South West Peninsula NHS

Strategic Health Authority

Internal Review Into the Care and Treatment of PG

A Report Commissioned By Cornwall Partnership NHS Trust

November 2003

By Dr Margaret Cogan, Tim Jones and Dr Marilyn Mitchell

We were commissioned in June 2003 by the Chief Executive of Cornwall Partnership NHS Trust to undertake this Internal Review into the care, treatment and circumstances surrounding the death of PG's wife and his subsequent apparent suicide.

We have now completed our report.

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EXECUTIVE SUMMARY

This Internal Review was commissioned by the Chief Executive of Cornwall Partnership NHS Trust.

The purpose of its remit was to review the care and treatment afforded to PG during the period of his contact with Cornwall Partnership Trust from 19 November 2002 until 11 March 2003, following which he allegedly killed his wife LG and subsequently took his own life on 21 May 2003.

In undertaking this remit it was also the Review Panel's task to consider issues relating to the care of LG who was a patient of Cornwall Partnership Trust from 23 December 2002 until 11 March 2003.

The Panel was appointed in June 2003. In the course of the Review the Panel heard evidence from a wide range of professionals and also sought advice and clarification from a number of experts.

The Review Report falls into four chapters supported by a number of appendices. The first section is in the form of a preface. This, and the following two chapters (one and two) deal respectively with an introduction to the Review process, a factual summary, and an overview of the events surrounding LG's death; and management and practice issues. Chapter three deals with care management problems (according to the ALARM protocol) and chapter four gives recommendations. There are eight appendices for further information.

ABBREVIATIONS

ACI	-	Acting Chief Inspector (police)
AMA	-	Against Medical Advice (Form)
AV	-	[redacted information]
ASW	-	Approved Social Worker
BF	-	Blackberry Farm
BM	-	[redacted information]
CBT	-	Cognitive Behavioural Therapy
CHT	-	Cornwall Healthcare Trust (now Cornwall Partnership Trust)
CMHT	-	Community Mental Health Team
CPA	-	Care Programme Approach
CPN	-	Community Psychiatric Nurse
CPT	-	Cornwall Partnership Trust
DO	-	[redacted information]
DW	-	[redacted information]
ECG	-	Electro Cardio Graph
GC	-	[redacted information]
F Grade	-	Grading within A – I grading structure for clinical nurses
G Grade	-	Grading within A – I grading structure for clinical nurses
GP	-	General Practitioner
PG	-	Subject of the Review
H/O	-	History of
HSG	-	Health Service Guidance
IPR	-	Individual performance review (staff appraisal process)
KW	-	[redacted information]
LG	-	Homicide victim – wife
LW	-	[redacted information]
MA	-	[redacted information]
MAPP	-	Multi-Agency Protection Panel
MF	-	[redacted information]
MH	-	[redacted information]
MW	-	[redacted information]
MP	-	[redacted information]
MHA	-	Mental Health Act 1983
MW	-	[redacted information]
NE	-	[redacted information]
NSF	-	National Service Framework
O/N	-	Overnight
OPA	-	Outpatient appointment
PC	-	Police Constable
PICU	-	Psychiatric Intensive Care Unit
RMO	-	Responsible Medical Officer
SHO	-	Senior House Officer (doctor)
SK	-	[redacted information]
ST	-	[redacted information]
SW	-	[redacted information]
SWPHA	-	South West Peninsula Health Authority
TADs	-	Training all day sessions (Cornwall Social Services)
VB	-	[redacted information]
VT	-	[redacted information]

PREFACE

THE REVIEW PROCESS

INTRODUCTION

1. This report sets out the findings and recommendations of a Review into the care and treatment of PG. The Chief Executive, Cornwall Partnership NHS Trust following the alleged homicide of LG by PG on 21 May 2003, commissioned the Review. The terms of reference are at Appendix A.

2. At the time of the homicide PG was discharged from the Carrick Mental Health Services of Cornwall Partnership Trust (date of discharge 11.3.03).

3. Membership of the Review Panel comprised Dr Margaret Cogan, Consultant Clinical Psychologist and Deputy Director of Psychology, Dr Marilyn Mitchell, Consultant Psychiatrist and Associate Medical Director, Tim Jones Service Manager, (Older Persons Mental Health Service).

4. All references to PG have been anonymised and we have adopted the expedient of PG. The identity of his alleged victim has been similarly reduced to the use of capital letters LG. However, the need for the accountability of the Services involved in providing care to PG prior to the homicide requires reference to staff members. This is done by initial with names given in the abbreviation list.

5. There have now been close to one hundred external inquiries after a homicide by a person under the care of the Mental Health Services, and as here the majority have been commissioned in compliance with HSG(94)27. Even so, there are no prescribed procedures to be followed by such an inquiry, which have no statutory powers or status. Until recently the sole guiding principle has been the concept of 'fairness', recognised by the common law of England and Wales. However the Internal Review Panel has chosen to follow the Protocol for the Investigation and Analysis of Clinical Incidents (Clinical Risk Unit and ALARM September 1999).

6. The Panel is mindful of criticisms in the process often adopted by Reviews into homicides and the inherent difficulties in the methodology adopted. We have striven to overcome these by adopting standards of procedure in accordance with good practice.

7. This is the second Panel appointed to investigate the death of LG and the care and treatment received by PG from the Mental Health Services. The first was appointed in May 2003. The first Chair appointed asked to be removed from the process due to a potential conflict of interest with his role as Manager of Carrick Mental Health Services. A new Chair whose role within Cornwall Partnership Trust was independent of the area under investigation subsequently replaced his position.

8. The Review Panel has endeavored to deal with matters as expeditiously as possible, but inevitably delays have been occurred, most of which have been completely outside of the Panel's control.

Review Procedure

9. In our view our procedures ensured that the Review was undertaken with expedition and allowed for candour in evidence.

Approach of the Review

10. The Review Panel was acutely aware of the stress that is experienced by individuals while a Review is under way and the perception of a 'climate of blame' that a Review creates. It was crucial therefore that all witnesses were advised regarding a means of support throughout the process and beyond.

11. The Review Panel is of the view that 'attaching blame' or finding scapegoats' is not a positive way forward. For that reason, focus is on a series of Care Management problems identified through the ALARM Protocol.

12. We are also only too aware that some tragic incidents are unavoidable, and we do not wish to perpetuate a culture, which thinks otherwise. We support the view that, as a society, we must learn to understand that serious adverse incidents will sometimes happen, and it is not always necessary or productive to find someone to blame as long as lessons are learnt along the way.

13. Although mental health professionals must be accountable for good practice they cannot ultimately be expected to carry complete responsibility for the actions of their patients. There is a limit to the control and influence, which it is possible for them to achieve over any individual. It would also be wrong to overlook the right of a patient to refuse interventions by the Services.

14. The Review Panel has considered the care and treatment received by PG throughout his time in contact with the Mental Health Services, a period of approximately four months between 2002 and 2003, and focused particularly on the period November 2002 and March 2003. We have endeavored during our deliberations to come to conclusions without the benefit of hindsight and to consider the standards of practice that would have prevailed at the relevant time. However, it is accepted that some degree of hindsight is both an acceptable and unavoidable aspect of any review.

15. The practice of individual practitioners has been judged by reference to that of a reasonable and responsible body of practitioners in the relevant field.

16. This report contains the unanimous findings and comments of the Review Panel.

Documentation

17. Documents used were the written care records (B Notes) from PG and LG, and supporting documentation from health professionals. We have sought documentation from the police via the Trust management system, but as yet this information has not been provided.

Hearings

18. Meetings with witnesses were held at the Carrick Community Mental Health Team base at Pydar Street, Truro and the small meeting room at Bellingham House, Bodmin Hospital.

19. The protocol followed the ALARM process, which included the completion of a post-interview checklist of contributing factors completed by each witness following their interviews.

Administration

20. Although eventually supported by excellent individuals the administrative support to the Review Panel was insufficient and inconsistent. Support was provided by a number of administrative staff involved at different stages of the process. This clearly hampered proceedings and affected the coherence of the whole. It also increased the workload for the Review Panel. This said, we would like to thank the following for their willing support Ann Conway, Trudy Ferguson, Maria Smith and Julie Wotherspoon. The Trust needs to address this issue in any further Reviews ensuring that such support is prioritised over other administration activity.

Acknowledgements

21. We would like to offer our sympathies to the family and friends of PG and LG.

22. We would like to thank all the witnesses for their openness and willingness to participate, Cornwall Partnership NHS Trust, Cornwall Social Services and Carrick Central Primary Care Trust.

CHAPTER 1

FACTUAL SUMMARY AND OVERVIEW

Introduction

1. It is reported that on 21 May 2003 PG was found hanged, dead at his property in Cornwall. Prior to this, his wife LG had been found strangled in London. PG had been a patient of the Carrick Community Mental Health Team and had recently used inpatient services at Harvest Ward and Bowman Ward, Bodmin Hospital, and the Gwaynten Unit at Truro. LG (wife) was referred to the 27 Lemon Street Counselling Service on 23 December 2002, which is co-ordinated by, and works alongside, Cornwall Partnership Trusts and provides mild to moderate mental health services provision. She was seen for two sessions of counselling and had three telephone conversation contacts. The final contact was in February 2003 and she was discharged on 11 March 2003. This counselling was in relation to the break up of her marriage and the threats her former husband had been making in relationship to his own suicide.

PG: brief biography

2. PG was born and raised in Stratford-upon-Avon. He had at least one sister in Truro. His father was a mechanic and, as far as we can ascertain, is still alive in Cornwall. He described his childhood as a 'normal little family' and he had a 'normal schooling'. He studied dentistry at London University and then worked in London for a year after graduation. After that he moved to Cornwall about twenty-five years prior to the incident, mainly because he did not like London. His wife LG worked as a dental nurse at the dental practice where he worked in Cornwall and he described her as a 'very attractive woman'. They married shortly after, around 1974, and had two children, C (approximately 23 years of age) and M (approximately 21 years of age).

3. PG made his money by buying and selling properties to achieve his current level of prosperity, which was considerable. Four years prior to the incident PG had a gardening accident in which he lost the use of his fourth and middle fingers of his right hand. He was unable to continue practicing as a dentist and retired with a private pension which prohibited him from resuming any form of employment.

4. Social history: he lived between his yacht in Falmouth and his farm in Feock. His wife LG (49 years old) resided at BF, Feock. His daughter C had recently married in New Zealand two months prior to his first referral to the Mental Health Services and her husband, it is thought, was attached to the Services. His son M was studying business management in Oxford. PG's parents live in Cornwall but he had little contact with them. He also had a sister and her husband (a police officer) both living in Truro and who were very supportive of him.

Mental illness and services

5. Prior to his referral to the Community Mental Health Services PG had no known psychiatric history.

6 Over the period November 2002 to March 2003 PG had three informal admissions: to Bowman Ward, Bodmin Hospital, 22.11.02 to 25.11.02; Gwaynten Unit 21.12.02 to 23.12.02; Harvest Ward 14.2.03 to 17.2.03. Throughout the rest of the four-month period he was supported by the Carrick Community Mental Health Team. Carrick Mental

Health Services discharged him following a Multidisciplinary Meeting on 11 March 2003.

CHAPTER 2

CHRONOLOGY OF EVENTS

First Admission – Bowman Ward

7 **PG was admitted to Bowman Ward, Bodmin Hospital from Treliske Hospital, Truro on 22 November 2002. The circumstances of his admission to Treliske were that he had taken an overdose on 19.11.02, was admitted to Treliske, discharged himself against medical advice and was readmitted on 20.11.02 following a second overdose. Both overdoses were extremely serious and occurred after he had consumed quite large amounts of alcohol.**

8. **The first overdose apparently occurred at his home, where he was found by a member of his family still conscious, but with empty bottles of alcohol and pills and a loaded gun on the table in front of him. Following admission to hospital he discharged himself the next day against medical advice in a sober state claiming he was no longer suicidal.**

9. **Later that day he was discovered on his yacht by his sister in an unconscious state, having taken most of the contents of the medication kept on the yacht (it is suggested that 100 x DF118) with a suicide note after locking the yacht's cabin. On this second occasion he was brought to Treliske Hospital and assessed there by KW, Consultant Psychiatrist (working with the Psychiatric Liaison Service). KW was very concerned about him and recommended that PG should be detained in hospital under Section 2 of the MHA with which the GP agreed. However later on that same day (21.11.02) when the Social Worker arrived to do his part of the Section 2 PG had changed his mind and was willing at that time to come into hospital as an informal patient. The ASW did not complete his part of the Section 2 and instead recommended he be admitted as an informal patient. He was transferred over to Bodmin Hospital on 22.11.02 as an informal patient there being no beds available in the Gwaynten Unit and in accordance with the Bed Policy at the time.**

Background to this presentation

10. **PG retired from dentistry four years previously following an accident in which he lost the tips of two of the fingers of his right hand and was currently in receipt of a pension.**

11. **PG had recently returned from a yachting trip to New Zealand where his daughter C had recently married. He sailed with his son M and his wife LG until they reached Spain, at which point his wife and son returned to the UK by air while he sailed the yacht back with two other crewmembers. Due to storms this trip took him the better part of a month and he only arrived in the UK about two weeks prior to admission. Over the period of this journey his wife apparently spent about £4000 (he alleged) on clothes and shoes in London.**

12. **On arrival in Falmouth he was not met on the dockside by his wife who instead arrived late and had dinner with him. Over the course of this dinner she told him that she wanted 'some space' so that she could go and live in London and enjoy the 'high life' as he put it. She knew that he did not like London or the lifestyle much and in effect she was asking for a break up of their marriage of twenty-six years.**

PG became very upset and after the dinner, outside the restaurant, he admitted that he grabbed her and threw her to the ground but did not otherwise injure her in any way.

13. PG did not see his wife again, until an arranged meeting at a motorway station a few days prior to his admission, during which she made it much clearer that she did not wish to continue the marriage with him. He then returned to the farm and proceeded to painstakingly cut up and destroy the two wardrobes of clothes and shoes that LG had at the farm, before taking the first overdose (on 19.11.02).

