Independent Investigation

into the

Care and Treatment Provided to Mr. Z

by the

Devon Partnership NHS Trust

Commissioned by
NHS South West
Strategic Health Authority

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Z was commissioned by NHS South West pursuant to *HSG (94)27*[1].

This Investigation was asked to examine a set of circumstances associated with the death of Mr. N.

Mr. Z received care and treatment for his mental health condition from the Devon Partnership Mental Health Trust. It is the care and treatment that Mr. Z received from this organisation that is the subject of this Investigation.

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

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trust Senior Management Team who has granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in an exceptionally professional and open manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

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

[1] DoH Guidance EL (94)27, LASSL (94) 4

2. Condolences to the family of Mr. N

The Independent Investigation Team would like to extend their sincere condolences to the family and friends of Mr. N. His family felt unable to take part in this review.

The Independent Investigation Team are aware of the age and fragility of some of Mr. N's family and hope that this report does not cause them any further upset.

3. Executive Summary

3.1 Incident Description and Consequences

On the morning of 9 February 2007 Mr. Z caught a taxi into Okehampton where he went to a pharmacy to collect repeat prescriptions for both himself and his housemate Mr. N. He then did some shopping, including buying 1.5 litres of whisky, and had a drink in a pub. He later caught a bus home and spent the afternoon watching television and drinking alcohol. When asked, Mr. Z thought that he had drunk approximately 70cl of whisky.[2]

On the evening of 9 February 2007 Mr. N went to his local pub where he had several pints of cider and several whiskies.[3] A taxi was ordered by the bar staff and Mr. N was taken to the house that he shared with Mr. Z arriving at about 21.00 hours.[4]

When asked Mr. Z recalled that when Mr. N returned home they both drank some red wine and then Mr. Z took his medication and went to bed. Mr. Z reported there had been no arguing, animosity or tension between himself and Mr. N.[5]

Mr. Z's next memory is that of standing over the body of Mr. N who was lying on the floor of his bedroom with a pillow under his head. Mr. Z went to his neighbour's house but was unable to rouse them so he went back into his own house and retrieved his mobile telephone from his bedroom from where he called for an ambulance.[6]

The Police were contacted by the Ambulance Control Centre at 02.45 hours on 10 February 2007. The report was that a male had been stabbed in a rural property. At 03.05 hours a further call was made to the Police stating that a male was on the telephone stating that he had stabbed a man several times with a large carving knife. At 03.06 hours the Police and the ambulance crew entered the property and located a deceased male in the rear first floor bedroom.[7]

[2] Forensic reports case summary pg 10
[3] Police records pg 7
[4] Police records pg 11
[5] Forensic reports case summary pg 10
[6] Forensic reports pg 21
[7] Forensic reports case summary pg11

When the Police arrived Mr. Z was outside the house, he smelt strongly of alcohol and was dressed only in a tee shirt. Mr. Z made the statement "*I stabbed him I done that*"[8]

The male was confirmed life extinct by the ambulance crew at 03.19,[9] who believed that Mr. N had been stabbed several times. Mr. Z was arrested on suspicion of murder.[10]

The autopsy report summarised that Mr. N had received 11 knife wounds to the torso and chest and further cuts to the arms head and neck. It concluded that severe force would have been employed to cause the injuries and that there were no defence type injuries to the hands. [11]

On 12 February Mr. Z was charged with the murder of Mr. N contrary to common law[12] and remanded to Exeter Prison on 13 February 2007.[13] Medical reports were completed for the prosecution and defence on 30 August 2007 and 2 May 2007 respectively.[14]

On 10 March 2008 Mr. Z pleaded guilty to the charge of manslaughter with diminished responsibility and sentencing was adjourned for further reports to cover potential aspects of dangerousness to the public.

On 17 April 2008 Mr. Z pleaded guilty to manslaughter on the grounds of diminished responsibility. The case was described as an "*unusual case*" noting that both the defendant and the deceased were addicted to alcohol and had come from troubled backgrounds. The Judge concluded that:
"it was a combination of alcohol and anti-depressant medication that reduced Mr. Z to a state where he was able to carry out the killing of another human being". [15]
Mr. Z was sentenced to six years imprisonment.

[8] Police Records pg 13
[9] Police Records pg 17
[10] Forensic reports case summary pg 11
[11] Autopsy Report for Mr. N
[12] Police records pg 46
[13] Forensic report pg 22
[14] Forensic Reports pg 38 and 12
[15] Court Report Summary pg 17

3.2 Background to the Independent Investigation

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

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

3.3 Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS South West. The Devon Partnership NHS Trust and NHS Devon, the Primary Care Trust, were consulted with regard to the content of the Terms of Reference and did not wish to make any amendments.

The terms of reference were set as follows in order to:

1. review the quality of the health and where relevant social care provided by the Trust and establish if whether this adhered to Trust policy and procedure;
2. identify whether the Care Programme Approach (CPA) had been followed by the Trust;
3. identify whether any risk assessments were timely, appropriate and followed by appropriate action;
4. examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
5. review the Mental Health Act assessment process, where applicable;
6. examine the adequacy of collaboration and effectiveness of communication with any other agencies who may have been involved in the care and treatment;
7. review the Internal Investigation into the care of Mr. Z already undertaken by Devon Partnership NHS Trust and any action plans that may have been formulated, including any immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Investigation;

8. consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence the public interest may require;
9. prepare an Independent Report for Devon Partnership NHS Trust, NHS South West and any other relevant bodies.

3.4 The Investigation Team

Investigation Team Leader and Chair

Ms. Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service.

Investigation Team Members

Dr. Simon Britten	Consultant Psychiatrist, Medical Member of Team
Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service, Nurse Member of Team

Support to the Investigation Team

Mrs. Louise Chenery	Stenographer and Administration, HASCAS Health and Social Care Advisory Service

Independent Advice to Team

Mr. Ashley Irons	Solicitor, Capsticks

3.5 Findings

When conducting Investigations of this nature careful consideration is given to the notion of causality. Causality is the relationship between a series of events. In the case of HSG (94) 27 the care and treatment a service user received is examined to determine whether any acts of omission or commission provided the circumstances in which the serious untoward incident (the homicide), was likely to occur. Causality determines whether one series of events (the homicide) was a direct consequence of another series of events (the care and treatment received).

This report defines causality and contributory Factors in the following way:

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the events of 10 February 2007. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

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

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 10 February 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

Independent Investigations conducted under the auspices of HSG (94) 27 are frequently critical of services and how they were delivered to an individual. On these occasions it would be relatively easy to say that the services failed and that this caused the homicide. However in mental health and other areas of health and social care it is not always so straight forward as

there are many variables to consider not least of which is the changing presentation of an individual.

Aggression as a result of alcohol intoxification is a common phenomenon. Mr. Z had a long history of drinking to excess but had no history of being violent as a result. Both the forensic medical assessments and the Judge in the summing up noted this was a most unusual case of homicide and that Mr. Z's depression alone could not be connected with the index offence.

When examining the quality of the care and treatment a person receives the following four findings categories can be utilised:

1) Trusts can produce high standards of service delivery that are appropriate, effective and in keeping with best practice. Sometimes in this situation the Independent Investigation Team would be unable to identify any causal or contributory Factors to the homicide in question.

2) Trusts can produce high standards of service delivery that are appropriate, effective and in keeping with best practice. However a single act of omission or commission may have led to the circumstance in which a serious untoward incident is more likely to happen. In this case causality can sometimes be determined between the untreated mental state of the service user and the care and treatment provided.

3) Trusts can deliver less than perfect services where systems are chaotic and best practice standards have not been implemented. However there is *no* direct relationship between what the services actually did or did not do and the homicide. This may be because the mental state of the service user was stable at the time, the person may have been drunk or under the influence of non prescription drugs, which is not the responsibility of mental health services. Service users also have responsibilities within the health care system such as keeping appointments, taking medication as prescribed and making, where possible, healthy life style choices. The service user is recognised as central in the management of their mental health and where this does not occur there is a potential barrier to treatment.

4) Trusts can deliver less than perfect services where systems are chaotic and best practice standards have not been implemented. This can result in direct acts of negligence and poor practice resulting in an individual not receiving care and treatment or the wrong care and

treatment. In these circumstances there would be a high probability of identifying Factors that had a direct causal bearing on the incident.

Service users cannot be compelled to do things they do not wish to do unless detained under the Mental Health Act. Mr. Z was an independent person living in the community at the time of the homicide. He was not subject to any Section under the Mental Health Act and was free to make his own life style choices as he saw fit regardless of what others perceived as being in his best interests. In the case of Mr. Z category 3 applies as although the Trust could have done things differently the Independent Investigation Team found no direct causal Factors which connected the care and treatment Mr. Z received and the events of the 10 February 2007.

Contributory Factors

The following Factors were identified as contributing to the fact that at best Mr. Z's condition remained partially treated. The Independent Investigation Team found eight Factors that contributed to the less than effective care and treatment package that Mr. Z received.

Contributory Factor 1

Mr. Z was not treated in an integrated manner in terms of his co-morbidity as defined in the dual diagnosis good practice guide 2002.[16]

Contributory Factor 2

There was a lack of robust medical intervention and as a consequence Mr. Z was only ever partially treated.

Contributory Factor Number 3

The CPA policy was poorly implemented and understood. Consequently Mr. Z did not receive a comprehensive and holistic assessment or care plan. As a result Mr. Z did not receive all of the care, support and treatment that he could have benefited from if he had had a comprehensive assessment of his health and social care needs on which to base a care plan.

[16] *Department of Health (2002)* Mental Health Policy Implementation Guide: Dual diagnosis good practice guide. *Department of Health, London.*

Contributory Factor 4

Mr. Z's discharges from hospital and transfers of care fell below the expected standard as they were not planned in accordance with best practice or Trust policy, leading to serious delays in follow-up and missed opportunities to plan care. The poor practice appears to be widespread across the inpatient and community teams that provided care and treatment to Mr. Z.

Contributory Factor 5

There was a lack of adherence across inpatient, community, and emergency teams to the Risk Assessment and Management Policy. Mr. Z was not comprehensively risk assessed by any of the services that he had contact with resulting in his care pathway being less than effective.

Contributory Factor 6

The mental health 'emergency' services missed opportunities to intervene appropriately with Mr. Z as they did not understand his presentation believing his depression was alcohol or personality driven rather than a severe untreated depression. Consequently there were missed opportunities to intervene at a more assertive level resulting in a lack of appropriate intervention and management of Mr. Z's co-morbidity.

Contributory Factor 7

The clinical leadership and management throughout Mr. Z's care pathway was weak resulting in the absence of an overall multi disciplinary management plan. Mr. Z continued an alcohol based life style and this did little to ameliorate his depression.

Contributory Factor 8

The Trust Clinical Governance systems were in a state of flux. There were no operational policies to provide guidance for teams, clinical policies were not understood implemented or monitored at a local level nor were the wider Trust governance structures robust enough to detect and correct these failings.

The Independent Investigation Team found six Service Issues whilst examining the care and treatment Mr. Z received.

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping. This ensured that the personal data regarding Mr. Z was not appropriately shared in a timely manner with those providing his care and treatment over time.

Service Issue 2

The Trust failed to assure via clinical governance and audit processes the adherence by staff to basic record keeping standards.

Service Issue 3

The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

Service Issue 4

The approach to the treatment and care of people who have a dual diagnosis was under developed and not integrated, leading to vulnerable people, with a mental illness being at risk and under treated.

Service Issue 5

Robust systems were not in place to monitor the standards and implementation of the CPA policy.

Service Issue 6

Mental Health Act assessment documentation was not available within the clinical record reflecting a poor standard of clinical record keeping.

3.6 Conclusions

Mr. Z had increasing contact with mental health services in both Exeter and latterly in Okehampton from 2000 until the death of Mr. N in 2007. He suffered significant early negative life events but largely overcame teenage delinquency and poly drug misuse. He married and had two children. He then developed a recurrent depressive disorder and intermittent alcohol misuse. He overdosed seriously four times over a seven-year period during which he was assessed by generic, liaison and crisis mental health teams from different areas of the DPT. His complex diagnosis of recurrent depressive disorder and alcohol dependency presented significant challenges for integrated assessment, successful treatment and containment of risk for himself and others. Mr. Z did not have a history of violent or aggressive behaviour.

Mr. Z's care and treatment as provided by the Devon Partnership NHS Trust did not adhere to local policy and procedure, or fall within national guidance at an individual or team level. Mr. Z did not receive a comprehensive assessment, care or treatment plan. The approach that the Devon Partnership NHS Trust chose to pursue could not be seen as best practice especially in the light of the evidence based approach to treating those with a dual diagnosis.

The Independent Investigation Team would like to acknowledge that Mental Health Trusts face considerable challenges when faced with delivering care and treatment to service users who are ambivalent about their own well being. Mr. Z was ambivalent about his alcohol dependency, as well as being a complex individual and was at times difficult to accurately assess as it was well documented that he was able to mask the severity of his depression. The Trust personnel did establish a rapport with Mr. Z and worked hard to support him, however this was not within the framework of a clear management plan or understanding of dual diagnosis.

Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe. The Independent Investigation Team found that the governance systems and

practice in operation throughout the time that Mr. Z was in their care were ineffective, enabling practitioners to practice without the safety net of adhering policies and procedures.

The Independent Investigation Team could not make a causal link between the care and treatment that Mr. Z received and the events of February 2007. However the Team was able to identify eight contributory Factors each of which each played a part in management of Mr. Z's care and treatment. It is the view of the Independent Investigation Team that Mr. Z's mental health problems were not fully understood and therefore managed. As a result Mr. Z's condition was at best partially treated.

3.7 Recommendations

Recommendation 1

The Trust and the PCT need to develop and implement a dual diagnosis strategy based on their needs assessment, National Policy and best practice. This needs to include:

- *the appointment of a Clinical Lead who should be either a Team Leader or Consultant who is prepared to persevere and drive treatment on both substance misuse and mental illness;*
- *the development of a Dual Diagnosis Steering Committee to include the key stakeholders from statutory, including the PCT, and voluntary sector to take this work forward;*
- *the development of a dual diagnosis network to provide protected time for case discussion and group supervision;*
- *develop the care pathway to include those presenting to accident and emergency;*
- *prioritise the need for effective training so that all staff members utilise evidence-based interventions when delivering treatment (assertive outreach, crisis team, liaison team and PICU staff);*
- *the committee should report directly to the Director of Operations and the PCT on progress and the work should be considered as "core" to adult services development;*
- *visits to nationally respected Dual Diagnosis services may be helpful (e.g. Haringey and Birmingham) in determining the model most appropriate for Devon.*

Recommendation 2

A care pathway, based on the 2009 NICE guidelines for treatment of depression, is developed across the well being and access, and recovery teams to incorporate the interface with primary care psychology/IAPT service.

- *Work in partnership with the PCT, GPs with special interest and the voluntary sector to develop the stepped care model for the treatment and management of depression.*
- *Introduce an evidenced based assessment such as Beck's Depression Inventory or the Hamilton Rating Scale for Depression for all adults presenting to mental health services with a low mood or depression.*

Recommendation 3

The 'emergency services' and those conducting on call services need to have priority for dual diagnosis training regarding assessment.

