REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF A PATIENT KNOWN AS J

Commissioned by:

The South West Peninsula Strategic Health Authority

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PANEL MEMBERSHIP

We were commissioned in June 2005 by the South West Peninsula Health Authority to undertake this Inquiry into the circumstances surrounding the treatment and care of J.

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INTRODUCTION

This is a report of the Inquiry surrounding the care and treatment of a patient known as J. The purpose of an Inquiry is to examine thoroughly and with objectivity the care and treatment provided to the patient, in order to make sure that the treatment and service given now and in the future is an effective, safe and appropriate response to patients' needs. The remit of any Inquiry is not to try and apportion blame or seek out possible scapegoats, but to try and identify underlying causes and improve practice. The outcome should be that if there are lessons to be learned, they are recognised by those responsible, and actions on recommendations are quickly implemented, so that the likelihood of further tragedies are lessened.

The members of the Panel would like to express their sincere sympathy to the family and to all those who have been, or continue to be, affected by this tragic event.

To all my fellow Panel members, I express my sincere thanks for their absolute professionalism, dedication and hard work. The Panel was ably assisted and facilitated in its work by Lynda Brooks, Inquiry Officer for the Strategic Health Authority (SHA), whose skill, ability, organisational capacity and understanding of the many complex issues involved, has co-ordinated and maintained the Inquiry throughout. We benefited greatly from the backing and support of Jayne Carroll, Director of Service Strategy, and Derek O'Toole, Mental Health Lead at the SHA. I would also like to thank Miriam Weisinger and Sandy Smith, who transcribed each interview, for their efficient and prompt manner, and Hazel Crook for her invaluable help with the RCA facilitation.

We met the family members at the very outset and at the conclusion of the Inquiry. They wanted to be assured that, in the circumstances at the time, all was done that could have been done. They also wanted to be reassured that if there were lessons to be learned, they would be quickly acted upon, in the hope of preventing a future similar tragedy occurring.

Undoubtedly the main impact and implications arising from this tragic event remains with the family, but it must also be acknowledged that there has been an impact upon the practitioners and staff who attempted to treat and maintain contact with J during the months of his illness, leading up to the death of his mother. There is no doubt that an incident such as this can have a devastating effect on those involved, and the Panel is grateful to those who came and gave their evidence for their honesty and candour in what were, by necessity, searching interviews. We were very reassured that following the incident staff had felt that they were enabled to cope, and able to access support and counselling if needed.

Although mental health practitioners are accountable for good practice, it is not reasonable to expect them to shoulder the entire responsibility for their patients' actions. There are, unfortunately, occasions when a serious tragedy occurs, which could not have been predicted. It is a credit to all those across the country who provide mental health and community care that such incidents are indeed comparatively rare.

The Panel held all meetings and interviews in private.

The Panel engaged in the process of Root Cause Analysis (RCA) in order to reach its findings and to make appropriate and relevant recommendations.

We found there to be five root causes:

1 Communication
2 Leadership
3 Learning
4 Resources
5 Boundaries,

and some underlying issues about processes.

All of our findings can be evidenced and supported by the RCA process. We have formed our recommendations in terms of outcomes, which we believe to be best practice.

Ian Hope
Chair of Inquiry Panel

Health Statutory Guidance (HSG 94(27))

The Inquiry was established under Department of Health Statutory Guidance (HSG 94(27))[1] published in 1994. The South West Peninsula Strategic Health Authority decided to include an additional approach using the RCA process.

Root Cause Analysis

It is widely accepted that there is a need to learn from serious adverse ('sentinel') incidents. It is acknowledged that system failures can lead to human errors, and evidence demonstrates that systematic investigations can expose system failures and highlight care delivery and service problems, but also identify notable practice.

RCA is a formalised problem-solving methodology for ascertaining and analysing the causes of problems, in order to determine what can be done to solve or prevent them. It fosters a systems-based approach to the analysis process, rather than a person-centred approach, and has been shown capable of identifying effective solution strategies to a broad range of problems (Dineen, 2002)[2].

The stages of a RCA are fact-finding, data mapping, analysis and conclusions. Gathering information is seen as the lifeblood of investigation. It is suggested that 60% of time should be spent on data gathering.

Information is typically grouped into four categories: people, documentation, sites and equipment.

[1] Department of Health. Statutory Guidance on the discharge of mentally disordered people and their continuing care in the community. 1994, (HSG 94(27))

[2] Dineen M. Six Steps to Root Cause Analysis. 2002, published by Consequence Ltd

The next stage of the process is to map the information collected into summary forms such as a tabular timeline, narrative chronology and/or simple timeline. This is followed by an analytical process to identify care and service delivery problems.

Causes, effects, failed barriers and root causes are identified. Considered conclusions, recommendations and commendations are drawn.

CHAPTER 1

FACTUAL SUMMARY AND OVERVIEW

Brief biography and family background

March 1984: J was born in the South East. A move to Wales followed not long after his birth. When he was aged three, the family moved to Devon. At the age of five his parents separated. He has a younger sister and stepsiblings.

There is no evidence or family history of mental illness, criminality, or drug or alcohol abuse.

Summary of events

17th August 1993, J aged nine: At the request of his mother, J's GP (who was also a family friend) referred him to a child and family clinic. His mother was concerned that two years after her divorce, discipline and behaviour were becoming a problem. An appointment was offered in November 1993, but by the time of the appointment J's mother believed that matters had improved, and cancelled the arrangement.

August 1994, J aged ten: J's mother contacted the child and family clinic directly, stating that J was being defiant with both families, and was presenting with discipline and behavioural problems. Ongoing appointments were offered and arrangements made to see a child and adolescent psychiatrist. Appointments then took place on a regular basis, and it was observed that J was reluctant to separate from his mother and would not be seen alone. Nevertheless, the child and adolescent psychiatrist recorded that the meetings were useful, and J's mother stated that the home and school situation had much improved.

February 2000, J aged 15: A community psychiactric nurse (CPN) specialising in child and adolescent mental health saw J. After attending, accompanied by his mother, J failed to follow up on further appointments and, despite great efforts on his part, the CPN was not able to engage any further with J. J's mother subsequently contacted the service stating that J no longer needed or desired further contact.

August 2003, J aged 19: J was referred by his GP to the adult community mental health team (CMHT) following a discussion with his mother. He complained of a lack of interest, poor appetite, low mood and poor sleep pattern. By now he was employed at a local store but was off sick from work. The GP felt that J might have been unwell for many years. There is a record of intrusive and recurring thoughts, and visual hallucinations at night. J was prescribed an anti-depressant, but failed to attend for his appointment with the CMHT.

February 2004, J aged 19: J was referred for a second time by his GP to the CMHT. This followed an emergency home visit at night by the GP. It is recorded that J was feeling threatened and frightened, believed his face to be distorted, and was seeing things in front of his eyes. J stated that this had been happening for about three weeks and was getting worse. There followed a discussion between the GP and the duty psychiatrist, who recommended treatment with an atypical antipsychotic medication.

12th February 2004: J had an outpatient appointment to see the senior house officer (SHO). J did not attend this appointment but his mother did, and she was able to give *SHO[1] a detailed account of J's medical and personal history, and of her concerns regarding his increasingly 'strange' behaviour during the previous twelve months.

* SHO[1], the first SHO to see J

A probable diagnosis of psychotic illness was made and explained to J's mother. It was recommended that he continue with the medication. SHO[1] also encouraged J's mother to persuade him to attend the outpatient clinic in the next week or two, so that his mental state and medication needs could be reviewed.