14. PG described his pre-morbid personality as a 'black and white sort of chap'. He tended to see things with clear distinctions without grey areas of uncertainty. He also described himself as not an emotional man and any outbursts of emotion were quite abnormal for him, especially his behaviour over the preceding few days. He said that he had never had anger or sadness to that extent before and was unable to explain how he could have gone to the lengths of wanting to kill himself. He described his personal history and it was quite clear that he regarded himself as a self-made man starting out with a dental degree, moving into property dealing, to arrive at his then currently materially wealthy situation. He owned several properties, including a tower block in New Zealand, a villa in Spain, BF in Feock and his yacht in Falmouth.

Progress on the ward

15. PG was initially very despondent following admission and had thoughts of suicide, believing that killing himself was 'the best way out'. He explained that the reason why he believed he should kill himself was so that his children would get the money from his insurance policy and deny his wife from taking any more of his money. This explanation did not make much sense and sounded more like rationalisation for his suicidal ideas, rather than the actual causes. According to notes made over the next two days on Bowman Ward and over the weekend he asked to be discharged as he said he was no longer suicidal but he was persuaded to stay until Monday, 25 November 2002, when he could be seen at the ward round by the Consultant MP, Locum Consultant, Cornwall Partnership NHS Trust. He did not pose any behavioural problems on the ward, nor did he make any attempts to harm himself in any way.

16. MP saw PG at the ward round on 25 November 2002. At this interview many points were discussed including the following from SW's' discharge letter:

    1. "The circumstances leading up to his overdoses with special emphasis on his thought processes. He admitted at the interview that his logic had been a bit flawed in wanting to kill himself so as to provide financial security for his children. In the event of his death, all of his property and belongings would go to his wife, which meant that she would get everything instead of nothing, as he had originally said on admission. He also said on admission that he believed his children would prefer to have the money from his insurance rather than having him alive. At ward round he admitted that this also was not true and he acknowledged that his son and daughter would be "absolutely devastated" if he killed himself.

    2. PG said that he would not attempt to kill himself anymore mainly because of the effect on his children. He also said that he wanted to live enough to see his grand children (from C's marriage).

3. He denied any homicidal intentions towards his wife and while he admitted that he was "very, very angry at her" for what she had done, he still "loved her to bits". He explained that the only way that he could hurt her was "in the heat of the moment", and if he could have done so, he would have, outside the restaurant three weeks ago, but he did not.

4. He said that he accepted the fact that his marriage was effectively over, but one worrying point was that he had not yet told his neighbours about this. He explained that if he told his neighbours then that would make it real and irrevocable. He did not seem to have any plans either, to tell his neighbours sometime in the near future. His internal beliefs about his relationship therefore, seemed to be at odds with his spoken beliefs but he did not seem to be aware of this.

5. He blamed his wife for "destroying" his marriage and the family by her actions. Her statement compounded his anger that she had not loved him for the last ten years and what he sees as a carefully orchestrated plan on her part to leave him at this time. He believed that this plan started as far back as six years ago, resulting in her taking a lot of his money and all her jewellery among other things. Again this is PG's version of events and I feel a collateral history from his wife might put things somewhat differently. There is definite polarisation of PG's feelings towards his wife, as on the one hand he is very angry at her for what he sees as her betrayal over the last six to ten years and her "destroying the family", but on the other hand he said he still loved her to bits and that if he could, he would "set the clock back four weeks", to when everything was still alright.

6. This polarisation is quite clearly a continuation of his pre morbid personality in terms of his "black and white" way of seeing things. MP put it to him that while that mood of thinking proves to be very successful in getting him to where he was now; it was currently hampering his ability to cope with events. He suggested that perhaps it would be useful to be able to come to a compromise in dealing with events, to see the situation as shades of grey rather than black and white. For example, he challenged PG on his belief that the family was "destroyed" by the divorce according to PG's black and white philosophy. PG admitted that while the family was no longer functioning as a unit, its individual members could still continue to live and grow, which he grudgingly admitted was not the old black picture that he painted, although he still maintained "its definitely not the same".

7. We talked about his plans for his immediate future and he denied that he had ever told his daughter that he would try to kill himself as soon as he left hospital, and that "this time they won't find me". (MP later discussed this with PG's daughter, and she confirmed that he had said this, although it seems he was under the influence of opiates and alcohol at the time just after his overdose). He said he planned to spend more time on his boat and get it ready to sail to New Zealand in the next two months. He talked of selling off all his properties here in Europe before sailing away. He also said that he looked forward to spending more time with his children and talked of volunteering his yacht to teach Sea Cadets at Falmouth, as he enjoyed teaching the younger ones how to sail.

8. He admitted that since his wife left him he had been having problems with his sleep, appetite, weight loss, concentration, mood, and that he had been "crying all the time". He also broke down in tears at several points during the interview, for example, when talking about his wife or the "destruction" of his

family. He said that this was very abnormal behaviour for him and that he was "not an emotional sort of chap". He was offered anti-depressants at several times before and after his admission and again at this ward round but he refused to take any sort of medication.

9. **If discharged on that day he said, he intended to go back to his yacht and stay there on his own, although he said that there were many other yachts and people in them in close proximity to him. He was persuaded to go instead to BF, where his daughter and her husband are currently staying and to accept their support, although initially he was very resistant to this idea. He felt that his daughter should not need to stay at the farm with him, but should instead be back in Aldershot with her husband because as he explained, she was newly married and he did not want to upset her marriage at this early stage. He was finally dissuaded of this notion, which I wonder might have come from either his feelings of worthlessness or rationalisation to justify him being on his own so as to isolate himself. He also seemed quite determined to attempt to leave either that day or the next. He maintained that being on the ward was actually doing him more harm than good."**

<u>Community Care - 1</u>

17. **25.11.02** PG was referred to the Carrick Community Mental Health Team. Visited at home by AV, CPN, accompanied by a student nurse. A screening assessment was carried out. Screened into Adult Mental Services.

18. **27.11.02.** AV attempted a home visit. There was no reply. Attempts were made to contact him by phone but again there was no response. His sister was contacted with only answer phone response. The Team Leader, GC, was contacted and she was advised to leave a message on the answer phone, to try and contact the brother-in-law, and if no luck to phone the police to check his yacht. His brother-in-law answered the phone and explained that he and PG had been on the phone all the morning. He gave his wife's mobile so the CPN could contact PG. PG's phone was engaged. Again his sister was contacted with no response. His brother-in-law stated PG's mood had improved; they were aware of the risks and had removed all tablets available and his air gun. A final attempt to contact PG met with no response.

19. **2.12.02.** PG's sister was contacted and she stated that she had seen PG earlier and was concerned over his mood but he had visited his GP and been prescribed antidepressants at his request. The CPN spoke with PG who was on a train to London planning to visit his wife. He then planned to visit his son in Oxford and return to see KW on 6.12.02.

20. **4.12.02.** AV contacted PG on his mobile and confirmed that he was visiting his son in Oxford. She arranged a home visit the following morning on his return.

21. **5.12.02**. AV saw PG at home. He was a bit calmer and somewhat tearful, thinking of his children. He had approached the Lifeboat Training Service to see if he could help but due to his age and disability this was not possible. He was planning to get an English bulldog. He was encouraged to remain active and spend time with supportive people. Medication prescribed was **Dothiepin,** a tricyclic antidepressant taken on a split dose. He described his mood as swinging between thinking of plans for his future and times of despair. He did not admit to further thoughts of suicide and he was urged to discuss these if his mood lowered. A further appointment was arranged to meet with him on 10 December 2002.

22. **6.12.02.** Seen by KW in outpatients. He expressed suicidal ideation with no intent planning for the future. He was considering a referral to Relate but his wife declined. His antidepressant was changed for purposes of safety to **Mirtazapine.** Hospital admission was offered but he refused.

23. **10.12.02.** AV phoned PG on his mobile and left a message. PG phoned KW's secretary stating that he was going to Antigua for a few weeks. He was advised to contact his GP for medication.

24. **11.12.02.** PG was contacted by AV. He informed her he was no longer going on the trip.

25. **13.12.02.** PG was contacted. He was taking medication but was feeling disorientated as a result of his life feeling totally disrupted.

26. **16.12.02.** PG phoned AV. He had had a bad night with negative thoughts. His wife was planning to return over Christmas and this had made him feel somewhat better and he asked for some sleeping tablets. He had had some disturbing thoughts at night when he had thought of doing something to 'mess everything up'. He stated he had an AK47 gun, which he had purchased whilst abroad in order to protect his wife and himself from pirates. He was advised to hand his gun to his brother-in-law (a police officer) and this he flatly refused to do. He was angry that his wife did not wish to return straight away. He was encouraged to give his wife LG the time and space she required.

27. **16.12.02.** AV contacted her line manager VT over her concerns about PG owning a gun. They discussed the options on PG being able to hand the gun in without repercussions regarding an illegal weapon. A prescription for night sedation was made available from his GP. AV contacted PG to tell him of this and to emphasise her concerns about the gun. PG refused to hand the gun to his brother-in-law or any Health Authority and said he would not do anything silly and if he was going to, could climb in his car and poison himself with carbon monoxide. It was made clear to him by AV that her concerns for his safety would over-ride any issues of confidentiality and that she would inform KW. He stated that he would get rid of the gun by dropping it at sea. AV stated that she would prefer he handed it in and that she would still inform KW. Again he reiterated that he would drop the gun over the side of his dinghy when he was out at sea. KW was then contacted with these concerns and PG was re-contacted when he assured AV that he had disposed of 'the article' and was feeling much better and had subsequently collected his medication. KW was further informed and an urgent outpatient appointment arranged to meet KW on 18.12.02.

    VT contacted LG to make her aware of general concerns. LG was only able to recall a shotgun, which was left in Malta.

28. **17.12.02.** PG was contacted by AV and an appointment made to see him at Threemilestone Surgery on 18.12.02, which he subsequently cancelled. He was aware that this further appointment was linked to the concern over the gun and assured her that he would not harm anyone. He also declined the outpatient appointment with KW. He then spoke at length about his concerns regarding LG's return and his anger over her actions. He also stated that he would prefer just to maintain telephone contact at that time as that was all he required.

29. **18.12.02.** Phone call from PG saying that his wife had contacted him to say that she had had a phone call from the Health Authority advising her that she was at risk and should not return that weekend. He was very concerned about it and he was urged to keep his appointment with KW.

Second Admission - Gwaynten Unit

30. **21.12.02. PG was admitted informally to Gwaynten Unit, Truro. He had been expecting his wife to return that day and this 'kept him going'. However she had rung to say that she wouldn't be returning. He then drove his tractor into the kitchen with the intent to poison himself with the fumes, which proved too smelly, and he subsequently gave up. He then went driving in his Porsche with the intention of crashing his car and ending his life, possibly whilst speaking to his wife on his mobile, but eventually he was unable to proceed with this. He felt both attempts were manipulative and cries for help, but that his earlier attempts with the gun and overdose were serious. Although he was distressed and close to tears he insisted he was safe to return home and pinned his hopes on his wife returning. He was reluctant to be admitted despite attempts to stress the seriousness of his risk at that time. He was adamant that he did not want a Mental Health Act assessment and feared being detained might stop him from being able to live in America or Australia so he agreed to stay. It was explained that leave could be negotiated for 23 December (a family birthday) and Christmas, after consultation with KW. A suicide note had been written to his wife/children. He made comments such as 'I can't go on without her' and stated that he wished his previous attempts via overdose had been successful. He denied suicidal intent but was preoccupied with his wife leaving. He admitted also to having previously hit people or 'flooring them with judo' as he was a black belt.**

31. **22.12.02. PG was much brighter. His wife was returning to Cornwall following a conversation with her and she had declared her ambivalence about leaving him.**

32. **22.12.02. PG wished to leave the ward but was persuaded to stay.**

33. **23.12.02. PG seen by SK who had contact with LG. She sounded very distressed, she stated that she was finding the whole situation distressing and that her husband was pushing her to make a decision about their marriage. She stated that she did not wish to live with him any longer and was afraid to tell him this. She felt that he may react and kill himself and was more worried about his safety than hers. She also believed that he was manipulative, at high risk of causing great anxiety to himself and family. It was explained to her that it was essential that she looked to her own safety as a priority and that if she felt unsafe she should be with someone when she decided to tell him she was leaving.**

34. **23.12.02. PG seen by KW who made a diagnosis of further dysfunctional depressive response to crisis. He noted circular content to his thinking and he was preoccupied with relationships and past failures. He was adamant he wished to leave. KW made a recommendation for detention under the MHA Section 2. PG felt that Section 2 was inappropriate. He felt safe at home and denied any possibility of killing himself. It was considered by KW that PG was at high risk of harm to himself and his wife. It was explained to him that Section 2 would not affect his residency abroad.**

35. **23.12.02. PG seen by his GP MF who felt unable to support the Section 2 as he felt PG's presentation was plausible. He had known PG for a number of years.**

36. **23.12.02. PG seen at ward round by KW. The clinical decision was that he was at a high risk of self-harm and of harming his wife. He was advised he needed to stay on the ward. He stated that he planned to go to America with his wife and believed that the detention would stop him.**

37. **PG was insisting on self-discharge against medical advice and a full risk assessment was carried out. KW was consulted and aware of the failure of completion of the earlier MHA assessment, and felt that they were no longer able to detain PG in hospital.**

38. **His brother-in-law (the policeman) was contacted; the risk was explained that PG was at high risk of suicide, particularly in association with large amounts of alcohol. All relevant information was then handed over to the Out of Hours Team.**

39. **PG subsequently took his discharge against medical advice with TTOs. He was urged to contact his CPN as soon as possible and he was in receipt of the Out of Hours telephone contact number.**

Community Care - 2

40. **2.01.03.** AV carried out a home visit. PG was feeling low and hated being alone. He was drinking alcohol to excess and on one occasion his son had not been able to rouse him and had called an ambulance. He had also left a suicide note. He was also angry about LG's intentions. He felt he was a bad person who had done lots of bad things.

41. **9.01.03.** Further visit by AV. The risk of excessive alcohol was explained to him when he felt vulnerable. She described the need for routine. OPA organised to see KW.

42. **15.01.03.** Seen by KW. His mood remained low and he admitted to excessive alcohol consumption. An appointment had been arranged for him by the psychologist to see a private psychotherapist which he planned to keep but PG and LG had not made any efforts to seek marriage guidance. His antidepressant medication was increased and a sedative provided.

43. **24.01.03.** PG saw DO Clinical Psychologist for initial assessment.

44. **28.01.03.** AV visited at home. He was requesting to see the clinical psychologist again to see what form the therapy could take and was requesting phone contact only from AV.