- *Research indicates that assertive outreach, crisis teams and PICU staff, will have the highest density of patients who have a dual diagnosis. They should therefore be expected and supported to undertake training at a minimum of level 3.*
- *Liaison psychiatry staff and home treatment/crisis staff are more likely to have contact with people in crisis. They need to be able to distinguish between those who have an underlying chronic problem as opposed to those who are using substances as a means of coping. They should therefore be expected and supported to undertake training at a minimum of level 2.*
- *In order to ensure that training is put into practice a supervision network needs to be developed.*

Recommendation 4

The Professions Directorate develop and put in place an action plan to strengthen, support and empower the role of the Clinical Team Leaders across the Trust to support the professional leadership structure at Board level through:

- *the creation of action learning sets;*
- *the use of executive coaching;*
- *clinical master classes;*
- *360 appraisals;*

- *considering the merits of developing an in-house leadership programme.*

Recommendation 5

The Trust must commission/complete a review of clinical records and their storage against the standards cited in the Data Protection Act.

- *All clinical areas must ensure that records have been returned to the central archive when patients are discharged or move through services.*
- *An audit needs to be conducted in relation to the most recent 10 near misses or serious incidents to ensure that the clinical records have been correctly archived following an internal investigation.*
- *Trust personnel must be reminded of their duties and obligations to maintain clinical records to professional standards during clinical supervision.*
- *Random spot audits of clinical case files should be conducted across all clinical teams to ensure correct ordering and storage of clinical records.*

Recommendation 6

Following the introduction the electronic record system RiO, the Trust must, ensure using regular audit and supervision, that:

- *all relevant clinical information is stored in a manner that is readily accessible to all clinicians working with a client;*
- *that information is appropriately cross referenced;*
- *that the quality of clinical notes is of an acceptable standard and complies with best practice guidance and professional standards.*

Recommendation 7

The Trust CPA policy is clear about the roles and responsibilities of professionals and managers. These responsibilities should be restated at all staff development reviews and appraisals. These responsibilities should be presented to all new members of staff as part of the formal induction process. The CPA process should be a standing item within management supervision with case files being checked for:

- *up to date holistic assessment of health and social care needs;*
- *a CPA care plan that is reflective of the identified needs;*
- *a review date has been set;*

- *supervisors and managers need to complete the Practice Audit during supervision and be able to demonstrate adherence to the CPA policy;*
- *the Trust needs to ensure that the current policy is compliant with the Refocusing the CPA guidance 2008.*

Recommendation 8

The risk policy needs to be reviewed to more closely align the risk screening tool (level 1) with the in depth risk assessment (level 2). The policy needs to specify that where a risk is identified at the screening stage then an in-depth assessment focusing on that particular risk needs to be conducted and a management plan developed.

- *Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services (Department of Health, 2007) should be used as guidance to underpin the revised risk assessment and management policy.*
- *The policy should be structured to reflect the functions of the various teams e.g. Crisis Team, CMHT etc.*
- *The Trust needs to ensure that risk management plans are drawn up following risk assessments where either significant risk is identified or where current trigger Factors, which might increase risk, are present.*
- *Random spot audits need to be carried out to support the annual audit plan.*
- *Risk assessment is a component of the CPA process and is to be included in management and clinical supervision.*
- *A service audit needs to be completed six months after the implementation of the revised policy to ensure that it has been acted upon.*

Recommendation 9

The Trust must issue a short protocol, within six months of the publication of this report, clarifying how relatives of staff will be treated within the Trust. This recommendation was made following the Internal Investigation but had at the time of writing the report not been actioned. It is therefore repeated.

Recommendation 10

Clear concise Operational Policies are developed to enable staff to understand their core function and responsibilities. These should include reference to core policies such as CPA and the key Clinical Practice Standards.

- *Operational service managers need to develop a core operational policy for the area they manage highlighting the area of practice such as age range, geographical area covered and services available.*
- *Clinical team leaders need to plot out the systems and processes that operate within their team such as referral criteria, assessment method, liaison with primary care/specialist services, allocation, supervision, discharge criteria and team meetings.*
- *Operational policies must be consonant with best practice guidelines such as the national Policy Implementation Guides, CPA policy or NIHCE guidelines*
- *A mechanism for the disseminating policies and policy revisions needs to be devised and implemented by the Clinical Governance Committee.*
- *Adherence to operational policies needs to be regularly monitored as part of an on-going audit programme.*

This will in effect create a service map and the beginnings of a service care pathway.

Recommendation 11

The implementation of the Clinical Practice Standards and the Practice Quality Audit needs to be strengthened across the Trust. Clinical audit participation needs to be developed through:

- *being a standing item on all clinical team meeting agendas;*
- *being included in individual annual appraisal and personal development plans;*
- *being monitored through supervision;*
- *forming part of all employees core job description.*

Recommendation 12

A robust annual audit plan, reflecting the Clinical Practice Standards and the standards specified in 'Services Good Enough for My Family', needs to be developed and widely disseminated. This will need to detail the roles and responsibilities of team leaders and managers not just in terms of data collection but also their involvement in action planning to rectify shortfalls.

- *The support services that are available across the Trust, such as coaching and Patient Safety Officers need to be targeted at those teams that struggle to complete the audit cycle.*
- *Clear time scales need to be incorporated into the annual audit plan to enable individual practitioners and teams to manage their time.*

Recommendation 13

The Trust need to review the SUI Policy to include:

- *the introduction of reflective feedback sessions following serious incidents and near misses;*
- *the involvement of clinical teams in the development of recommendations;*
- *how learning and recommendations are to be shared across the Trust;*
- *greater clarity about the involvement of the family of victim and perpetrator in Internal Investigations and how they will be supported thorough out the process.*

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5. Background and Context to the Investigation

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 4, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

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

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

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

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

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

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

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

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

6. Terms of Reference

The Terms of Reference for the Independent Investigation were set by NHS South West. The Devon Partnership NHS Trust and NHS Devon, Primary Care Trust was consulted with regard to the content of the Terms of Reference and did not wish to make any amendments.

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6. examine the adequacy of collaboration and effectiveness of communication with any other agencies who may have been involved in the care and treatment;
7. review the Internal Investigation into the care of Mr. Z already undertaken by Devon Partnership NHS Trust and any action plans that may have been formulated, including any immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Investigation;
8. consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence the public interest may require;
9. prepare an Independent Report for Devon Partnership NHS Trust, NHS South West and any other relevant bodies.

7. The Investigation Team

Investigation Team Leader and Chair

Ms. Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service.

Investigation Team Members

Dr. Simon Britten	Consultant Psychiatrist, Medical member of Team
Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service, Nurse Member of Team

Support to the Investigation Team

Mrs. Louise Chenery	Stenographer and Administration, HASCAS Health and Social Care Advisory Service

Independent Advice to Panel

Mr. Ashley Irons	Solicitor, Capsticks

8. Investigation Methodology

NHS South West commissioned this Independent Investigation under the Terms of Reference set out in section six of this report. This Investigation was led by the HASCAS Health and Social Care Advisory Service (HASCAS). In February 2010 a meeting was held with Devon Partnership NHS Trust, NHS Devon, NHS South West and HASCAS to discuss and confirm the terms of reference.

Consent

Mr. Z willingly gave his written consent for his clinical records to be accessed by the Independent Investigation on 23 February 2010.

Communication with the Family of Mr. N

The family of Mr. N were invited via the Police liaison service to participate in the Independent Investigation. They declined this offer.

Communication with the Family of Mr. Z

The family of Mr. Z were invited to meet with the Investigation Team. They accepted this invitation and met with the Investigation Chair in July 2010.

Communication with Mr. Z

On 21 July Mr. Z was interviewed by the Investigation Chair in the presence of his Probation Officer.

Initial Communication with the Devon Partnership NHS Trust

The Chief Executive of Devon Partnership NHS Trust was informed of the Independent Investigation. The Trust Clinical Risk Manager was appointed as the liaison person for the Investigation and the clinical records and policies were requested on 22 March 2010. The first tranche of clinical records was received from the Trust on 7 April 2010.

An initial briefing meeting was held with the Trust Chief Executive, one of the Medical Directors (this is a shared post), the Director of Compliance and Corporate Development (accountable for Corporate Governance), the Clinical Risk Manager and the Independent Investigation Chair to

discuss access, process, and involvement on 20 April 2010. At this stage a preliminary identification was made regarding further documentary evidence that the Independent Investigation Team would require.

On 28 April 2010 further clinical records and policies were requested from the Trust.

It is the practice of the HASCAS Health and Social Care Advisory Service to offer all Trusts subject to Independent Investigation a clinical witness workshop to provide clarity around the process prior to any interviews being held. A workshop was scheduled for mid June as were the corporate interviews. Clinical witness interviews had to be delayed as, on examination, the clinical records were incomplete to the extent that clinical witnesses could not be identified. On 17 June a further meeting was held with the Chief Executive Officer, the Director of Compliance and Corporate Development, the Clinical Risk Manager and the Independent Investigation Chair regarding significant gaps within the clinical records. Specific records in relation to inpatient admissions and Crisis Team interventions were requested. Further clinical records were submitted on 26 June 2010.

On 30 June a staff briefing workshop was conducted. HASCAS provided briefing packs to all identified witnesses and all witnesses were invited to speak with the Independent Investigation Chair if they had any questions or concerns. These packs contained the Investigation Terms of Reference, advice to witnesses, and a letter which detailed the Investigation process and what would be required of them. All witnesses were given a full list of the questions that would be asked of them in advance and were invited to attend their interviews in the presence of either their Union Representative or a work colleague for support.

Witnesses Called by the Independent Investigation Team

Date	Witness	Interviewer
14 July 2010	NHS Devon and Torbay Health Trust (PCT) Co-Medical Director's DPT Director of Operations DPT Director of Compliance and Corporate Development DPT Chief Executive Officer DPT	Independent Investigation Team Chair and Medical Team Member and Nurse Team member (also present were two other Investigation Chairs representing three other Independent Investigations that were running concurrently within the Trust)
19 July 2010	General Practitioner CMHT Managers Clinical Psychologist CPN 5 Occupational therapist CPN 3 Specialist Nurse (Drugs and alcohol) Director of Nursing and Practice DPT (Corporate)	Independent Investigation Team Chair and Medical Team Member
20 July 2010	Consultant Psychiatrist 5 Consultant Psychiatrist 2 Consultant Psychiatrist 3 Psychiatric Liaison Nurse Manager (Internal Investigation) CMHT Managers	Independent Investigation Team Chair and Medical Team Member
13 October 2010	Consultant Psychiatrist 6	Independent Investigation Team Chair and Medical Team Member

The Independent Investigation Team was advised by DPT that it was not possible to interview Mr. Z's Consultant Psychiatrist, Consultant 6, in July due to his/her ill health.[31]

Independent Investigation Team Meetings

The full Independent Investigation Team met on a total of three occasions. Additional work was completed by the Team in a 'virtual' manner. This work included a full documentary analysis of the primary archive (clinical records and Trust data) and review of relevant secondary literature.

21 June 2010. First Team Meeting: this day consisted of a full briefing regarding the case and the Investigation process and a review the draft timeline.

19 and 20 July 2010. Clinical and managerial witness interviews were held.

10 August 2010. Second Team Meeting: this day consisted of collating evidence and discussing findings. Root Cause Analysis took place on this day whereupon the data was considered in a systematic fashion as explained in the section directly below.

3 September. The Independent Investigation Team Chair held a briefing meeting with the Executive Team of the Devon Partnership NHS Trust to share the findings of the Investigation and to initiate work on appropriate and pertinent recommendations.

Root Cause Analysis (RCA)

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

[31] Email from Clinical Risk Advisor dated 12 August 2010

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

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

Salmon Compliant Procedures

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

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

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

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

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

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

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

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

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

(h) that they will be able to access copies of the clinical records both before and during

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

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

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

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

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

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

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

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

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

Anonymity

All clinical witness identities have been anonymised. All have been identified by their designation and an identifying number as appropriate. Consultant Psychiatrist are referred to as Consultant 1, Consultant 2, Consultant 3 and so forth and the same for Community Psychiatric Nurses, CPN 1, CPN 2 and so forth. All other individuals have been identified by their designation. The patient is referred to as Mr. Z and the victim Mr. N.

9. Information and evidence gathered (documentation)

During the course of this investigation some 2,500 pages of documentary evidence were gathered and considered. The following documents were actively used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Z's Devon Partnership NHS Trust records
2. Mr. Z's GP records
3. Mr. Z's ENDAS clinical records 2004
4. The Trust Internal Investigation Report
5. Police witness statements
6. Pre-sentence Probation report
7. Pre-sentence medical reports and addendums
8. Exeter court report (prosecution opening, mitigation, sentencing remarks)
9. The Independent Investigation witness statements
10. The Independent Investigation witness transcriptions
11. Trust policies and procedures in operation both in 200/67, and where different, those of the present day
    - Discharge Policy 2008
    - Corporate Identity Policy 2003
    - Supervision Policy 2004
    - Care programme approach policy 2006/2008
    - Safeguarding adults policy 2006
    - Access to health records
    - Deceased service user policy 2005
    - Freedom of information policy 2004
    - Records management and record keeping standards policy 2006
    - Incident reporting, management and review policy
    - Risk management, strategy, policy and risk assessment process 2005/2008
    - Devon and Cornwall Multi-Agency Public Protection arrangements 2003
    - Guidance on being Open 2008
    - Peer walk around audit tool
    - Case records audit tool
    - Policy and procedure for clinical supervision for nurses 2003

- Supervision policy 2004
- Supervision, personal development review and job planning policy 2010
- Supervision policy 2010
- The electronic supervision planner
- Policy Implementation Guide-Recovery Coordination

12. Crisis Team Operational Policy

13. Operational Policy Liaison Psychiatry Service 2005 and 2010(draft)

14. The Annual Report of the Devon Directors of Public Health 2006

15. Governance reporting structure

16. Clinical Directorate Governance Arrangements 2010

17. Care Quality Commission Investigation report 2010-08-29

18. Public Health Report 2006

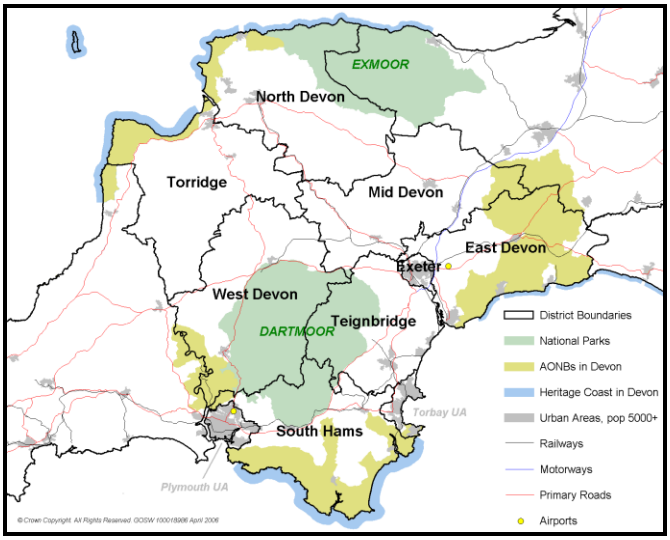
19. Primary Care Trust Annual Report 2007, 2008

10. Profile of Devon Partnership NHS Trust (past and present)

Demography

In order to contextualise the services in Devon it is necessary to have an overview of the demography as a whole.