4th March 2004: J was seen by SHO[1], when a full mental state examination was completed. He was taking an increased dose of antipsychotic medication prescribed by his GP. A referral to the CMHT was considered if his mental state worsened. There was no known family history of psychiatric illness.

24th March 2004: J was seen again by SHO[1]. Auditory hallucinations had reduced, particularly over the previous week. However, he continued to experience visual hallucinations, had poor concentration and felt detached and remote. He reported that he was not thinking of suicide. Possible diagnoses were considered, the most likely being schizophrenia. An electroencephalogram (EEG) was organised to eliminate an organic basis for his symptoms. A further outpatient appointment was offered for two to three weeks' time, and his medication was increased to the maximum dose according to British National Formulary[3] (BNF) guidelines.

27th March 2004: Just after midnight J took an overdose of prescribed medication and alcohol, and his mother found him the following morning. She
called for an ambulance, and he was taken to the local acute hospital (LAH), and admitted.

29th March 2004: Referral by the medical team to the liaison mental health nurse (LMHN), a psychiatric nurse attached to the LAH, following J's overdose of

[3]Royal Pharmaceutical society of Great Britain. British National Formulary, BMJ Publishling Group Ltd 2005

medication and alcohol. J reported that this overdose was in response to increasing auditory hallucinations, telling him he was going to die. He described a sudden drop of mood on the day of the overdose, and an increase in intensity of his hallucinations. The LMHN consulted with SHO[1] prior to her assessment. J was feeling much better and his auditory hallucination had receded. He was not suicidal and regretted his actions. He reported feeling overwhelmed by hopelessness about his future mental health at the time of his overdose. His mother was still worried but felt he seemed better. J showed some insight into his actions, but was adamant he would not go into a psychiatric unit. J and his mother highlighted their concerns that J was not getting the level of treatment and support they felt he needed. He had no structure to his day, and spent a lot of time alone when his parents were at work. The LMHN spoke with SHO[1] who agreed to come to the ward with the consultant psychiatrist to see J and meet his parents.

The locality consultant psychiatrist and SHO[1] assessed J in the LAH. Their findings were similar to that of the LMHN. J stated that he felt much better and more confident about the future, although he wished to have someone to talk to and to contact in a crisis. His mother felt confident of having J at home, and that she could manage his illness. A discharge plan was formulated, to include an alternative atypical antipsychotic medication, allocation of a care co-ordinator (CC), emergency contact numbers, and a further outpatient appointment.

Following discharge from hospital, an urgent referral was made to the CMHT and a CC was assigned, who in this case was a CPN.

31st March 2004, J aged 20: The CC made initial contact with J, seeing him in the company of his mother. The CC formulated a care plan, which included a referral to the team's clinical psychologist.

8th April 2004: J was reviewed in the outpatient clinic by SHO[1]. His auditory hallucinations had reduced, but visual hallucinations continued and his sleep was poor. It was recommended that his antipsychotic medication be increased. A computerised tomography (CT) scan was organised at the request of his family in view of a family history of cerebral aneurysm, after consultation with a neurosurgeon. This CT scan showed no abnormalities.

5th June 2004: An EEG report (taken in March), showed no abnormalities and the consultant psychiatrist informed J's mother by telephone.

July 2004: SHO[1] went on leave and then rotated to another SHO post.

May to August 2004: The CC arranged for J to attend a community social group. (The Garden Workshop). He attended on one occasion but did not return for further sessions. The CC only saw J on one further occasion. J than began cancelling appointments and although the CC made repeated attempts at further engagement, including home visits, she was not able to re-engage with J face-to-face. In the event, the only contact was with J's mother. The psychologist only managed to see J on one occasion and, despite offering further appointments, received no response.

12th August 2004: After consultation with other practitioners involved in J's care, the CC recorded on the Care Programme Approach (CPA) paperwork that CMHT involvement would cease and J was discharged from the team caseload, although outpatient care with the consultant would continue.

18th August 2004: J was seen in the psychiatric outpatient clinic by the consultant psychiatrist. Psychotic symptoms were much less in evidence, despite him not

having taken antipsychotic medication for some time, by his choice. Depressive symptoms were noted, and an antidepressant prescribed.

5th September 2004: J's mother telephoned the consultant psychiatrist's secretary expressing her concerns about side effects to J's medication, namely, being 'spaced out and giggling'. The consultant arranged an urgent appointment for J with his senior house officer (*SHO2), with instructions to look for specific side effects and depressive features.

8th September 2004: J was seen in the outpatient clinic by SHO2. J reported that his sleep and appetite had improved. He complained of periodic low moods, but this was considerably improved following the taking of antidepressant medication. Psychotic symptoms had significantly lessened, despite not taking antipsychotic medication, although he described episodes when he felt 'spaced out'. It was recommended that he continue with the antidepressant at the current dose and with no increase. A further outpatient appointment was made for October 2004. J and his mother were told to make contact with the consultant's secretary if they had any further questions, or wanted an earlier appointment.

21st October 2004: J did not attend his outpatient appointment. Another appointment with the consultant psychiatrist was offered for 5th November 2004.

4th November 2004: J went absent from home for several days, taking his mother's car without her consent and driving to Cumbria, where the police apprehended him. He then returned to Devon, staying in motels and guesthouses, before returning home over the weekend.

The second SHO to see J

5th November 2004: J's mother informed the consultant psychiatrist at the outpatient clinic that he had absconded with her car. The outpatient clinic offered J another appointment on 17th November 2004.

17th November 2004: J did not attend the outpatient appointment with SHO[2].

22nd November 2004: At 13:10 the team manager of the CMHT received a telephone call from J's GP. The GP had received a telephone call at home the previous evening from J's mother and stepfather, expressing concern at his behaviour. J's mother and stepfather had not conveyed any great sense of urgency, or of aggressive or threatening behaviour, during their conversation with the GP. The GP requested that the CC telephone the mother to offer support.

At approximately 13:15, following a call to the team leader, the CC rang J's mother. The situation was discussed and the CC asked J's mother about his mental state. An immediate appointment was offered for that afternoon, which J's mother declined, as she did not consider the situation was an emergency and it was not convenient for her or J. She was offered appointments for the 23rd, 24th and 25th November. J's mother opted for the appointment on the 25th, agreeing to try to get J to attend as well.

23rd November 2004: During the early morning J stabbed his mother at the family home, which resulted in her death.

23rd May 2005, J aged 21: J was convicted of the manslaughter of his mother, and was made the subject of a hospital order under Section 37 of the Mental Health Act 1983, together with a Restriction Order under Section 41 of the Mental Health Act.

J is currently a patient in a medium secure mental health unit.

CHAPTER 2

INQUIRY FINDINGS – RECOMMENDATIONS

COMMUNICATION

Communication is essential for effective clinical care and case management. Poor communication has routinely been identified as a significant factor in other Inquiries investigating breakdown in care processes. We found numerous examples of ineffective communication resulting in "hotspots" (events at key junctures), which may have contributed towards the final outcome. Whilst these do not represent a failed duty of care, they do indicate that the system processes lacked robustness in their delivery.

Management of non-attendance

There are several instances of non-attendance in J's record of contact with child and family, and adult mental health services.

We found no effective protocol for dealing with Non-attendances (DNAs). The outpatient clinic booking system used and the way in which the medical secretary filled up "DNA slots" in the outpatient clinic diary meant that the medical staff were not always alerted to repeated non-attendance. Moreover, we saw no evidence of a policy or system for monitoring and auditing this.