45. **31.01. 03.** Seen by DO, PG accompanied by his wife, for further assessment and for suitability for psychotherapy and subsequently PG sought an appointment with MW, Consultant Psychotherapist on a private basis.

46. **31.01. 03** Letter from DO to AV.

47. **13.02.03.** PG phoned AV. His wife had phoned him and he felt that this was a critical time about their future and her decision. He was advised to stay occupied. An anonymous Valentine's card had upset him. He had seen two psychotherapists, both of whom he described as 'rubbish'. He again did not want any further visits, preferring a phone call as and when needed.

48. **13.02.03.** AV received a phone call from the Surgery stating that someone had called to express concerns about PG's mental health. However following further contact with PG there was no noted change in his mental state, although he was somewhat tearful.

49. **13.2.03.** KW's secretary received information regarding an incident with a gun. The GP was contacted who was unaware of the incident. He called the Custody Centre in Newquay and ascertained that PG had been arrested. VB Duty Consultant Psychiatrist saw him. She wrote a full letter on 19 February 2003 to KW as follows: "On 14 February 2003 PG had made threats of suicide to his wife, stating that it would only take a minute, and had wrung from her a promise to come down by train to visit him.

Speaking later on the phone to his mother-in-law he was told that his wife was not coming. He then threatened to kill himself with a gun and when his mother-in-law expressed doubt that he had a gun 'clicking' noises were heard over the phone as though a gun was being cocked and the trigger pulled. The police were called and an armed Unit came to the house at about 3 am. According to the police PG seemed intoxicated and was aggressive with them. He said apparently 'I don't care if you shoot me'. He was arrested for possession of a firearm."

50. VB felt that PG probably had a mental disorder of some sort and that he required a further assessment to be more sure of its precise nature She felt he was an intelligent man, well read about mental illness, who was good at 'pressing the right buttons' and she was concerned that he might be disguising his psychopathology in an attempt to avoid being detained. She also stated that he might have depression, although "it is hard to gauge the severity at the moment. He is very angry and sees no hope for the future. He talks of having to do things but there seems to be nothing he is actually looking forward to. He sees things rather negatively, for example his family life is ruined." VB made references to KW's previous letter, 30 January 2003, and the risk of suicide and homicide. She also considered whether he had a psychopathic personality disorder as he had problems with jealousy and possessiveness. He had little regard for the feelings of others. She also commented that she had no doubt that he was a danger to his wife LG and that his behaviour had been geared towards getting his own way in a manner that could be described as manipulative. She was also concerned that he appeared to have a gun with him, borrowed from a neighbour, when he was expecting LG to visit and that he had cocked it to his mother-in-law down the phone. She accepted that there were risks to admission in that it may antagonise him and worsen the situation and that it may have some effect on his ability to travel around the world, but on balance believed that the risks of admission for assessment were less than those of not doing so.

51. Although the Section 2 was not completed by DW the Approved Social Worker VB was of the view that the Section should proceed as his agreement to admission was not reliable. However following this she understood that he would be admitted informally to Gwaynten but having arrived he asked for a single room and made an offer to pay for one. This request could not be granted and therefore he went to leave the ward. She did not feel it advisable to detain him at Gwaynten, as she did not feel that there were sufficient nurses to safely contain him if the situation became violent. He signed an AMA form but returned after five minutes having been told by his brother-in-law that the police would arrest him if he left the ward as he was charged with an outstanding firearms offence and would return to the police cell. It was not felt appropriate for him to remain on Gwaynten, as the Unit was not secure and with few staff at night. Although PG at this stage was quite polite VB was concerned that the situation might 'blow up' again and as a consequence he was transferred to Harvest Ward at Bodmin Hospital as an informal patient. VB was of the view that he might warrant a formal forensic assessment.

Third Admission – Harvest Ward

52. **16. 02.03 – PG not sleeping well and requesting staff presence. He was noted to have repetitive thought processes and was phoning friends and family frequently. PG received a phone call from the police stating that if he continued to harass his mother-in-law he would be cautioned. He also had a lady visitor whom he claimed was his sister but who was thought to be a friend.**

53. **17.02.03. PG was requesting to leave and advised to discuss this with NE at the next ward round. The police were contacted and there were no outstanding charges awaiting him. An ECG was carried out which showed a mild tachycardia with ectopi only.**

54. **17.02.03. NE Consultant Psychiatrist on Harvest, had a discussion with KW in which formulation was discussed, it was noted that PG was not showing signs of mood disorder or any other psychosis.**

NE documents about PG:

- **Personality traits include over-controlling behaviour but he is not detainable under the Mental Health Act and does not require hospital treatment.**
- **Possibility of gun at home. ? where is neighbour's shotgun. Inform police.**
- **Wife is aware of risks and police need to be involved, as she is concerned.**
- **Medical investigations.**
- **Nursing Team has spoken to wife on the telephone and has advised that she needs to seek legal advice or contact the police if threats are made to her.**
- **Copy of discharge letter to be sent to GP and CPN to be informed.**

<u>Community Care - 3</u>

55. **17.02.03** GP informed of PG's discharge and message left for CPN AV to visit. Property returned. Discharge paperwork completed.

56. **21.02.03**. PG seen by MW, Consultant Psychotherapist and Approved Analyst. All he had been able to offer was an extended assessment. However the assessment could not be completed as PG left quickly after the second session, 'to be close to his wife'.

57. At a discharge planning meeting on **11 March 2003** at Pydar Street with PG, KW, VT and DO, PG's mental state was noted to be more stable and he was not clinically depressed. He had abstained from alcohol over three weeks and felt he was through the worst of this crisis and moving on. He was happy with his present prescribed dose of medication. He agreed that his commitment to his new therapist made the roles of the CMHT redundant and was happy to be discharged back to his GP's care.

58. **16.04.03**. AV wrote to GP a discharge letter stating that PG had found a 'therapist' and they appeared to have developed a good relationship. She was providing marital guidance to him and his wife and she was involved in charity work in South Africa. PG was actively pursuing this charitable work as a viable way of being occupied and feel useful without jeopardising his retirement income, and he had already organised significant contributions from various dental organisations.

59. **23.05.03**. Reported that PG found dead.

CHAPTER 3

CARE MANAGEMENT PROBLEMS

1. In order to systematically investigate and analyse the care received by PG and LG the Internal Review Panel adopted the "Protocol for the Investigation and Analysis of Clinical Incidents" published by the Clinical Risk Unit of the University College London and ALARM (Association of Litigation and Risk Management) in September 1999.

2. In accordance with the protocol, through scrutiny of the clinical record and interviewing staff involved, the panel has identified a series of Care Management Problems (CMPs).

3. Care Management Problems are described in the protocol as "actions or omissions by staff in the process of care".

4. For each Care Management Problem the Clinical Context and Patient Factors are described. These record the salient clinical events and other patient factors affecting the process of care.

5. For each Care Management Problem the framework has guided the Internal Review Panel to identify Specific Contributory Factors and General Contributory Factors. The protocol suggests that Specific Contributory Factors may be:

    - Individual factors may include lack of knowledge or experience of particular staff
    - Task factors might include the non-availability of test results or protocols
    - Team factors might include poor communication between staff.
    - Work environment might include high workload or inadequate staffing.

6. The protocol suggests that General Contributory Factors are those more general problems that come to light through the consideration of the specific contributory factors. The protocol describes examples such as:

- Does the lack of knowledge shown on this occasion imply that this member of staff requires additional training?
- Does this particular problem with the protocol mean that the whole protocol needs to be revised?
- Does this specific instance of poor communication reflect more general problems within the unit?
- Is the high workload due to a temporary and unusual patient set of circumstances, or is it a more general problem affecting patient safety.

7. Ten Care Management Problems have been identified in relation to the care of PG. These are identified using the format of "Annex A " of the protocol.

8. For each Care Management Problem there is a description of the Organisational Management and Institutional Factors and then a list of Implications and Action Points.

9. This information is provided in the following pages using an adapted version of the "Investigation Form B" from the protocol.

Investigation Form A

Taken from: A Protocol for the Analysis of Clinical Incidents September 1999

Principal Care Management Problems

Patients Name: PG
Incident Date: May 03

Record Number: B-76354
Location: Cornwall and London

Summary of the Clinical Incident

Homicide of LG in London and suicide of PG in Carrick

Care Management Problem
1. The variable understanding, implementation and adherence to policies.
2. The lack of Multi-agency working.
3. The "Extraordinary" patient.
4. Perception of the Forensic Service.
5. Documentation.
6. Accumulation of Risk.
7. Managing Personality Disorder.
8. Staff Supervision.
9. Staff Organisation, Leadership and Management.
10. Training.

Staff Involved:

Care Co-ordinator: AV
Practice Care Manager: VT
Responsible Medical Officer: KW

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

1. The variable understanding, implementation and adherence to policies.

Clinical Context and Patient Factors

- Throughout the clinical teams involved in the care of PG (and LG) there has been a variable understanding of the key policies of Cornwall Partnership Trust relating to the assessment, treatment and care of Service Users. In particular the policies related to:
  Care co-ordination, Risk Assessment; Discharge Planning, Bed Management, Vulnerable Adults, Serious Untoward Incident.
- A full list of the relevant Trust policy framework considered in relation to this Care Management Problem is provided at Appendix G.

Contributory Factors

Specific	General
Work Environment Carrick Community Team: The apparent tensions between the community nursing staff at the Threemilestone sub base may have prevented the flow of information regarding policies. The Carrick CMHT has a named policy librarian at the Pydar Street CMHT Base and copies of policies are kept at the Threemilestone base.	There is a system in place throughout the county to ensure that policies are accessible however staff in the different clinical areas appeared not to know how to access this information, or did not recognizes the need to access policies. Staff report that accessing the policies via the Intranet is complex.
Team The Care co-ordination and Clinical Risk Assessment policies: appear to be understood differently by different members of the same teams. An example of this is in relation to the different levels of care co-ordination, in particular enhanced and priority. Carrick CMHT: Appeared to have an informal approach to policy adherence. Harvest : Appeared to adapted policies to the local environment. Gwaynten: Decisions on bed management at night appeared to be made outside of the policy framework.	Throughout the different clinical environments training on the content of policies appears to have been variable. Inpatient teams tended to view risk once the service user was out of hospital as a Community responsibility.

Individual Practice Care Manager :(VT) appeared to have a lack of understanding of the policies that existed, their content and when they should be applied. Serious Untoward Incident policy: Managers and staff demonstrated a variable interpretation of this policy, particularly in relation to what constitutes a Serious Untoward Incident. In particular there was a variation in view as whether the siege scenario, which lead to PG being arrested and being subject to a mental health assessment in a custody center, was a Serious Untoward Incident. It is also noted that none of the clinical staff involved in the care of PG immediately following this scenario raised the issue as a Serious Untoward Incident to a manager. It only came to the attention of a manager "On Call" later in the day that the incident had happened when the manager was contacted by the Gwaynten unit regarding advice on the appropriateness of PG being cared for in that environment. The manager at the time did not consider reporting the siege. It is suggested that if it had been reported as such the Learning From Experience process would have come into play, which would have highlighted a number of key issues and ensured that the case of PG and LG was discussed by others outside of the immediate team. The same comments apply to an earlier scenario where clinical staff were told that PG had in his possession a firearm. The Carrick Community Staff did not report this through an Incident Report, Serious Untoward Incident, or Near miss process. Nor was a multi-agency risk review called. The consequence was that no one outside of the Team was aware of the potential risks.	There appeared to be a variable knowledge base of the managers and all tiers of staff in relation to policy content. It would appear that individuals did not take responsibility for following through various aspects of the policy framework. There is a suggestion of a culture with in the organisation that perceives policies as the domain of senior managers and those who write them, rather than practical working documents that apply to clinical practice. There is a perception that too many policies exist for staff to have a working understanding of each of them.
Task Throughout the treatment and care of PG the accumulation of risk was not identified, adherence to appropriate policies would have identified this.	Care was provided to PG without reference to the policy framework.

Organisational-Management. & Institutional Context Factors

1. The number and range of policies may be too great for operational staff to have a clear working understanding of them.
2. Critical policies such as Care Co-ordination and Risk Assessment (and Risk Management) are long documents that may appear inaccessible to staff.

Implications and action points

1. Cornwall Partnership Trust needs to stream line and simplify policies, providing accessible documents that provide the essential amount of information to all staff to ensure good, safe, clinical care.
2. Cornwall Partnership Trust needs to identify and prepare a tier of key staff (for example

the Practice Care Managers) to understand the detail of the policy and who can cascade clearly their understanding of the policy, and who can be expected to be the local policy expert.

3. A training process needs to be further developed by Cornwall Partnership Trust to ensure that staff are aware of the policy framework and the key content of the policies.
4. There is a need Cornwall Partnership Trust to ensure that in the working lives of clinical staff there is an opportunity for the assimilation of policy content.
5. Through audit and review Cornwall Partnership Trust needs to ensure that staff have the understanding and knowledge of policies and their application necessary for safe practice, and that such review becomes an ongoing part of Continuing Professional Development and Supervision.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

2. The lack of Multi-agency working

Clinical Context and Patient Factors

- Although PG and LG were both service users of Cornwall Partnership Trust there was no process put in place to share information, concerns and risks.
- It appears that concerns related to risks were not communicated to the police.
- At no time was a multi-agency forum convened to discuss, assess and manage risk.

