Chapter 7

Review of Guidance and Reference Material

This chapter reviews the specific guidance and reference material relevant to this case and service provision in Mental Health. As with previous chapters, it is essential that the reader consider this section before considering the final conclusion. It is important that the legislative and statutory framework is understood so that this case is put in context.

Other relevant extracts and detailed reference sources for each Guidance and Reference document used in the course of this Inquiry are contained in Appendix 3.1 and 3.2. Extracts taken directly from published reports are reproduced in shaded boxes.

The Cornwall Partnership Trust, the Primary Care Trusts, the Strategic Health Authority, the Hospital Trust, the Criminal Justice Agency Group and Local Criminal Justice Board (L.C.J.B), should study and review these reports (see Appendices 3.1 and 3.2). A special annual conference may be the best way for reviewing cases, reports and guidance.

1. Mental Health Act 1983 Code of Practice

Guiding Principles

The detailed guidance in the Code needs to be read in the light of the following broad principles, that people to whom the Act applies (including those being assessed for possible admission) should:

1. *Receive recognition for their basic human rights under the European Convention of Human Rights (ECHR);*
2. *Be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics;*
3. *Have their needs taken fully into account, though it is recognised that, within available resources, it may not always be practicable to meet them in full;*
4. *Be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people.*

5. *Be treated and cared for in such a way as to promote to the greatest practicable degree their self determination and personal responsibility, consistent with their own needs and wishes;*
6. *Be discharged from detention or other powers provided by the Act as soon as it is clear that their application is no longer justified.*

General

This chapter is about the roles and responsibilities of ASWs and doctors when making assessments of the needs of a person with Mental Health problems where the assessment may lead to an application for admission to hospital under the Act. An individual should only be compulsorily admitted if the statutory criteria are met and other relevant factors have been considered as set out below. A decision not to apply for admission under the Act should be supported, where necessary, by an alternative framework of care and/or treatment. The decision should also be clearly recorded in the patient's medical notes.

Doctors and ASW's undertaking assessments need to apply professional judgement and reach decisions, independently of each other but in a framework of co-operation and mutual support.

Good working relationships require knowledge and understanding by the members of each profession of the other's distinct role and responsibilities. Unless there are good reasons for undertaking separate assessments, assessments should be carried out jointly by the ASW and doctor(s). It is essential that at least one of the doctors undertaking the medical assessment discuss the patient with the applicant (ASW or nearest relative) and desirable for both of them to do this.

Everyone involved in this assessment should be alert to the need to provide support for colleagues, especially where there is a risk of the patient causing physical harm. Staff should be aware of circumstances where the Police should be called to provide assistance, and how to use that assistance to minimise the risk of violence.

Chapter 2 – Assessment

2.3. *Doctors and ASW's undertaking assessments need to apply professional judgment, and reach decisions, independently of each other but in a framework of co-operation and mutual support. Good working relationships*

require knowledge and understanding by members of each profession of the others distinctive role and responsibilities. Unless there are good reasons for undertaking separate assessments, assessments should be carried out jointly by the ASW and Doctor(s). It is essential that at least one of the doctors undertaking the medical assessment discusses the patient with the applicant (ASW or nearest relative) and desirable for both of them to do this.

2. **Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001)**

Suicides under Mental Health Services

Approximately one quarter of suicides in England and Wales, Scotland and Northern Ireland had been in contact with Mental Health Services in the year before death; this represents around 1,500 cases per year.

Mental health teams in England and Wales regarded 22% of the suicides as preventable, with lower figures in Scotland and Northern Ireland, but around three-quarters identified factors that could have reduced risk, mainly improved patient compliance and closer supervision.

Mental health teams more often regarded in-patient suicides as preventable.

Twenty-three percent of suicide Inquiry cases in England and Wales, 26% of cases in Scotland and 30% of cases in Northern Ireland died within three months of discharge from patient care. Post-discharge suicides were at a peak in the first 1-2 weeks following discharge.

Homicides in General Population

Around a third of all perpetrators of homicide had a diagnosis of mental disorder based on life history; the most common diagnosis were alcohol dependence, drug dependence and personality disorder.

Nine per cent of all perpetrators in England and Wales had been in contact with Mental Health Services in the year before the offence. At least 18% had been in contact with services at some time. In Scotland, the corresponding figures were substantially higher, at 18% and 29%. These figures represent around 55 cases per year with contact in the previous year.

Around 20 people per year were reported to have committed suicide after homicide and before conviction; only 7% of these were known to have been in contact with Mental Health Services.

Twelve Points to a Safer Service

- *Below we list what we consider to be the most important clinical recommendations. This is intended as a checklist for local services.*
- *Staff training in the management of risks – both suicide and violence – every 3 years.*
- *All patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care.*
- *Individual care plans to specify action to be taken if patient is non-compliant or fails to attend.*
- *Prompt access to services for people in crisis and for their families.*
- *Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients.*
- *Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side effects.*
- *Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service.*
- *In-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails.*
- *Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months.*
- *Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks.*
- *Local arrangements for information sharing with criminal justice agencies.*
- *Policy ensuring post-incident multi-disciplinary case review and information to be given to families of involved patients.*

3. Suicide in Cornwall

This specially commissioned confidential report, requested by the D Independent Inquiry and commissioned by the South West Peninsula Strategic Health Authority, should be studied and reviewed, in conjunction with *Safety First,* by Cornwall Partnership Trust, Strategic Health Authority & Local Criminal Justice Board.

4. The Duties of the Medical Director

In reviewing clinical and professional leadership issues, the Partnership Trust should consider this report and others with regard to Nursing, Psychology and Social Work.

The Medical Director of a NHS Trust holds one of the most influential positions within the Health Service. A challenging and demanding job to take on, the Medical Director has a unique opportunity to shape and steer, to develop and enhance the clinical service delivered by the Trust.

Real change, improvement and development of clinical services cannot happen in remote offices, or high-powered committees. Real change happens in clinical teams, working together, listening to the needs of patients and their carers. The Medical Director has a real and legitimate duty to bring about a culture within the Trust that embraces precisely this approach to change and development of patient services.

Range of specific Responsibilities for Clinical Leaders

- *Clinical governance – quality of clinical care, clinical performance of the medical workforce, clinical standards and risk management, continuing professional education and training, complaints and litigation, processes for performance improvement.*
- *Designing the clinical service configuration, strategy, delivery and performance of the service.*
- *Planning and developing the clinical workforce – ensuring that an effective appraisal process is in place for all clinicians, disciplinary matters, responsibility for clinical staffing, continuing professional development, clinical appointments.*
- *Research and development.*
- *Education and training.*

- *Information systems and quality of information, particularly as it impacts upon clinical performance, both organisational and individual.*
- *Confidentiality issues.*

The role is a key clinical leader and champion of change within the organisation. It is one of the most complex and challenging roles within the Trust, and the skills required to do the job well are considerable.

With the evolution of an explicit multi-disciplinary team-working ethos the Clinical heads and Leaders need to increasingly be working very closely with other healthcare professional leaders of clinical services.