Devon has the largest land area of any county in the South West with 27.5% of the region's total land area. It also has the most districts (8) as shown on the map below and two large National Parks, Exmoor and Dartmoor.



Devon has the largest population of any county or unitary authority in the South West, and is home to 14.3% of the region's total population. However, Devon is largely rural and has the lowest population density of the region's counties and unitary authorities, and is the most sparsely populated district in the South West.[32] The rural population of Devon is increasing faster than the national average, and in particular for the over 60's. In the short term this adds to the social capital and volunteering resource pool, but adds pressure on houses for non-economically active. The longer-term impacts are likely to be an increased demand for health services, care facilities and services, and public/ community transport. Linked to this is the dispersed settlement pattern which currently impacts upon service delivery. Market towns can

[32] *ONS Mid Year Estimates 2008 (revised) /ONS Area data*

provide a good range of key services and facilities but for the 15% with no car and for those households with one car, used by the main wage earner on a daily basis, access to market towns remains a challenge. Devon also contains two independent unitary authorities, Plymouth and Torbay.

Devon Partnership NHS Trust (DPT)

DPT was established in 2001. It serves the whole of Devon with a population of around 900,000. The Trust employs around 2,000 members of staff and has about 100 staff members' assigned form Devon County Council and Torbay Unitary Authority. The Trust works in partnership with health and social care providers. DPT has 294 mental health beds on 11 sites all over the county. There are 70 community teams spread over 40 sites across the county. The current Chief Executive was appointed in 2005 and the Chair of the Trust has been in post since 2009.

In 2005 the Trust had a large financial deficit. An external review into alleged bullying and harassment was being undertaken and this revealed that there had been deficiencies in human resource management, a lack of clinical engagement, and a culture of fear. The Trust was also subject to a Cross Party Parliamentary review due to concerns regarding partnership working.

The Trust embarked on a programme of financial recovery and break even was achieved in 2006/7. At the same time a decision was taken to have one lead commissioner.

Service configuration prior to 2006

Prior to 2006 the Trust was divided into localities, each with its own Director:

- North and mid Devon locality
- Exeter and East locality
- Torbay and South Devon

Each locality delivered its own portfolio of services. These comprised adult services for people of working age such as Inpatient Services, Community Mental Health Team's, Drug and Alcohol Services and Psychology Services. They also comprised services for Older People. The Trust

operated a matrix system of responsibility so a Locality Director would also provide a leadership role across the Trust for an area such as older peoples' services.

At this time the Learning Disability Services sat with the local authority. Forensic Services were based at Langdon with Medium Secure Services, Low Secure Services and Rehabilitation Services. The Trust also had responsibility for Child and Adolescent Mental Health Services including an inpatient provision.

Transition

2006 onwards was a time of major change for DPT.

- In 2006 the Trust reorganised its specialist services (psychological therapies, drug and alcohol services, and an embryonic eating disorder service) and appointed an overarching manager and leadership team.
- Child and Adolescent services stopped being providing within Devon Partnership NHS Trust and were transferred to NHS Devon and managed by what is known as a provider service.
- Changes were made so the inpatient services reflecting the strategy of moving from a predominately bed-based service to a more community-focused service. the following units ceased to provide an inpatient service:
    - Watcombe Hall (adult rehabilitation) in Torbay
    - Harbourne Unit (older people) in Totnes
    - Ash and Bucknill wards (adults) in Exeter
    - Redvers (older people) in Okehampton
    - Boniface (older people) in Crediton
    - Forest Hill House (learning disability) in North Devon
    - Ivycroft (learning disability) in Newton Abbot

  This resulted in a more even spread of inpatient units with two in Exeter, two in North Devon, and two in South Devon. Learning Disability Services developed community alternatives and worked more closely with mental health services
- Adult Mental Health began moving to a 'network delivery of care model' in order to develop a single point of access to the service wherever that might be and rapid access to specialist mental health services.

- In 2006, NHS Devon and Torbay Care Trust delegated the management of Individual Patient Placements (IPPs) to DPT (the Trust now has responsibility for funding and case-managing those people whose needs cannot be met within the county). The Trust's strategic plan was to provide as many services locally as possible.
- The Consultants implemented a functional spilt so that they covered either the community or an inpatient setting moving towards *New Ways Of Working*[33]
- 2008 Crisis Resolution and Home Treatment Teams came into being

The structure of the drug and alcohol services in 2006/07

Prior to 2006 each drug and alcohol service was directly accountable to its local mental health service:

- Quay Centre – North Devon Mental Health
- ENDAS – Exeter, East and Mid Devon Mental Health
- Shrublands – Torbay, South and West Devon Mental Health

During 2006 a project was undertaken to unify these services into one dedicated service that was accountable to a General Manager. This unified service and governance structure was formally incorporated into the Specialist Services Directorate and a Directorate Manager for Specialist Services was appointed in January 2007

Services provided by the Trust 2010[34]

DPT have introduced networks of care that deliver all the necessary health and social care services through four network areas based on the following four geographical areas:

- North Devon
- Exeter, East and Mid Devon
- South and West Devon
- Torbay

Each network area has three core network functions:

[33] New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts 2005 DoH
[34] DPT web site August 2010

1) Mental Wellbeing and Access Teams that work closely with GPs and provide a service that is easily accessible for:

- people presenting with a mental health problem for the first time and who need more help than their GP can provide;
- people who have previously used special mental health services and need further help;
- people experiencing common mental health problems;
- people experiencing a potential first episode psychosis.

These teams offer specialist assessment, consultation and advice between 8am and 6pm Monday to Friday and link with other network function teams who respond outside of these hours.

The Specialist Teams for Early Psychosis (STEP) focus upon caring for people who are experiencing symptoms of psychosis for the first time. Typically, these are younger people and the team works with each person to help them manage their symptoms and support them in their daily lives.

The teams also work in partnership with a number of providers ensuring that a range of Psychological Therapies are offered depending on the needs of each service user. These follow nationally agreed best practice.

2) Urgent and Inpatient Care

This service provides care and treatment at home or in hospital for people in times of crisis and acute illness

The Urgent and Inpatient Care Teams include hospital wards and the Crisis Resolution and Home Treatment Teams. Together they provide a flexible 24 hour service, seven days a week, to care for service users who have urgent mental health needs or who are in crisis. These services also support those who require a stay in hospital.

When a hospital admission is needed teams work towards minimising the length of stay, involving carers and families to ensure that arrangements are in place to support people when they are discharged.

3) Recovery and Independent Living Services

The purpose of the Recovery and Independent Living Service is to support recovery by using a holistic approach and by promoting social inclusion, self-management and independence. This provision is for people who have had complex relationships with services and whose needs cannot be met through the Mental Wellbeing and Access function.

By providing more flexible tailored services for people that address their individual needs, the service can support them more effectively in living a full and satisfying life. This includes support to live where they choose, obtaining access to education, training and employment and to engage with social activities and relationships outside mental health services.

The Trust specifically provides the following services with this function:

- Assertive Outreach
- Rehabilitation and Recovery
- Vocational Rehabilitation

In addition, the staff in the Recovery and Independent Living Teams also work closely with local providers in the public, private and voluntary sector to address the individual needs of service users in order to help and support them lead the life they choose.

The Trust began establishing Clinical Directorates in April 2010. There are four Clinical Directorates:

- Adult Mental Health.
- Specialist Services Directorate incorporating Drug and Alcohol, Gender reassignment, Learning Disabilities, Psychology Therapy Services including Personality Disorder Services.
- Secure Services.
- Older Peoples Mental Health.

The structure within each Directorate is that there is a medical clinical director who works in tandem with a ‘managing partner’, a person whose background is management and may or may not be a clinician. This is to ensure that clinical services are led predominantly by a clinician.

Commissioning

How services were commissioned

Prior to October 2006 work was initiated by the CEO of Teignbridge PCT to bring together a Devon wide commissioning arrangement to align service planning and investment decisions.

Devon PCT was formed in October 2006 with the amalgamation of six PCTs (excluding Torbay). Prior to this each of the PCT's had their own commissioning arrangements which were in line with the national service framework although there were significant geographical variations in the services provided due to the different levels of investment. Strategic planning was led by the Devon and Torbay Local Implementation Team (LIT) which brought together the Local Implementation Groups (LIGs) for each of the PCT areas together with the statutory and voluntary sectors, users and carers.

Since 2006 Devon PCT has acted as the lead commissioner with DPT. Torbay Health Care Trust is regarded as an associate commissioner. There is a functional separation between strategic commissioning and contract and performance monitoring.

Local Authority services are not commissioned as part of the NHS contract but performance monitoring arrangements do include a number of local authority key performance indicators.

How services are monitored

It is recognised that prior to 2006 monitoring and performance were not well developed and varied across all the PCT areas. Since then work has been undertaken to improve the contract performance arrangements through the initiation of monthly meetings held with the provider Trust. These meetings have been separated into two components:

1. Clinical quality review
2. Contract and performance issues

The same arrangements are in place for Torbay Health Care Trust.

There is a Joint Commissioning Manager for Adult Mental Health and Alcohol Services with Devon County Council and NHS Devon.

11. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external Factors that may have impacted upon the life of Mr. Z and on his care and treatment from mental health services.

Background Information

Mr. Z was born in 1954 in Cardiff when his mother was 48 years old and he was the youngest of four siblings.[35] This was an unplanned pregnancy and his mother suffered with post natal depression and was hospitalised[36]. As a result of this he was raised by his grandmother until he was three years old when he returned to the family home.

Mr. Z's mother died when he was aged seven.[37] His father remarried 18 months later and Mr. Z did not get on with his step mother.[38] The impression given is of an unhappy childhood. Mr. Z spent a lot of his time reading in his room as he was not permitted to have friends in the house and his stepmother has been described as emotionally abusive[39]. Reference is made to the fact that Mr. Z used to cut himself as a teenager. Mr. Z had an episode of drug dependency in the 1970's[40] and alcohol dependency in the 1980's. [41]

Mr. Z was very close to his older sister who emigrated to Australia when he was 14 years old. He had hoped to go with her but his father would not allow him to leave home.[42]

Mr. Z attended main stream school where it was noted that he had difficulties with spelling and left at the age of 15 years to work with a tyre firm. During this time he started to take drugs, LSD, 'uppers' and 'downers', ('uppers' is the street name for dugs such as speed and cocaine

[35] Clinical Records Volume 2 pg 130
[36] Clinical Records Volume 2 pg 156
[37] Clinical Records Volume 2 pg 166
[38] Clinical Records Volume 2 pg 169
[39] Clinical records Volume 2 pg 166
[40] GP records pg 1
[41] Clinical records Volume 2 pg 130
[42] Clinical records Volume 2 pg 130

as they result in the user feeling energised, 'downers' is the street name for drugs such as heroin and benzodiazepines and have a calming effect) and socially drank alcohol.[43] He then trained as a bricklayer and a wood machinist.[44]

Mr. Z met and married his wife in his mid 20's. They lived in Norfolk for a period of time returning to Devon to enable his wife to pursue some training. During this time Mr. Z was a 'house husband' a role that he did not enjoy and found difficult to adapt to.

Forensic history

At an unknown age there was involvement with the Police as Mr. Z took responsibility for his father's shop lifting (as his father thought that he might lose his job if he took responsibility for this himself). This resulted in a period of Probation for Mr. Z. He was then caught during a burglary and given a further period of Probation. He spent a year in borstal after being convicted of conspiracy to fraud (cheque books).[45]

Mental Health Chronology

During November 1992 Mr. Z was referred by his GP to a Psychiatrist at his own request. At this time he was unemployed and drinking a three quarter of a bottle of vodka a day to help him sleep. He was started on Prozac 20 mg.[46] He was invited to make an appointment with the Psychiatrist but he had moved to Norfolk.

During December 1996 Mr. Z returned to Devon. The GP referred Mr. Z to a Clinical Psychologist at the request of Mr. Z's wife as he had experienced a relapse of his anxiety and depression that had settled on Dothiepin 150 mg although he was noted to be far from well.[47] During 1997 Mr. Z saw a Clinical Psychologist. Mr. Z disclosed a long standing experience of depressive episodes and a history of periodic alcohol abuse stemming from his early teens. His mother died when he was aged seven, his father remarried and Mr. Z had a poor relationship with his stepmother leading to a history of petty criminal activity, drug abuse and self harm behaviors. He presented with a profound sense of low self worth and strong feelings of

[43] Clinical records Volume 2 pg 156
[44] Clinical Records volume 2 pg 157
[45] Clinical records Volume 2 pg 157
[46] Clinical Records Volume 2 pg175
[47] Clinical Records Volume 2 pg 160

inadequacy developing a significant dependency on alcohol in his teens. At the end of the sessions Mr. Z had responded well to psychological intervention, remained abstinent from alcohol, resolved work related stress issues and improved the relationship with his wife.[48]

There is no further reference to mental health issues until 7 November 2000 when the Occupational Health Department of Mr. Z's employer wrote to his GP. There were concerns that Mr. Z was under increasing stress due to the ill health of a work colleague, that he was binge drinking and experiencing explosive outbursts of anger. Mr. Z had also increased his dose of Dothiepin to 300 mg daily in an attempt to cope[49]

On 14 November 2000 Mr. Z was assessed in the Royal Devon and Exeter Hospital (RD&E) following an overdose of Dothiapin. He took the overdose when he knew his wife would be out of the house. It was noted that there was a long standing history of depression and anxiety with occasional binge drinking. The impression was that this was a serious overdose and a significant risk of further self harm existed due to work related stress. An urgent referral was made to the CMHT (Exeter) and the medication was changed to Citalopram 20 mg.[50]

Mr. Z was assessed by CPN 1 (Honiton Team) at home on 17 November 2000. Work stressors were identified. CPN 1 saw Mr. Z on a monthly basis to monitor his mental state (mood rating) and medication whilst providing practical advice and support.[51] CPN 1 referred Mr. Z to Consultant Psychiatrist 1 (Honiton Team) for follow up. Mr. Z could not be seen by the Exeter CMHT, his catchment area team, as his wife was working within the team and he was therefore given 'out of area staff status'.[52] Mr. Z was assessed and reviewed by Consultant Psychiatrist 1 at Wonford House Hospital on 27 February 2001 where further background information was elicited and a diagnosis of a severe depressive episode was made. The GP had changed the medication back to Dothiepin 150 mg daily and this was increased incrementally over the following couple of weeks to 200 mg daily.[53]

A further review was conducted on 27 April where Mr. Z had his medication reduced to 125 mg daily which he was advised to continue as he was experiencing impulsive suicidal thoughts. He

[48] Clinical Records Volume 2 pg 173
[49] Clinical Records Volume 2 pg 174
[50] Clinical Records Volume 2 pg 169
[51] Clinical Records Volume 2 pg 165 and Volume 3 pg 59
[52] Clinical Records Volume 2 pg 159
[53] Clinical Records Volume 2 pg 157

had been assessed by a Clinical Psychologist and was on the waiting list for psychotherapy.[54] By June 2001 CPN 1 had persuaded Mr. Z to increase the medication to 150 mg and at the Consultant review he appeared to be doing well.[55] By the September 2001 review Mr. Z was experiencing an increase in his work pressure due to staff sickness and was becoming increasingly depressed and anxious. The plan was to incrementally decrease the Dothiepin and introduce Seroxat 20 mg.[56] By his October 2001 review Mr. Z had resigned from his job and appeared to be benefitting from the combination of medication. No changes were made.[57] CPN 1 referred Mr. Z and his wife to couples counselling.[58]