Contributory Factors

Specific	General
Work Environment Carrick Community Team: The remoteness of the Threemilestone sub-base from the rest of the Carrick CMHT, based at Pydar Street in Truro, may have impeded the sharing of information. Apparent tensions within the Threemilestone team, particularly between nurses and the Practice Care Manager, and between the Mild to Moderate service element (supporting LG) and the Severe Mental Illness element (supporting PG) may have reduced effective communication.	Throughout all of the clinical teams that had contact with PG, staff was unaware of any formal liaison arrangements between Cornwall Partnership Trust and the police. The team management made no apparent efforts to address the tensions within the team or ensured that processes were in place to ensure smooth communication.
Team Carrick Community Team: kept risks contained within the team in the belief that the therapeutic relationship would be damaged if they did otherwise, and that loss of the therapeutic relationship would present its own risks. The Team appears to have prioritized the therapeutic relationship over public safety.	Although some staff were aware of the process at no point in the mental health service's contact with PG was a Multi-agency protection of the public process triggered. The focus of public safety did not appear high on the agenda.
Individual The "On call" consultant (VB) believed that the Forensic Assessment provided though Harvest Ward would ensure the appropriate multi-agency communication. The G grade nurse (ST) working in the Mild to Moderate service supporting LG requested a multi-agency review but this was not thought to be necessary by other members of the team. Consequently it did not happen.	No reference was made to the existence of any Trust policy that would guide staff toward multi-agency sharing of risk. Although processes exist in the organization for resolving disagreements in clinical opinion within teams there is no evidence of this process being used in the case of either PG or LG
Task	

PG had at one point reported to a member of the Carrick Community Team that he had in his possession an automatic firearm. This was discussed in the team and it was decided not to report this to the police, as a relative of PG who was a policeman had been contacted and it was anticipated that this relative would be able to resolve the issue, or that PG would dispose of it. It is reported that PG told staff he had dropped it in the sea.	Staff were unaware on any obligation on them to report the alleged possession of a firearm to the appropriate authority. It appears that staff had an unrealistic acceptance of the honesty of PG.

Organisational-Management. & Institutional Context Factors

1. The value of Multi-agency working appears not to have been clear to the Carrick Community Team.
2. The Carrick Community Team maintained a higher level of risk than the usual threshold.
3. It appears that the inpatient units that provided care to PG had an expectation that the Community Team would ensure the appropriate multi-agency working if this was thought to be appropriate.

Implications and action points

1. There is a need for Cornwall Partnership Trust to promote, through training and its policy framework, the need for the sharing of Risk across agencies.
2. Cornwall Partnership Trust needs to assist its clinical staff to understand their obligation to public safety, and provide guidance as to how this is balanced with maintaining the therapeutic relationship.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

3. The "Extraordinary" patient

Clinical Context and Patient Factors

The Exceptional approach to PG based on the rationale of maintaining a therapeutic relationship lead to staff operating outside of normal working practice.

Contributory Factors

Specific	General
Work Environment Examples of extra-ordinary occurrences: Gwaynten Unit: PG requested a side room and when one could not be found he left the unit. A transfer to Harvest ward occurred without being "admitted" to Gwaynten Harvest: Spent a lot of time on the public phone, spending much more money than other service users, yet staff tolerated this behaviour although, and outside of normal practice. Bowman: Was "allowed" to see his female friend in his room although outside of normal practice.	Discharge of patients on Temporary Transfer from the west of the county from Bodmin hospital units was unusual as people are usually referred back to the host unit. The discharge from Harvest without return to the host unit was exceptional.
Team Examples of extra-ordinary occurrences: Carrick Community Team: 1. Did not report risks to the police as it was thought this would damage the maintenance of the therapeutic relationship. 2. At PG's insistence the CPN maintained contact mainly by telephone. 3. When concerns were raised by the mild to moderate CPN (SC) these were dismissed. 4. The option to seek a private psychotherapist occurred which resulted in a blurring of boundaries.	Rationales for not using a section of the Mental Health Act are linked to issues other than risk such as the fact that PG intended to travel abroad that this would be put at risk. The emphasis of maintaining confidentiality of PG's care seems to have excluded the sharing of information regarding LG's care
Individual Examples of extra-ordinary occurrences: The Psychiatric Liaison Nurse: Accompanied PG to hospital. Bowman Ward: Staff (MA) described being fascinated by PG and reported spending a disproportionate amount of time with him. Carrick Community Team: Despite examples of behaviour to the contrary staff presumed that PG would tell the truth. Although some staff (AV) were aware of PG's potential for dishonesty his version of the truth	Staff objectivity appears to have been impaired by PG's status as a health professional, wealth, charisma and authority. Staff took his word that he had disposed of the firearm If the system did not meet PG (and LG's) wants they would seek a private option – this proved disruptive to continuity and the clarity of responsibility. Private finance enabled the couple to move around, which blurred the continuity further.

potential for dishonesty his version of the truth was accepted at the "discharge" from caseload meeting.	
Task The focus of assessment and treatment appeared secondary to maintaining a "therapeutic" relationship.	Carrick Community staff relied on the fact that PG's brother in law was a police officer and would resolve issues connected to fire arms rather than following through official channels.

Organisational-Management. & Institutional Context Factors

There was no overview of the whole case where these "Extra-ordinary" features were identified and shared between the care teams.

Implications and action points

1. Cornwall Partnership Trust needs to increase staff awareness of the need to maintain boundaries whilst balancing this with the individual's rights.
2. Cornwall Partnership Trust needs to enable staff to adhere to policies, monitored by audit and supported through supervision.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Clinical Context and Patient Factors
A lack of clarity and misunderstanding of the role of Harvest Ward, Bodmin Hospital. A lack of clarity and misunderstanding of the role the Consultant Psychiatrist for Harvest Ward A lack of clarity and misunderstanding regarding the Criteria for a Forensic Assessment

Contributory Factors

Specific	General
Work Environment As PG posed no risk on Harvest and was informal he was seen as low risk by the nursing staff. There was no scrutiny of the overall risk. It has remained unclear as to the total amount of information Harvest ward received regarding PG.	There is ambiguity regarding the role of Harvest, which has been seen throughout all levels of the organisation. The Forensic Community Team is a cohesive team, separate from Harvest Ward. The Forensic Community Team is able to take direct referrals from the district Community Mental Health Teams and Harvest.
Team Harvest: Nursing Staff appeared ambivalent in relation to their role. For example some interviewed saw their role as a "specialist" service in contrast to others. Others interviewed were unclear if Harvest was a Psychiatric Intensive Care Unit (PICU) or a Forensic Unit. The Harvest Team did not appear to appreciate the difficulties posed to the community team in relation to risk, and their frame of reference did not embrace the ongoing management of risk in the community.	Harvest was going through significant change in terms of function and leadership. Harvest caters for a wide range of patients (some detained under 37/41 MHA '83, some detained under assessment and treatment orders of the MHA '83, and occasionally informal patients) leading to an ambiguity of the role provided.
Individual One consultant (VB) had the expectation that admission to Harvest would lead to a Forensic Assessment. As a result of his (NE) duel role as the Consultant Psychiatrist for the Forensic Community services and as Consultant with responsibility for patients on Harvest Ward it is believed that when the consultant passes an opinion it represents a Forensic Assessment and carries a lot of weight.	Some staff reported that there is difficulty communicating the Forensic and Harvest role to the Trust. There appears to be no clear-shared vision of the current and future role of Harvest ward in relation to the question of whether it is Forensic or PICU. The operational policy of Harvest does not identify it as a Forensic Unit.

Task	
The expert opinion of the Forensic Consultant is heavily relied on within Cornwall Partnership Trust. The consequence of this appears to be that once it was seen that PG was discharged from Harvest to the Community there was a perception that the problem was less related to mental health and therefore the on going role and responsibilities of the mental health service was limited. This influenced the discharge planning and further involvement in contingency planning.	The apparent illusiveness of a shared view across Cornwall Partnership Trust of the role of Harvest ward and the Forensic team leads to raised expectations as to what Harvest ward can provide. It is noted that a Multi-Agency Public Planning (MAPP) meeting did not take place for PG.

Organisational-Management. & Institutional Context Factors

The "Forensic" view is unchallenged and this influences subsequent care.

Implications and action points

1. Cornwall Partnership Trust needs to develop a clear statement and policy framework around the Forensic service and the role of Harvest Ward.
2. Cornwall Partnership Trust's adoption of the Department of Health's guidance on Psychiatric Intensive Care Units (PICU) needs to be agreed and distributed across the Organisation.
3. Clarity needs to be provided on Cornwall Partnership Trust's policy for admission and discharge to Harvest ward.
4. Cornwall Partnership Trust needs to ensure that there is a clear understanding of the use of the Multi-Agency Public Planning meeting (MAPP) process and incorporated in the policy framework.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

5. Documentation

Clinical Context and Patient Factors

Throughout each stage of the care process the completion of documentation fell below that expected by Cornwall Partnership Trust.

Contributory Factors

Specific	General
Work Environment At interview some staff described that the pressures of care provision prevented them from recording appropriately. Some risk assessments were incomplete and the "Critical Incident Form" was never utilised.	**At various points in PG's care there were omissions related to:** Core Assessment Risk Assessment Risk Summary Critical Incident Form Risk schedule Care Plans Discharge summary Discharge check list Letters In addition there were incomplete and undated entries in the unified clinical record, and in ASW documentation in relation to the MHA.
Team Inpatient: It appears that different inpatient units have different recording processes and choose to focus on using different components of the care co-ordination paperwork.	From the process of interviewing staff it is clear that there is an inconsistent approach to record keeping within the mental health service.
Individual Carrick Community Team: It appears that individual members of staff chose which parts of the care co-ordination paperwork they would use.	The records of LGs contact with the mental health services are very brief and do not include care co-ordination documentation.
Task The care and treatment of PG and assessment and support to LG would have been enhanced by the completion of the appropriate documentation. The compilation of the Unified Record varied according to the care setting (in some settings it is	It is reported that the Unified Records was frequently not available and consequently staff recorded on single sheets for inclusion in the file at a later stage. The system failed and vital sheets are missing and not filed

the ward clerk, in others the clinician). There would appear to be no systematic approach. This has a bearing on what paperwork is included in the record. There is a lack of clarity regarding the use of the triplicate form completed when an ASW makes a decision not to apply for an application under the Mental Health Act 1983. This appears to result in staff being unclear of the reasons for the decision and what action should be taken.	contemporaneously.

Organisational-Management. & Institutional Context Factors

1. Cornwall Partnership Trust provides a comprehensive training programme in relation to the provision and documentation of care using the care co-ordination process, however this does not appear to result in a uniformed approach to record keeping.
2. Although there is a clear expectation of the standards of record keeping within the policy framework there is a gulf between policy and practice.
3. None of the inconsistencies between the standard of documentation and the existing policy framework were highlighted through audit or records, use of records, or supervision.
4. Documentation is key to recording and communicating essential information, the current system lacks robustness.

Implications and action points

1. There is a need for Cornwall Partnership Trust to re-issue guidance and the expectation of the standard of record keeping in a way which promotes a culture of good record keeping.
2. There is a need for Cornwall Partnership Trust to ensure a rigorous audit programme of clinical records.
3. There is a need for Cornwall Partnership Trust to focus attention on the recording of information related to risk in line with the care co-ordination policy.
4. Cornwall Partnership Trust needs to review the robustness of its current system for accessing and completing Unified Records.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

6. Accumulation of Risk

Clinical Context and Patient Factors

It appears that:

1. There was no record that captured the overall pattern of the care.
2. There was an inconsistent approach to risk documentation.
3. There was an absence of multi-agency planning – without which there was any capture of the accumulation of risk.
4. There was little clarity as to the overall co-ordination and capturing of each salient factor.
5. The impact of a very persuasive and confident service user led to an underestimation of risk.

Contributory Factors

Specific	General
Work Environment In all care settings it is reported that the pace of work did not allow for adequate risk assessment.	The pace and nature of interventions were dictated by the service user.
Team Inpatient Settings: Appear to have taken a Snap shot of risk at the time. There was a sense that this was a community problem. Harvest Ward: pressure on the ward round process appears to have led to rapid decision-making. It remains unclear as to how much information from the community assessments had actually accompanied the patient to enable the team to make an informed decision. The care plan was formulated on the presentation of PG at the time and did not capture the complexities of the situation in the community, or the accumulation of the risk.	It is unclear as to who was collecting information related to the whole picture of PGs condition, and as a consequence no one had collected the total overview. There appears to be a gap between inpatient and community understanding, which resulted in the care not being joined up. The paperwork included in the care co-ordination paperwork to record the total presentation of risk over time, the critical incident form, was not used at any point in PGs contact with the service.
Individual Care co-ordinator: it appears that the allocation of PG to a relatively inexperience member of the team, not long returned to community mental health nursing (AV) was inappropriate particularly with the lack of structured supervision.	No one recognized the existence of the Critical Incident Form and the need for its completion.

Task	
The provision of safe care and treatment to PG would have been enhanced considerably with the use of a Critical Incident Form and a assessment by the Forensic team.	There was not a system in place to ensure that all the documentation went to the units at times of admission. Paperwork could not inform care planning Records did not effectively follow the patient

Organisational-Management. & Institutional Context Factors

1. A lack of clarity as to who co-ordinates information on the inpatient units.
2. Organisational difficulty in the care co-ordinator having access to the record.
3. Lack of clarity regarding the Named Nurse in the inpatient environment and their role.

Implications and action points

1. There is a need to review the Risk Assessment Documentation.
2. Training needs to be provided regarding relevant documents relating to risk and needs to include: Discharge Planning, Risk Assessment, Critical Incident Form.
3. There is a need to identify a care co-ordinator on the inpatient environment (Named case co-ordinator) for each admission of a service user on the enhanced level of care co-ordination.
4. The care process must include a review of care co-ordination on admission to hospital and at time of discharge.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem
7. Managing Personality Disorder

Clinical Context and Patient Factors
Cornwall Partnership Trust did not have a robust policy in place at the time to ensure a joined up approach to the care of the person with a personality disorder. Difference in clinical opinions regarding diagnosis that impacts on clinical management.

Contributory Factors

Specific	General
Work Environment It is reported that in all care environments the pace of the work did not allow time for adequate reflection.	It would appear that as a consequence of the use of Unified Health Record, paperwork could not catch up with the speed of PG's travel through the system. The Care co-ordinator was based three miles from the Consultant psychiatrist and psychologist, which meant that the health record was not always available at the time it was needed. At the time of admissions the health record would have been at the CMHT base (in Truro) and at times of discharge to the Community teams the health record would be at the hospital ward (on two occasions Bodmin).
Team There was a variation in the formulation and diagnosis of PG's condition: Bowman Ward: nurse belief that PG was depressed. Gwaynten: ward nurse aware of depression. Carrick Community Team: Did not involve outside opinions such as Clinical Nurse Specialist in the care of people with personality disorder (MH), or Forensic Psychologist. Did not request "Difficult to manage patient meeting" Did not request a MAPP meeting.	The staff were unclear if there was a protocol for working with people with a personality disorder, It appears that there was not an occasion when all aspects of the case were brought together.
Individual Carrick Community Team: Individuals managed a complex case in isolation. The care co-ordinator, RMO and others took PG view's account of his situation as truthful.	No external objective opinion was sought regarding the management of Personality Disorder.