5. **Seven steps to patient safety: Full reference guide produced by the National Patient Safety Agency 2004**

Seven steps to patient safety:

- *Step 1: Build a safety culture – create a culture that is open and fair.*
- *Step 2: Lead and support your staff – Establish a clear and strong focus on patient safety throughout your organisation.*
- *Step 3: Integrate your risk management activity – Develop systems and processes to manage your risks and identify and assess things that could go wrong.*
- *Step 4: Promote reporting – Ensure your staff can report incidents locally and nationally.*
- *Step 5: Involve and communicate with patients and the public – Develop ways to communicate openly with and listen to patients.*
- *Step 6: Learn and share safety lessons – Encourage staff to use root cause analysis to learn how and why incidents happen.*
- *Step 7: Implement solutions to prevent harm – Embed lessons through changes to practice, processes or systems.*

6. **The Code for Crown Prosecution, published by CPS in 2000**

Each case is unique and must be considered on its own facts and merits. However, there are general principles that apply to the way in which Crown Prosecutors must approach every case.

Crown Prosecutors must be fair, independent and objective. They must not let any personal views about ethnic or national origin, sex, religious beliefs, political views or the sexual orientation of the suspect, victim or witness influence their decisions. They must not be affected by improper or undue pressure from any source.

It is the duty of Crown Prosecutors to make sure that the right person is prosecuted for the right offence. In doing so, Crown Prosecutors must always act in the interest of justice and not solely for the purpose of obtaining a conviction.

It is the duty of Crown Prosecutors to review, advise on and prosecute cases, ensuring that the law is properly applied, that all relevant evidence is put before the court and that obligations of disclosure are complied with, in accordance with the principles set out in this Code.

7. **Multi-Agency Audit Report: Referrals into Children's Services. An example of the sort of report that might benefit cases like this could be produced under the emerging policy work for vulnerable adults.**

8. **Domestic Violence – Policy for Prosecuting Cases of Domestic Violence, Published by CPS 2001.**

We regard domestic violence as particularly serious because there is often a continuing threat to the victim's safety and, in the worst cases, the victim's life and the lives of others (including children's) may be at risk.

There is no statutory offence in domestic violence, as such. "Domestic violence" is a general term to describe a range of behaviour often used by one person to control and dominate another with whom they have, or have had, a close or family relationship.

"Any criminal offence arising out of physical, sexual, psychological, emotional or financial abuse by one person against a current or former partner in a close relationship, or against a current or former family member"

9. Devon & Cornwall Local Criminal Justice Board, Published Jan 2004

Local Criminal Justice Boards

Local Criminal Justice Boards (LCJB's) bring together the chief officers of the CJS agencies. Accountable for local targets and working together to improve the whole of the CJS in their area, the local boards are a landmark in developing solutions across the whole of the system.

If someone with Mental Health or learning difficulties is arrested, the Police will ask an 'appropriate adult' – like a parent or social worker – to sit in on the interview. Likewise, an appropriate adult is required if a juvenile is arrested. Members of the Youth Offending Team may also be called in to offer advice and support.

Once the investigation is complete, the Police will either:

- *Charge the suspect*
- *Summon them to return at a later date*
- *Give them a formal warning (a caution)*
- *Release them.*

Currently, the Police handle charging in consultation with the Crown Prosecution Service (CPS). In future, however, the CPS will take most charging decisions.

There are three types of cases that come to Magistrates' courts:

- *Summary offences – where the defendant is not entitled to trial by jury. These offences include motoring offences and minor offences.*
- *Either-way offences – where the defendant can be tried either at the Magistrates' Court or the Crown Court. Such offences include theft and handling stolen goods.*
- *Indictable-only offences – such as murder, manslaughter, rape and robbery, which must be heard at Crown Court.*

Chapter 8

Conclusions, Recommendations and Commendations

Overall Conclusion

Two views emerged from the Inquiry Panel's initial debate and analysis of this case. On the one hand, those with Mental Health clinical backgrounds understood that many of the factors identified were likely to be general to the method of operating of the Partnership Trust. On the other hand, other Panel members held the view that D's suicidal ideation meant there was a duty of care from Mental Health Services.

The factors identified would have impacted on most, if not all, patients in the care of various parts of the service over the period concerned. It was difficult to identify specific areas that were relevant to the very peculiar risk of suicide and homicide.

It was discussed that suicide more commonly occurs in people not in contact or in recent contact with Mental Health Services. Evidence was presented that in 20 (100%) homicides committed nationally, by people in contact with Mental Health Services, in any one year period, less than 2 (7%) per year on average go on to commit suicide.

The Panel considered the nature of the Mental Health Act 1983 and the associated Code of Practice. Two key points of debate emerged. Firstly, the Act requires the presence of, or suspected presence of, a mental disorder of a nature or degree that could be treated. (The issue of harm to self or others, threatened or actual, is considered separately). In isolation, the intention to self-harm or to harm other people does not automatically mean that the Mental Health Act could, or should, operate.

The Panel gave careful consideration to the three attempts to assess and detain D under Section II of the Mental Health Act 1983. Reference by some interviewees to a perceived failure to detain is common to the testimony supplied to the Inquiry. Each assessment and attempt to detain should be viewed as a separate entity. The fact that the same conclusion was arrived at on three separate occasions is significant.

It is a concern that those taking part in assessments did not always meet with the patient at the same time. Whilst the availability of information to each of the assessors may not have been

complete, with the benefit of hindsight it is unlikely that a poor decision was made in regards to his detention. It is significant that D was able to present himself differently, to different agencies, at different times. It is likely that, had he been detained under the Act, he would have been successful at appeal.

It was considered how an earlier detention of D might have affected the overall outcome. It was considered that coercing him through the use of the Mental Health Act might have precipitated his suicide. It was also considered that, had he not been found and subsequently resuscitated, he would have completed suicide.

The review Panel debated a number of occasions when a 'near miss' may have occurred. These events were not regarded as 'near misses' at the time. They may have represented missed opportunities for potential support and supervision, which may have resulted in action by relevant agencies to reduce those risks posed at that time.

Expert advice suggested D's mood appeared at times normal, high or low, and varied between observers. His mood was variously described as reactive, tearful or with laughter. It is considered that alcohol acted as a depressant, and would have also impacted negatively on the effectiveness of his anti-depressant. His anti-depressant was unlikely to have contributed to suicidal thinking or impulsivity. The co-prescription of risperidone (an antipsychotic drug) was most likely to be reducing emotional lability and impulsivity. He was unlikely to have been experiencing Akathisia (a severe mental restlessness associated with suicidal behaviour); there was no evidence to support this.

The Panel debated the nature of Adjustment Disorder, and the final diagnosis of two Consultant Psychiatrists that D had an Adjustment Disorder with obsessional and narcissistic personality traits. It was concluded that it would have been unusual to detain someone under the Mental Health Act for assessment and management of these conditions.

It was considered an appropriate strategy for managing Adjustment Disorder to offer support through psychotherapy and counselling over a prolonged period of time to help the individual to develop and adjust to new situations. It was recognised that further options existed within the services at that time, specifically anger management. D exercised user choice in preferring a

private psychotherapy route, and the Mental Health team, in the interest of protecting that therapeutic alliance, accepted this. It was noted that D returned to some form of equilibrium with his therapists and his wife after his discharge from the Community Mental Health Team. D and Mrs D enjoyed over 25 years of consistency in their relationship, had been gainfully employed, had raised children, and had a number of friends. Whilst the term 'psychopathic personality' was considered previously for D, it cannot have been severe, as there is clear evidence of him having formed relationships.