Non-engagement

It is essential that patients with psychotic disorder are effectively engaged by mental health practitioners in the management and care of their condition, so that recovery is facilitated and they are enabled to develop fulfilling lives. There are clear examples of J not engaging with the CC during home visits, or 'dropping out' after

only one visit to the Garden Centre Workshop, community group. On these occasions communication did take place between the CC and the mother, but this inadvertently led to subsequent loss of focus on the patient.

In J's situation the complexity and severity of his condition led to challenges for individual practitioners and the clinical team, to which they could not find effective solutions. Most communication appears to have been channelled through J's mother. This overly emphasised the role of the mother, as carer, and at times distracted from the care and treatment of J.

Significantly, the methods of communication did not vary, despite disengagement. For example, when he failed to attend the outpatient clinic, the response was a further invitation to attend through a standard letter to J.

Unified integrated Health and Social Care records

Clinical teams are required to develop a strategic approach in the management and care of patients with complex conditions, but it is difficult to take a strategic line without the benefit of a unified care record.

It is also the tendency for practitioners working autonomously to record their notes separately; whereas a unified record is a clear expectation, as first articulated in HC(90)23LASSL(90)11 (the original Care Programme Approach guidance) and up-dated in the February 2000 - 'Effective Care Co-ordination: Modernising the CPA[4].

Paragraph 69 of the Care Programme Approach (CPA) Guidance booklet (DH, 1999) explicitly comments:

[4] Department of Health. Effective care co-ordination in mental health services: modernising the care programme approach – a policy booklet. 1999 (applicable from April 2000), DH, Cat# 16736. Updated February 2000

> *'All effective CPA information systems are likely to have a computer at their heart. However, whether this takes the form of a stand-alone system in the CPA co-ordinator's office or a wide area network is less important than the operational arrangements agreed for its use. Systems should be designed to minimise the burden on, and maximise support to clinical staff.'*

We are aware that the Trust had an electronic record system (ePEX), which could have underpinned this process. It is unclear whether, or to what extent, the team used that system.

Integrated team working

There was evidence of a lack of cohesive integrated team working, in particular in the medical staff and the rest of the community mental health team. Factors contributing to this may have been:

- The divided geographical base (Exeter/Tiverton), which separated the medical team (including the medical secretary), from the remainder of the community mental health team.
- Insufficient use of a unified health and social care record.
- Time and travel logistics meant that multi-disciplinary team review processes were less likely to be well attended. Furthermore we had no evidence of an audit trail of these meetings, which might have allowed a more consistent overview.
- Administrative time lags (setting of appointments, typing and sending of letters), resulting in delays communicating with J, seemed to have compounded some of the non-attendance.

- There is evidence that J and individual practitioners were consulted by the CC about the discharge on 12th August 2004. In the opinion of the Panel, this does not substitute for a face-to-face multi-disciplinary meeting, where all the issues can be discussed.
- When faced with some uncertainty about the diagnosis and rationale for J's treatment and prescribing, we received no evidence that the GP had tried to seek clarity by talking to either the team or the consultant psychiatrist.

Communication with specialist services

At significant stages there seems to have been a reluctance to refer concerns to other specialist services, e.g. Early Intervention in Psychosis Service (EIS), Assertive Outreach Service (AOS), if only for advice or support.

Prescribing of medication

There are three separate recordings of a medication issued at discharge, which conflict in regard to dosage and regime, although all are within 'prescriber' guidelines. These were recorded by practitioners within the same team, so representing a "within team" communication problem. Two of these (the hospital discharge form and discharge letter) were sent to the GP. The result of this was that the GP received conflicting information. We could find no written record of why the changes took place, and have been unable to establish whether the changes were deliberate or unintended.

Communication recommendations

The Mental Health Trust needs to review its mechanisms for communication, to ensure that:

- Where non-attendance (DNA) occurs, this is brought to the attention of the care co-ordinator, who will risk assess the relevance, and develop a carefully thought-through strategy to address this, with colleagues if necessary, and preferably in discussion and agreement with the individual concerned.
- Practitioners involved in the provision of care and treatment have access to, and make use of, a unified and integrated health and social care record-keeping system, whether this be ePEX or any other system adopted in the future - which ensures that contemporaneous information is consistently available on which to base sound clinical decisions.
- The record is created and controlled by the practitioners involved, regardless of who enters the information onto the system.
- Irrespective of how multi-disciplinary (and multi-agency) teams are structured and located, mechanisms are in place to ensure that all practitioners can utilise the above system.
- Prescribing practitioners ensure that they clearly record medication regimes, and, if changes occur the reasons for it. Ref: Guidance on Good Practice, RPS of Great Britain[5].

[5] Guidance on Good Practice, Royal Pharmaceutical Society of Great Britain, July 2005

LEADERSHIP

Leadership is referred to within the 'Team factors' section of the Clinical Risk Unit 'ALARM' taxonomy (Vincent et al., 1998)[6]. It comprises both management and clinical leadership.

Clinical leadership

Clinical leadership is recognised as an essential component for the modernisation of services. Any person of clinical background able to provide clear, consistent, evidence-based direction can become a clinical leader. It requires an enthusiasm and *gravitas* so that the rest of the team is able to commit to, and follow, an agreed consistent direction. The leadership responsibilities need to be clear and understood. These principles apply equally to management leadership. We have found a range of shortcomings in both clinical and management leadership. These are as follows:

- We could not identify clear leadership within the multi-disciplinary team. This might have contributed to a drift from the Care Programme Approach (CPA) processes.
- We saw no evidence of coherent supervision arrangements.
- Stronger clinical leadership of the multi-disciplinary team may have stimulated debate about a broader range of interventions in this complex case.

Collectively, these factors may have influenced the outcome.

[6] Vincent CA, Adams S and Stanhope N. A framework for the analysis of risk and safety in medicine. British Medical Journal 1998: 1154-1157. Also: http://www.ucl.ac.uk/patientsafety/APP1CRU-ALARMprotocol.pdf

Management leadership

A number of people interviewed expressed concerns about organisational turbulence, and changes of management personnel. The lack of a steady presence of management leadership in the locality meant that communicating these concerns assertively to senior managers within the Mental Health Trust does not appear to have happened. Absence of consistent management leadership appears to have led to the lack of robustness of co-ordination of both the CPA and supervision processes.

Concerns were also expressed about the lack of resources. Shortcomings were acknowledged by the Primary Care Trust responsible for commissioning services within that locality.

Other shortfalls that effective leadership might have addressed were:

- Practitioners' negative attitudes toward specialist services leading to the non-referral and non-discussion with those teams, which may have had a significant impact on the outcome in to this case.
- An inadequate monitoring system between primary and secondary care, to ensure prescriptions are collected and that there is adherence to the medication regime.
- Underpinning policies, which should have been available for the team's reference, were often out of date, or in draft form.

Leadership recommendations

As a matter of urgency, the Mental Health Trust has to ensure that clear, unambiguous clinical and managerial leadership is demonstrated at all levels of the organisation so that:

- Practitioners have access to consistent support mechanisms such as clinical and managerial supervision, mentorship, appraisal, and appropriate learning and development opportunities.
- Multi-disciplinary teams are encouraged to consider a range of evidence-driven treatment and care intervention options.
- Practitioners and multi-disciplinary teams are required to consistently follow policies and processes, for high quality evidence-driven interventions.