No formal assessment for Personality Disorder was requested or carried out.	
Task There is no evidence of a formal assessment or formulation of personality disorder. There is no evidence of boundary setting.	No clear guidelines were sought or followed.

Organisational-Management. & Institutional Context Factors

There appears to be an absence of Policy, specialist supervision and infrastructure within Cornwall Partnership Trust in relation to the assessment and treatment of people with personality disorder.

Implications and action points

1. There is a need for Cornwall Partnership Trust to draw together a Policy for the assessment and treatment of people with personality disorder.
2. A training programme needs to be developed to enable clinical staff to adopt the policy and provide the most appropriate care for this group of service users.
3. Structured supervision provided by experts in this field of work needs to be available to clinical staff involved in the care of service users with personality disorder.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

8. Staff Supervision

Clinical Context and Patient Factors

The focus of clinical supervision and its relationship to the "Named Nurse" principle in hospital and "care co-ordinator" in the community.

Cornwall Partnership Trust has in place a policy entitled "A Supervisee Led Approach to the Supervision of Clinical Practice", ratified in February 2003, which provides policy guidance to all professional groups.

Contributory Factors

Specific	General
Work Environment Inpatient Units: It is suggested that the work pressures on nursing staff on the inpatient units does not enable a planned and effective structure for clinical supervision. Carrick Community Team: It is suggested that the community staff felt more enabled to commit to the clinical supervision process.	No staff interviewed made reference to the content of the Trust policy on supervision and the framework for clinical supervision that it advocates.
Team Inpatient Units: It appears that there is a general lack of clarity regarding supervision arrangements. The providers of supervision varied on different units, as did the process for recording supervision, its duration and frequency. Carrick Community Team: – There was a clearer process in place for supervision, however not all staff received supervision on a regular basis.	There was a general lack of awareness of the supervision policy and the standards connected with supervision. It remained unclear as to what percentage of clinical teams had undertaken the two-day formal training programme described in the policy, and how the follow up refresher training was to be organized.
Individual Gwaynten Unit: One member of nursing staff identified that regular supervision had not been a reality; however the manager interviewed described how well the supervision process worked and provided assurance that all staff received supervision. Carrick Community Team: The supervision arrangement for the care co-ordinator appeared irregular and inconsistent. The approach to	The commitment to supervision seemed to vary according to professional group. The consultant psychiatrists interviewed suggested that peer supervision existed for them. The psychologist interviewed engaged in a structured approach to supervision. It did seem, however, that a supervision relationship existed between the care co-ordinator and the psychologist. The supervision arrangements for the

supervision appeared to lack clarity and focus.	nursing and ASW staff were variable.
Task The supervision arrangements did not match the complexity of the case of PG, nor bring in to focus the needs of LG	An opportunity was missed for well focused clinical supervision to positively impact on the care of both PG and LG

Organisational-Management. & Institutional Context Factors

1. Cornwall Partnership Trust has in place a policy on supervision of clinical practice, however staff had a varying understanding of the policy and its expectation of staff.
2. The attendance at training events on this theme may have been affected by the Cornwall Partnership Trust's decision in the last year to focus training in the mental health service on mandatory training only.
3. It is noted that the supervision of clinical practice policy provides guidelines from professional bodies for all professional groups employed by Cornwall Partnership Trust with the exception of psychiatrists, and managers. It is anticipated that as the Trust is now an integrated organization it will incorporate standards for Approved Social Workers

Implications and action points

1. Ensure that staff are aware of the system that is in place for the training of Cornwall Partnership Trust staff in clinical supervision and the supervision of clinical practice policy, and are encouraged to attend by their line managers.
2. Ensure that there is a process in place to audit the practice and process of supervision.
3. The policy has an aspiration that "In the future all job descriptions will reflect organisational, managerial and individual practitioners responses to clinical supervision", this work needs to continue.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

9. Staff Organisation, Leadership and Management.

Clinical Context and Patient Factors

The organisation of the staff involved in the care of PG lacked the benefit of direction and leadership.

This was identified as being most noticeable in relation to:

1. the process of care co-ordination in the community
2. the role and function of the care co-ordinator
3. the role function and practice of the Practice Care Manager
4. the role, function and practice of the Named Nurse in the inpatient setting.
5. in the sharing of information regarding the care of LG and PG

Contributory Factors

Specific	General
Work Environment It would appear that the demands on the time of key staff members out stripped their capacity to effectively complete all the duties being asked of them.	
Team The Carrick CMHT management structure appeared loose, which left individual practitioners practicing in an autonomous fashion outside of the policy framework. The management structure relied on the Practice Care Manager to act appropriately in relation to presenting risks and to make the decision when to liaise with the Community Team Manager on such issues. Due to changes in the management of the Community Team (GC left the role and LW took this role over) there seemed to be a lack of awareness of the tensions that existed within the CMHT at the Threemilestone base, which may have impeded the smooth sharing of information and professional opinion.	In the Inpatient Units: There was a lack of clarity regarding the role of the Named Nurse, particularly in relation to care co-ordination. There was no consistency in the process that would identify and allocate a named nurse. The role of the named nurse in relation to discharge planning and ward rounds appeared inconsistent. In relation to the Care Programme Approach-Co-ordination: There appeared to be a lack of overview of the process. Although VT reports having audited the records of PG and arranged local training on care-co-ordination documentation there is no evidence that this had a positive effect.

Issues with the co-location of the Mild to Moderate (C2) staff and the severe and enduring staff at Threemilestone: Whilst this co-location caused concern to the Review Panel in terms of the maintenance of confidentiality, it did enable an informal sharing of concerns regarding LG. Although there was no formal response to the concerns raised by the C2 G grade nurse (SC) she was able to make her concerns known.	Although care was being provided to LG and PG by the same organization the management structure did not ensure the sharing of information regarding both parties. LG was not identified as being a carer in need of a carer's assessment by the Mental Health service, or as a vulnerable adult.
Individual Within the Carrick CMHT The care co-ordinator (AV) was working in isolation without the benefit of a management overview, which may have lead her to believe that the appropriate managerial direction in the case of PG would come from the RMO. The RMO (KW) was also in the position of a change in working role. One staff member (SC) who had concerns regarding the risks to LG was unable to convince her colleagues of the authenticity of her concerns. Access to managers senior to the Practice Care Manager appeared not to be part of the team culture, nor to raise professional concerns with the professional head of nursing, or to look at the policy framework to overcome a difference of opinion in the team.	There appeared to be no managerial overview of the inpatient and community care of PG. The assumption was made that all involved were working appropriately, without mechanisms being in place to test out, from time to time, if this was the case or not.
Task The lack of clarity of the role of the named nurse led to a vacuum of information collection and sharing in the inpatient environment. The lack of first line managerial direction in the community lead to autonomous practice outside of the policy framework.	Communication between all involved in the care of PG and LG was not promoted by the organisation and management of the inpatient and community structure.

Organisational-Management. & Institutional Context Factors

Cornwall Partnership Trust's Management structure in terms of the Ward Managers and Community Team Managers appeared unaware of the complexities of PG case, and consequently were unable to provide guidance and direction.

Implications and action points

1. The role of the inpatient Named Nurse requires clarification, and consistent application of practice across the organization, adopting the principles of care co-ordination.

2. The Care Programme Approach through Care Co-ordination needs to be rigorously managed. The Trust may wish to change the name of the process back to CPA to ensure its focus of a care process is maintained.

CARE MANAGEMENT-PROBLEMS AND- CONTRIBUTORY-FACTORS FORM

Care Management Problem

10. Training

Clinical Context and Patient Factors

The policy framework of Cornwall Partnership Trust sets out an expectation that staff will attend certain training. The Trust has identified some training as mandatory. Evidence would suggest that mandatory training is perceived as:

1. Health & Safety
2. Breakaway (Lone worker safety)
3. Control and Restraint (Therapeutic Management of Aggression)
4. First Aid
5. Food Hygiene
6. Moving and Handling
7. Fire

This review has particularly focused on training related to care co-ordination and risk management, and has identified that difficulties related to the attendance sharing, and implementation of the learning are contributory factors in relation to the care of PG.

Cornwall Partnership Trust has in place a rigorous training programme entitled "Care Co-ordination Cornwall Joint Agencies Training Initiative (Mental Health)". This programme, outlined below with the details of the course capacity and frequency for 2004, consists of a range of study events central to care co-ordination and risk assessment.

Title	Duration	Places	Annual Frequency	Total Annual Capacity
1. Basic Clinical Risk Assessment and Management in Mental Health for Mental Health Workers/Professional	1 day	20/30	4	120
2. Clinical Risk Assessment and Risk Management in Mental Health ~ Follow-up and Development Training	1 day	15	?2	30
3. Needs-led Assessment and Care Planning ~ An Holistic Approach	1 day	25	3	75
4. Crisis and Contingency Planning ~ Developing the Care Co-ordination Care Plan	1 day	20	3	60
5. The Role of the Care Co-ordinator	1 day	20	3	60
6. Embracing the Principles and Practice of Engaging with Carers and Assessing Carers Needs	1 day	25/30	2	60
7. Single Point of Access ~ "Getting it Right at the Shop Front"	1 day	25	3	75
8. Diversity and Discrimination in Mental Health Practice ~ Rights and Responsibilities	1 day	25	2	50

It is noted that the course material of the "Basic Clinical Risk" identifies this study day as mandatory but it does not appear on the Trust's mandatory training list. This study day provides staff with a comprehensive overview on the following themes:

1. Be familiar with local risk policies in clinical risk /risk management in mental health.

2. Be more confident and knowledgeable in negotiating with colleagues, service users and carers in pursuing effective risk assessments.
3. Construct effective written care plans outlining risk issues and negotiating positive service user focused risk options.
4. Meet the requirements of the NSF for risk assessment and management and the capable practitioner for ethical practice and the process of care.

Theoretically this one day course would have been sufficient to cover the key care co-ordination and risk assessment aspects of the care of PG and LG.

Contributory Factors

Specific	General
Work Environment Inpatient Unit staff identified the difficulty that for staff to attend training replacement staff need to be provided and that the cost of drafting in replacement staff made managers cautious at sending staff on training; this is particularly relevant in relation to staying within budget and contributing to the financial recovery programme. The Trust had announced last year that only mandatory training could be supported. Community staff identified that there were no covering arrangements when they attended training other than their colleagues covering their workload, and that in busy teams this affected their decisions to apply for training out of concern for service user care and their colleagues workload.	All clinical staff that were asked for an overview of the training they had attended in relation to these two themes identified that the demands on their time deterred them from attending training.
Team Inpatient Units: Uptake on risk and care-coordination training limited within all the inpatient units. Community Teams: Within the nursing elements of the teams training uptake is reported to be better. However no refresher training in risk assessment has been offered.	All teams report a similar situation. On the Bodmin hospital site an initiative has been introduced by the on site managers to have training provided locally to reduce the need for staff to be away from the work place for long periods. There is no evidence to suggest that this has improved the uptake of training.
Individual Care Co-ordinator: Reported to have attended care co-ordination and risk assessment training and had applied for care co-ordination training. Practice Care Manager: Reported to have attended care co-ordination and risk assessment training.	Currently there is not a reliable central database of mandatory, care-co ordination or risk assessment training that can be easily accessed. At the annual appraisal there is an opportunity for staff (non medical) to record their training attended in the last year and identify training needs for the next year. In theory this is the opportunity for line managers to be aware of the training needs of their staff and how these are met. There is no central process for managers to identify the up take of and attendance at training.
Task There is no evidence that staff identified that they had received insufficient training to meet the	The majority of the staff involved in the treatment and care of PG (and LG) had not

needs of PG (or LG).	been prepared for their roles in relation to care co-ordination and risk assessment through training. This also applies to other areas of care such as: discharge planning, vulnerable adult protection, caring for people with a personality disorder and the role of the named nurse.

Organisational-Management. & Institutional Context Factors

1. Although comprehensive lists of staff that have attended training are now kept, Cornwall Partnership Trust does not appear to have a centralised process for capturing the training needs of staff, particularly in the areas of care co-ordination and risk assessment, ensuring that courses are attended and monitoring that training needs have been met. It is understood that this is being addressed.
2. There is some ambiguity as to what training is mandatory.
3. Managers do not have an identified training budget.
4. Managers have been concerned at releasing staff for training because of the impact on their budgets.

Implications and action points

1. There is a need for Cornwall Partnership Trust to have a clear and definitive list of the training courses that are mandatory for each employee to attend. This process would be best supported by a system, which can provide an overview, by clinical area, of staff that has attended training.
2. Cornwall Partnership Trust needs to ensure that there is a clear process in place for the identification of learning needs in relation to all the key aspects of care provision for service users, and that the meeting of these needs is audited and reviewed by managers.
3. Cornwall Partnership Trust need to ensure that where ever possible training is provided close to clinical areas so that clinical staff does not need to be away from their workplace for long periods.
4. A network of champions needs to be created on the theme of care co-ordination and risk assessment that can provide cascade training and mentorship in the workplace.
5. The provision of a training budget for managers may help the promotion of a planned approach to training.
6. Cornwall Partnership Trusts needs to ensure that operational budgets reflect the reality that staff will need to be released for training and in certain clinical areas and circumstances replacement staff will be required.

CHAPTER 4

IDENTIFIED CARE MANAGEMENT PROBLEMS

RECOMMENDATIONS

The Internal Review Panel has conducted its Review in accordance with the Terms of Reference set out at Appendix A.

The Internal Review Panel identified ten Care Management Problems.

The Internal Review Panel concludes that although omissions in practice led to the occurrence of the Care Management Problems there was no neglect of duty of care

The Internal Review Panel suggests that if all the areas of care had been provided without omissions the tragic incidents of suicide and homicide may still have occurred.