The Panel noted clear and consistent advice to Mrs D that D was a risk to her. The Panel also noted at least four other women in his life, relatives and therapists, who felt at risk of harm from D, especially after they heard of the death of Mrs D. It was clear that there existed significant dependency issues between both Mrs D and D. This meant it proved very difficult for Mrs D to leave D, to the extent that after she had decided to leave him and had left to set up a home in London, she worried what she would do if he went abroad to live and work in South Africa.

After considerable debate and analysis of the available information, the Panel reached a consensus that there were some areas of practice, in terms of NHS organisations and to a lesser extent the Criminal Justice System, which could have strengthened communication and risk management. None of these in themselves would have been likely to prevent the outcome. To the contrary, the balance of factors responsible for the outcome seemed to lie with D and Mrs D.

Much sympathy was expressed for the hurt and anguish experienced by the bereaved family and the health professionals who had been involved in D and Mrs D's care. It is hoped that, by addressing the issues in this Inquiry report, better understanding for the family could be arrived at, and a more secure sense of closure is achieved for the health and other professionals involved.

The Inquiry Panel concluded that it was highly likely that these tragic deaths could <u>not</u> have been prevented. Deaths in particular circumstances such as this case are extremely rare.

Nationally an average of three people every two years commit homicide and suicide in circumstances similar to D. Both D and Mrs D were known to the Police and Health Service for a relatively brief period of their lives. There was no evidence of a Psychiatric diagnosis in either

case, and no Psychiatric history or history of Mental Health Care before November 2002. With the agreement of clinicians, D and Mrs D had disengaged with NHS health care, and decided to pursue private therapy. D and Mrs D were not involved with Mental Health Services at the time of their deaths in 2003 and had not been significantly involved for three months before then. Inevitably, in Inquiries such as this, there are lessons to be learnt and room for improvement is identified. It is most important that the Panel's conclusions are not read and considered in isolation from the main body of the report. They must be kept in perspective and considered in their proper context.

The Strategic Health Authority and the Cornwall Partnership Trust should consider the content of this report. The observations and conclusions in Chapters 5, 6, and 8 should provide appropriate detailed information for on-going action planning. Certain conclusions and recommendations are similar to those made in previous local reports and in *Safety First* (See Appendix 3). To avoid repetition and rework, and to take account of recent changes, it will be important that the conclusions and recommendations in this report are compared and contrasted with previous reports, listed in Appendix 3.1.

Conclusions and Recommendations

Note: Due to the volume of specific cross-reference, and to avoid overcomplicating this section, recommendations are linked to chapters.

1 Multidisciplinary, Interdisciplinary Working

In the Partnership Trust clear evidence existed of services being structured and organised in a modern and multi-disciplinary way. The quality and quantity of multi-disciplinary input and attendance for team meetings, ward rounds, learning lessons, meetings and other critical meetings, need review and improvement.

Note: See Recommendation 4

2 Multi-agency, Interagency Working

Evidence exists of appropriate multi-agency working, in particular around multi-agency Planning and Mentally Disorder Offenders meetings. No evidence existed of a multi-agency case conference taking place for this case. Evidence exists of improved working relationships between key agencies, in particular the Police and Mental Health services. Evidence to support the

existence of appropriate multi-agency local operational forums exists. Attendance at certain established forums does not seem sufficiently representative of operational personnel. There is a lack of involvement of key practitioners and operational staff (Police officers, Custody Sergeants, Superintendents, Domestic Violence Unit, Probation, Consultants, Community Psychiatric Nurses, Psychologists, Social Workers, and Ward Managers) in some forums. Appropriate joint operational forums, to review 'near misses' and exceptional and difficult to manage cases, need to be reviewed.

Note: See Recommendations 3, 4, 5 and 6

3 Information

During the period November 2002 to May 2003, all the relevant information about both D and Mrs D was not available to the key decision-makers of the agencies involved, in any one place at the same time. Knowledge and information held by the family, the Criminal Justice System, and various parts of the NHS, was not recorded in the same place or available in time to those involved in making critical decisions. Significant work has recently been undertaken to improve record keeping and record sharing. However, sharing records between agencies remains problematic; sharing information between NHS organisations remains problematic; and further work is needed on unified patient records within the Partner Trust.

RECOMMENDATION 3

Statutory sector partners, in particular Health, Social services and the Criminal Justice system, should ensure that an infrastructure is put in place so that all the information held can be available to the decision taker ahead of the decision point.

3.1 The Partnership Trust should improve access to information by co-locating team members, and advancing the plan for introducing electronic unified records.

3.2 All statutory sector partners should ensure access to information is further enhanced by identifying regular interagency forums for informal sharing of information.

Note: See Chapter 4

4 Communication

In this case, working practices, both within and between key agencies, inhibited the decision-making process. Pressure of work, a lack of timely follow up, failure to refer back for review to referring personnel, and the absence of face-to-face debate during critical assessments affected the quality of communication and robustness of decision-making. Time for review and reflection on a team and individual basis seems lacking in some areas.

The quality and extent of clinical supervision and review of clinical records by most disciplines needs further improvement. Communications between care providers was deficient, and comprehensive risk assessments were not completed, or were partly completed, on some occasions.

RECOMMENDATION 4

The Partnership Trust should conduct a root and branch review of all meetings and records to ensure:

4.1 All meetings are appropriate and approved.

4.2 Weekly multi-disciplinary clinical meetings are established.

4.3 Weekly multi-disciplinary business meetings are established.

4.4 Attendance at meetings and frequency of clinical supervision is measured.

4.5 Time for review and reflection is built into meetings.

4.6 Meetings to discuss roles and responsibilities are held and professionally facilitated.

4.7 Compliance with recording date, time and designation of entrants in the clinical record is measured.

Note: See Chapters 4,6 and 7

5 Mental Health Act

Senior Clinical Reviews of non-completed Mental Health Act Assessments did not take place. There should be a mechanism for reviewing Section papers not progressed, as there is for reviewing completed Section applications. There is a sense of disempowerment of those involved when sections are not sustained.

It is important that GP training and qualification for Section 12 approval is maintained to ensure consistency of application of the provisions of the Act.

RECOMMENDATION 5

The Provider and Commissioning Trust should review Mental Health Act arrangements to ensure that:

5.1 Mental Health Act assessments, which do not result in the detention, should be reviewed within 72 hours.

5.2 Mental Health Act joint assessments should be introduced within 12 months.

5.3 GPs should consider training themselves up to the level of Section 12 approved Doctors.

5.4 Current GP Section 12 approved doctors should consider undertaking appropriate refresher courses.

Note: See Chapter 6

6 Range and Location of Services:

The variety of locations used for assessments, especially those carried out in response to a crisis, presents significant logistical problems. In particular, having the right people and the relevant information available at critical times, in the same location where the patient is being assessed. Changes over time, affecting the diversity and location of services, have also led to a lack of understanding, and confusion about the role and function of certain services.

RECOMMENDATION 6

The partnership Trust should review and update its information on services, and ensure a booklet is available in all its work places and relevant work places of partner organisations, in particular the Police, Social Services, Hospital Trust, and to the public.