LEARNING

In the context of continuing professional development, learning is the process of acquiring knowledge, skills and attitudes through role modelling, experience, reflective monologue, supervision, group work, teaching and enhanced practice.

Various systems exist for learning throughout the National Health Service, and have been endorsed by the Royal College of Psychiatrists and other relevant professional bodies. However, examples exist throughout the Inquiry, which indicate that better use might have been made of the systems available.

Multi-disciplinary Team Review (MDTR)

We observed that medical staff were located separately from the rest of the multi-disciplinary team (MDT). However, the multi-disciplinary team review (MDTR) remained based on the ward. We were told that the expectation was for members

of the MDT to attend MDTRs to discuss individual cases. It was logistically difficult for the MDT members to commit to this on a consistent basis. Moreover, the MDTR was not attended by any administrative staff, and we saw no documentary evidence of review meetings that had taken place. Of particular significance was the fact that the consultant was unable to recall a meeting at which it was agreed to discharge J.

Supervision arrangements

Throughout the Inquiry supervisory arrangements have given rise to some concern. Our opinion is that J presented a complex set of issues, which required well-supervised practitioners.

Consultant/SHO[1]

We learned that regular supervision for SHO[1] did not occur, and heard a disparity of views between the consultant and SHO[1] as to why this was.

The Royal College of Psychiatrists training guidelines state that educational supervision is mandatory. It must be provided by the educational supervisor on a regular basis for one hour per week, and this should form part of the trainee's timetable.

Care co-ordinator

The CC described supervision arrangements as "pretty hit and miss". We were given evidence that supervision of the CC caseload occurred only five times over a nine-month period, November 2003 – July 2004. Following the appointment of a new team manager, four supervision meetings occurred in a three-month period, September 2004 – December 2004.

Peer supervision

Peer supervision between medical staff, is recognised as being a productive way of learning through 'practice' experience and the sharing of difficulties encountered with problem solving. It is a recognised learning tool for continued professional development. It is encouraged by the Royal College of Psychiatrists and is included within most consultant psychiatrist job descriptions. All supervisors need to be registered for continuing professional development (CPD), and part of the CPD process is peer supervision and personal development.

The consultant peer group did not meet very frequently, approximately three times a year, with other support on an informal basis. However, this does meet current Royal College of Psychiatric guidelines.

Learning recommendations

The Mental Health Trust should ensure that the different professional groupings within the MDT commit to meeting together regularly. This will enable:

- The sharing of key information concerning patient care.
- The resolution of complex problems.
- The formulation of strategic care plans and contingency arrangements.
- The processing of new referrals.
- The sharing of achievements and difficulties.
- The availability of administrative staff to provide documented evidence of cases reviewed and reasons for the decisions made.

The Trust must ensure that there are robust supervision arrangements, consistently applied.

The Trust should support robust procedures allowing consultants to meet in peer groups on a regular basis, for the purposes of peer supervision. If records are not kept, it would be advisable to do so, to ensure targets for CPD are agreed and met.

When achieved, these recommendations will provide a learning opportunity, enhance team morale and prevent isolation of individual practitioners. A review of custom and practice should ensure that there is clarity on clinical leadership, terms of reference and effective ways of working.

RESOURCES

Until recently, the Local Implementation Team did not have access to detailed investment per head of population data.

The PCT accepts there has been a historical mismatch between the level of investment made and the service delivered by the mental health trust.

As a consequence, the CMHT, including medical staff, was under-resourced. Another factor was that new specialist services were being developed – Assertive Outreach Service (AOS) in the locality and Early Intervention Service (EIS) in North Devon. Significantly, if the EIS had been available, the Panel believes that this service could have provided a systematic and evidence-based way of working for younger patients with emerging psychotic illness, such as J. When this incident occurred, the EIS only operated a pilot service in North Devon, and their caseload was full. It is felt by the Panel that the EIS may have more fully reviewed the child and family service records, thereby identifying a lifelong pattern of non-engagement/

non-attendance with services. Consequently this may have then influenced the ways in which interventions were offered and the ways in which J might have been engaged. An EIS may also have been better targeted and resourced to engage younger clients. Their remit to provide continuous involvement over a three-year period may have provided greater consistency and overview.

The Panel was consistently told that AOS would not have taken J onto their caseload because of a strict adherence to the referral criteria at that time.

AOS were present in Mid-Devon, but newly established. We feel an opportunity was lost to at least discuss advice or help about a more assertive approach with J that this service could have provided.

Resourcing issues were manifest in some of the following:

- The workload and staff/patient ratio was inadequate for the known mental health needs of the locality at that time.
- Senior medical staff perceived themselves to be working under pressure, with a heavy workload at that time. It was quoted to the Panel that the geographical catchment area was in excess of Royal College recommendations.
- The senior consultant, whilst acknowledging some of the shortcoming of resources, displayed some despondency about positive improvement, and consequently had not assertively communicated his concerns to senior managers.
- Given the unevenness of distribution of resources (e.g. specialist resources, inpatient resources), there appears to have been little flexibility in terms of opening up access to these services for the Mid-Devon team.

- Although there is evidence-based support for the use of family work in families where a member is suffering with psychosis, there appears to have been no consideration of trying to provide such a resource in J's case. It seems to have been beyond the resources available and the capacity of this team.

Other information

With appropriate services in place, as those already mentioned, it is far more likely that the care of J may have been dealt with, and delivered, in a more effective, consistent and sustained way, which may have had a bearing on the outcome of this case.

Resource recommendations

Commissioners have to ensure that mental health service investment is grounded in an evidence-based strategy which:

- Ensures that the provision is adequate to meet the assessed health and social care needs of a population.
- Enables the resident population to access contemporary services in a timely manner, not influenced by geographical location.

BOUNDARIES

Boundaries provide clarity for planning of care, allocation of roles and professional delivery of care, and also confer safety within therapeutic relationships. Even within an intended seamless service for the patient, boundaries are important to ensure that there is no duplication, confusion or lack of clarity about respective roles, responsibilities and accountabilities, which can result in people being deflected from a focussed approach or deviating from agreed care plans.

We identified several examples of significant boundary issues in this case:

- The GP had to reconcile a professional role as GP to the family, alongside his social friendship with the family.
- On the evidence that we were given, the family's social relationship with the GP may have provided them with immediate support, but inadvertently seems to have served as a barrier to making direct contact with secondary mental health services out of hours in order to facilitate a crisis response.
- The focus on J seems to have been consistently blurred by a predominance of contacts between the practitioners and his mother. We were given evidence that J's mother cancelled appointments, and took a 'care co-ordinator-type role' in liaising with practitioners.
- J's mother did not receive a carer's assessment. However, she was often at the centre of communications and decision-making.
- J was not adequately engaged or involved by the practitioners with regard to his care plan. A consequence of the blurring of the boundary with his mother seems to have been that, on a number of occasions, contacts were arranged with her by services. On the evidence we received there was a pattern of either cancellation or re-arrangement, which influenced the timing of interventions.

Boundaries recommendation

The Mental Health Trust must ensure that wherever carers are actively involved, their statutory rights to a separate assessment of needs should be respected and met.

PROCESS ISSUES

Care Programme Approach (CPA)

Application of the National Guidance on the Care Programme Approach should be a basic standard expected by the public and commissioners of all practitioners and mental health service providers.

The Guidance was issued following extensive consultation with both providers and recipients of mental health services, and took account of the many criticisms levelled at the previous expectations. In particular, the Guidance explicitly sought to reduce perceptions of bureaucracy, which many practitioners claimed frustrated their previous attempts to apply CPA effectively. It set out to ensure that those people assessed as most at risk should receive careful, well thought-through, evidence-based, and clearly negotiated care plans, including comprehensive and coherent risk assessments and crisis/contingency plans.