The Internal Review Panel makes the following Recommendations:

Care Management Problems	Implications and Action Points for Cornwall Partnership NHS Trust
1. The variable understanding, implementation and adherence to policies.	1. Stream line and simplify policies, providing accessible documents that provide the essential amount of information to all staff to ensure good, safe, clinical care. 2. Identify and prepare a tier of key staff (for example the Practice Care Managers) to understand the detail of the policy and who can cascade clearly their understanding of the policy, and who can be expected to be the local policy expert. 3. Further develop a training process to ensure that staff are aware of the policy framework and the key content of the policies. 4. Ensure that in the working lives of clinical staff there is an opportunity for the assimilation of policy content. 5. Through audit and review, ensure that staff have the understanding and knowledge of policies and their application necessary for safe practice, and that such review becomes an ongoing part of Continuing Professional Development and Supervision.
2. The lack of multi-agency working	6. Promote, through training and its policy framework, the need for the sharing of Risk across agencies. 7. Assist its clinical staff to understand their obligation to public safety, and provide guidance as to how this is balanced with maintaining the therapeutic relationship.
3. The "Extraordinary" patient	8. Increase staff awareness of the need to maintain boundaries whilst balancing this with the individual's rights. 9. Enable staff to adhere to policies, monitored by audit and supported through supervision.
4. Perception of the Forensic Service	10. Develop a clear statement and policy framework around the Forensic service and the

	role of Harvest Ward. 11. Adoption of the Department of Health's guidance on Psychiatric Intensive Care Units (PICU) needs to be agreed and distributed across the Organisation. 12. Provide clarity regarding the policy for admission and discharge to Harvest ward. 13. Ensure that there is a clear understanding of the use of the Multi-Agency Public Planning meeting (MAPP) process and its incorporation in the policy framework.
5. Documentation	14. Re-issue guidance and the expectation of the standard of record keeping in a way which promotes a culture of good record keeping. 15. Ensure a rigorous audit programme of clinical records. 16. Focus attention on the recording of information related to risk in line with the care co-ordination policy. 17. Review the robustness of its current system for accessing and completing Unified Records.
6. Accumulation of Risk	18. Review the Risk Assessment Documentation. 19. Provide training regarding relevant documents relating to risk and needs to include: Discharge Planning, Risk Assessment, Critical Incident Form. 20. Identify a care co-ordinator on the inpatient environment (Named case co-ordinator) for each admission of a service user on the enhanced level of care co-ordination. 21. Ensure that the care process includes a review of care co–ordination on admission to hospital and at time of discharge.
7. Managing Personality Disorder	22. Draw together a Policy for the assessment and treatment of people with personality disorder.

	23. Develop a training programme to enable clinical staff to adopt the policy and provide the most appropriate care for this group of service users. 24. Provide structured supervision by experts in this field of work, to be available to clinical staff involved in the care of service users with personality disorder.
8. Staff Supervision	25. Ensure that staff are aware of the system that is in place for the training of Cornwall Partnership Trust staff in clinical supervision and the supervision of clinical practice policy, and are encouraged to attend by their line managers. 26. Ensure that there is a process in place to audit the practice and process of supervision. 27. Ensure the work continues to fulfill policy aspiration that "In the future all job descriptions will reflect organisational, managerial and individual practitioners responses to clinical supervision".
9. Staff Organisation, leadership and management	28. Clarify the role of the inpatient Named Nurse requires clarification, and ensure consistent application of practice across the organisation, adopting the principles of care co-ordination. 29. Ensure rigorous management of the Care Programme Approach through Care Co-ordination. Consider changing the name of the process back to CPA to ensure its focus of a care process is maintained.
10. Training	30. To have a clear and definitive list of the training courses that are mandatory for each employee to attend. This process would be best supported by a system, which can provide an overview, by clinical area, of staff that has attended training. 31. Ensure that there is a clear process in place for the identification of learning needs in relation to all the key aspects of care provision for service users, and that the meeting of these needs is audited and reviewed by managers.

	32. Ensure that where ever possible training is provided close to clinical areas so that clinical staff do not need to be away from their workplace for long periods. 33. Create a network of champions on the theme of care co-ordination and risk assessment that can provide cascade training and mentorship in the workplace. 34. Consider creating the provision of a training budget for managers that may help the promotion of a planned approach to training. 35. Create operational budgets to reflect the reality that staff will need to be released for training and in certain clinical areas and circumstances replacement staff will be required.

APPENDIX A

TERMS OF REFERENCE

The terms of reference for this investigation were set out in the letter of 18, June 03 to the Panel Members, which stated:

The Terms of Reference for the internal review are as follows:

1. With reference to the serious untoward incident that occurred on the 21 May 2003, to examine the circumstances of the treatment and care of Mr PG by the Mental Health Services, in particular

   (a) The quality and scope of the health care and risk assessment.

   (b) The appropriateness of Mr PG's treatment, care and supervision in respect of any of the following that are relevant:

   (1) His assessed health care and social care needs;
   (2) His assessed risk of potential harm to himself or others;
   (3) Any previous psychiatric history, including drug and alcohol abuse;
   (4) Number and nature of any previous court conviction

   (c) Statutory obligations; national guidance (including the Care Programme Approach, SG (90) 23/LASSL (90) 11); Discharge Guidance HSG (94) 27; Mental Health Act 1983 and code of practice as well as any local operational policies for the provision and support of mental health services.

   (d) The extent to which Mr PG's prescribed treatment and care plans were:

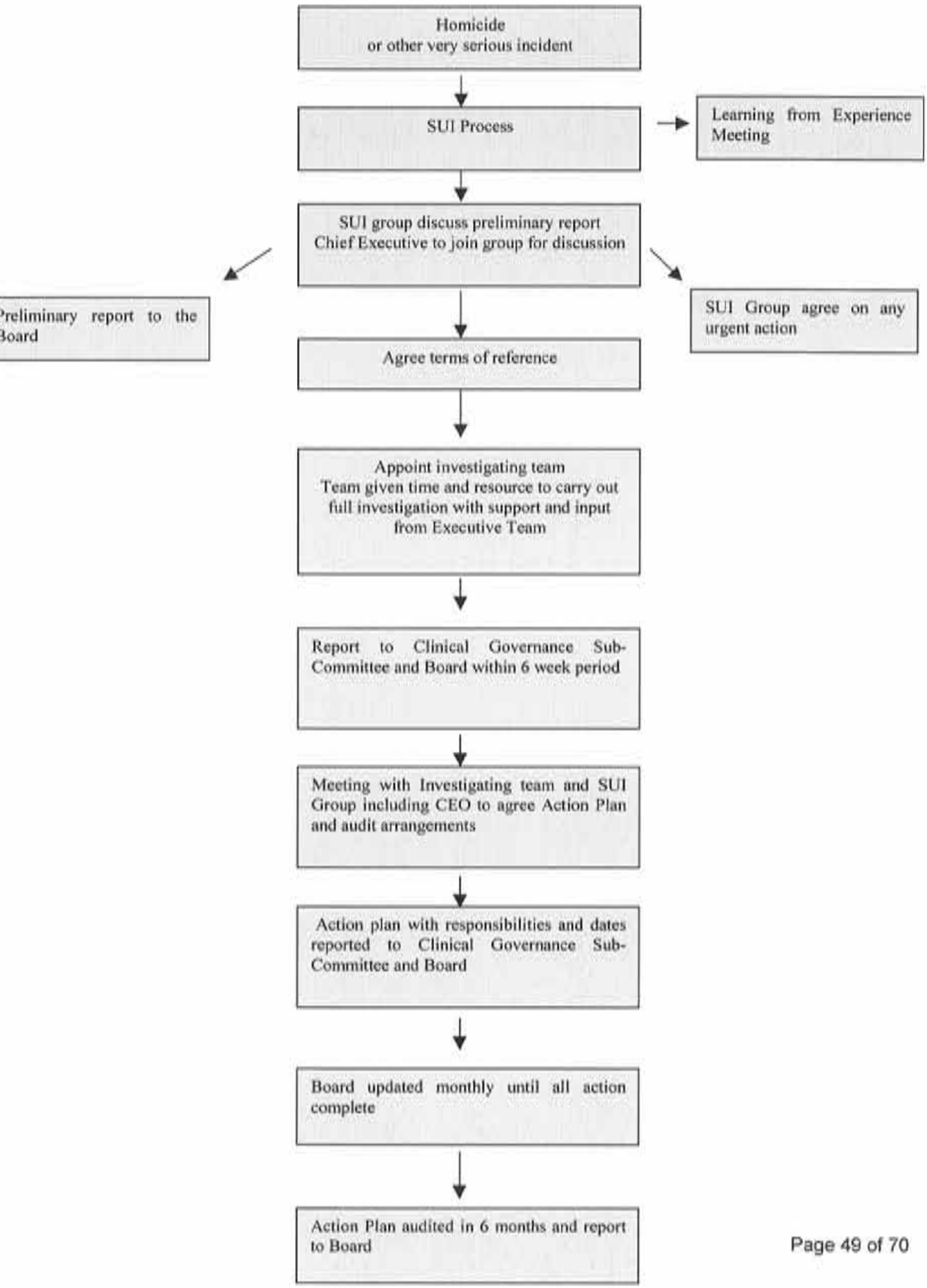
   (1) Documented;
   (2) Agreed with him;
   (3) Communicated with and between relevant agencies and his family;
   (4) Delivered;
   (5) Complied with by Mr PG and assisted by his carer.

2. To examine the appropriateness of the training and development of those involved in the care of Mr PG.

3 To examine the adequacy of the collaboration and communication between Health, Social Services and any other agencies, which were, or might appropriately have been, involved in the care of Mr PG.

4. To review the implementation of the serious untoward incident process in response to the incident.

5. To prepare a report and make recommendations as appropriate to the Cornwall Partnership Trust Senior Management Team and Board.


Homicide
or other very serious incident
SUI Process
Learning from Experience Meeting
SUI group discuss preliminary report
Chief Executive to join group for discussion
Preliminary report to the Board
SUI Group agree on any urgent action
Agree terms of reference
Appoint investigating team
Team given time and resource to carry out full investigation with support and input from Executive Team
Report to Clinical Governance Sub-Committee and Board within 6 week period
Meeting with Investigating team and SUI Group including CEO to agree Action Plan and audit arrangements
Action plan with responsibilities and dates reported to Clinical Governance Sub-Committee and Board
Board updated monthly until all action complete
Action Plan audited in 6 months and report to Board

APPENDIX B

REVIEW PROCEDURE

Introduction

1. All hearings of the Review will be held in private.
2. The Review hearings will be conducted as informally as possible. The evidence will be led by the most appropriate professional to take that role, as deemed by the Review Panel, to ensure that the views of all those participating in the review process are properly and fully canvassed in evidence.
3. Factual evidence will be sought from those working within the Services involved with PG at the relevant time.
4. Advice may be sought from relevant experts on practice issues.

Oral Evidence

5. Each factual witness will receive letters informing them of:
   - The terms of reference and the procedure adopted by the Review.
   - The proposed timetable for the Review.
   - The method of accessing records relevant to their own role in the care of PG for the limited purpose of responding to the Review.

6. Witnesses attending in person to provide evidence may raise any matter they feel might be relevant to the Review.

7. Witnesses may bring with them, at their own personal cost, a lawyer or a member of the Defence Organisation, friend, relative, colleague or member of a Trades Union, provided that no such person is also a witness to the Review: it is the invited witness that will be expected to answer questions.

8. All evidence will be recorded and a transcript sent to the relevant witness to check for accuracy.

Publication of Report

9. Findings of Fact will be made on the basis of the evidence received by the Review. Comments that appear within the narrative of the Report, and any recommendations, will be based on those findings.

10. The findings and any recommendations of the Review will be presented in a report and submitted to the Chief Executive and the Board of Cornwall Partnership NHS Trust as commissioned.

APPENDIX C

STAFF INTERVIEWED

In the process of this Internal Review the panel interviewed 27 staff and held a total of 32 interviews.

These interviews are detailed below. The venue abbreviations relate to;
Pydar St = Carrick CMHT Base, 57 Pydar Street, Truro.
St Aub V = Training Centre, St Aubyn Villa, Bodmin Hospital.
Bell Hse = The "small meeting room", Bellingham House, Bodmin Hospital.

Name	Role	Date	Venue	Number of times Seen
Amber Vitae	CPN Care Co-ordinator	03 Jul 03 29 Aug 03	Pydar St St Aub V	2
Val Taylor	Practice Care Manager	03 Jul 03 26 Aug 03	Pydar St Bell Hse	2
Bob Taylor	Psychiatric Liaison Nurse	03 Jul 03	Pydar St	1
Nigel Eastwood	Consultant Psychiatrist	08 Jul 03 27 Aug 03	Pydar St St Aub V	2
Ian Matthews	ASW	08 Jul 03	Pydar St	1
Vicky Bridges	Consultant Psychiatrist	08 Jul 03	Pydar St	1
Ken Wood	Consultant Psychiatrist RMO	08 Jul 03	Pydar St	1
Dave Oxford	Psychologist	08 Jul 03	Pydar St	1
Dave Willmot	ASW	15 Jul 03	Pydar St	1
Lorraine Warne	Team Manager Carrick CMHT	15 Jul 03 29 Aug 03	Pydar St St Aub V	2
Maggie Atherton	Staff Nurse Bowman Ward	15 Jul 03	Pydar St	1
Shelly Eveleigh	Ward Manager Harvest Ward	15 Jul 03	Pydar St	1
Sarah Gabert	Joint Lead Officer Care Co-ordination	26 Aug 03 26 Aug 03	Bell Hse Bell Hse	2
Andy Martin	Deputy Team Leader Harvest Ward	26 Aug 03	Bell Hse	1
Dawn Spry	Team Leader Forensic Community Services	27 Aug 03	St Aub V	1
Noreen Lockwood	Staff Nurse Harvest Ward	27 Aug 03	St Aub V	1
Barry O'Muirithe	Staff Grade Psychiatrist	27 Aug 03	St Aub V	1
Katherine Thomas	Staff Nurse Harvest Ward	28 Aug 03	Bell Hse	1
Shonagh Trudgeon	Staff Nurse Gwaynten	28 Aug 03	Bell Hse	1
Tania Killen	Staff Nurse Bowman Ward	28 Aug 03	Bell Hse	1

Name	Role	Date	Venue	Number of times Seen
Edward Chambers	Ward Manager Bowman Ward	28 Aug 03	Bell Hse	1
Martin Faulkner	General Practitioner	28 Aug 03	Bell Hse	1
Lynn Verran	Ward Manager Gwaynten (Now Longreach House)	29 Aug 03	St Aub V	1
Gerry Cantwell	Community Team Leader Carrick CMHT (now project manager)	29 Aug 03	St Aub V	1
Sharon Collier	G grade CPN Mild to Moderate Service Carrick CMHT	29 Aug 03	St Aub V	1
Mark Young	Mental Health Act Advisor	12 Sep 03	St Aub V	1
Lindsay Parkyn	Nurse Consultant	12 Sep 03	St Aub V	1