Note: See Chapter 6

7 Roles and Responsibilities

A lack of clarity and understanding existed within disciplines, between disciplines and between agencies.

In this case, there was extensive and high quality Health Service involvement from Community

Psychiatric Nurses. The quality and level of medical input was high, although continuity of medical input was lacking on some occasions. The quality of input from the Emergency Department and Ambulance staff was high, both in terms of care and risk management. The involvement and input of Psychology was limited to consultancy advice, and Social Work was limited to Mental Health Act assessments.

Responsibility and authority to act was not clear in certain areas, and practice did not appear to reflect policy on all occasions. The role and involvement of the Professional Heads and Clinical Leaders in the Trust appears limited in certain areas of policy, practice and management.

In the Criminal Justice System the Police were significantly involved and numerous efforts were made to deal with events. The involvement and records of the Police also seem to have been of high quality. There was no evidence of any appropriate involvement with the Crown Prosecution Service, the Courts, the Domestic Violence Unit, or Probation services.

RECOMMENDATION 7

The Partnership Trust should set up a series of professionally facilitated meetings and workshops to ensure:

7.1 Roles of all disciplines in multi-disciplinary teams are clear and understood. The roles of clinicians and managers in management and leadership are clear. An annual review should be standard.

7.2 The Partnership Trust, in association with Social Services and the Criminal Justice System, sets up a series of meetings and workshops to consider this area of the report, build on existing good practice, and enhance working relationships. Annual reviews should be standard.

Note: See Chapter 6

8 Policies and Procedure

Considerable work has been undertaken to review and update policies in the Partnership Trust. Eight substantial Trust manuals of considerable weight were presented to the Panel for reference. In ward areas two manuals appeared common, each one substantial in weight and volume. In

crisis assessment locations, such as Custody Centres and Emergency Departments, no manuals or guidance was readily available; practitioners were dependent on their memories and experience. Practical guides are required, which need to be in hand or pocket book form for Clinicians. The style and content of documentation needs further improvement.

Transport, escort and hand-over arrangements for moving Mental Health patients within and between agencies and areas require review.

RECOMMENDATION 8

The Partnership trust should build on the extensive work it has carried out so that:

8.1 Each policy has a single front sheet that defines and describes

8.1.1 The context for the policy.

8.1.2 Any referral or relationship elements in a diagram or chart.

8.1.3 A summary of the main points of the policy in bullet points.

8.2 Policy manuals are produced electronically and in hard copy, as practical guides, in handbook or pocket book form, and are updated as needed or annually as a minimum. These should be available to all staff in the work place and in other organisations where staff carry out work.

Note: See Chapters 1 and 6

9 Education and Training

Evidence of training and education exists within the area between agencies and within the Partnership Trust. Despite this, the majority of those interviewed had not ensured that they had attended sufficient training on relevant policy and guidance. They did not have sufficient relevant guidance readily available in the work place, and did not appear familiar with an appropriate amount of guidance and reference material relevant to services and staff who manage clinical cases in Mental Health Care. All interviewees were clear about, and familiar with, their legal, statutory and professional responsibilities.

RECOMMENDATION 9

The Partnership Trust should ensure that:

9.1 Education and training programmes should be evidence based and research led.

9.2 Appropriate reports and guidance (as in this report) are integral to training programme development and course materials.

9.3 That management and leadership programmes deal with the cultural and other dynamics associated with this and other reports.

Note: See Chapters 5 and 6

10 Risk Management

There appears to be a lack of joint agency review and appraisal of critical incidents and 'near misses' for this case. The threshold and tolerance levels for coping with risk seem high in all agencies.

In the Partnership Trust (also to some extent the Police and Ambulance services), policy and practice seems to differ when dealing with escalating risk, in particular where weapons, violence (actual or threatened), and self-harm (actual or threatened) are involved. Risk assessment tools require urgent and ongoing review. There is a need for an evidence based risk assessment tool that is responsive to the needs of service users whilst being straightforward to use by frontline staff. In this case the risk assessment tools that did exist were rarely completed in full. Dealing with escalating risk is also an issue for further consideration by the Police and Ambulance services.

Practical joint guidance and tools are required for clinicians and Police officers to refer to during Mental Health assessments. The Local Criminal Justice Board should, in liaison with other agencies, review current legislation and policy for dealing with cases like this. It should also consider and review new and emerging policy and procedures to protect vulnerable adults.

RECOMMENDATION 10

The Strategic Health Authority, The Criminal Justice Agencies Group and Local Criminal Justice board should build on recent good practice and collaborate further with all relevant organisations to ensure:

10.1 More effort is put into creating confident organisations that will:

- **Improve and share learning.**
- **Reduce risks and modify the threshold for dealing with violence and danger.**
- **Increasing public confidence that we learn.**

10.2 Joint team assessments under the Mental Health Act are undertaken, and joint Health and Criminal Justice responsibility is assumed for assessing and taking action in cases like this.

10.3 Joint team assessments under the Mental Health Act should be introduced within 12 months. Mental Health Act Assessments that do not result in detention should be reviewed within 72 hours. (See also conclusion and recommendations at 4 above).

10.4 The development of an appropriate Risk Assessment Tool (See Appendix 5), and ensure clinical staff are aware of the profiles for most high-risk individuals, and differing local trends from local and national research.

Note: See Chapters 6 and 7

11 Stigma and Prejudice

Evidence of stigma and prejudice against those with mental health problems exist locally. This affects people with mental health problems, their families and the quality of service provision. It is accepted that this is a 'national disease' and a major political and social problem throughout society. Locally, the wider society and community issues need to be addressed by all agencies on a long-term basis.

In the short-term, specific challenges for organisations and agencies, for example Police custody and Casualty assessment areas, need to be addressed through further improvements to joint working, and through regular joint review.

In the medium to long-term, sustained joint education and training on an ongoing basis is essential. A countywide strategy to deal with stigma and prejudice should be produced and agreed with all appropriate local agencies.

RECOMMENDATION 11

In conjunction with NIMHE (National Institute Mental Health Executive), organisations should develop strategies to address this issue. The strategies developed will require working alongside public and private sector agencies to fully address this agenda. The Local Authority and Strategic Health Authority, in conjunction with NIMHE, should provide the leadership to take this agenda forward.

11.1 The National Patient Safety Agency should be made aware of these specific recommendations and help support this agenda through collaboration with other national organisations and Government departments.

11.2 In the short term, the local provider organisations, in conjunction with NIMHE, should agree development programmes to address this agenda.

Note: See Chapters 1,5,6 and 7

12 Commendations

In the course of the Inquiry's work, a number of notable practices were identified as praiseworthy and to be encouraged. These are listed below and are not in any priority order. The comments in this report should be fed back to those responsible for, and involved in, these practices. We encourage all appropriate individuals and organisations to share good practice and learning.

1. The level of Health and Police involvement demonstrated that agencies fulfilled their duty of care and showed a desire to be helpful to both D and Mrs D.
2. The standard of medical assessments, in the Emergency Department and in Mental Health wards, was of high quality.
3. The Psychiatric Liaison Nurse's initiative in escorting the patient from Emergency Department to the Mental Health Unit was commendable.
4. The level of persistence of the Community Mental Health Team support to both D and Mrs D was praiseworthy and reflected a professional desire to be of service.
5. The contact of D via his mobile phone was insightful.