On 15 February 2002 Mr. Z reported to Consultant 1 that he was keen to reduce his medication and this was cautiously agreed to at a reduction of Dothiepin 25 mg a month until he was just taking Seroxat.[59]

On 19 March 2002 CPN 1 discharged Mr. Z from the case load at the CMHT (Honiton) as Mr. Z had secured full time employment and presented as stable.[60] Consultant 1 reviewed Mr. Z on 9 April 2002 there were no concerns about his mental state and the Dothiepin had been reduced to 50 mg daily.[61] At the next appointment on 7 June 2002 Mr. Z had found alternative employment and was doing well. He was advised to reduce the Dothiepin to 25 mg and stop this altogether after a further two weeks.[62]

On 2 August 2002 Mr. Z was admitted to the RD&E hospital having taken an overdose of 56 tablets of Dothiepin and one third of a bottle of vodka. He was found unconscious by his wife. He was resuscitated numerous times and required intubation.[63] On 5 August Mr. Z was referred to the Emergency Duty Team as he was disinhibited, agitated and stating that he was going to leave the ward. He was assessed for a Section 5/2 of the Mental Health Act (1983) on 6 August 2002 by Consultant 1 but this was not applied.[64] Notes in the clinical record (undated and unsigned) record a consultation with Mr. Z's wife and CPN1 who both stated that Mr. Z

[54] Clinical Records Volume 2 pg 155
[55] Clinical Records Volume 2 pg 154
[56] Clinical Records Volume 2 pg 153
[57] Clinical Records Volume 2 pg 156
[58] Clinical Records Volume 2 pg 143
[59] Clinical Records Volume 2 pg 141
[60] Clinical Records Volume 2 pg 63
[61] Clinical Records Volume 2 pg 135
[62] Clinical Records Volume 2 pg 133
[63] Clinical Records Volume 3 pg 52
[64] Clinical Records Volume 3 pg 18

underplayed his depression.[65] Mr. Z agreed to an informal admission to Delderfield Ward at Wonford House Hospital (Mental Health) and was transferred there on 10 August. At the admission assessment Mr. Z presented as relaxed and reported that he had taken the overdose as his wife wanted a separation and that he wished that the overdose had worked.[66] Mr. Z was placed on Section 5/2 Mental Health Act (1983) as he wished to leave the hospital (the dates are not clear in the clinical record). Mr. Z was reassessed under the MHA on 13 August 2002 and was not thought to be detainable as he was not suicidal, was willing to stay in hospital if he could have more freedom but was not willing to take any treatment. The outcome of the assessment was that Mr. Z was not thought to be detainable and that personality difficulties were more apparent than depression.[67]

Mr. Z settled on the ward and was visited regularly by his family. On 16 August 2002 at a Consultant review with Mr. Z's wife she expressed her concern that Mr. Z was pushing boundaries and that she was feeling 'bruised' having found him following the overdose. Mr. Z was granted two hours leave and access to his motorbike although the staff were to hold the keys.[68] By 23 August the leave had been increased to four hours a day unescorted at the nurse's discretion. [69]

On 27 August 2002 Mr. Z took his own discharge against medical advice; he denied any suicidal thinking and had clear plans for his future. He was not on any medication at the time of discharge and it is recorded that he refused any whilst he was an inpatient.[70] He was noted not to be sleeping well and objectively he appeared low.[71] His wife was on the ward at the time of his discharge and took him home whilst making it clear that this was a temporary situation and that their separation was to go ahead.[72] CPN 1 contacted Mr. Z the following day and visited him on 2 September 2002 when it was noted that he was not coping and was experiencing some suicidal thoughts but not acting upon them although he was unsure why this was. The records indicate that a further appointment was made for 2 October 2002 but there are no further entries in the clinical records.[73]

[65] Clinical Records Volume 3 pg 50
[66] Clinical Records Volume 2 pg 292 & 285
[67] Clinical Records Volume 2 pg 291 & 15
[68] Clinical Records Volume 2 pg 298
[69] Clinical Records Volume 2 pg 274
[70] Clinical Records Volume 2 pg 128
[71] Clinical Records Volume 2 pg 21
[72] Clinical records Volume 2 pg 213
[73] Clinical Records Volume 3 pg 64

On I8 November 2002 Mr. Z took an overdose of Paracetamol and Aspirin; he was again found by his wife and admitted to RD&E hospital. It was noted that his alcohol intake had increased and that he had started drinking spirits.[74] The Devon Doctors on Call records indicate that Mr. Z was reported as having a borderline personality disorder as he had been to hospital before and that he had wanted to die in his own home.[75] He was transferred to the Mental Health Unit on 22 August 2002.[76] Mr. Z settled on to the ward and was noted to displace his feelings and decision making with activities and was negative about his future. His wife wrote to Consultant 1 regarding her view on Mr. Z's dependency and the need for the team to pick up where she had left off managing him e.g. his money and housing needs.[77] By December Mr. Z was making use of his day leave and proactively addressing his housing needs whilst presenting as being superficially bright.[78]

On 27 December 2002 Consultant 2 (locum cover for Consultant 1) requested that Consultant 3 took over the medical care of Mr. Z at the point of discharge as Mr. Z had separated from his wife and therefore no longer had out of area staff status. Consultant 2 noted that Mr. Z had a recurrent depressive disorder and a possible dependent personality disorder as he had poor coping strategies.[79]

On 23 January 2003 Consultant 2's Secretary forwarded the community referral letter to Consultant 4 as Mr. Z's new accommodation was in his catchment area.[80]

Mr. Z remained on the ward until accommodation was ready and was discharged on 24 January 2003 on Cipramil 20 mg daily. Mr. Z had secured a room in a shared house.[81]

Consultant 4 replied to Consultant 2's referral letter on 29 January 2003 asking for Mr. Z's key worker to negotiate a handover to his team so he could take over responsibility.[82]

[74] Clinical records Volume 2 pg 204 and 124
[75] GP records pg 144
[76] Clinical Records Volume 2 pg 270 & 271
[77] Clinical Records Volume 2 pg 123
[78] Clinical Records Volume 2 pg 269 & 269
[79] Clinical Records Volume 2 pg 144
[80] Clinical Records Volume 2 pg 114
[81] Clinical Records Volume 2 pg 208
[82] Clinical Records Volume 2 pg 113

On 30 January 2003 Consultant 2 wrote again to Consultant 4 asking him to urgently take over Mr. Z's case stating that he has a very dependent personality with a tendency to harmful use of alcohol with repeated acts of deliberate self harm through serious overdose.[83]

An undated risk assessment was completed by CPN 1 this noted that Mr. Z was living in a one bed flat on benefits and had been experiencing periods of acute anxiety and panic. The warning signs for relapse were identified as increased anxiety, sleep disturbance and increased alcohol consumption.[84]

On 12 March 2003 Consultant 4 offered Mr. Z an appointment for 24 March 2003.[85] Mr. Z did not keep the appointment as a close family member worked with Consultant 4 on the inpatient ward.[86]

On 2 April 2003 Consultant 4 wrote to Consultant 3 asking him if he could take over the care of Mr. Z and stated that CPN 2 was happy to remain as his key worker.[87] On 18 May Mr. Z wrote to Consultant 3 requesting an appointment and a change of CPN as CPN 2 had regular professional contact with Mr. Z's daughter.[88] Consultant 3 initially agreed to take over[89] but had to withdraw this offer due to organisational change and suggested that Consultant 4 approached Consultant 5.[90] Consultant 4 wrote to Consultant 5 on 20 May 2003.[91]

On 30 June Mr. Z was reviewed by Consultant 5. Mr. Z presented with some signs of a depressive illness with sleep disturbance, anxiety and depressed mood. It was noted that there was a slight scent of alcohol. A diagnosis was made of a moderate to severe reactive depression with harmful use of alcohol. By this time Citalopram had been changed back to Dothiepin by the GP and this was increased to 225 mg daily with advice that he had short term prescriptions to avoid the risk of overdose.[92]

[83] Clinical Records Volume 2 pg 111
[84] Clinical Records Volume 2 pg 198
[85] Clinical Records Volume 2 pg 106
[86] Clinical Records Volume 2 pg 105
[87] Clinical Records Volume 2 pg 105
[88] Clinical Records Volume 2 pg 101
[89] Clinical records Volume 2 pg 99
[90] Clinical Records Volume 2 pg 103
[91] Clinical Records Volume 2 pg 100
[92] Clinical Records Volume 2 pg 90

On 15 August 2003 CPN 3 acknowledged Mr. Z's cancelled appointment for the previous day. Mr. Z did not want anyone from mental health services at the Exeter Team to have any contact with him as his estranged wife was working there. Mr. Z was discharged from the case load at the Exeter Team although the duty system was made available to him.[93]

On 29 September 2003 Mr. Z did not keep his appointment with Consultant 5.[94]

On 28 November 2003 Mr. Z wrote to Consultant 5 requesting an appointment.[95] An appointment was offered for 21 January 2004.

Mr. Z was reviewed by Consultant 5 on 14 April 2004. Mr. Z smelt strongly of alcohol and had been binge drinking between four and five days a week and it was therefore difficult to assess his mental state. The GP had referred Mr. Z to ENDAS (Exeter and Devon Addictions Services). Mr. Z was encouraged to keep his appointments with CPN 3 and Consultant 5.[96]

A further review took place with CPN 3 and Consultant 5 on 26 May 2004. This was the first time that CPN 3 had met Mr. Z. Mr. Z had had one pint of beer prior to the appointment, he reported that he had stopped drinking spirits although was still drinking larger and had an appointment at ENDAS. The plan was to review the anti depressant therapy, after the assessment at ENDAS due to an underlying depressive illness.[97]

On 7 June 2004 CPN 3 met with Mr. Z and subsequently wrote to the GP outlining a plan of onward referral for Mr. Z to counseling services and the heart-fit programme. Mr. Z had declined a referral to Bell Industries (Arts and Crafts Day Centre) and CPN 3 planned to see him again in a few weeks time.[98] A further appointment was offered for 16 August 2004.[99]

CPN 3 next met with Mr. Z on 7 September 2004. Mr. Z was awaiting allocation at ENDAS although he was reluctant to participate in group work there as he thought this might compromise his family. He stated that he wanted to make his death look like an accident

[93] Clinical Records Volume 2 pg 89
[94] Clinical Records Volume 2 pg 84
[95] Clinical Records Volume 2 pg 83
[96] Clinical Records Volume 2 pg 79
[97] Clinical Records Volume 2 pg 78 & 39
[98] Clinical Records Volume 2 pg 76
[99] Clinical records volume 2 pg 72

although he did not reveal any plans as to how he might do this. Mr. Z shared a house with other tenants and was worried that he might end up like them.

On 20 September 2004 Mr. Z met with the Specialist CPN (drugs and alcohol). Mr. Z was consuming 20 units of alcohol a day and did not see this as a big issue. He disclosed self harm/suicide attempts in the previous two weeks but refused to clarify what these were. They agreed that the case would close as Mr. Z was not willing to do any work around his alcohol consumption.[100]

On 26 November 2004 Exeter CMHT Duty received a telephone call from Mr. Z's Counsellor at the Victory Centre who reported that Mr. Z had been missing his sessions and often appeared under the influence of alcohol; his presentation was increasingly morbid and he would state that he wished he was dead. The Counselor requested support with his management. CPN 4 from Exeter CMHT offered an assessment appointment for 14 December 2004.[101]

On 28 January 2005 CPN 4 conducted an initial assessment at the GP surgery. It was recorded that Mr. Z was suffering from excessive alcohol consumption and depression. The impression was that Mr. Z had turned to alcohol as a means of coping with his family breakdown and that the heavy use of alcohol was resulting in physical dependence. The plan was to discuss the case with alcohol services and to see him again the following week to check his motivation to change.[102]

On 17 February 2005 CPN 4 completed the assessment concluding that Mr. Z had clear symptoms of alcohol dependency but was unmotivated to tackle his drinking despite the offer of an out of area placement at the Cedars. [103] The GP was informed.

In March 2005 a Social Worker from Exeter CMHT was allocated to assist Mr. Z in an application for DLA. There was confusion over the appointment and Mr. Z cancelled the appointment.[104] The Social Worker was not able to meet with Mr. Z but did speak to him on the telephone and ascertained that he was drinking in excess of 120 units of alcohol a week. The

[100] Clinical Records Volume 2 pg 74
[101] Clinical Records Volume 3 pg 99
[102] Clinical Records Volume 1 pg 108
[103] Clinical Records Volume 3 pg 44 & Volume 1 pg 109
[104] Clinical Records Volume 3 pg 80 & 82

GP was informed of this and the fact that Mr. Z had moved and requested of the GP that he be referred to the Crediton/Okehampton CMHT.[105]

On 10 August 2005 Mr. Z took an overdose of 60 tablets of Dothiepin. He was found by his house mate (Mr. Z had moved to a house in a very rural area that he shared with someone he had met at his previous accommodation) the following day collapsed, and was admitted to RD&E hospital. He was assessed by a Liaison Psychiatric Nurse on 15 and 16 August 2005. The assessment concluded that Mr. Z had taken an intentional planned overdose with high intent of suicide having written two wills and a suicide note. Three months earlier he had been inserting acupuncture needles into his chest cavity in order to induce a heart attack and die. He was thought to be high risk of completed intentional suicide in both the short and long term. He was noted to have a low mood, feelings of guilt, chronic ongoing suicidal ideation, hopelessness and alcohol misuse. It was thought that his symptoms were related to his personality rather than severe clinical depression. Mr. Z refused admission to a Mental Health Unit or to see a Psychiatrist. It was thought that admission to a Mental Health Unit would increase the risk and promote further disengagement with services. The situation was discussed with the Medical Staff, the Liaison Psychiatrist and the Duty Manager who agreed that Mr. Z could be discharged with Crisis Team support in the short term. An urgent referral was made to the CMHT (Crediton/Okehampton) and the Catchment Area Psychiatrist.[106] Mr. Z was discharged from RD&E on 18 August 2005.