The majority of Independent (Homicide) Inquiry reports continue to make reference to poorly and inadequately applied CPA processes. In this instance, again, we found:

- The CPA policy was not followed, specifically in not placing J unequivocally at the centre of the care plan.
- J was in receipt of interventions from more than one practitioner; had a history of self-harm; had demonstrated a reluctance to engage with different services (over many years); and was diagnosed as having psychotic illness which, if not addressed assertively in its early phases, can lead on to a 'life-long career' of contact with mental health services. Even so, he was assigned to the standard level of CPA, rather than enhanced. We would consider this to be inappropriate.

Process issue recommendations

The Mental Health Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that:

- People in receipt of mental health services are placed firmly and unequivocally at the centre of a collaborative and regularly reviewed Care Plan, which is acted upon.
- All practitioners should receive regular and effective clinical supervision, and have access to a mentor if appropriate.
- All practitioners, and components of the mental health service, are aware of newly developing services and effectively interface with these to the benefit of the person in receipt of mental health services.

Serious Untoward Incident (SUI) process

Application of the Mental Health Trust, and ultimately Strategic Health Authority (SHA), Serious Untoward Incident (SUI) process was not a root cause of this incident. However, the Panel found sufficient deviation from expected practice to warrant a section in this Report.

- Contemporary policies: The Trust provided the Panel with a SUI policy that, according to its review date, was out-of-date and neither referred to nor reflected the SHA policy of May 2004. Other policies and processes submitted to this Inquiry (e.g. Assertive Outreach Service draft operational policy, Community Mental Health Team operational policy, Early Intervention Service draft statement) were also out-of-date.
- Non-independent investigation: The initial ('72-hour') report into the incident was conducted by the CMHT manager – who had been involved in the events immediately prior to the incident.
- Additional reports: We were informed that the acting director of mental health requested 'an enhanced 72-hour report', which is not a strategy contained within the Trust's SUI policy.

- Deviation from process: We received no evidence that the Trust has followed its own SUI policy and process as submitted (DPT, 2002, p10); namely, to ensure a systematic review of the issues raised by this incident, the identification of learning which might arise from these issues, and the communication of that learning across the Trust.
- Cascaded learning: We received no evidence that the issues identified within either the 72-hour, or enhanced 72-hour reports, received any attention across the Trust, and we were told that some issues were identified but not addressed within the relevant locality.
- Hybrid review process: We were told that the SHA and Trust had discussed the conduct of 'Internal' and 'Independent' reviews of this incident. We would have expected this to occur. However, we received differing accounts of the decision-making, which ultimately led to combining an internal and external review, which we were asked to conduct. The Trust was clear that this was an SHA instruction, whereas the SHA representative suggested it was by mutual agreement. Whatever its merits, the combined review process took some nine months to organise – and has not reported until nearly 18 months after the Incident; meaning that the internal process was truncated and incomplete, and the potential for quick 'local' learning by internal review may have been lost.
- Use of Root Cause Analysis expertise: The composition of the Independent Inquiry Panel included one practitioner who had received formal training in Root Cause Analysis (RCA), and a further practitioner who had experience of RCA in a previous Inquiry. A briefing session was arranged for all Panel members prior to commencement of the Inquiry. Neither the terms of reference for the Inquiry, nor the letters inviting participation, made clear and unambiguous reference to the role which the trained practitioner might be expected to undertake, in terms of facilitating and leading the debate and development of this report. At the

request of the Panel, a member of the National Patient Safety Agency (NPSA) attended, to support a session of the RCA work. This attendance was, however, in the afternoon of the third day.

- Confidentiality: Although the Panel included an Inquiry Officer, employed by the SHA, the direct communication with those identified by the Panel for interview was routed through a Director of the Trust. That Director also acted as the conduit for the return of interview transcripts to those interviewed, meaning the discussions were not, necessarily, private and confidential to the Panel and person interviewed.

SUI process recommendations

The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent inquiry processes into SUIs follows best practice and stated policy, so that:

- The Trust has up-to-date SUI (and other) policies, which all managers and members of staff understand and follow, without deviation.
- Members of staff who have been involved in the events immediately prior to an Incident should not be asked to undertake the formal internal review process.
- Issues identified within the internal review process are acted upon, as a matter of urgency, across the Trust.
- Future discussion regarding the conduct of 'Internal' and 'Independent' reviews should not result in an undue delay before potential learning is shared.
- The role of Independent (Homicide) Inquiry Panel members is clear and unambiguous, including any expectations of a facilitation and leadership role.
- The recently issued revised national expectations for Independent Inquiry Panels to use RCA techniques will be incorporated within future Independent (Homicide) Inquiries.

- Arrangements for the attendance of expert assistance to Panels must be considered in advance, and agreed with Panel members.
- There must be a clear and direct line of communication between the Panel and witnesses called.
- Future Inquiries should give consideration to the value of a preliminary 'stakeholder' meeting, involving senior officers of the agencies most likely to be providing evidence.
- All stakeholders should consider how to disseminate the learning from this report.
- In addition to the formal scrutiny to be undertaken by the SHA, those stakeholders with actions arising from this report should consider inviting representatives of the Panel to independently evaluate achievements in 12 months time.

CHAPTER 3

INQUIRY FINDINGS - NOTABLE PRACTICE

GP's response to mother's telephone call

The GP had both a professional and social friendship with the family of J. As a consequence he could have been compromised by the phone call he received on the night that J returned home after absconding with his mother's car. It is recognised by professional bodies that there may be a conflict of interest arising for practitioners where a blurring of boundaries between professional and social commitments may occur. This is especially so in close communities. However, not to respond to a friend who is also a patient would be seen as unacceptable behaviour. In the circumstances, the GP responded appropriately, gave sound advice and recommendations, and made further contact with the family on the following morning, also making a referral to the CMHT.

Senior House Officer 1 (SHO[1])

We commend SHO[1] for acting in a prompt, conscientious and professional manner in J's case, with evidence of diverse thinking regarding complex problems and their resolution.

GP - Post incident.

The GP promptly incorporated into practice lessons learned arising from his interview with the Panel. We have been assured that the surgery concerned has implemented a system of two monthly reviews for all patients on psychotropic medications. A system is required to ensure that patients take medication as prescribed.

Future mental health awareness training for the Police

We have been told of intentions to introduce a new training regime for police probationer officers from April 2006. This will include placement of one month's duration with prospective partner agencies (e.g. mental health services, education, social service departments).

Notable practice recommendations

The Panel commends the new training programme for probationer officers and suggests that this should be a reciprocal arrangement between partner agencies with the aim that:

- Members of staff of all agencies develop a mutual respect for each others' ways of working.
- An avoidance of jargon including medical terminology is to be encouraged.

CHAPTER 4

SUMMARY OF CONCLUSIONS

We have written our report and, having presented our findings and recommendations, we now summarise our conclusions.

We heard of the circumstances in regard to the provision, communication and organisation of mental health services in Mid-Devon at the time of this incident. Had those circumstances been different, it may or may not have averted the final tragic outcome. Our report recognises this. Some 18 months after the incident we have been assured that there is a different structure of provision, and increased financial resources.

Unfortunately, there was a history of appointments either cancelled or not attended, which ultimately led to J not receiving the treatment and care that he urgently needed.