6. The use of GP electronic records by the Community Mental Health Team is to be complimented.
7. The practice of staff in the Mental Health unit checking with the Police for outstanding charges was good practice.
8. The advice given to Mrs D by a range of individuals with respect to risk was clear and is commended.
9. The quality of the Report and the expertise of the Internal Review team were of a high standard. This expertise needs to be harnessed and disseminated accordingly.
10. The projects to develop unified and electronic patient records, electronic Care Programming, and electronic dissemination system for learning from experience are commendable and need to be supported as a priority.
11. The weekly Executive Serious Incident meetings are commendable.

RECOMMENDATION 12

The organisations involved should ensure:

12.1 Those who took part in the Inquiry and all relevant service areas receive appropriate feedback and that this report is disseminated accordingly.

12.2 That the examples of notable practice and commendations as shown above should be shared and disseminated throughout appropriate organisations.

12.3 Internal review statements/transcripts are agreed with interviewees and final reports disseminated accordingly.

Note: See Chapter 6

Appendix 1

TERMS OF REFERENCE

External Inquiry into the Care and Treatment of D

The remit of the Inquiry, discussed and agreed with the Chief Executive of the South West Peninsula Strategic Health Authority, is as follows.

1. With reference to the homicide that occurred in May 2003, to examine the circumstances of the treatment and care of D by the Mental Health Services, provided by Cornwall Partnership NHS Trust, in particular:

   1.1 The extent to which D's prescribed treatment and care plans were:
   - (a) Documented,
   - (b) agreed with him,
   - (c) communicated with and between relevant agencies and his family,
   - (d) carried out, and
   - (e) complied with by D.

   1.2 The quality and scope of his health, social care and risk assessments.

   1.3 The appropriateness of his treatment, care and supervision in respect of any of the following that is relevant:
   - (a) His assessed health and social care needs;
   - (b) His assessed risk of potential harm to himself or others, and the associated risk management planning arrangements;
   - (c) Any previous psychiatric history, including drug and alcohol abuse;
   - (d) The number and nature of any previous court convictions;
   - (e) Statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers JSG(94)5, and the discharge guidance HSG(94)27) and local operational policies for the provision of Mental Health Services.

2. To engage in a process of Root Cause Analysis as a basis for the External Inquiry. In doing this appoint a panel to undertake the review process.

3. To examine the appropriateness of the training and development of those involved in the care of D.

4. To examine the adequacy of the collaboration and communication between the agencies involved, or in the provision of services to him.

5. To review the internal Inquiry into the care of D; examine the process and robustness of the final Internal Inquiry report.

6. To prepare a report on and make recommendations as appropriate to the South West Peninsula Strategic Health Authority.

7. **Documentation**

The following schedule of documents will be used by the Panel in undertaking its Inquiry:

7.1 All medical records relating to D and Mrs D, including all hospital records whether as an inpatient or outpatient, GP records, all records prepared by any other Doctor or Nurse, registered or non registered practitioner, or other professionals involved in his/her care.

7.2 All documents in the possession of the Social Services Department relating to D.

7.3 All documents in the possession of the Police relating to the investigation into the death of Mrs D, and the subsequent coroner investigation.

7.4 All documents in possession of the Home Office relating to D.

8. **Timescale**

It is anticipated that the external Inquiry report will be published in early 2005.

Appendix 2

Witnesses Interviewed by The Panel

In advance of appearing to give evidence received a letter that enclosed the Terms of Reference and a list of questions to answer. Witnesses were invited to bring with them anyone they wished to accompany them. Each witness was informed of the Terms of Reference at interview, and informed that they would receive a written summary of the interview for them to sign.
All Inquiry interviews were held in private with the witness, and no more than three panel members present.

Information and evidence was also obtained from a number of individuals during a series of meetings, interviews and visits.

W - Witness O - Other individual

W / O	NAME & QUALIFICATIONS (* Qualifications not requested)	JOB TITLE (at the time of the events)
W	Bridges Dr V. MBCHB, MRC, psych.	Consultant Psychiatrist
O	Byers R (Mr)*	Acting Director, Estates & Support
W	Cantwell G Mr. RN. RMN, Dip Hosp & Health Administration.	Community Team Leader
O	Carlyon Dr E *	Coroner, Truro
W	Chambers E Mr*	Team Leader
W	Collier S Mrs. RGN, RMN	Community Mental Health Nurse
O	Creswell A (Mr)*	Chief Crown Prosecutor Devon & Cornwall Crown Prosecution Service
O	Davies Dr J *	GP
O	Dommett Dr *	Local Medical Council
W	Eastwood Dr N Behir, MB, MRCPsych, Section 12 approved, MRCGP, CJPTGP	Consultant Psychiatrist
W	Faulkner Dr M	GP
W	Fox A (Mr)*	Training Consultant & Manager, Social Services
W	Gabert S (Mrs)*	Lead Officer CPA

W / O	NAME & QUALIFICATIONS (* Qualifications not requested)	JOB TITLE (at the time of the events)
W	Haining W A (Mr) BA (Hons)	Community Psychiatric Nurse
O	Hambly Dr J*	GP
O	Harvest Ward*	Psychiatric Intensive Care Unit
W	Lockwood N (Mrs) CPN, RMN	Staff Nurse
O	Mallon B (Mr)*	Deputy Chief Executive, Cornwall Partnership Trust.
W	Martin A (Mr)*	Deputy Team Leader
O	Martyn C (Mrs)*	Chair of Local Magistrates
W	Matthews I (Mr) CQSW	Approved Social Worker
O	McAuley D (Mr)*	Locality Manager
O	McClatchey Dr T*	Director of Services and Modernisation
W	Meijer Dr G*	Police Surgeon
O	Micek B (Mr)*	Assistant Director HR
W	Milton M (Mr)	Team Leader, Chair of Unison
W	Muirithe B (Mr)*	Staff Grade Psychiatrist
W	Oxford D (Mr) B.Tech. (hons); M.Psychol. (clin).	Consultant Clinical Psychologist
O	Prouse Juliette*	Locality Manager
W	Spry D (Mrs)RMN	Service Development Manager
O	Steer M (Mr)*	Director of Nursing and Service Governance
O	Stowe R (Mr)*	Assistant Chief Constable, Devon & Cornwall Constabulary.
W	Taylor R (Mr) RMN, RGN	Clinical Nurse Specialist
W	Taylor V (Mrs) RMN, RGN, RCNT, Bsc.Hon. ,RSA Certificate in Counselling.	Practice Care Manager
W	Thomas K (Mrs)*	Staff Nurse
O	Tozer Dr C *	Director Social Services

W / O	NAME & QUALIFICATIONS (* Qualifications not requested)	JOB TITLE (at the time of the events)
W	Trudgeon S (Mrs)*	Staff Nurse
W	Verran L (Mrs) RMN	Ward Manager
W	Vitae A (Mrs) CPN, RMN	Community Psychiatric Nurse
O	Wainwright A (Mr)*	Head of Psychology.
O	Waters D (Mrs)*	Head of Education & Training
O	Willis M (Mr)*	West Country Ambulance Services Trust
	Willmott D (Mr)BA, CQSW, ASW	Approved Social Worker
W	Wood Dr K MB, ChB, MSc, MIHM, FRCPsych., Medical Director.	Consultant Psychiatrist
O	Yates Dr W	Independent Consultant Psychiatrist