The Crisis Team undertook a home visit and assessment on the same day, 18 August 2005, and noted that Mr. Z's speech was slow and low, he had poor eye contact, poor concentration and was subjectively and objectively depressed. He had recently lost two stones in weight. Mr. Z agreed to see a Psychiatrist for a medical opinion and to see his GP for something to help him sleep and to reduce his alcohol intake. Mr. Z declined a visit for the following day and stated that he would be in the local pub.[107]

On 22 August 2005 Consultant 6 and the Crisis Team conducted an urgent home visit. Mr. Z presented as very depressed and was admitted to Coombhaven Ward, North Devon DGH, where he underwent a detoxification programme.[108] He was discharged on 30 August 2005. The

[105] Clinical Records Volume 3 pg 78
[106] Clinical Records Volume 2 pg52
[107] Clinical Records Volume 4 pg 6
[108] Clinical records Volume 2 pg 40

discharge summary noted that Mr. Z was not keen to take an anti depressant, that the separation from his wife remained a major issue and that his suicidal thoughts had became less of a problem. It was hoped that Okehampton CMHT would follow him up. He was diagnosed with depression and alcohol misuse.[109]

CPN 5 (Okehampton CMHT) contacted Mr. Z on 2 September 2005 and offered an appointment for 7 September 2005.[110] At this assessment Mr. Z estimated that his alcohol intake was a couple of pints at lunch time and a couple of glasses of wine in the evening and disclosed that prior to the overdose he had been drinking a bottle of whisky a day. He could not see the point of looking to the future due to not being in a family unit. However he spoke positively about setting up a workshop to do furniture restoration and being able to explore the local countryside as he had bought a car. He became distressed when ruminating about the loss of his family. CPN 5 agreed with the risk cited in LPN assessment. CPN 5 advised Mr. Z to control his drinking. CPN 5 discussed Mr. Z with the Team Manager and an urgent referral was made to the Clinical Psychologist (Okehampton CMHT).[111]

On 9 and 16 September 2005 Mr. Z was written to and offered an appointment with the CMHT Clinical Psychologist.[112]

CPN 6 (covering for CPN 5 who was on leave) offered Mr. Z a further two appointments on 21 September 2005 and 23 September 2005. Mr. Z did not attend either. CPN 6 had time to make a home visit on 23 September. Mr. Z was in bed and appeared physically unwell, vomiting. Mr. Z reported that he had a car and felt that this had helped limit his alcohol use. He admitted to a desire not to be alive but denied any plans to act on this.[113] A further appointment was sent for 26 September 2005.[114]

13 October 2005 Mr. Z had his first appointment with the Clinical Psychologist. In a letter to CPN 5 the Clinical Psychologist wrote that Mr. Z presented as a rather passive man who was resigned to his fate, that he believed that he had lost everything and that it was too late to start again. He summarised that Mr. Z's difficulties predated the marital breakup although this no

[109] Clinical Records Volume 4 pg 52
[110] Clinical records Volume 1 pg 38
[111] Clinical Records Volume 1pg 7
[112] Clinical Records Volume 1 pg 101 & 99
[113] Clinical records Volume 1 pg 38
[114] Clinical Records volume 1 pg 97

doubt contributed to his present situation. The Clinical Psychologist accepted Mr. Z on to his case load.[115]

The Clinical Psychologist met with Mr. Z on 27 October 2005 and 8 November 2005 during which they began to discuss Mr. Z's marital breakup, his alcohol dependence and perceived rejection.[116]

On 10 November 2005 CPN 5 phoned Mr. Z to arrange an appointment and agreed to write to him. [117] The letter suggested that Mr. Z could contact CPN 5 if he thought that this would be helpful.[118]

On 11 November 2005 Mr. Z contacted the Clinical Psychologist in a drunken state. He was not suicidal and was reminded about contact with the Samaritans if he did feel suicidal.[119]

On 22 December 2005 Mr. Z met with the Clinical Psychologist and described his recent hospitalisations (he had been admitted to RD&E for physical health reasons). Mr. Z was to have his gall bladder removed in the near future. Mr. Z stated that he hoped that he would die during the operation although he also had plans to move after this event. Mr. Z stated that he was having problems with his housemate who drank heavily.[120] Loss reaction work sheets (psychological intervention) and coping over Christmas were discussed.

Mr. Z and the Clinical Psychologist met on 20 January 2006,[121] 2 and 16 February 2006, 2 March 2006, and 28 April 2006 as they worked through Mr. Z's loss reactions and the possibility of restoring the relationship with his wife. In February Mr. Z reported that he had drunk to excess in order to be assertive with his housemate.[122]

[115] Clinical Records Volume 1 pg 92
[116] Clinical Records Volume 1 pg 39
[117] Clinical Records Volume 1 pg 40
[118] Clinical Records Volume 1 pg 89
[119] Clinical Records Volume 1 pg 40
[120] Clinical Records Volume 1 pg 40
[121] Clinical Records Volume 1 pg 40
[122] Clinical Records Volume 1 pg 41& 42

On 12 May 2006 Mr. Z presented as tearful, describing himself as pathetic but felt that he was starting to come out of it. He reported that he had damaged his hand in anger when dealing with his flat mate.[123]

On 25 May 2006 the Clinical Psychologist received a letter from the GP advising him that Mr. Z had had two recent admissions for alcohol related gastritis/pancreatitis.[124]

On 6 June 2006 the Clinical Psychologist attempted to discuss Mr. Z's alcohol consumption. Mr. Z stated that he did not want to give up alcohol as this was his means of escaping his thoughts and getting some sleep. Mr. Z discussed the problems he was experiencing of living with an alcoholic. The Clinical Psychologist advised Mr. Z to consult with the Citizen's Advice Bureau (CAB) regarding advice about moving.[125] By 26 June 2006 the Clinical Psychologist reported that Mr. Z had reduced his alcohol intake and was doing well.

On 11July 2006 Mr. Z attended his appointment in an intoxicated state as he had been trying to block out the problems caused by his housemate.[126]

On 18 July 2006 Mr. Z reported feeling low due to the effects of living with an alcoholic who was causing financial problems by not paying his share of the bills. Mr. Z was reluctant to move as he valued his workshop and space for his chickens.[127]

On 1 August 2006 Mr. Z had drunk two bottles of whisky in two days as he was fed up with his situation and wanted a passive way of killing himself. Mr. Z believed that many of his problems would be solved if he had transport or could move.[128]

On 31 August 2006 Mr. Z presented as a mixed picture with many positives but continued to think of slow passive suicide. [129]

[123] Clinical Records Volume 1 pg 43
[124] Clinical Records Volume 1 pg 88
[125] Clinical Records Volume 1 pg 43
[126] Clinical Records Volume 1 pg 44
[127] Clinical Records Volume 1 pg 44
[128] Clinical Records Volume 1 pg 45
[129] Clinical Records Volume 1 pg 45

On 19 September 2006 Mr. Z telephoned to say that he was unable to make his appointment with the Clinical Psychologist. Mr. Z sounded very down and admitted to drinking. The Clinical Psychologist was aware of the potential risks, and a home visit was conducted as a result. Mr. Z presented as very distressed and tearful, he denied self harm but stated that he needed help. During the visit Mr. Z's daughter telephoned and Mr. Z was able to conceal the depth of his distress.[130] Mr. Z was referred to the Crisis Team.

On 21 September 2006 the Crisis Team assessment outcome plan recorded significant evidence of alcohol withdrawal with mild to moderate depressive features, probable malnutrition, expressed feelings and thoughts of suicide but cited his children as protective Factors. There was no evidence of serious mental illness noted and Mr. Z was not taken on by the team.[131]

On 22 September 2006 The Clinical Psychologist contacted Mr. Z in the absence of any contact with the Crisis Team. Mr. Z informed him that he had not been taken on by them (earlier assessment of 20 September did not happen as he had been drinking) and that he had concealed the depth of his despair i.e. suicidality. [132]

On 26 September 2006 the Clinical Psychologist discussed Mr. Z at the CMHT MDT and completed a "notification of serious concern" document[133] the plan was for an urgent referral to ENDAS.[134] The Occupational Therapist and CPN 5 offered a joint appointment for 4 October 2006.[135]

On 29 September 2006 Mr. Z met with the Clinical Psychologist where he played down his use of alcohol but agreed to attend an assessment with ENDAS. He continued to express suicidal ideation but did not reveal any active plans. The Clinical Psychologist recorded that he was confused about the lack of support that Mr. Z was receiving.[136]

On 4 October 2006 a home visit was conducted by the Occupational Therapist and CPN 5. Mr. Z's house was noted to be well ordered and he presented as kempt so it was thought that his

[130] Clinical Records Volume 1 pg 46
[131] Clinical Records Volume 1 pg 16
[132] Clinical Records Volume 1 pg 47
[133] Clinical Records Volume 1 pg 4
[134] Clinical Records Volume 1 pg 86
[135] Clinical Records Volume 1 pg 85
[136] Clinical Records Volume 1 pg 47

living had not become chaotic. It was noted that his suicidality was exacerbated when intoxicated and that this was the most immediate problem. [137]

On 10 October 2006 the Clinical Psychologist was informed by the specialist CPN (drugs and alcohol) that Mr. Z could not be seen until Mid November.[138] Mr. Z was discussed in the CMHT clinical meeting. Acknowledgement was given to ongoing risk of suicide being consistent throughout his involvement with services and that this was perpetuated by ongoing use of alcohol and the inability to accept that that his marriage had ended. The risk management plan was to continue to offer engagement and encourage attendance at appointments with ENDAS.[139]

On 12 October 2006 the Clinical Psychologist: discussed with Mr. Z his alcohol consumption and how this might put Mr. Z at greater risk[140]

On 19 October 2006 a home visit was conducted by the Occupational Therapist and CPN 5. Mr. Z had been drinking but was lucid and responsive. He stated that his mood was low and that his level of suicidality remained the same. Mr. Z did not see any benefit from ongoing contact with CPN 5 or the Occupational Therapist as the Clinical Psychologist was helping with his depression but agreed for the Occupational Therapist to arrange an appointment with Rethink.[141]

On 30 October 2006 Mr. Z did not keep his appointment at ENDAS.[142]

On 7 November 2006 Mr. Z presented as very tearful. The Clinical Psychologist explored the relationship Mr. Z had with his wife. Mr. Z was keen to arrange anti depressant therapy and the Relate facility. The Clinical Psychologist liaised with the GP about prescribing antidepressants,[143]

[137] Clinical Records Volume 1 pg 84
[138] Clinical Records Volume 1 pg 47
[139] Clinical Records Volume 1 pg 50
[140] Clinical Records Volume 1 pg 50
[141] Clinical Records Volume 1 pg 83
[142] Clinical Records Volume 2 pg 41
[143] Clinical Records Volume 1 pg 51

On 21 November 2006 Mr. Z presented as tearful as his brother was dying of cancer; his estranged wife was being supportive and he seemed to be coping in difficult circumstances. [144]

On 11 December 2006 the Occupational Therapist received a voice mail from the Clinical Psychologist who was concerned about Mr. Z. The Occupational Therapist telephoned Mr. Z, and learned that his brother had died, they arranged to meet on the 18 or 20 December. On 13 December CPN 5 spoke with Mr. Z's GP. Mr. Z had not had a drink for the past 10 days and was requesting tranquilisers. The GP had proposed an SSRI's that was declined by Mr. Z as he wanted Dothiepin, but the risk was thought to be too high by the GP. CPN 5 discussed the case with Consultant 6 who agreed with the GP.[145]

On 14 December 2006 Mr. Z left a distressed and incomprehensible telephone message for the Clinical Psychologist. The Clinical Psychologist conducted a home visit. The housemate answered the door and appeared to be drunk. The Clinical Psychologist recorded that there then followed an absurd conversation between the two of them (Mr. Z and his housemate) where they each accused the other of being an alcoholic. Mr. Z was determined to attend his brother's funeral on 19 December and stated that he was using this as strength to not drink. The Clinical Psychologist noted that Mr. Z appeared to be well supported by his housemate and did not appear to be at risk of suicide.[146]

On 20 December 2006 CPN 5 wrote to the GP following a discussion with Consultant 6 about a possible anti depressant, SSRI if Mr. Z was not drinking. Mr. Z was reported to be coping with the death of his brother by increasing his alcohol intake. Additional support was offered by CPN 5 and an Occupational Therapist within the CMHT.

On 20 December 2006 Mr. Z agreed to have a trial of Escitalopram 10 mg. This was prescribed by the GP.[147]

On 21 December 2006 and 5 January 2007 Mr. Z met with the Clinical Psychologist. He had successfully managed his brother's funeral and coped over the festive season. He did not think that the anti depressants were helping him. The Occupational Therapist had arranged to

[144] Clinical Records Volume 1 pg 51
[145] Clinical Records Volume 1 pg 55 & 56
[146] Clinical Records Volume 1 pg 56
[147] GP records pg 50

accompany Mr. Z to Rethink and he appeared open to the idea of Cognitive Behaviour Therapy.[148]

On 5 January 2007 Mr. Z reported to his GP that he did not think that the anti depressants were helping. The GP increased the dose of the Escitalopram to 20 mg.[149]

On 17 January 2007 Mr. Z attended a review with Consultant 6 who noted chronic low self esteem, alcohol misuse and low mood. It was recorded that Mr. Z went to bed at nine o'clock every evening as he would by so doing avoid his housemate who drank every night. Mr. Z's medication was noted as Escitalopram 20 mg for the past four weeks but with no improvement. This was changed to Mirtazapine 15 mg. The Escitalopram was to be reduced to 10 mg for one week and then stopped and the Mirtazapine increased to 30 mg. No further out patient appointment was arranged.[150]

On 24 January 2007 The Occupational Therapist met with Mr. Z in Oakhampton to attend Rethink. [151]

On 25 January 2006 Mr. Z met with the Clinical Psychologist. Mr. Z spent the session trying to convince the Clinical Psychologist that he had a realistic view of himself and that he would end his life by passive suicide. Mr. Z rejected Cognitive Behaviour Therapy on the grounds that '*he knew it all'*.[152]

On 5 February 2007 an unplanned visit by the Occupational Therapist took place but there was no reply.[153]

On 8 February 2007 Mr. Z cancelled his appointment with the Clinical Psychologist stating that he had been in a fight with his housemate and had hurt his ribs and nose and his breathing was poor. He was reluctant to attend his GP surgery but wanted to meet with the Occupational Therapist on the following Monday. [154] This was his last contact with mental health services.

[148] Clinical Records Volume 1 pg 57
[149] GP records pg 50
[150] Clinical Records Volume 1 pg 58
[151] Clinical Records Volume 1 pg 62
[152] Clinical Records Volume 1 pg 54
[153] Clinical Records Volume 1 pg 62
[154] Clinical Records Volume 1 pg 63

On 12 February 2007 the CMHT were informed that Mr. Z had been involved in an incident and that the Police were involved.[155]

[155] Clinical Records Volume 1 pg 59

12. Time line and Identification of Critical Issues

Root Cause Analysis (RCA) Second Stage

Timeline

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

Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified six overall critical issues and junctures that rose directly from the care and treatment that Mr. Z received from the Devon Partnership NHS Trust. These critical issues and junctures are set out below.

1. The Care Programme Approach process in terms of assessment and care planning was not put into practice throughout Mr. Z's care pathway. Critical junctures were identified as the points of admission and discharge in 2002, 2003 and 2005 and the points of acceptance in to the CMHT's in 2000, 2002, 2003 and 2005. At each of these junctures Mr. Z was thought to be at high risk of completed suicide.
2. There was a six month delay in follow up following the discharge in 2003.
3. Mr. Z was given a diagnosis of personality disorder, dependant or borderline, without any justification which detracted from his primary diagnosis of a recurrent depressive disorder.
4. Mr. Z was not admitted following a serious overdose in 2005, his social and home circumstance were not taken into account, nor was he assessed under the Mental Health Act (1983).
5. There was no comprehensive risk assessment of process visible within the clinical records.
6. There was a lack of overall care management and care coordination due to no comprehensive assessments having taken place.

The six critical junctures listed above are incorporated under the relevant headings listed directly below. They are examined in detail under these headings in Section 13 of this report.

Critical Issues Arising from the Review of other Data

The Independent Investigation Team found other critical issues that were not immediately apparent from analysing the timeline and the chronology. These issues are set out below under the key headings of the Independent Investigation Terms of Reference.