At the time, all those involved, both family and practitioners, believed that they were genuinely doing their best to provide care for J, amid the difficult circumstances that undoubtedly existed.

We found no demonstrable written record of prior aggression or possibility of violence to others by J. At no time did anyone, family, Mental Health Trust staff or the long-time family GP, ever note any aggressive or violent tendencies in J, or have any reason to fear that he would ever cause significant harm to others. Only on the Sunday evening, less than 48 hours prior to the incident, did he display any aggressive behaviour.

Unfortunately, in the subsequent telephone conversation with the family GP, neither the degree of aggression nor sufficient sense of urgency appears to have been communicated, which meant that no positive course of action was followed that evening. Nevertheless, the next morning (Monday), the GP followed up his concerns, and as well as contacting the mother, also contacted the mental health team. The mother declined an appointment for J to be seen the same afternoon. The mother also declined further appointments offered on subsequent days, and the first convenient time was identified by the mother to be on the Thursday of that week. By then, the tragic event had taken place. It is not possible to say with certainty what the effect would have been on the eventual outcome, had the first offered appointment been taken up.

Therefore, it is our conclusion that, in all probability, the death of J's mother could not have been predicted.

APPENDIX A

RECOMMENDATIONS

Recommendation 1 Communication

The Mental Health Trust needs to review its mechanisms for communication, to ensure that:

1.1 Where non-attendance (DNA) occurs, it is brought to the attention of the care co-ordinator, who will risk assess the relevance and develop a carefully thought-through strategy to address this, with colleagues if necessary and preferably in discussion and agreement with the individual concerned.

1.2 Practitioners involved in the provision of care and treatment have access to, and make use of, a unified and integrated health and social care record-keeping system. This could be ePEX or any other system adopted in the future, which ensures that contemporaneous information on which to base sound clinical decisions is consistently available.

1.3 The record is created and controlled by the practitioners involved, regardless of who enters the information onto the system.

1.4 Irrespective of how multi-disciplinary (and multi-agency) teams are structured and located, mechanisms are in place to ensure that all practitioners can utilise the above system.

1.5 Prescribing practitioners ensure that they clearly record medication regimes and if changes occur, the reasons for it. Ref: Guidance on Good Practice, RPS of Great Britain[5].

Recommendation 2 **Leadership**

The Mental Health Trust has to ensure, as a matter of urgency, that clear and unambiguous clinical and managerial leadership is demonstrated at all levels of the organisation, so that:

2.1 Practitioners have access to consistent support mechanisms such as clinical and managerial supervision, mentorship, appraisal and appropriate learning and development opportunities.

2.2 Multi-disciplinary teams are encouraged to consider a range of evidence-driven treatment and care intervention options.

2.3 Practitioners and multi-disciplinary teams are required consistently to follow policies and processes for high quality evidence-driven interventions.

Recommendation 3 **Learning**

The Mental Health Trust should ensure that all the different professional groupings within the MDT commit to meeting together regularly. This will enable:

3.1

- The sharing of key information concerning patient care.
- The resolution of complex problems.
- The formulation of strategic care plans and contingency arrangements.
- The processing of new referrals.
- The sharing of achievements and difficulties.
- Administrative staff to provide documented evidence of cases reviewed and reasons for the decisions made.

3.2 The Trust must ensure that there are robust supervision arrangements, consistently applied.

3.3 The Mental Health Trust should support robust procedures allowing consultants to meet in peer groups on a regular basis for the purposes of peer supervision. If records are not kept, it would be advisable to do so to ensure targets for CPD are agreed and met.

Recommendation 4 **Resources**

Commissioners have to ensure that mental health service investment is grounded in an evidence-based strategy which:

4.1 Ensures the provision is adequate to meet the assessed health and social care needs of a population.

4.2 Enables the resident population to access contemporary services in a timely manner, not influenced by geographical location.

Recommendation 5 **Boundaries**

The Mental Health Trust must ensure that wherever carers are actively involved, their statutory rights to a separate assessment of needs should be respected and met.

Recommendation 6 **Process Issues**

The Mental Health Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that:

6.1 People in receipt of mental health services are placed firmly and unequivocally at the centre of a collaborative and regularly reviewed Care Plan, which is acted upon.

6.2 All practitioners should receive regular and effective clinical supervision, and have access to a mentor if appropriate.

6.3 All practitioners, and components of the mental health service are aware of newly developing services, and effectively interface with these, to the benefit of the person in receipt of mental health services.

Recommendation 7 **Serious Untoward Incident (SUI) processes**

The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that:

7.1 The Trust has up-to-date SUI (and other) policies, which all managers and members of staff understand and follow without deviation.

7.2 Members of staff who have been involved in the events immediately prior to an Incident should not be asked to undertake the formal internal review process.

7.3 Issues identified within the Internal process are acted upon, as a matter of urgency across the Trust.

7.4 Future discussion regarding the conduct of 'Internal' and 'Independent' reviews should not result in an undue delay before potential learning is shared.

7.5 The role of Independent (Homicide) Inquiry Panel members is clear and unambiguous, including any expectations of a facilitation and leadership role.

7.6 The recently issued revised national expectations for Independent Inquiry Panels to use RCA techniques will be incorporated within future Independent (Homicide) Inquiries.

7.7 Arrangements for the attendance of expert assistance to Panels must be considered in advance, and agreed with Panel members.

7.8 There must be a clear and direct line of communication between the Panel and witnesses called.

7.9 Future Inquiries should give consideration to the value of a preliminary 'stakeholder' meeting, involving senior officers of the agencies most likely to be providing evidence.

7.10 All stakeholders should consider how to disseminate the learning from this report.

7.11 In addition to the formal scrutiny to be undertaken by the SHA, those stakeholders with actions arising from this report should consider inviting representatives of the Panel to independently evaluate achievements in 12 months time.

Recommendation 8 **Notable Practice**

The Panel commends this new training programme for probationer officers and suggests that this should be a reciprocal arrangement between partner agencies with the aim that:

8.1 Members of staff of all agencies develop a mutual respect for each other's ways of working.

8.2 An avoidance of jargon including medical terminology to be encouraged.

APPENDIX B

TERMS OF REFERENCE

South West Peninsula Strategic Health Authority

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

- To engage in a process of root cause analysis as a basis for the Inquiry.
- A panel will be appointed to undertake this task.

1. With reference to the homicide that occurred in November 2004, to examine the circumstances of the treatment and care of J by the Devon Partnership NHS Trust Mental Health services, in particular:
   (i) the quality and scope of his health, social care and risk assessments;

   (ii) the appropriateness of his treatment, care and supervision in respect of any of the following that are relevant:
      (a) his assessed health and social care needs;
      (b) his assessed risk of potential harm to himself or others;
      (c) any previous psychiatric history, including drug and alcohol abuse;
      (d) the number and nature of any previous court convictions;
      (e) statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, the discharge guidance (HSG94(27)), and local operational policies for the provision of Mental Health Services.

(iii) the extent to which J's prescribed treatment and care plans were

(a) documented,

(b) agreed with him,

(c) communicated with and between relevant agencies and his family,

(e) implemented,

(f) complied with by J.

2. To examine the appropriateness of the training and development of those involved in the care of J.
3. To examine the adequacy of the collaboration and communication between the agencies involved, or in the provision of services to him.
4. To prepare a report, and make recommendations as appropriate to the South West Peninsula Strategic Health Authority.