Appendix 3.1

REFERENCE MATERIAL AND SOURCES OF DOCUMENTS RECEIVED AND REVIEWED

1 Documents relating to D and Mrs D

1.1 GP Case notes

1.2 Mental Health records – Cornwall Partnership Trust

1.3 Inpatient Records – Royal Cornwall Hospital Trust

1.4 West Country Services Ambulance Trust Records

1.5 Police Statements

1.6 Coroner's Reports

1.7 Staff Interviews

1.8 Panel Agenda and Papers

1.9 Internal Review Inquiry Report, statements, files and policies

1.10 Inquiry correspondence file

1.11 Inquiry Chair File – Statements, questions and notes

1.12 Inquiry Chair File – Reference file for: Trade Union & Staff Associations, Review of Psychiatric Intensive Care Services. Independent Inquiries after Homicides, Publicity, Financial Statements, Sickness Records, Organisational Charts, Operational Policies Longreach, Guides to Services

1.13 Inquiry Chair File – Panel notes of visits and meetings

2 Reference Material

1.1 Managing the Iatrogenic Risks of Risk Management – Jonathan Baert Wiener, Duke University

1.2 Suicide & Homicide in Cornwall – Report by Devon Partnership Trust, V Fistzsimons & G Ryder, November 2004

1.3 Root Cause Analysis – Delegates Workbook GCS Training Ltd

1.4 Code of Practice – Mental Health Act 1983

1.5 National Suicide Prevention for England – DoH 2002

1.6 No Secrets – DoH and Home Office

1.7 The Code for Crown Prosecutors – Crown Prosecution Service 2000

1.8 Working together for Justice – Criminal Justice System, Home Office, CPS, Department for Constitutional Affairs 2004

1.9 Policy for Prosecution Cases of Domestic Violence – Crown Prosecution Service 2001

1.10 Inquiry Chair File - Reference and Guidance notes

1.11 Review of Psychiatric Intensive Care Services within CPT – Cornwall Partnership Trust

1.12 Equity, Fairness and Support in the Workplace - Cornwall Partnership Trust

1.13 Clinical Policies and Procedures - Cornwall Partnership Trust

1.14 Corporate Policies and Procedures - Cornwall Partnership Trust

1.15 Human Resource Policies - Cornwall Partnership Trust

1.16 General Health & Safety Policy and Operating Guidelines - Cornwall Partnership Trust

1.17 Internal Review - Cornwall Partnership Trust

1.18 Policy Framework - Cornwall Partnership Trust

1.19 Seven Steps to Patient Safety – The full reference guide, and Incident Decision Tree - National Patient Safety Agency 2004

1.20 SWPSHA Briefing Paper on Independent Inquiries after Homicide

1.21 Multi-agency Audit Report – Cornwall County Council 2004

1.22 Building a Safer NHS – Implementing an Organisation with a Memory 2001

1.23 The Duties of a Medical Director – The British Association of Medical Managers 2001

1.24 Safety First – Five year report of the National Confidential Inquiry into Homicide by People with Mental Illness - DoH 2001

1.25 A Protocol for the Investment & Analysis of Clinical Incidents – Clinical Risk Unit and ALARM University College London 1999

1.26 An Organisation with a Memory – Report of an expert group on learning from adverse events in the NHS, Chaired by the Chief Medical Officer 2000

1.27 Counter Fraud and Security Management Services – A professional Approach to Root Cause Analysis, Department of Health 2003

1.28 Preliminary Survey Results – Transfer policy to mental health units - Devon Partnership Trust 2004.

3 Other Inquiry Reports

2.1 Report of the Independent Inquiry into the Care and Treatment of a patient known as S.

2.2 Report of the Independent Inquiry into the Care and Treatment of a patient known as H.

2.3 Report of the Independent Inquiry into the Care and Treatment of a patient known as X.

Appendix 3.2

Extracts from Reference Material

1. *An Organisation with a memory*: Report of an expert group on learning from adverse events in the NHS, chaired by the Chief Medical Officer, first published by the Department of Health in 2000.

> ***"Executive Summary***
>
> *The great majority of NHS care is of a very high clinical standard, and serious failures are uncommon in relation to the high volume of care provided every day in hospitals and in the community. Yet where serious failures in care do occur they can have devastating consequences for individual patients and their families, cause distress to the usually very committed health care staff involved and undermine public confidence in the services the NHS provides. In addition, the cumulative financial cost of adverse events to the NHS and to the economy is huge. Most distressing of all, such failures often have a familiar ring, displaying strong similarities to incidents, which have occurred before, and in some cases almost exactly replicating them. Many could be avoided if only the lessons of experience were properly learned.*
>
> *The introduction of clinical governance provides NHS organisations with a powerful imperative to focus on tackling adverse health care events. This report, commissioned by Health Ministers from an expert group under the chairmanship of the Chief Medical Officer sets out to review what we know about the scale and nature of serious failures in NHS health care, to examine the extent to which the NHS has the capacity to learn from such failures when they do occur and to recommend measures, which could help to ensure that the likelihood of repeated failures is minimised in the future. The work of the group was informed by evidence and experience from a range of sectors other than health, including industry, aviation and academic research."*

The reader is encouraged to cross-reference and peruse the full executive summary in the above report.

2. *Building a safer NHS for patients: Implementing an organisation with a memory,* published by the Department of Health in 2000.

"Building a Safer NHS for Patients sets out the Government's plans for promoting patient safety following the publication of the report 'An organisation with a memory' and the commitment to implement it in the NHS Plan. It places patient safety in the context of the Government's NHS quality programme and highlights key linkages to other Government initiatives. Central to the plan is the new mandatory, national reporting scheme for adverse health care events and near misses within the NHS. This will enhance existing mechanisms for improving quality of care and promoting patient safety by harnessing learning throughout the NHS when something goes wrong.

In the past, most health services around the world have underestimated the scale of unintended harm or injury experienced by patients as a result of medical error and adverse events in hospitals and other health care settings. There has been no real understanding of the approach necessary to reduce risk to patients based on analysing and learning from error and adverse events.

This is changing. The whole issue of patient safety, medical error and adverse event reporting is becoming a high priority in health care systems in this country and across the world. During the preparation of this programme of implementation extensive contact and discussion has taken place between representatives of the United Kingdom, the United States of America and Australia. This work has shown that:

- *Health care is a complex and at times high-risk activity where adverse events are inevitable; but it is not unique – there are many parallels with other sectors (e.g. aviation).*
- *Capturing and recording information on adverse events, and analysing them in the right way is an essential step to reducing risk to patients, as is creating the right culture within health organisation.*

The new national system for learning from error and adverse events

- *The report focuses on action, both nationally and locally, necessary to establish a system, which ensures that lessons from adverse events in one locality are learnt across the NHS as a whole. The system will enable reporting from local to national level. It will introduce a new integrated approach to learning from medical error, adverse events and near misses, and it will capture adverse event information from a wide variety of sources.*

Local reporting of adverse events and action to reduce risk within the organisation concerned is essential. On a selected basis reports to national level will enable service-wide action where patterns, clusters or trends reveal the scope to reduce risk or prevent recurrence for future patients in other parts of the country.