1. Documentation
2. Dual Diagnosis
3. Use of the Mental Health Act (1983)
4. Clinical Governance and Leadership

The above four critical issues were identified by the Independent Investigation Team as requiring an in-depth review. It must be stressed that critical issues in themselves do not have a direct causal bearing upon an incident however they are relevant to the overall picture concerning service delivery. The Trust Clinical Governance systems have also been examined and the findings of the Independent Investigation Team are set out below.

The Independent Investigation Team also conducted a review into the Devon Partnership NHS Trust Internal Investigation process, reporting, and action planning implementation outcomes. This is explored in Section 13 below.

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

RCA Third Stage

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

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue Factors.

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the events of 10 February 2007. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

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

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 10 February 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

13.1 Documentation

Context

'The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.

The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *Fairly and lawfully processed*
- *Processed for limited purposes*
- *Adequate, relevant and not excessive*
- *Accurate and up to date*
- *Not kept for longer than is necessary*
- *Processed in line with your rights*
- *Secure*
- *Not transferred to other countries without adequate protection*[119]'

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Data Protection Act. All records should be archived in such a way that they can be retrieved and are not lost. All records pertaining to individual mental health service users should be retained by NHS Trusts for a period of 20 years from the date that no further treatment was considered necessary; or eight years after the patient's death if the patient died whilst still receiving treatment. [119]

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

The GMC states that:
'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct

the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off '

DPT Standards for record keeping State that:

- *'Trust CPA documentation and the Trust file format must be used as standard.*
- *Where electronic CPA forms are available, these should be used, keeping signed paper backups.*
- *Records should be kept of all contacts with the service user and with significant others in relation to the care that the patient receives.*
- *There should be a single, integrated, sequential, written record for each service user.*
- *All records should conform to the Mental Health Minimum Data Set.*
- *All documentation should be signed and dated. Black ink must be used and writing must be legible. Hard copies should be printed out from eCPA and signed as correct.*
- *Assessments completed under the Mental Health Act should be handed to the hospital on admission and should be placed on file whether or not an admission has been completed.*
- *Service users have the right to access files through existing Access to Records procedures'*.[156]

At the time of the incident there was in existence clear and well developed national and local policy guidance for the development and safe storage of clinical records as has been set out directly above.

[156] CPA policy 2006 pg 26

Findings

During the course of this investigation two main issues regarding documentation came to light. They are as follows:

1. Standards of professional clinical record keeping
2. Data Protection

1. Issue Number One: Standards of professional clinical record keeping

In 2004 the Trust moved to a partial system of integrated record keeping. This should have ensured easy access to patient data in order to ensure good communication and continuity of care.

Four volumes of clinical records were submitted to the Independent Investigation Team. The ENDAS records were the only records that were clearly delineated as being from any particular service. The Trust records were a jumble of clinical data. It was not always possible to understand which team or service had generated them, or when. When witnesses were interviewed by the Independent Investigation Team, (the Investigation Team having reviewed all the clinical records) it became apparent that clinicians who were working with Mr. Z had not had access to his complete set of clinical records whilst treating him. One clinical witness said *"two files – I don't recall previously having seen. Clearly access to those would have been illuminating….. The information we had was from the point of referral to the team*".[157] The Independent Investigation Team understands that the records may have become jumbled following the incident; however there is evidence to suggest that the records were in a chaotic state prior to this time.

The quality of the content of Mr. Z's records was variable. For example CPA documentation was often incomplete or entirely missing. Risk assessment and care planning documentation was sparse and not completed to the standard set out by both local and national policy expectation. This omission in the development of the clinical record was of concern to the Independent Investigation Team. It is dealt with in detail in sections 13.5 and 13.7 of this report under the CPA and Risk sections respectively. Throughout the records there are examples of incomplete,

[157] AT 4 pg 5

unsigned and undated entries.[158] However the majority of the records that were complete were dated and signed. As a point of good practice all clinicians wrote to the GPs involved on a regular basis.

One of the complicating Factors in this case was that Mr. Z's wife was a member of staff within a local CMHT. To preserve his anonymity and privacy Mr. Z was given 'out of area staff status', he was allocated a pseudonym and a second clinical file was created to maintain his confidentiality. There was no protocol or policy to support this practice (this has been confirmed by the Trust[159]). This practice led to two separate case files being created instead of one integrated set of records. When Mr. Z was transferred to a new team only one set of his notes followed him, ensuring a dislocation in the flow of clinical communication. No one at the time appeared to understand that there were two separate files and important information about Mr. Z was not passed on to his new clinical team.

2. Issue Number Two: Data Protection

It became apparent to the Independent Investigation Team that some of the original records were missing. This was clearly evident by the Team being presented with photocopied material in some instances despite the request for the originals having been made. It was certain that the Trust could no longer access the complete set of original records despite having been given three months to do so. Neither was the Trust able to give an explanation as to why this was the case.

Another aspect of this issue was that within the records submitted to the Independent Investigation Team as a complete, if not original, set of clinical notes, data was missing. The most notable omission was the Mental Health Act Assessment records and reports following Mr. Z's detention in 2002. There were no Approved Social Worker reports in any of the volumes relating to assessments under the Act. There were no written records from CPN 2. There were no records available between 2 September 2002 following Mr. Z's discharge against medical advice and his third admission on 21 November 2002. It is the view of the Independent Investigation Team that these omissions are due to poor record retrieval and storage systems in operation at the time Mr. Z received his treatment and care.

[158] Clinical Records Volume 2 pg 139-147; Volume 3 pg 30, pg 35, pg 40, pg 50, pg 57, 212
[159] Email dated 20 August 2010

The Trust was unable to retrieve Mr. Z's case files from archiving in a timely manner. Even after a rigorous search, and three meetings between the Trust and the Independent Investigation Team, the Trust struggled to collate Mr. Z's complete clinical record archive for use by this Investigation. The Police requested the original medical records on 12 February 2007.[160] The Trust Serious Untoward Incident Policy 2008 clarifies that, following an incident of this kind, the original records are required by the Police. A full copy of the records needed to have been forwarded to the Information Governance Office before the original records left the Trust.[161] This did not occur and it is probable that the clinical records became increasingly disrupted and jumbled at this point.

Summary

The Independent Investigation Team found that a combination of poor record keeping by clinicians and poor archiving and retrieval processes by the Trust were evident throughout the seven year period during which Mr. Z received his treatment and care.

Conclusions

After conducting a full documentary analysis the Independent Investigation Team came to the following conclusions:

1. Issue Number One: standards of professional clinical record keeping

It is important that health care professionals keep contemporaneous documentation. The clinical record is primarily a communication tool. In the case of Mr. Z the standard of contemporaneous record keeping fell well below that expected of a NHS Trust.

Due to the potential significance of this issue the Independent Investigation Team considered carefully how and why this may have occurred.

First, the quality of contemporaneous CPA and risk assessment documentation was poor and fell below both local and national policy expectation. This was evidenced by absent or incomplete entries made routinely in the clinical record of Mr. Z. The Trust had in operation sound policies and procedures outlining guidance to professional staff regarding these matters.

[160] Clinical Records Volume 1 pg 61
[161] Incident Reporting, Management and Review pg 6

These policies and procedures were not adhered to. At the time Mr. Z was receiving his care and treatment the Trust was struggling to implement clinical governance processes. This has to be seen in the context of a great deal of organisational change during this period. During this period audit procedures were being developed and failed to pick up professional shortfalls in this area. Please see section 13.10 which attends to the subjects of clinical governance and audit in more detail.

Second, the taking of a psychiatric history is one of the vital components when assessing and planning care and treatment. The clinical teams caring for Mr. Z during his time with the Trust did not have access to his full history which may have further informed their approach to his care. This is due in part to Mr. Z being treated by three different CMHT's and two inpatient sites over time and the case records not following him. This was further exacerbated by his records being held under a pseudonym.

Policy and protocol appears to have been developed at a local rather than corporate level when the decision was made to use a pseudonym for Mr. Z. The use of a pseudonym is very unusual and can lead to confusion not only in terms of documenting clinical records but also around decision making as in order to make an informed decision about an individual's care and treatment one must be in full possession of the facts. The Independent Investigation Team could not find any logical reason as to why this course of action was taken. This process left the practice of the clinical staff open to criticism because there was a distinct fracture in clinical communication at this point. Potentially it also put Mr. Z at risk as his history could not be followed easily and the clinical teams that inherited his case were not always aware of all the facts during the ensuing multidisciplinary discussions. The Independent Investigation Team concluded that this course of action was taken to preserve the privacy of Mr. Z but the process was poorly conceived and rather than serving to act in the best interest of the patient, it impacted upon the quality of the care and treatment offered to him. (See discharge planning under section13.6). Clinical staff put themselves and their service users at risk when they either depart from policy or create their own. In such unusual circumstances as this professional senior advice should have been sought instead of local determination.

In the findings section directly above it was noted that the different clinical teams working with Mr. Z over time did not appear to have access to his complete clinical record. The Independent Investigation Team appreciated that this was largely due to Trust corporate management

custom and practice. However all clinicians have a responsibility to access and maintain clinical records. The practice of the staff within the teams who cared for Mr. Z was to work outside of Trust policy and practice guidance exacerbated the inherent problems with the poorly managed integrated records system. The Independent Investigation Team wishes to emphasise the importance of all clinical staff adhering to both local and national best practice policy guidance in the interests of patient safety. In the case of Mr. Z a vulnerable man with complex mental health needs, this was not always managed in the context of his full psychiatric history.

2. Issue Number Two: Data Protection

Management of records pre-incident

The Trust implemented a partial system of integrated record keeping in 2004. The location of clinical records has been an ongoing issue for the Trust due to the dispersed nature of the population and its services. It was evident to the Independent Investigation Team that clinical staff did not have access to Mr. Z's complete set of clinical records during the period that they provided care and treatment to him. It is not possible to state whether this compromised the quality of the service he received, however witnesses interviewed by the Independent Investigation Team did state that the missing information may have led to a revaluation of his care and treatment. Trust records management processes were not effective during this period. As a result this ensured clinical information was not always accessible at the point of care and treatment. This situation potentially left the Trust's service users vulnerable.

The Trust clinical governance and audit programmes did not pick up upon any of the issues relating to the identified patient record keeping and management problems identified in this report. This is written about in more detail in section 13.10. It is the conclusion of the Independent Investigation Team that the Trust assurance processes failed to provide a safe and effective provision in this regard.

Location of Records Post Incident

It would appear that a complete set of Mr. Z's case records were not archived and stored in accordance with the requirement of the Trust Policy after an incident such as the death of Mr. N. What appears to have occurred is that the most recent clinical records i.e. those within the Okehampton CMHT and possibly Exeter CMHT were copied and the originals submitted to the

Police. It was only after the initiation of the Independent Investigation that a review of the gaps in the records occurred and an almost complete set of records were able to be collated.

The Independent Investigation Team considered whether or not they had actually seen the original case files. The Team concluded that they had not. It was apparent that whilst some of the original documentation existed, photocopies had been substituted for the rest. The Trust endeavoured to locate the entire original clinical record for Mr. Z, however after a search which took three months they were unable to do so. The extant records are a mixture of original and copied data with some significant anomalies and omissions still being apparent.

The Independent Investigation Team considered the impact that the Internal Investigationmight have had in this area. In order for the Internal Investigationto have taken place all the clinical records would have had to be disassembled to be photocopied and then reassembled back into their original files. It is possible that records became increasingly muddled during this process.

In conclusion the Independent Investigation Team found that there were serious problems with the archiving and retrieval of clinical records. This topic is addressed further under the clinical governance in section 13.10. It is the conclusion of the Independent Investigation Team that a significant portion of the clinical records of Mr. Z have been lost.

Summary

Significant failings were apparent on an individual, team and corporate level regarding clinical record keeping, archiving and retrieval. Individual clinicians did not fulfil their professional obligations when maintaining the clinical records, teams did not adhere to Trust policy and procedure and the corporate body did not provide adequate systems to manage records and to audit and assure the process. However, regardless of the seriousness of the findings the Independent Investigation Team does not conclude that documentation featured as either a casual or contributory Factor to the incident.

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping. This ensured that the personal data regarding Mr. Z was not appropriately shared in a timely manner with those providing his care and treatment over time.

Service Issue 2

The Trust failed to assure via clinical governance and audit processes the adherence by staff to basic record keeping standards.

Service Issue 3

The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

13.2 Diagnosis

'*Diagnosis... is the art or act of identifying a disease from its symptoms and signs. The concept of diagnosis also has a broader definition - the analysis of the cause or nature of a condition, situation or problem*.[162]

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. Psychiatry uses the ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to address some care, treatment and risk management issues.

The National Institute of Clinical Excellence also provides guidelines to support diagnoses and treatment.

[162] Meyer, A. (1951/52) *Collected Papers* (Four Volumes) (Ed. E. Winters). Baltimore: John Hopkins Press

Description of events

The diagnosis of recurrent depressive disorder with anxiety was made initially by the GP of Mr. Z.[163] This was confirmed by Consultant 1 [164]and later by Consultant 5.[165]

Consultant 1 initially referred to personality difficulties when he was assessing Mr. Z under the Mental Health Act (1983) in 2002.[166] Further reference is made to personality issues by Consultant 2 in the discharge summary in 2002.[167] The Devon Doctors on Call records indicate that Mr. Z was reported as having a borderline personality disorder as he had been to hospital before and that he had wanted to die in his own home.[168] The Psychiatric Liaison Nurse refers to Mr. Z's symptoms as being personality driven. [169]

It was widely documented through out the clinical records that Mr. Z used to have frequent bouts of excessive alcohol consumption of up to 120 units a week.[170] In 2004 Mr. Z was recorded as having drunk approximately 20 units of alcohol a day.[171]

Mr. Z attended appointments with the GP, [172] Consultant 5 [173] and the Clinical Psychologist whilst smelling of alcohol. Mr. Z required an admission in 2005 for detoxification[174]

There is evidence that Mr. Z's alcohol intake was fairly sustained as he was experiencing alcoholic gastritis and pancreatitis for which he required admissions to hospital in 2006.[175]

Significant alcohol withdrawal symptoms were noted at the assessment by the Crisis Team in 2006.[176]

[163] Clinical Records Volume 2 pg 160
[164] Clinical Records Volume 2 pg 157
[165] Clinical Records Volume 2 pg 90
[166] Clinical Records Volume 2 pg 15
[167] Clinical Records Volume 2 pg 117
[168] GP records pg 144
[169] Clinical Records Volume 2 pg 52
[170] Clinical Records Volume 3 pg 79
[171] Clinical records Volume 2 pg 74
[172] GP records 53
[173] Clinical Records Volume 2 pg 90 & 79
[174] Clinical Records Volume 2 pg 14
[175] GP records 76, 54, 52
[176] GP records pg74

A further mental health team Consultant 6 outlined depressive symptoms and suicidal ideation at the assessment in January 2007, a few weeks prior to the incident where Mr. N was killed, but did not make note of a specific diagnosis. [177]

Findings

Mr. Z had three diagnoses that were recognised by the mental health care teams. These are described using the ICD 10 definitions:[178]

- ICD 10 Recurrent Depressive Disorder

A disorder characterised by repeated episodes of depression as described for depressive episode, without any history of independent episodes of mood elevation and increased energy (mania). There may, however, be brief episodes of mild mood elevation and over activity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The first episode may occur at any age from childhood to old age, the onset may be either acute or insidious, and the duration varies from a few weeks to many months.