The panel in undertaking its Inquiry will use the following schedule of documents:

1. All medical records relating to J, including all hospital records whether as an inpatient or outpatient, GP records and all records prepared by any other doctor or nurse.

2. All medical records of J relating to his treatment whilst a patient in hospital.

3. All documents relating to J in the possession of the Social Services department.

4. All records relating to J in the possession of the Probation Service.

5. All documents in the possession of the Police relating to the investigation into the death of J's mother and the subsequent prosecution of J.

   To note that the criminal proceedings have not yet been completed, therefore Police information may not be available.

6. All documents in possession of the Home Office relating to J including the C3 departmental records.

APPENDIX C

LIST OF WITNESSES INTERVIEWED

*Denotes written evidence only

Assertive Outreach Manager, Primary Care NHS Trust
Author of additional 72 hour report, Devon Partnership NHS Trust
Care Co-ordinator to J
Chief Executive, Devon Partnership NHS Trust
Child And Young Persons Service Manager, Devon Partnership NHS Trust (Interviewed in capacity of previous role as: Mental Health Lead, SHA)
Clinical Psychologist, Devon Partnership NHS Trust
CMHT Team Manager, Author of original 72 hour report, Devon Partnership NHS Trust
Consultant Psychiatrist, Devon Partnership NHS Trust
CPN to J
Detective Chief Inspector for Devon & Cornwall Constabulary
Detective Sergeant for Devon & Cornwall Constabulary
Early Intervention Service Co-ordinator, Devon Partnership NHS Trust
Family of J
GP to J
Psychology Department, Devon Partnership NHS Trust
Risk Manager, Devon Partnership NHS Trust
Secretary to Consultant Psychiatrist*
SHO[1] to Consultant Psychiatrist, Devon Partnership NHS Trust
Sister of J
Workforce and Organisational Development Services Director, Devon Partnership NHS Trust, (Interviewed in capacity of previous role as: Director of Mental Health Services North and Mid-Devon)

APPENDIX D

REFERENCES

Department of Health. Statutory Guidance on the discharge of mentally disordered people and their continuing care in the community.
1994, (HSG 94(27))

Dineen M. Six Steps to Root Cause Analysis. 2002, Consequence Ltd

Royal Pharmaceutical Society of Great Britian. British National Formulary, BMJ Publishing Group Ltd. 2005.

Department of Health. Effective care co-ordination in mental health services: modernising the care programme approach - a policy booklet.
1999 (applicable from April 2000), DH, cat# 16736. Updated February 2000.

Guidance on Good Practice, Royal Pharmaceutical Society of Great Britain July 2005

Vincent CA, Adams S and Stanhope N, A framework for the analysis of risk and safety in medicine. British Medical Journal 1998; 316: 1154-1157.
Also: http://www.ucl.ac.uk/patientsafety/APP1CRU-ALARMprotocol.pdf

APPENDIX E

GLOSSARY

AOS	Assertive Outreach Service
BNF	British National Formulary
CC	Care Co-ordinator
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPD	Continual professional development
CPN	Community Psychiatric Nurse
CT	Computerised Tomography
DNA	Did Not Attend
DH	Department of Health
DPT	Devon Partnership Trust
EEG	Electroencephalogram
EIS	Early Intervention Service
ePEX	An electronic record system
GP	General Practitioner
HSG	Health Statutory Guidance
LAH	Local Acute Hospital
LMHN	Liaison Mental Health Nurse
MDT	Multi-disciplinary Team
MDTR	Multi-disciplinary Team Review
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
RCA	Root Cause Analysis
SHA	Strategic Health Authority
SHO	Senior House Officer
SUI	Serious Untoward Incident

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
1 **The Trust needs to review its mechanisms for communication to ensure that:**					
1.1 Where non-attendance (DNA) occurs, this is brought to the attention of the care co-ordinator, who will risk assess the relevance and develop a carefully thought-through strategy to address this, with colleagues if necessary and preferably in discussion and agreement with the individual concerned.	a. Undertake a review of the current DNA policy. b. Undertake a review of the booking programme. c. Ensure that staff receive training in (a) and (b). d. Develop effective mechanism for joint work with primary care.	Aug 06 Sept 06 Aug 06	Director of Nursing, Operations and Professional Practice	The assurance is gained that the DNA policy and booking programme is clear. That awareness/ adherence to both is improved.	Audit of DNA and booking programme implementation.
1.2 Practitioners involved in the provision of care and treatment have access to, and make use of, a unified and integrated health and social care record-keeping system, whether this be ePEX or any other system adopted in the future, which ensures that contemporaneous information is consistently available on which to base sound clinical decisions.	a. To commence roll out of National care record. b. Implementation of new eCPA. c. Increase I.T. capacity	Commence May 06 - Dec 07 April 06 Commence April 06	Medical Director Director of Nursing, Operations and Professional Practice	That unified and integrated records are created. That contemporaneous information is readily available. That eCPA is readily accessible.	Audit of eCPA. Audit of clinical records.

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
1.3 It is important that the record is created and controlled by the practitioners involved, regardless of who enters the information onto the system.	a. To commence roll out of National care record. b. Implement new eCPA and increase I.T. capacity.	Commence May 06 - Dec 06 April 06	Medical Director Director of Nursing, Operations and Professional Practice	That unified and integrated records are created. That contemporaneous information is readily available. That eCPA is readily accessible.	Audit of eCPA. Audit of clinical records.
Irrespective of how multi-disciplinary (and multi-agency) teams are structured and located, mechanisms are in place to ensure that all practitioners can utilise the system.	c. Implement robust programme of training to support eCPA.	Commence April 06	Director of Nursing, Operations and Professional Practice		
Prescribing practitioners must ensure that they clearly record medication regimes and if changes occur the reason for it.	d. Remind prescribing practitioners of acceptable practices through policy guidance and training.	Commence April 06	Medical Director/ Director of Nursing, Operations and Professional Practice	That medicine regimes are clearly recorded initially and when altered and communicated to GP and Care Co-ordinators for community patients.	Audit of patient prescription cards and patient notes.

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
2. **The Trust has to ensure, as a matter of urgency, that clear and unambiguous clinical and managerial leadership is demonstrated at all levels of the organisation; so that:**					
2.1 Practitioners have access to consistent support mechanisms such as clinical and managerial supervision, mentorship, appraisal and appropriate learning and development opportunities.	a. Review consultant job plans in order to clearly link clinical capacity to teams.	Achieved	Medical Director	Identified clinical leadership in each team.	Clinical cabinet
	b. To re-confirm expectation with all professions as to the Trust's clinical, managerial, mentorship and appraisal systems.	March 06	Locality/Service Directors and Professional Heads.	That practitioners have access to support mechanisms and appropriate learning and development.	Audit of supervision provision and use. Staff survey
	c. Identify capacity to deliver and implement supervision systems. Assess and plan for training.	June 06	Director of Workforce and Organisational Development.		
2.2 Multi-disciplinary teams are encouraged to consider a range of evidence-driven treatment and care intervention options.	Clinical Cabinet to implement process for the use of evidence based practice and the consideration/adherence of NICE guidelines.	March 06	Chair of Clinical Cabinet	That evidence-based interventions are available	Clinical Cabinet audit S4BH compliance

Action Plan to address the Report into the Patient Known as J					
Recommendation	**Action Required**	**Timescale**	**Accountability**	**Intended outcome**	**Monitoring Arrangements**
2.3 Practitioners and multi-disciplinary teams are consistently required to follow policies and processes for high quality evidence-driven interventions.	Clinical Cabinet to implement process for the use of evidence based practice and the consideration/adherence of NICE guidelines.	March 06 and ongoing	Chair of Clinical Cabinet	That evidence-based interventions are available and consistently followed.	Clinical cabinet