- *The report describes the necessary steps to be taken to set up the linked components of the new system, including:*
  - *Establishing agreed definitions of adverse events and near misses for the purposes of logging and reporting them within the NHS (moving gradually to agreed international standards); detailed guidance for organisations, staff and patients will be issued and pilot sites activated;*
  - *Formalising a minimum data set for adverse events and near misses.*
  - *Producing a standardised format for reporting (initially on paper as well as electronically but gradually moving towards the latter exclusively.*
  - *Building expertise within the NHS in root cause analysis (the more in-depth approach to identifying causal or systems factors in more serious adverse events or near misses);*
  - *Ensuring that information from all other major existing event reporting systems (e.g. medical devices, reactions to medicines, complaints to the Health Service Commissioner, serious accidents reported to the Health and Safety Executive) are fed into the new system*
  - *Promoting a culture of reporting and patient safety within NHS organisations, building on the transformation already under way as part of the clinical governance initiative.*

The National Patient Safety Agency

- A new independent body, The National Patient Safety Agency, will be established within the NHS. It will implement and operate the system with one core purpose – to improve patient safety by reducing the risk of harm through error.
- The National Patient Safety Agency will:
  - Collect and analyse information on adverse events from local NHS organisations, NHS staff, and patients and carers.
  - Assimilate other safety-related information from a variety of existing reporting systems and other sources in this country and abroad;
  - Learn lessons and ensure that they are fed back into practice, service organisation and delivery;
  - Where risks are identified, produce solutions to prevent harm, specify national goals and establish mechanisms to track progress.

3. *The Root Cause Analysis System and Incident Decision Tree: Exploring incidents and improving safety*, published by the National Patient Safety Agency 2004.

"The Root Cause Analysis System

Root Cause Analysis is one method for objectively determining the underlying, as well as the immediate, causes of patient incidents so enabling staff and management to learn from and avoid similar incidents in the future.

Those involved in an incident will have personal and sometimes very different theories about causation. These ideas influence the decisions that are made (or are not made) about managing the workplace and preventing incidents."

4. *A Professional Approach to Managing Security in the NHS*: A report produced by the NHS Counter Fraud and Security Management Service. Published by the DoH in 2003.

"There are many NHS security issues to be addressed. Physical assaults and abuse are particular concerns that have to be given priority. All those who work so hard to deliver quality patient care and services have the right to do so without fear of violence. Violent or abusive behaviour will not be tolerated and we will press for measures to be taken against individuals guilty of such acts. We will not hesitate to seek prosecutions where appropriate."

5. *National Suicide Prevention Strategy*: Published by the DoH in 2002.

"The strategy aims to support the saving of lives: Our Healthier Nation target of reducing the death rate from suicide by at least 20% by 2010. It is not a one-off document but an on-going, co-ordinated set of activities, which will evolve over several years. The strategy seeks to be comprehensive, evidence-based, specific and subject to evaluation, and will be delivered as one of the core programmes of the National Institution for Mental Health in England (NIMHE)

Goal 1: *To reduce risk in key high risk groups - Actions to be taken include:*

- *Local mental health services will be supported in implementing 12 points to a Safer Service; these aim to improve clinical risk management*
- *A national collaborative is being established for the monitoring of non-fatal deliberate self-harm*
- *A pilot project targeting mental health promotion in young men will be established and evaluated for national roll-out*

Goal 2: *To promote mental well-being in the wider population - Actions to be taken include:*

- *A cross government network will be developed to address a range of social issues that impact on people with mental health problems, e.g. unemployment and housing*
- *The suicide prevention programme will link closely with the NIMHE substance misuse programme to:*
- *Improve the clinical management of alcohol an drug misuse among young men who carry out deliberate self-harm*
- *Make available training in suicide risk assessment for substance misuse services*

Goal 3: *To reduce the availability the lethality of suicide methods - Actions to be taken include:*

- *NIMHE will identify additional steps that can be taken to promote safer prescribing of antidepressants and analgesics*
- *NIMHE will help local services identify their suicide 'hotspots' e.g. railways, bridges and take steps to improve safety at these*

Goal 4: To improve the reporting of suicidal behaviour in the media - Actions to be taken include:

- *A media action plan is being developed as part of the mental health promotion campaign, mind out for mental health, which will include:*
- *Incorporating guidance on the representation of suicide into workshops held with students at journalism colleges; round table discussion sessions with leaders in mental health and senior journalists*
- *A series of road shows at which frontline journalists can discuss responsible reporting*
- *A feature on suicide media journals e.g. Press Gazette, Media Week, British Journalism Review*

Goal 5: To promote research on suicide and suicide prevention - Action to be taken will include:

- *A national collaborative group will oversee a programme of research to support the strategy, including research on ligatures used in hanging and suicides using firearms*
- *Current evidence on suicide prevention will be made available to local services through NIMHE's website and development centres*

Goal 6: To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target for reducing suicide - Actions to be taken will include:

- *A new strategy group of experts and other key stakeholders will be established*
- *The new strategy group will regularly monitor suicides by age and gender, by people under mental health care, by different methods and by social class."*

6. *No Secrets:* Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Published by the DoH and Home Office.

DEFINING WHO IS AT RISK AND IN WHAT WAY

In defining abuse for the purpose of both national and local guidance it is important to clarify the following factors:

Definitions

- *Which adults are vulnerable?*

- *What actions or omissions constitute abuse?*
- *Who may be the abuser(s)?*
- *In what circumstances may abuse occur?*
- *Patterns of abuse, and*
- *What degree of abuse justifies intervention?*

Which adults are vulnerable? In this guidance 'adult' means a person aged 18 or over. The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper 'Who decides', *issued by the Lord Chancellor's Department, is a person "who is, or may be, in need of community care services by reason of mental or other disability, age or illness; and who or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"*

7. Managing the Iatrogenic (care-induced) Risks of Risk Management: Article by Jonathan Baert Wiener, submitted by Mr A Wainwright.

"This document describes a formal, practical protocol for investigating and analysing clinical incidents. A process of investigation developed in a research context has been adapted and refined by clinicians and researchers to produce a tool to be used by risk managers and others trained in incident analysis. Only a minority of events will need to be analysed in this detail in clinical practice. However, in-depth analysis of a small number of incidents will bring greater dividends than a cursory examination of a large number. The protocol is still being developed and will be refined in the light of experience and formal evaluation."

8. A Protocol for the Investigation and Analysis of Clinical Incidents: Clinical Risk Unit and ALARM (Association of Litigation and Risk Management), published by the University College London and The Royal Society of Medicine in 1999.

"Risk management aims to protect, but many's the slip betwixt help and health. Medical care is meant to make people well but it can harm as it heals. This is the pervasive problem of "iatrogenic" (care induced) and "nosocomial" (hospital induced) injury. "Most treatments have side effects as well as benefits". Medical

care is an inherently risky enterprise. Medical progress has provided physicians with an arsenal of double-edged swords. The modern medical community appears, more or less, to accept iatrogenesis as a fact of life, and to work diligently to manage the risks of its own risk management measures. Each case is unique and must be considered on its own facts and merits. However, there are general principles that apply to the way in which Crown Prosecutors must approach every case.