APPENDIX D

November	Tue	Wed	Thu	Fri	Sat
				1	2
3	4	5	6	7	8	9
10	11	12 AV's Care Plan for PG has this date. Incorrectly dated entry	13	14	15	16
17	18	19 PG takes 1st overdose	20	21	22 Admitted to Bowman	23
24	25 Discharge letter to GP Discharge from Bowman Ward Referral to AV	26	27 Screening Assessment. Attended by Student Nurse	28	29 AV makes contact attempts HV	30

2002

December

	Tue	Wed	Thu	Fri	Sat
1	2 Phone contact AV	3	4 From Interview: AV Home Visit	5 AV Home Visit	6 Dr Wood OPA	7
8	9	10 AV attempted phone contact. PG phoned Elaine Dell	11 AV Phone Contact	12	13 AV Phone Contact	14
15	16 AV Tel Contact	17 AV Tel Contact	18 PG phones AV	19	20 PG seen by AV	21 LG contacts AV PG Admitted Gwaynten
22	23 DAMA from Gwyanten LG 1st appointment with counselor and SC	24 LG reviewed by SC	25	26	27	28 OOH contacted by PG
29 OOH contacted by PG	30 LG reviewed on telephone by SC	31				

2002

January

		Tue	Wed	Thu	Fri	Sat
			1	2 AV Home Visit	3	4
5	6	7	8	9 AV Home Visit	10	11
12	13 KW letter to GP.	14	15 *OPA KW*	16	17	18
19	20	21	22	23	24 DO OPA PG DO letter to AV	25
26	27	28 AV Tel contact with PG	29	30	31 DO OPA PG+LG Letter DO to AV	
						2003

February

	Tue	Wed	Thu	Fri	Sat
					1
2	3	4	5	6	7	8
9	10	11	12	13 AV Tel. Contact with PG	14 PG to Custody Centre Assessment by Dr Bridges LG phone contact with SC	15 Admitted Harvest
16	17 Discharged	18 Letter from Ian Mathews to Dr Wood	19 Letter from Dr Bridges to Dr Wood	20 AV Tel. Contact with PG	21 Letter from Mike Watson to Dave Oxford	22
23	24	25 AV Tel. Contact with PG	26	27	28	

2003

March

		Tue	Wed	Thu	Fri	Sat
						1
2	3 Discharge letter from Harvest	4	5	6	7	8
9	10	11 Discharge Meeting Discharge from Caseload	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

2003

April

		Tue	*Wed*	*Thu*	*Fri*	*Sat*
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16 Discharge Letter from CMHT to GP	17	18	19
20	21	22 GP sees LG	23	24	25	26
27	28	29	30			

2003

May

	Tue	Wed	Thu	Fri	Sat
			1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20 Reported that LG body found in London flat	21	22	23 Reported that body of PG found at his home in Cornwall	24
25	26	27	28	29	30	31

2003

APPENDIX E

SUI INFORMATION SHEET

Today's Date: 27th May 2003

SUI Ref No. 015-03

Name:	**PETER GRANT**
DoB (if known):	16.03.52
Occupation: *(Must be completed)*	Retired Dentist
Staff or Patient:	Discharge client - April 2003
District:	**Carrick**
RMO:	Dr. Ken Wood
Diagnosis *(Must be completed)*	Unclear. Unable to identify diagnosis from notes.
When last seen:	11th April, 2003
CPN/Key Worker:	AV, CPN
Care Plan – Enhanced or Standard:	Discharged, previously enhanced
Informal/Sectioned:	informal
Date of incident	21.05.03
Who informed of incident	Team information obtained via media/press
When Informed	23.05.03
A/I form completed	Yes
SUI form complete	Yes

Additional Information:

Mrs. L. Grant, estranged wife of Mr. P. Grant was found dead at her home in London on 20th May 2003. Cause of death – strangulation. Police investigation alleges deaths to be linked. No other suspects involved.

APPENDIX E

Cornwall Partnership NHS
NHS Trust

REPORT INTO SERIOUS UNTOWARD INCIDENT 015-03

NAME: PETER GRANT

D.O.B. 16.3.52.

TEAM: FORMERLY CLIENT OF CARRICK CMHT

RMO: KW

CARE CO-ORDINATOR: AV

CPA: ENHANCED LEVEL OF CARE CO-ORDINATION. DISCHARGED AT TIME OF INCIDENT

LEGAL STATUS: INFORMAL

INTRODUCTION

On the 23 May 2003 it came to light that Mr Peter Grant had been found dead at his property. Prior to this his wife had been found strangled in London. Mr Grant had been a client of the Carrick CMHT and had recently used inpatient services at Harvest Ward and Bowman ward, Bodmin Hospital and the Gwaynten Unit. Mrs Lynn Grant (wife) was referred to 27 Lemon Street Counselling Service on the 23 December 2002. She was seen for four sessions of counselling and discharged on 10 February 2003. This was in relation to the break up of her marriage and the threats her former husband had been making in relation to his own suicide.

MR GRANT'S MENTAL HEALTH HISTORY WITH CORNWALL PARTNERSHIP TRUST

Mr Grant was first referred to Cornwall Partnership Trust Mental Health Services on 22 November 2002. This took the form of an informal admission to Bowman Ward (Bodmin Hospital). This was preceded by two overdoses on the 19 and 20 November 2002 following the breakdown of his marriage. Mr Grant was discharged on the 25 November 2002 with a diagnosis of Adjustment Disorder. Mr Grant was seen on the 29 November 2002 by AV following his discharge.

He was contacted again by telephone on the 2 December 2002 and again on the 4 December 2002 followed by a home visit on the 5 December 2002. There were numerous and regular contacts made with him up until 21 December 2002 when he was informally admitted to Gwaynten Unit. This was again triggered by an overdose and verbalised intentions to harm himself by shooting. He is also reported to have driven his tractor into the kitchen with the intention of poisoning himself on the fumes and driving his motorcar at speed. It is also reported that he consumed large amounts of alcohol at times and made threats involving firearms.

A recommendation for detention under Section 2 of the Mental Health Act was made by Dr Wood during this admission but was not converted into a formal detention. Mr Grant was visited by his GP Dr Faulkner and his wife on the same day (23 December 2002). Dr Faulkner felt unable to support the application on assessment and Mr Grant took his discharge against medical advice following a full risk assessment and the development of a community support package. Mr Grant continued to be followed up by his CPN (AV).

On the 7 January 2003 Mr Grant's case was discussed with the Clinical Psychologist, Mr DO. He was asked to assess his suitability for psychological therapy. DO referred Mr Grant on to Mr Mike Watson (Consultant Psychotherapist). Mr Mike Watson produced a report following the referral detailing Mr Grant's past. Unfortunately the full assessment was unable to be completed as Mr Grant left following the second session and said this was because he wanted to be near his wife. Mr Watson highlights risk both in relation to Mr Grant's suicidal ideation but also towards his wife and felt that both risks were of equal significance.

On the 14 February 2003 a further inpatient admission was recommended. He attended the Gwaynten Unit at approximately 20.00 hours requesting a single room and stated that he would be willing to pay for this. Mr Grant was asked to wait at the Gwaynten Unit until the Senior House Officer could see him. He declined to do so but was later admitted to Harvest ward from the Police Custody Centre at Newquay. He had been arrested for the possession of a firearm.

Again a Section 2 MHA Assessment was undertaken however Mr Grant was admitted informally. It is reported that Mr Grant had agreed to admission to Harvest Ward informally.

Mr Ian Matthews – Approved Social Worker, Carrick CMHT – in an assessment undertaken at this time states that

> "Mr Grant is an ex Dentist who had made a fortune from property development. He informs us that he had read lots of books about depression. He did not present as being mentally ill or depressed and tried to make out the whole incident was due to his mother-in-law's fabrication…." "However, both Dr Bridges and I agreed that it was appropriate to detain Mr Grant under Section 2 MHA because we felt that a full assessment in hospital was needed for the following reasons.
>
> 1 He may possibly have a treatable depression masked by anger.
> 2 He may have a psychopathic disorder including morbid jealousy, which could place his wife in danger.
> 3 He is impulsive.
> 4 He has made five previous attempts/gestures of self-harm some of which were melodramatic but nevertheless placed him at risk.
> 5 He may need a forensic assessment."

Mr Matthews goes on to say that he and Dr Meijer (Police Surgeon) returned to speak to Mr Grant who assured them that rather than be sectioned under the Mental Health Act he would accept an informal admission and co-operate with any medical advice. Mr Matthews says that it was a difficult decision to make but that he and Dr Meijer decided, "we lacked strong enough grounds to say that Mr Grant's agreement was not reliable".

On the 17 February 2003 Mr Grant was discharged from Harvest Ward to home and was followed up against by AV. Whilst at Harvest Ward, Dr Eastwood states:

1 My own view is that the patient is not showing signs of mood disorder or any psychosis.
2 Personality traits include over controlling.
3 Not detainable under Mental Health Act, does not require hospital treatment.

He goes on to say that his wife is aware of risks and that Police need to be involved if she is concerned. AV followed Mr Grant up following discharge from Harvest Ward on 17 February 2003 once again.

It is reported that he had planned to go to New Zealand on the 22 February 2003. Mr Grant's wife asking that they undergo a further period of six months separation triggered this. Subsequently however he decided not to go.

On the 11 March 2003 a Multi-Disciplinary risk meeting took place in relation to Mr Grant's ongoing treatment. At this meeting it was stated that Mr Grant had found a therapist in whom he had great faith. This lady (Annette Montague-Thomas) was providing marital guidance for Mr

Grant. It appeared at this time that Mr Grant was making plans for the future. At this meeting it is stated that Mr Grant's mental health was more stable and he was not clinically depressed. He had abstained from alcohol for over three weeks and felt that he was through the worst of this crisis and was moving on. It is reported that Mr Grant had agreed with the team that his commitment to his new Therapist made the CMHT's role redundant at that particular time and he was happy to be discharged back to the care of his General Practitioner.

ACTIONS FOLLOWING REPORTED INCIDENT

Lorraine Warne sent immediate notification form to Rosemarie Lane on the 23 May 2003. Immediate support was offered to the CPN involved in Mr Grant's care (AV) by Lorraine. Other staff involved and informed at this particular time were KW and his secretary Elaine Dell, NE and the Forensic Team. The Practice Care Manager, VT, was advised of the events. Dr Vicky Bridges and Ian Matthews were informed, as were the inpatient teams at Harvest and Gwaynten Wards. Dr Faulkner (GP) was also made aware (via message as he was on leave) and Sharon Collier was advised due to the fact that she had been seeing Mrs Lynn Grant. The private Therapist (Annette Montague-Thomas) was advised on the 27 May 2003. Dr Frieder Lehman-Waldau (Duty Consultant) was also made aware of events. Mr David McAuley (Clinical Manager) verbally notified the Chief Executive's Office immediately on the 23 May 2003 and asked that the General Manager also be made aware.

A Learning from Experience meeting has been arranged for Tueday 3 June 2003.

RECOMMENDATIONS

1 That an Investigating Officer be appointed.
2 That a Facilitator be sought in relation to Learning from Experience meeting on Tuesday 3 June 2003.
3 Ongoing support needs for staff involved in Mr and Mrs Grant's treatment be ongoingly reviewed. I would suggest that it is important to be mindful of the fact that this may be a particularly traumatic time for those that have been involved in both the care of Mr & Mrs Grant.
4 That the Trust review as part of the learning from this incident, discharge and service entry criteria.

David McAuley
Clinical Manager
28 May 2003

APPENDIX F

LEARNING FROM EXPERIENCE MEETING

3RD JUNE 2003

SUI 015-03

Mr PETER GRANT
BLACKBERRY FARM
FEOCK
TRURO
CORNWALL.

In Attendance:

Dr Vicky Bridges - Consultant in Psychiatry of Old Age
Lorraine Warne - CMHTL
VT – PCM
AV – CPN
Dave Oxford – Psychologist
Dr K Wood – Consultant Psychiatrist
Elaine Dell – Medical Secretary
Dr Sol Wong – SHO
Sharon Collier – CPN

Apologies:

Ian Matthews – ASW
Dr Marilyn Mitchell – Consultant Psychiatrist
Dr N Eastwood – Consultant Psychiatrist
Gwaynten
Harvest Ward
Dr Falkner
Private Therapist Annette Montague Thomas
Dave McAuley

The meeting takes the form of background information. Events of Concern and What Learnt.

KW supplied background information. Mr Grant was a 50-year-old man who first came to psychiatric attention in November 2002 when he presented on the advice of his brother in-law to Treliske. He had been feeling maudlin, drinking to excess and thinking of suicide. He had been toying with a verey pistol (yacht pistol). Bob Taylor saw him on the 19th November 2002. Mr Taylor drew the conclusion that Mr Grant was a late middle-aged man whose life was falling apart after his wife had left several weeks before. He felt that Mr Grant was distressed, drinking to excess but not ill. Bob Taylor decided to discharge Mr Grant with no follow-up.

Mr Grant presented a day or so later after a large overdose of DF118. He was seen by KW who felt concerned enough to offer admission. There were symptoms suggestive of depression (diurnal variation, low mood biological symptoms) but these extended back only two weeks causing diagnostic difficulties. Another cause of concern was that Mr Grant was a Dentist and therefore at high risk of self-harm because of the knowledge that he would have. There also appeared to be loss issues associated with Mr Grant having to give up his profession due to an accident. KW filled out a form for Section 2 but Mr Grant was persuaded to come informally. He was admitted to Fletcher Ward (there were no beds on Gwaynten Ward) and was seen by Dr Patfield a Locum Consultant. There were some diagnostic difficulties. Did Mr Grant have an adjustment disorder? Or depression? His mood picked up as he dried out from the alcohol and he wanted to go home. Dr Patfield felt it was not appropriate to detain Mr Grant when he wanted to go home, saying that if he had detained him it would have turned it in to a power struggle and would have been counter therapeutic. He discussed this with KW at the time. Dr Patfield also commented on Mr Grant's personality traits including narcissistic personality. Mr Grant was followed up by the CMHT (namely AV, CPN) and KW in outpatients. He continued to drink heavily, his thoughts were circular and he was pre-occupied with the breakdown of his marriage.