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
3 **The Trust should ensure that all the different professional groupings within the MDT commit to meeting together regularly. This will enable:**					
3.1 The sharing of key information concerning patient care. The resolution of complex problems.	a. Review the terms of reference for the MDT meeting to include membership, frequency, and purpose.	May 06	Director of Nursing, Operations and Professional Practice	That there are regular meetings with agreed terms of reference.	Audit.
The formulation of strategic care plans and contingency arrangements The processing of new referrals.	b. To facilitate time within team meetings for developmental activity i.e. case presentations treatment approaches. To re-clarify and map supervision arrangements.	May 06		That team morale is improved.	Staff survey Audit of content of team meetings.
The sharing of achievements and difficulties. Administrative staff to provide documented evidence of cases reviewed and reasons for the decisions made.	c. Undertake audit and application of supervision arrangements.	Aug 06	Medical Director	That robust arrangements of support/supervision are in place and that learning outcomes are achieved.	
The Trust must ensure that there are robust supervision arrangements, consistently applied.	d. To review use of peer group supervision arrangements for consultants	Ongoing	Medical Director	Wider clinical advice and peer support available for management of complex cases.	

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
The Trust should support robust procedures allowing consultants to meet in peer groups on a regular basis for the purposes of peer supervision. If records are not kept, it would be advisable to do so to ensure targets for CPD are agreed and met.	e. To ensure method of record keeping is introduced,	Aug 06	Medical Director		

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
4 **Commissioners have to ensure that mental health service investment is grounded in an evidence-based strategy which:**					
4.1 Ensures the provision is adequate to meet the assessed health and social care needs of a population. 4.2 Enables the resident population to access contemporary services in a timely manner; not influenced by geographical location.	The Devon and Torbay Local Implementation Team is developing a commissioning strategy focussing on 3 key areas: - primary care - crisis resolution - rehab and recovery This will form basis for developing a consistent countywide approach to commissioning and providing a locality network of services based on evidence of need and effectiveness.	Plans agreed by 31.03.06. Implementation phased over next 3 years.	PCT Commissioners. Director of Planning and Development	Effective services delivered to meet assessed need of community.	LIT DPT/PCT joint meeting (bi-monthly) Trust Board

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
5 **The Trust must ensure that wherever carers are actively involved, their statutory rights to a separate assessment of needs should be respected and met.**	a) Appointment of a carers development manager. b) Ensure systems are in place to complete carers assessments and care plans. c) To develop an inter-agency training programme to increase awareness of carers needs.	May 06 Dec 06 May 06	Director of Social Care	That carers have an assessment of their needs and a care plan. Inter-agency training programme. Increased awareness of carers needs	Performance monitoring number of assessments. Audit of clinical records. Feedback to Big Action Group and Local Implementation.

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
6 **The Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that:**					
6.1 People in receipt of mental health services are placed firmly and unequivocally at the centre of a collaborative and regularly reviewed care plan, which is acted upon.	a) Review of CPA policy and refresher training to support policy implementation. b) To ensure discussions within MDT meetings are recorded in integrated healthcare records.	Policy agreed April 06.	Director of Nursing, Operations and Professional Practice	CPA policy is implemented. Service users have copy of care plan. Decisions recorded in care record.	Audit of CPA care plans Audit supervision arrangements.
6.2 All practitioners should receive regular and effective clinical supervision, and have access to a mentor if appropriate.	To develop a trust-wide approach to mentorship.		Director of Workforce and Organisational Development	That staff have supervision in line with Trust policy and their personal development plan and access to mentorship.	Staff survey
6.3 All practitioners and components of the mental health service are aware of newly developing services, and interface effectively with these, to the benefit of the person in receipt of mental health services.	Extend the interface project as a mechanism in promoting cross team working and understanding.				

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
7 **The Trust and the Strategic Health Authority (SHA) have to ensure that the conduct of internal and Independent Inquiry processes into SUI's, follows best practice and stated policy, so that:**					
7.1 The Trust has up-to-date SUI (and other) policies, which all managers and members of staff understand and follow, without deviation.	7.1 - 7.11 a) Review Trust SUI and other policies in line with all related recommendations.	July 06	Director of Public Health	That there is clear policy based on best practice. That policies compliment SUI policies of the SHA.	SUIs reviewed locally and within Trust's SUI group. DATIX monitoring of reporting of SUI Action Plans - locally and corporately.
7.2 Members of staff who have been involved in the events immediately prior to an incident should not be asked to undertake the formal internal review process.	b) To communicate policy and provide training to support implementation.	Sept 06	Director of Corporate Development and Performance.	That there is clarity of policy.	
7.3 Issues identified within the internal process are acted upon, as a matter of urgency across the Trust.	c) To form part of the Trust SUI policy. SUI internal processes to be reviewed refined and communicated on an ongoing basis.	July 06	Director of Corporate Development and Performance.	Continuous clarity and improvement of process	To form part of governance arrangements – regular assurance to be provided via Trust SUI committee
7.4 Future discussion regarding the conduct of internal and independent reviews should not result in an undue delay before potential learning is shared.	7.4 – 7.9 *SHA responsibilities* The SHA will continue to review its application of inquiry 'best practice'.	August 06	Director of Service Strategy	To ensure that future Inquiry Panels have a clear framework to support their work, and an improved interface with all stakeholders.	Audit & Clinical Governance Committee

Action Plan to address the Report into the Patient Known as J

Recommendation	Action Required	Timescale	Accountability	Intended outcome	Monitoring Arrangements
7.5 The role of independent (homicide) Inquiry Panel members is clear and unambiguous, including any expectations of a facilitation and leadership role. **7.6** The recently issued revised national expectations for Independent Inquiry Panels to use RCA techniques will be incorporated within future Independent (homicide) Inquiries. **7.7** Arrangements for the attendance of expert assistance to Panels must be considered in advance, and agreed with Panel members. **7.8** There must be a clear and direct line of communication between the Panel and witnesses called. **7.9** Future Inquiries should give consideration to the value of a preliminary 'stakeholder' meeting, involving senior officers of the agencies most likely to be providing evidence.	The SHA will incorporate the Panel's recommendations in its review of its Serious Untoward Incidents policy.		Director of Public Health		

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7.10 All stakeholders should consider how to disseminate the learning from this report.	Taking account of the reviews above to ensure the key lessons are disseminated to organisations and individuals. Who should be aware.	Ongoing	Chief Executives (check)		
7.11 In addition to the formal scrutiny to be undertaken by the SHA, those stakeholders with actions arising from this report should consider inviting representatives of the Panel to independently evaluate achievements in 12 months time.	Review action taken with Panel reconvened.	March 07			

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8 **The Panel commends this plan and suggests that this should be a reciprocal arrangement between partner agencies with the aim that:**					
8.1 Members of staff of all agencies develop a mutual respect for each other's ways of working.	a) Continuing attendance at Local Strategic Partnership Meetings.	On-going	Area Director	Mental Health featured in community plans.	Local Implementation Team.
	b) Support ongoing collaboration and training of other professional groups e.g. police.	April 06	Area Director	Improved awareness of mental health issues.	Local Strategic Partnerships.
8.2 An avoidance of jargon including medical terminology is encouraged.	Review the Trust Communication Strategy.	June 06	Director of Corporate Development and Performance	Accessible communication.	