Crown Prosecutors must be fair, independent and objective. They must not let any personal views about ethnic or national origin, sex, religious beliefs, political views or the sexual orientation of the suspect, victim or witness influence their decisions. They must not be affected by improper or undue pressure from any source.

It is the duty of Crown Prosecutors to make sure that the right person is prosecuted for the right offence. In doing so, Crown Prosecutors must always act in the interest of justice and not solely for the purpose of obtaining a conviction.

It is the duty of Crown Prosecutors to review, advise on and prosecute cases, ensuring that the law is properly applied, that all relevant evidence is put before the court and that obligations of disclosure are complied with, in accordance with the principles set out in this Code."

Appendix 4

A Survey of Contemporary Practice – Transferring Mentally Ill People from Emergency Departments to Acute Mental Health Wards.

Background

The Devon Partnership Trust receives acutely mentally ill patients following their presentation to the Emergency Department (ED) at the adjacent acute trust, the Royal Devon and Exeter Hospital. The issue of best method of safe transfer was raised as part of developing best practice for a pathway of care from ED to the acute mental health wards.

Safe transfer would be the least restrictive most cost-effective means of transferring people from ED to the mental health ward. No current policy for transfer exists. Ambulance, Police, Acute Trust and Mental Health Trust could all think of reasons why there were risks associated with the various means employed. These include the patient walking from A to B, ambulance transfer, police vehicle transfer, private transport, variously escorted by approved social workers, relatives, friends, mental health nurses and doctors, sometimes following rapid tranquillisation or sedative medication.

Aim

To identify acute trusts in England with current policies and ask them to send a copy to Devon Partnership NHS Trust.

Method

To establishing best contemporary practice, a literature review of medline and embase was conducted using the search terms: accident and emergency, transfer, mental health; emergency psychiatry, mental health; transfer mental health; transfer psychiatry. We found limited literature, mainly addressing the transfer of forensic patients between secure mental health sites.

This apparent gap in the literature is used as a basis for conducting a telephone survey of current best practice across 120 Acute NHS Trusts in England.

The telephone interviews, designed to be brief, are to be conducted by the liaison psychiatry service clinical team members as part of their commitment to research and development, supported

by the small grants scheme from the R&D Directorate in the Devon Partnership Trust. The interviews are being conducted at the time of writing, January 2005.

The project officer identifies each trust with an accident and emergency department from the NHS Directory. A telephone call is made to the senior nurse or clinical manager on duty who would have responsibility for the care of mental health patients assessed in the department and could be expected to know if the trust had a policy for the transfer of patients to the mental health acute inpatient environment. The purpose of the call, namely to survey contemporary UK practice to develop local policy and to publish the findings, is explained and consent sought for the interview to proceed. In addition supplementary questions are asked about general current practice for informal patients and patients detained under the mental health act, risk assessment for absconding, harm to self and harm to others, and the usual methods of transfer. Finally the recipient is asked how they would currently transfer a standard patient:

> *"A 40 year old male with mania, verbally aggressive and threatening, under section of the mental health act, having received 2mg lorazepam."*

Notes are made of any supplemental comments made and the name and role of the interviewee is recorded.

Preliminary Results regarding transfer policy

So far telephone interviews with 26 Acute NHS Trusts across England have been held. 21 (80.77%) have no policies for the transfer of patients to the mental health acute inpatient units. Five (19.23%) responded 'yes'. Of this group, four were unsure of where to find the policy, one Trust provided a Trust website address where such policy was available, but this information could not be accessed.

The survey is progressing and will assess 120 Acute Trusts in total.

Dr. C.Antwi

Project Officer
SHO to Dr Peter Aitken
Consultant Liaison Psychiatrist

Appendix 5

Characteristics of Suicide and Homicide to be considered in the Development of risk tools.

Extracts from:

"*SAFETY FIRST*" Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (DOH 2001)

Characteristics: Suicide	
Contact with mental health services	Approximately one quarter of suicides in England and Wales, Scotland and Northern Ireland had been in contact with mental health services in the year before death
Access to medication	The commonest methods of suicide were hanging and self-poisoning by overdose.
History of schizophrenia, personality disorder, drug or alcohol misuse, and violence	Younger suicides more often had a history of : • schizophrenia, • personality disorder, • drug or alcohol mususe, and • violence.*
Employment, and Marital Status	Most people with schizophrenia who committed suicide were unemployed and unmarried. *
Lone carers of children	Four per cent of suicides were the lone carers of children. *
Compliance with medication	Mental health teams in England and Wales regarded 22% of the suicides as preventable, with lower figures in Scotland and Northern Ireland, but around three-quarters identified factors that could have reduced risk, mainly improved patient compliance and closer supervision.

Characteristics: Homicide	
Significant mental disorder based on life history	Around a third of all perpetrators of homicide had a diagnosis of mental disorder based on life history; the most common diagnoses were • alcohol dependence, • drug dependence, • personality disorder.
History of detention in hospital	Seven per cent of people convicted of homicide in England and Wales, and 6% in Scotland, were committed to psychiatric hospital.
Schizophrenia	Five per cent of all perpetrators of homicide in England and Wales (7% of those with a psychiatric report), and 2% in Scotland, had a diagnosis of schizophrenia.
Personality Disorder	Nine per cent of people convicted of homicide had a diagnosis of personality disorder. *
Alcohol and drugs	Alcohol and drugs were more likely to contribute to the offence in people convicted of homicide who were not mentally ill *
Estimations of violence	At final service contact, both immediate and long-term risk of violence were estimated to be low or absent in over 75% of cases.
Perceived preventability	Associated with schizophrenia, non compliance, recent contact and higher estimations of risk at final contact

* Refers to findings that apply to England and Wales only.

PLEASE INDICATE IF YOU HAVE READ, HAVE HAD READILY AVAILABLE AND HAD TRAINING ON THE BELOW.

PLEASE ANSWER: YES ☐ ✓

NO ☐ LEAVE BLANK

		Have You Read It	Readily Available For You	Had Any Training On It
1	Safety First – 5 year Report Homicides and Suicides	☐	☐	☐
2	Organisation with a memory	☐	☐	☐
3	Building a safer NHS for patients	☐	☐	☐
4	National Suicide Prevention Strategy	☐	☐	☐
5	Duties of Medical Director (For medical staff only)	☐	☐	☐
6	Protecting your NHS	☐	☐	☐
7	Internal Review into the Care and Treatment of PG	☐	☐	☐
8	Mental Health Act	☐	☐	☐
9	Trust Policy Manuals (x2)	☐	☐	☐
10	External Inquiry Terms of Reference	☐	☐	☐
11	Guidance on Discharge of Mentally Disordered People HSG (94) 27	☐	☐	☐
12	Guidance on Supervision Register JSG (94) 5	☐	☐	☐
13	Guidance on Care Programmes Approach HC (90) 23 / LASSL (90) 11	☐	☐	☐
14	Previous External Inquiries			
	(H)	☐	☐	☐
	(S)	☐	☐	☐
	(X)	☐	☐	☐