It emerged that Mr Grant had not lost his fingers in an accident but had deliberately caused them to be severed. At this time his Dental Practice was about to be investigated by the GDC and he benefited financially from a large insurance pay out.

At these times, references to firearms came up. These were not always consistent. The Team debated whether the Police should be involved, risking the disengagement of Mr Grant. It was decided on balance to allow the family members to inform the Police while the Team concentrated on establishing a rapport with Mr Grant.

There was ongoing concern about the risk to Lyn Grant, Peter Grant's wife episodes in particular that caused concern were an episode in a car park outside a restaurant when she first tried to leave him. Mr Grant assaulted Mrs Grant and she sustained marks on her throat. When Mrs Grant had first left Mr Grant and gone to live in London she left various belongings behind which he cut in to tiny pieces, even including her shoes. Mrs Grant was his major social contact and he was quite lost without her.

Before Christmas there was an episode of contact when Mr Grant was drinking heavily and made statements of suicidal intent. Lyn had said that she would come down for Christmas but later back tracked. There was an incident with reckless driving of a tractor. Mr Grant was brought in by his brother in-law. He was admitted to Gwaynten; his second psychiatric admission. During this admission, Mr Grant's mood improved as be sobered up. Shortly before Christmas there was a stormy ward meeting with Dr Wood. Dr Wood considered detention because of the risk of suicidality and the fact that Mr Grant was not engaging in services. Dr Wood filled out an application for Section 2. When Dr Falkner, the patients own GP arrived he found Mr Grant with his wife Lyn talking of reconciliation and wanting to have the chance to go home and sort out things right in the marriage. Dr Falkner therefore did not complete the second medical recommendation.

When Mr Grant was followed up in the New Year after being away for a while he seemed little changed other than talking of compliance with his medication. Detention continued to seem inappropriate. The Team talked of the risks to Mrs Grant as there was an ongoing sense of concern. The Team was coming to the idea of arranging a Forensic assessment.

14th February 2003.

Seige situation occurred with Mr P Grant in the home threatening to kill himself with a gun. Police marksman at scene. Dr V Bridges assessed Mr Grant at the Custody Centre where it had required 6 Policemen to restrain him. On interview it appeared that the situation had arisen following Mrs Grant breaking her promise to come to Cornwall and Mr Grant subsequent threat to kill himself. During the examination Mr Grant minimised the situation and accused family members of over estimating his threats.

Dr V Bridges and ASW Ian Matthews initially agreed to complete Section 2 of the Mental Health Act; however by the time the Police Doctor arrived to complete the application Mr Grant stated that he would go into hospital as a voluntary patient. Section 2 not completed. On arrival at Gwaynten Unit, Mr Grant refused to stay, as a single room was not available. He once again refused to stay. Dr V Bridges arranged for Mr Grant to be escorted to Harvest Ward due to his prior presentation as an informal patient with a view to a full forensic assessment being undertaken.

- ASW Mr Ian Matthews writes in a letter to Dr K Wood his concerns re Mr Grant ie:
  - He may possibly have a treatable depression masked by anger.
  - He may have a psychopathic disorder (including Morbid Jealousy), which could place his wife in danger.
  - He is impulsive.
  - He has made 5 previous gestures of self-harm, some of which were melodramatic, but nevertheless placed him at risk.
  - He may need a Forensic assessment. However when Mr Grant was interviewed by Dr Meyer, Police Station and in view of his acceptance of informal admission, no grounds remained for detention.

Dr N. Eastwood examined Mr Grant and team on Harvest Ward where no evidence of depressive illness or psychosis were found and preventative detention was found not to be appropriate in Mr Grant's case. He was subsequently discharged back to CMHT for follow-up.

The MD Team met with Mr Grant in March 2003 to identify future management plan. An agreed outcome with Mr Grant, who by this point had made considerable progress engaging with a Private Therapist, stopped drinking alcohol and stated his compliance with low dose of medication. The team's decision was to discharge based on the following: -

- Psychologist Mr D Oxford had seen both Mr and Mrs Grant . He identified that the danger point would be if Mrs Grant established a new relationship. Mr Grant was given guidance on various Therapists and advice on Psychological Therapies.
- Dr V Bridges had also informed Mrs Grant that jealous men can do dangerous things and advised her not to contact her husband. It was felt by the team that Mrs Grant had disengagement difficulties.
- GP Dr Falkner reports to the team that he was in contact with Mrs Grant over the last 2 weeks, when she once again did not appear to accept the potential risk to her from her husband.
- Mrs Grant was referred to the Carrick C2 Grant by her GP for Counselling and was seen by CPN Sharon Collier. Advice and guidance was given on how to maintain her own safety.
- Mr Grant telephoned CPN AV, where he expressed some concerns re his Therapist, the advice given was to be compliant with medication, abstain from alcohol and begin to re-build his life.
- P. Grant's change in presentation
- Discontinuation of alcohol consumption
- Two clear weeks without contacting his wife.
- Concrete future plans established that were very positive ie. move to Africa to set up an organisation to train Dentists. These plans were viewed by the team to be positive, as they did not involve his wife.
- Engaged with a Counsellor, which Mr Grant preferred to CMHT follow-up.
- Mr Grant's rejection of ongoing CMHT involvement and his DNA of arranged appointments with Dr K. Wood.
- Open access at anytime agreed and put in place.

Summary:

Mr P Grant was a 51-year-old man who appears to have committed homicide followed by suicide. He had been in contact with Carrick CMHT for a period of four months. He exhibited damaging drinking, an attachment disorder, a form of Personality Disorder, a diagnosis of Depressive illness, was not sustained, nor evidence of psychotic illness or morbid jealousy. He had three admissions to hospital for various reasons and was found not to be detainable.

More than one practitioner considered detention, it was however, not found to be appropriate. He was eventually discharged from the service following a MDT Meeting with Mr Grant with the following: -

- Advice on alcohol
- Advice on medication
- Open access in place

Learning Points:

- Should the MD Team have contacted the Private Therapist and briefed her on history/clinical information for risk management purposes. This would have required Mr Grant's permission, however the team did not discuss this course of action with Mr Grant.
- Should CPT have a Policy in place to clarify exchange of information/confidentiality/disclosure of risk and under what circumstances.
- Mrs Grant was fully informed of the risks and given guidance on how to maintain her own safety. The private Therapist was however not given any clinical history.
- Unified Records involving various team members and two Inpatient Units highlights the difficulties in maintaining notes in date order. This alone, with C2 Client information being recorded separately highlights the need for the early introduction of Electronic Client Records.
- Those present at the meeting recognised that great consideration was taken with this case and no other identified actions would ultimately have changed the outcome.
- The members present are aware of the forthcoming Internal Investigations and await their findings.

APPENDIX G

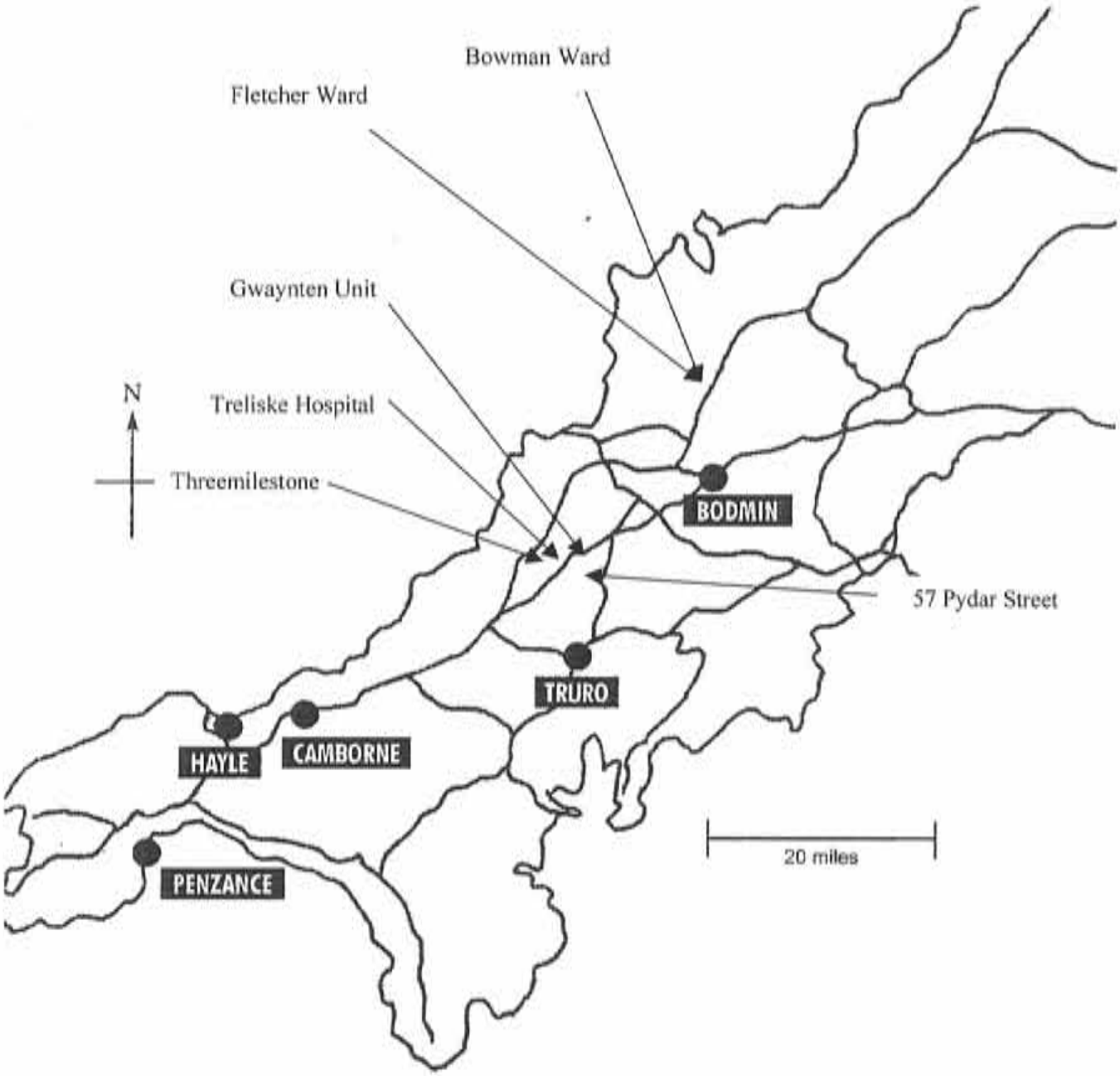
POLICY FRAMEWORK

The policies listed in the following table have been referred to in the course of this internal review.

POLICY REG NO	POLICY TITLE	SECTION NAME	DRAFT/RATIFIED
CLIN MHI-/00312001	PSYCHIATRIC INTENSIVE CARE UNIT OPERATIONAL POLICY	MENTAL HEALTH	UNDER REVIEW
CLIN MH/-100912002	THE SUPERVISION REGISTER SYSTEM (POLICY AND PROCEDURE)	MENTAL HEALTH	RATIFIED
CLIN MH/1-015.2002	STANDARDS FOR ON-CALL CLINICAL MANAGERS AND COMMUNITY TEAM LEADERS	MENTAL HEALTH	CONSULTATION
CLIN MH/-/016/2001	BED MANAGEMENT POLICY AT TIMES OF INCREASED PRESSURE	MENTAL HEALTH	RATIFIED
CLIN MH/-1039/2002	CARE CO-ORDINATION POLICY	MENTAL HEALTH	RATIFIED
CLIN MH/-104012003	FORENSIC MENTAL HEALTH SERVICES OPERATIONAL POLICY	MENTAL HEALTH	RATIFIED
CLIN MH/-104412002	CARE OF PSYCHIATRIC PATIENTS WHO ARE INPATIENT	MENTAL HEALTH	CONSULTATION
CLIN MH/-104612003	ADULT MENTAL HEALTH INPATIENT DISCHARGE PLANNING POLICY	MENTAL HEALTH	RATIFIED
CORP CL/-/003/2003	LEARNING FROM EXPERIENCE	CLINICAL GOVERNANCE	CONSULTATION
CORP CM/-/007/2001	FRAMEWORK DOCUMENT FOR THE ALLEGED ABUSE OF VULNERABLE ADULTS	CORPORATE MANAGEMENT	UNDER REVIEW
CORP CM/-/007/2001/MH	FRAMEWORK DOCUMENT FOR THE ALLEGED ABUSE OF VULNERABLE ADULTS – MENTAL HEALTH	CORPORATE MANAGEMENT	UNDER REVIEW
CORP RM/-/009/2000	SERIOUS UNTOWARD INCIDENT POLICY	RISK MANAGEMENT	RATIFIED
CORP RM/-/009/2003	CLINICAL RISK ASSESSMENT AND RISK MANAGEMENT POLICY	RISK ASSESSMENT	CONSULTATION
CORP RM/CHC/001/2002	POLICY FOR SIGNIFICANT EVENT MANAGEMENT	RISK MANAGEMENT	RATIFIED
CORP CG/-/001/2002	A SUPERVISEE LED APPROACH TO THE SUPERVISION OF CLINICAL PRACTICE	CORPORATE	RATIFIED

APPENDIX H

Map of Cornwall



Paper No:	2004 -

South West Peninsula NHS
Strategic Health Authority

REPORT

To:	South West Peninsula Strategic Health Authority
Title:	**'H and S' Action Plan – Progress Report**
From:	Anthony Farnsworth Director of Delivery
Contributors:	Susan Benjamin Policy Lead – Mental Health Mark Steer Director of Nursing – Cornwall Partnership Trust
Date:	11 November 2004
Summary:	This is the 12 month progress report of the implementation of the 'H & S' Action Plans. The report details the progress made and the outstanding actions.
Action requested:	The Board is asked to note the report and ongoing action.

Paper No:	2004 -

South West Peninsula NHS
Strategic Health Authority

REPORT

To:	South West Peninsula Strategic Health Authority
Title:	**'X' Action Plan – Six Month Progress Report**
From:	Anthony Farnsworth Director of Delivery
Contributors:	Susan Benjamin Policy Lead – Mental Health Mark Steer Director of Nursing – Cornwall Partnership Trust
Date:	11 November 2004
Summary:	This report is a summary of the progress that has been made in implementing the 'X' Action Plan.
Action requested:	The Board is asked to note the report and note that a further report will be made to May 2005 Board meeting.

SB/Inq.456