- Personality Disorder

Personality disorder is characterised by pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is often a tendency to transfer responsibility to others.

- ICD 10 Alcohol addiction/dependence

A cluster of behavioral, cognitive, and psychological phenomena that develop after repeated substance use and that typically include a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences, giving the substance a higher priority than other activities, increased tolerance and sometimes a physical withdrawal state.

[177] Clinical records Volume 2 pg 45
[178] ICD 10 2007 WHO

Conclusion

Recurrent Depression

There does not appear to have been any disagreement between any medical clinician who had completed a full mental state assessment regarding the diagnosis of a depressive disorder for Mr. Z. On reviewing all the available clinical records the Independent Investigation Team concludes that Mr. Z did suffer, amongst other conditions, from unipolar recurrent depressive disorder.

Personality Disorder

A further diagnosis of personality disorder, dependent type, is made by several members of Mr. Z's treatment team. These would appear to occur in settings where Mr. Z had been assessed after an overdose.

Although Mr. Z suffered significant traumas in early life that could well have contributed to his overall vulnerability to Personality Disorder and depression he does appear to have coped well in some areas e.g. he was able to make the decision to stop criminal activities in early adult life despite allegedly being led astray by his elder brother and father[179]. He also stopped taking illicit drugs and solvents in early adult life never to return to them. He managed to get married and help bring up two children with whom he is still keen to have relationships with. He had the capacity to cherish these and other relationships and was deeply grieved when his brother died a few years back. Mr. Z was reported as having a few aggressive outbursts and losses of temper although these incidents were recorded sparsely and not cited by his wife or family as a cause of the marriage breakup. It was clear that Mr. Z was deeply upset by the breakdown of his marriage. The Independent Investigation Team does not know all the Factors that contributed to this and feel that it is inappropriate to comment on this area however, clearly, Mr. Z's drinking habits may have contributed to the situation. All these Factors would suggest that large aspects of Mr. Z's personality function were intact.

The view of the independent Investigation Team is that Mr. Z did not appear, from the clinical notes, to have sufficient symptomatology to warrant a diagnosis of Personality Disorder or Borderline Personality Disorder according to ICD10 criteria. Although there appeared to be good evidence of serious depressive symptoms with suicidal ideation and behaviour throughout the

[179] Forensic Report pg 15

four separate episodes, these key symptoms got down played and the diagnosis of Personality Disorder amplified. This would suggest that at some interactional level staff were finding the management of his case difficult or even exasperating. This may have been due to either or both his personality or his alcohol dependency.

In conclusion, concerning his personality, Mr. Z certainly had some personality vulnerabilities and some of these show a degree of dependency and a reluctance to operate as an independent adult. However, whenever he was manifestly dysfunctional Mr. Z also had significant and high risk depressive symptoms and behaviour. It would therefore be more appropriate to attribute these to his primary diagnosis of depression rather than personality disorder. Further when Mr. Z responded to antidepressant medication (which he did do when he took the medication at the correct dose) he appeared to function well at work suggesting that he did not have persistent personality disorder symptoms.

Alcohol Dependency

Mr. Z was recorded as using alcohol from the age of 13 up until the incident. He was described as an intermittent heavy alcohol abuser with shorter and longer periods of abstinence. Mr. Z was not recoded as being physically dependent on alcohol but there was good evidence to suggest that he used alcohol in a damaging way to cope with the pressure of work, his life and his depression. There was also good evidence to show that at times he experienced alcohol withdrawal symptoms. The view of the Independent Investigation Team was that Mr. Z had severe alcohol dependency with considerable physical tolerance.

Dual Diagnosis/ Co-morbidity.

The conclusion of the Independent Investigation Team was that Mr. Z's key psychiatric diagnoses were recurrent serious depression and persistent alcohol dependency. Both these diagnosis interplay with each other and have a deleterious effect on any single attempt by Mr. Z or his treatment teams to successfully deal with the combined problems. He was therefore a good example of someone who was co-morbid for alcohol dependency and serious depression and that unless he had been treated in an integrated manner neither diagnosis was likely to respond completely to treatment. This meant that Mr. Z did not receive a treatment approach that met his needs appropriately and this contributed to his continued mental illness and distress.

Contributory Factor 1

Mr. Z was not treated in an integrated manner in terms of his co-morbidity as defined in the dual diagnosis good practice guide 2002.[180]

13.3 Dual Diagnosis

Context

The term dual diagnosis is a clinical category referring to people with mental health problems who also misuse alcohol or illicit drugs. It may, for example, include both someone with a psychotic condition who is also using street drugs, or someone who is depressed and also drinking heavily. There is, however, no formal definition of dual diagnosis The Department of Health summaries it as: [181]

"*people with severe mental health problems and problematic substance misuse, the substances concerned including legal and illegal drugs, alcohol and solvents*."

Department of Health policy states that:

"Dual Diagnosis covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- *A primary psychiatric illness precipitating or leading to substance misuse*
- *Substance misuse worsening or altering the course of a psychiatric illness*
- *Intoxication and/or substance dependence leading to psychological symptoms*
- *Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.*

The Department of Health's guidance spans both illicit substance and alcohol abuse.[182]

People with this combination of clinical problems may also have multiple social problems, potentially leading them into contact with housing and welfare agencies and the criminal justice

[180] *Department of Health (2002)* Mental Health Policy Implementation Guide: Dual diagnosis good practice guide. *Department of Health, London.*
[181] Department of Health (2002) *Mental Health Policy Implementation Guide: Dual diagnosis good practice guide.* Department of Health, London.
[182] Dual Diagnosis Good Practice 200 2DoH

system. They may then be stigmatised within their families and local communities, and excluded from normal social activities. They form a heterogeneous group, and may justifiably be seen as having complex needs. Addressing their needs may require a 'joined up' approach from different members of different agencies.

The management of people with dual diagnosis remains an area of concern and is one of high priority for mental health policy and in clinical practice. The *National Service Framework for Mental Health 5 years On* [183] emphasised that dual diagnosis was one of the most pressing problems facing mental health services today, and highlighted the importance of:

- assertive Outreach Teams and dedicated dual diagnosis services;
- better collaboration between mental health, drug and alcohol services;
- training for Mental Health staff in assessment and clinical management of substance misuse;
- preventing substance misuse in the population of people with a severe and enduring mental illness and those on acute in-patient wards, and elsewhere in the local mental health services.

Literature suggests that clients in the United Kingdom with a Dual Diagnosis are associated with unmet need, poor treatment compliance, high rates of disengagement and an increased risk of offending behaviours.[184],[185],[186] Dual Diagnosis clients are also often perceived as the most complex clients to treat by service providers.[187]

Description of events

[183] Department of Health 92004) *The National Service Framework for Mental Health: 5 Years On.* London, Department of Health.
[184] T. Weaver et al. (2003) Co-morbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, 183, 304-313.
[185] G. Strathdee et al. (2002) *Dual Diagnosis in a Primary Care Group*. London, Department of Health.
[186] N.M.J. Wright et al. (2003) Moving beyond single and dual diagnosis in general practice. *British Medical Journal*, 326, 512-514.
[187] V. Crawford, (2001) Co-existing problems of mental health and substance misuse ('Dual Diagnosis'): A Review of Relevant Literature. *London, Royal College of Psychiatrists Research Unit.*

Mr. Z was referred to the local addictions service ENDAS on several occasions by his GP's and the Mental Heath Services. He did not engage with this service.

He was assessed by a Specialist CPN for drugs and alcohol on one occasion where he was noted as not wishing to address his alcohol dependence.

Findings

The Trust produced a document entitled *The co-existence of mental health needs and substance misuse (Dual Diagnosis) pathway* which is an amalgamation of the attempts by prior services to generate a dual diagnosis treatment strategy. From a clinical perspective this document majors on descriptions of what Dual Diagnosis might be and what services are there to help. There are narratives on the philosophical approach and the skills and attitudes required. The document does describe how complex the subject is and how many different types of dual diagnosis patients there are. However, for clinicians working in the Trust this is an uninformative document as there is not a single case example or clinically based schema to suggest to a staff member what they should be aspiring to.

Some of the critical service indicators that manifest success in this area are the use of key phrases in policies within adult mental health such as Prochaska and Climente's Cycle of Change[188] (a model for understanding where a patient has got to in their misuse history) , Patient Functional Analysis Chart, and Persuasion Groups to sift out the pre-contemplative patient from those considering major decisions to quit misusing (contemplative), and finally the key attribute needed by all staff that of 'Persistence'; for success follows only those who never give up in their attempts to engage and encourage dual diagnosis patients. The Independent Investigation Team could find no evidence from interviews, clinical records or assessment proforma that these phrases had been internalised within the written or spoken culture of the Trust.

The expectation at a corporate level within the Trust (elicited at interview with the Independent Investigation Team) was that it was expected that "*all nurses should be to be able to recognise and respond and to understand the implications when somebody says they have issues with*

[188] addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1

substance mis-use" it was expected that they would be *"able to understand the impact that it has on [a patient's] ability to engage with mental health and on their impulse control and I'd expect them to understand the impact that would have on the people around them, support providers, carers*." [189]

Conclusion

Dual Diagnosis is a whole system multi-agency issue, affecting a broad cross-section of adults, with varying levels of severity and impact on the individual, their friends and family, as well as local communities. There are several different service models for providing effective dual diagnosis treatment within a general adult mental health treatment setting. Successful Trusts have to get two key Factors in place for successful clinical delivery and these are a product champion, either a lead clinician or consultant to force throughout the service the required cultural change and a committed executive to support operational managers and the clinical leads in delivering the service.

Further the DPT corporate view whilst being aspirational failed to take account of the fact that this is a known specialist area and at present does not form a core component of any basic training programme. It is therefore unrealistic to expect staff to take on what is in effect a complex set of formulations by understanding the course of a alcohol history, withdrawals, what the techniques for engagement are, what the modern available treatments are for each set of health, drug and alcohol dependencies are and also how to treat this in the context of serious mental illness.

If this is not addressed the social model with drugs and alcohol, "come in if you'd like to, we'll see you and when you are ready" rather than an assertive and integrated approach will remain dominant across the County.

Service Issue 4

[189] Ct 1 pg 13

The approach to the treatment and care of people who have a dual diagnosis was under developed and not integrated leading to vulnerable people, with a mental illness being at risk and under treated.

13.4 Medication

Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication). This section focuses on the issue of medication in relation to Mr. Z's care and treatment.

Description of events

Table to show medication prescribing

Date	Medication	Initiated/changed by	Outcome
1992	Prozac 20 mg[190]	GP	Not known
1996	Dothiepin 150[191] mg	GP Increased by Mr. Z to 300 mg prior to overdose	Good response coupled with psychological therapy
November 2000	Citalopram 20 mg[192]	Psychiatric SHO	Non effective, changed back to Dothiepin 75 mg by GP
February 2001	Dothiepin 150 mg[193]	Increased By Mr. Z	Increased incrementally by Consultant 1 to 200 mg
April 2000	Dothiepin 150 mg with occasional 25 mg in the am[194]	Mr. Z	Advised by Consultant 1 to stay on 100 mg
June 2001	Dothiepin 150 mg[195]	Persuaded by CPN 1 to	To continue with this

[190] Clinical Records Volume 2 pg 175
[191] Clinical Records Volume 2 pg 73
[192] Clinical Records Volume 2 pg 17o
[193] Clinical Records Volume 2 pg 156
[194] Clinical Records Volume 2 pg 155
[195] Clinical Records Volume 2 pg 154

		increase the dose	dose
September 2001	Dothiepin 200 mg[196]	Increased by Mr. Z	Decrease Dothiepin to 150 mg Seroxat introduced
February 2002[197]	Dothiepin 100mg nocte and Seroxat 20mg	Mr. Z keen to reduce medication	Consultant 1 advised reduce Dothiepin by 25 mg every three months
June 2002	Dothiepin 50 mg and Seroxat[198]	Consultant 1 reduce Dothiepin to 25 mg then stop in two weeks; maintain Seroxat	
August 2002	No medication	Mr. Z declined to take any medication	Relapse and overdose
November 2002	Citalopram 20 mg[199]	In patient team	
April 2003	Dothiepin 150 mg[200]	GP	Not helping
July 2003	Dothiepin 225 mg[201]	Consultant L	
October 2003	Dothiepin 150 mg[202]	GP	No change
August 2005	No medication	Stopped by GP following over dose	
10 December 2006	SSRI recommended by Dr Y[203]	Declined by Mr. Z wanted Dothiapin	
20 December 2006	Escitalopram 10 mg	GP	Not helping wanted something stronger
5 January 2007	Escitalopram 20 mg[204]	GP	
17 January 2007	Change Escitalopram to Mirtazapine	Consultant 6	

[196] Clinical Records Volume 2 pg 151
[197] Clinical Records Volume 2 pg 141
[198] Clinical Records Volume 2 pg 133
[199] Clinical Records Volume 2 pg 178
[200] GP records pg 101
[201] Clinical Records Volume 2 pg 87
[202] GP records pg 103
[203] GP records pg 103
[204] GP records pg 50

Findings

Mr. Z was predominantly treated with two antidepressants over the period of seven years that he was in contact with DPT, Dothiepin and Citalopram. Mr. Z also had a period of time when he was not treated with an anti depressant in part due to the risk of a further overdosing with Dothiepin and his high alcohol consumption.

Consultant 1 and Consultant 5 reviewed Mr. Z regularly whilst he was under their care in 2001/2 and then in 2003 after which the GP assumed responsibility for reviewing and prescribing medication.

It would appear that SSRI antidepressant therapy was not particularly successful and Consultant 1 in particular obtained a reasonable remission using a more dangerous and older form of Tricyclic anti depressant, Dothiepin. However this can be lethal in overdose due to its cardio toxic effects hence the reluctance of the GP to continue to prescribe in 2005. There appears to have been very little direct liaison between the GP and the Consultants involved with Mr. Z although all Consultants wrote to the GP's after a review.

Mr. Z was inclined to self titrate his medication. This is recorded when he was receiving regular Consultant reviews. It is not known if Mr. Z continued this pattern of self administration as he was not reviewed on a regular basis by the Consultant or any other medical personal, nor was this an issue addressed by CPN 5 or the Clinical Psychologist; consequently the level of concordance with medication is not known. Medication concordance is not an issue that is noted in the risk assessment and management policy.

The Clinical Psychologist and CPN 5 had been sufficiently concerned about Mr. Z to ask Consultant 6 for a medication review in August 2005. This review is recorded and the letter to the GP indicated the presence of significant depressive symptoms and a decision to change the antidepressant medication from the SSRI Escitalopram to a more complex drug, Mirtazepine using a two-week tail off and gradual restart regime. The rationale for this change was that Mr. Z had stated that he was drinking alcohol to help him sleep and Mirtazepine is noted for its more sedating effects. There is no record of a consideration to offer a psychiatric follow up to see whether the change in medication was effective or indeed whether the psychologist and CPN were encouraged to discuss either within the team or with ENDAS a Dual Diagnosis approach.

At interview with the Independent Investigation Team it was reported that where Consultant 6 had significant concerns about a patient then a follow up appointment would be offered according to the severity of the symptoms that the patient was presenting with. Consultant 6 was not overly concerned by Mr. Z's presentation and was aware that he was being followed up by other team members.

The workload of Consultant 6 was reported on by other members within the CMHT as "*having lots of people on the case load who were not being seen by other members of the CMHT…the work load was massive*".[205] The Consultant worked three days a week and had been gradually implementing the guidelines from "*New Ways of Working" (2005)* through promoting distributed responsibility within the multi disciplinary team according to individual team members experience and competence.

Conclusion

There is no written evidence that the teams or Consultants 1, 5 or more latterly 6, discussed the fact that Dothiepin was effective but carried with it certain risks. Dothiapin should not be used routinely because the evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and its toxicity in overdose.[206]

Earlier in Mr. Z's treatment it would be expected that there would have been a case discussion on the need or otherwise to continue with Dothiepin at reasonable dosage provided that a Care Coordinator could ensure regular weekly or two weekly visits to assess mood, compliance, side effects and alcohol consumption .

The Investigation Team was unable to identify the use of any NICE guidelines or protocols for guidance of the team or characterisation of Mr. Z's depression as 'partially resistant' and therefore requiring careful consideration of what should have been the next step in the treatment pathway. Because of the complex interactions generated by Mr. Z's intermittent use of alcohol and prescribed medication the Independent Investigation Team consider that a robust contingency plan should have been in place and shared throughout the team. The appropriate contingencies would have to include requests for the visiting team members to be especially

[205] AT 4 pg 14
[206] NICE Guidance-Depression Quick reference pg 10

aware of sudden changes in compliance and the stopping or starting of an alcoholic binge because of the latter's effect on the absorption of strong psychotropic medication.

Mirtazapine has a unique set of effects and has complex pharmacological action on brain receptors. The Independent Investigation Team was surprised to see that Consultant 6, in April 2007, made the decision to change from Escitalopram to Mirtazapine with no evidence of advice on what the team should look out for including the time it might take for any improvement, possible side effects and interactions with alcohol. The lack of arrangements for Consultant follow-up in the light of Mr. Z's partial treatment resistance and non compliance was surprising. In the context that Mr. Z was being seen by other members from the CMHT it may have been assumed, and quite reasonably so, that any further concerns would have been highlighted in due course. However, good practice dictates that patients started on anti depressant treatment should have initial follow up by their RMO within four to six weeks to monitor progress.[207]

In conclusion it appears as though there was a lack of planned medical follow up, and no reference to the national guidelines for the treatment of recurrent and possibly treatment resistant depression, (although the prescribing doctors did attempt to switch antidepressants in an attempt to treat serious depressive symptoms). As a result Mr. Z was only ever partially treated. This made a direct contribution to his continued mental ill health and distress.

Contributory Factor 2

There was a lack of robust medical intervention and as a consequence Mr. Z was only ever partially treated.

[207] Oxford Handbook of Psychiatry 2005 OUP

13.5 Care Programme Approach

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[208] Since its introduction it has been reviewed twice by the Department of Health:[209] in 1999 (Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach) to incorporate lessons learned about its use since its introduction and again in 2008 (Refocusing the Care Programme Approach).[210]

"The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services". [211] (Building Bridges; DH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective co-ordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

[208] The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DH; 1990
[209] Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach; DH; 1999
[210] Refocusing the Care Programme Approach, policy and positive practice; DH; 2008
[211] Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DH 1995

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a care coordinator whose job is:
    - to keep in close contact with the patient
    - to monitor that the agreed programme of care remains relevant and
    - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 service users were placed on either Standard or Enhanced CPA according to their level of need.

Standard: for individuals with a recognised mental health problem and a low risk rating, who are able to manage their mental health problem, have supportive social circumstances, and are active participants in their own care. They may require the intervention of one agency or discipline or low-key support from more than one agency or discipline.

Enhanced: for individuals with a recognised mental illness resulting in multiple care needs and requiring multi agency involvement. They are more likely to have co-existing physical or mental health problems, disengage with services and present a higher risk to themselves or others. They will require a higher level and intensity of intervention. Care plans at this level will include a crisis plan.[212]

DPT Care Programme Approach Policy 2006

The local CPA policy reflected the essence of the National Guidelines and in addition referred to the underlying philosophy of the Recovery Model of Mental Health.[213] The policy contained a section on general standards and specific standards in relations to:

[212] Callaghan and Waldock Oxford Handbook of Mental Health Nursing 2006 pg 36
[213] DPT Care Programme Approach Policy 2006 pg 20

- referral;
- assessment;
- personal plans;
- reviews;
- acute inpatient admissions;
- acute inpatient discharge;
- discharge where CPA does not apply;
- discharge of patients winning appeals from Mental Health Review Tribunals;
- CPA whilst in prison;
- transfer of care out of area;
- standards of transfer of care (within the Trust;
- re referral;
- discharge from CPA;
- record keeping;
- holding and sharing of information;
- allocation of care coordinator when old care coordinator leaves;
- standards for carers.

The standards were clear and precise about what was expected of clinical staff and mangers in relation to their practice and the implementation of the policy. The standards were also clear about the role managers were meant to fulfil in terms of monitoring the implementation of the policy and clinical practice.

CMHT Context

Operational Policies were not available for the CMHTs during the time that Mr. Z received his care and treatment.

Description of events

On 16 November 2001 a CPA care plan was completed by CPN 1 identifying short and long term goals and multi disciplinary interventions to include the Psychologist and Psychiatrist to

address psychological Factors such as relationships, anxiety management, developing coping strategies as well as mood and medication monitoring.[214]

On 8 July 2004 a CPA care plan was completed (unsigned) by CPN 4. Mr. Z was to be referred to counselling, the heart fit programme and Bell Industries. It was noted that increased alcohol was an indicator of risk. Mr. Z was placed on standard CPA.[215]

On 28 January 2005 CPN 4 completed a CPA initial assessment which concluded that Mr. Z was not motivated to tackle his drinking despite an offer of treatment out of area.[216]

On 18 August 2005 the Crisis Team completed CPA 2a (formulation and summary of assessment).[217] Mr. Z was accepted by the team and an arrangement was made to see him on 22 September with a Psychiatrist. Mr. Z was agreeable to reducing his alcohol intake but stated that he would not be available to the Crisis Team on 19 September as he would be in the pub. A 'specific intervention plan' was completed that included the above appointment, for Mr. Z to see his GP and to continue building his bird pens (a hobby of his), with the anticipated outcome being that Mr. Z would feel supported by mental health services.[218]

On 7 September 2005 a CPA initial assessment (a different format from that outlined in the policy) was completed by CPN 5 (Okehampton CMHT). Mr. Z was placed on enhanced CPA although noted not to have a serious mental illness. The plan was that Mr. Z would reduce his alcohol intake, have a prioritised referral to the clinical psychologist and a follow up visit from CPN 5.[219]

On 3 February 2006 CPN 5 completed a CPA 4 review. The Clinical Psychologist had reported that Mr. Z was engaged well and there was no change to the personal care plan. Mr. Z was discharged from CPN 5's case load.[220]

[214] Clinical records Volume 3 pg 37
[215] Clinical records Volume 1 pg 20
[216] Clinical records Volume 1 pg 10
[217] Clinical records Volume 1 pg 9
[218] Clinical records Volume 1 pg 24
[219] Clinical records Volume 1 pg 7
[220] Clinical records Volume 1 pg 25

On 19 September 2006 CPA 2a was completed by the Crisis Team. Mr. Z had presented as dishevelled and retching with significant evidence of alcohol withdrawal[221]. He declined referral to alcohol services stating that he was able to stop drinking on his own. Vitamin B was advised and anti depressant therapy was thought to be inappropriate due to the high level of alcohol consumption. He was not accepted onto the Crisis Team case load. [222]

On 26 September 2006 the Clinical Psychologist completed a notification of serious concern after a home visit on 19 September when Mr. Z had disclosed a high level of risk. Initially the Crisis Team had refused to assess him as he was under the influence of alcohol and when they did assess him on the 21 September Mr. Z concealed the level of risk. The circumstances noted that would increase his risk were alcohol consumption and decreased contact with his children. The plan was for a joint assessment by CPN 5 and the Occupational Therapist.[223] Mr. Z was removed from the serious concern list on 10 October 2006 by the Team Manager following discussion at the MDT meeting.

On 26 September 2006 the Clinical Psychologist completed CPA 3 Personal Plan and placed Mr. Z on Standard CPA. The plan was for:

- Referral to ENDAS
- Possible referral to Rethink in Okehampton
- Occupational Therapist assessment as skills under utilised
- Allocation of a CPN for practical support[224]

Findings

Okehampton CMHT

Between 2005 and 2008 there were three changes of Team Manager due to ill health and latterly retirement and during this time supervision "*fell off a bit*". One of the interim managers was reported as "*not engaging with the team*", and another was reported "*not to have been in clinical practice for several years*".[225] It was also reported that this was a small team who worked

[221] Clinical records Volume 1 pg 16
[222] Clinical records Volume 1 pg 12
[223] Clinical records Volume 1 pg 4
[224] Clinical records Volume 1 pg 18
[225] AT 4 pg 29

well together although there were staff shortages as a social worker left and a CPN was off on long term sick leave.[226]

The Clinical Psychologist worked for 2.5 days a week and had a case load of approximately twenty five people. CPN case loads were reported to be high although these have now been capped at twenty eight.[227]

There were weekly clinical team meetings attended by the whole team including the Manager and the Consultant. These meetings incorporated the 'notification of Serious Concern' discussions whereby any clinician could raise a concern they had about someone on their case load.[228]

When witnesses were interviewed by the Independent Investigation Team interviews it was reported that at this time the CMHT was beginning to undergo change, "*the CMHT was broken down into two new teams (Access and Well Being and Recovery) and it would be fair to say that in terms of the organisation there was perceived chaos*".[229]

There was no specialist dual diagnosis worker within the team.[230]

Level of CPA

There were no guidelines in the Trust policy as to what constituted enhanced or standard CPA however Mr. Z was placed on standard CPA in 2004 and enhanced CPA in 2005 and standard CPA once again in 2006. There was confusion within the minds of the workers as to what the criteria were for enhanced and standard CPA as evidenced through Mr. Z being placed on enhanced CPA whilst not being thought to have a serious mental illness.

Assessment

CMHT initial assessments were completed in January 2005 and September 2005 these were brief and did not convey a full picture of Mr. Z's needs. There was no evidence of a comprehensive holistic assessment having being conducted to ascertain Mr. Z's health and social care needs in accordance with the Trust Policy on CPA. That is not to say that nothing

[226] AT 4 pg 3
[227] AT 4 pg 18
[228] AT 4 pg 4
[229] AT 4 pg 30
[230] AT 4 pg 6

was known about Mr. Z as many of his problems and concerns were well-documented throughout the clinical records, the information however did not translate into an assessment. No consideration was given to the possible impact of social isolation when Mr. Z moved to a rural area; no base line was established for his alcohol intake. Account was taken regarding the impact Mr. N was having on Mr. Z's life by the Clinical Psychologist but this did not contribute to a holistic assessment. Mr. Z had reported to the Clinical Psychologist that he "*found him (housemate) annoying, he would misspend money, he would not do the shopping properly, make too much noise and was an alcoholic*".[231]

Care Planning

Three care plans were completed between November 2001 and September 2006. The care plan in 2001 was multidisciplinary and focused on specific interventions to enable Mr. Z to cope with clear aims. The care plan in 2004 was exploratory: for example to "*meet on a needs led basis to develop a therapeutic relationship, develop an understanding of the difficulties Mr. Z was facing and look at options for improvement*".[232] None of the actions noted could be said to constitute a comprehensive care plan.

The care plan completed by the Crisis Team was conflicting and stated that Mr. Z was going to cut down on his drinking but could not seen the following day as he would be in the local pub.[233]

In September 2006 the actions that were identified on the personal care plan were a series of onward referrals to ENDAS, a CPN, an OT assessment and Rethink. These actions were completed in a timely manner however other problems noted on the plan such as social isolation, serious alcohol problems and serious gastric and bronchial problems were not addressed.[234] Further there was no mention of any psychological intervention despite Mr. Z seeing a Clinical Psychologist on a regular basis. Again none of the actions noted could be said to constitute a comprehensive care plan. This in itself was reflective of the lack of a comprehensive assessment.

[231] Clinical records Volume 2 pg 20
[232] Clinical Records Volume 1 pg 21
[233] Clinical Records Volume 1 pg 9
[234] Clinical Records Volume 1 pg 18

Review

Throughout the years that Mr. Z was receiving mental health services only one CPA review, in February 2006, was conducted by the community teams involved in his care. From the documentation this was not a planned review and no one from the care team apart from the CPN who completed the form was in attendance although the Clinical Psychologist did give verbal feedback. In effect this review closed the case to the CPN although it remained open to the team as the Clinical Psychologist continued to work with Mr. Z. It was noted that there would be no change to the personal plan (care plan) however the only plan available in the clinical records was dated 2004.

It was reported during witness interviews with the Independent Investigation Team that EPEX (electronic record system) would flag up a case where there had been no contact with a worker for three months at which point the worker would be advised to close the case. Witnesses reported that the view of the Trust was that a case did not need to be kept open after three months unless the person was in residential care. It was further reported that "*if this was not done then the case load numbers would be massively high*"[235] and "*that would not be safe for our practice to keep being held responsible for so many people*".[236] Clearly the standards set within the Trust's CPA policy were not being adhered to and this appeared to have been a paper exercise relating to case load management rather than to the needs of an individual.

There is no evidence to suggest that Mr. Z had his needs reviewed on a regular basis throughout his contact with mental health services. As a result obvious and subtle changes in Mr. Z's presentation and social circumstances were not addressed. For example during 2006 Mr. Z raised concerns about difficulties and stress he was experiencing due to his living conditions and his alcohol intake was increasing albeit in a fluctuating manner.[237]

Care Coordination

The Trust's CPA policy clearly defined the role of the Care Coordinator with the primary function being to.

> "*co-ordinate all assessments and develop a Personal Plan which should be a joint plan, agreed with the service user and significant others, outlining what should happen and when.*

[235] AT 4 pg 15 & 16
[236] AT 4 pg 18
[237] Clinical Records Volume 1 pg 43

Upon completion, and at any review of the plan, it should be presented to the Team Manager who will sign off the plan on behalf of the Trust".[238]

However from clinical witness interviews with the Independent Investigation Team it appeared that those who were involved with Mr. Z were unclear and confused about the case in terms of care coordination. The clinicians working with Mr. Z were unable to identify who held the care coordination responsibility. All three clinicians are well qualified and experienced.[239] It was reported that "*there was no formal discussion about who the care coordinator was… no one did the care coordination... it was a difficulty with the system that we were working with*."[240] The care coordination role was "*by degrees taken by the clinical psychologist which is not so usual…but it was felt that there was a need to pin things down and recruit people at a practical level around keeping him alive*".[241] As a consequence there was no one person in the position to overview and manage the interventions offered to Mr. Z. In effect this fell below the standards set out with in the Trust CPA policy 2006.

Management of the CPA process

Team Managers were responsible for ensuring that all team members were familiar with, and conformed to, the Trust CPA standards. The notification of serious concern completed by the Clinical Psychologist was in keeping with policy being 'signed off' by the Team Manager. This would indicate an awareness that the Clinical Psychologist was acting as Care Coordinator for this case and is really the only example of where the Trust CPA policy had been adhered to.

Conclusions

Assessment is an important stage in the care of people with mental health problems. It involves collecting information and using it to decide on the need for, and the nature of, any subsequent mental health care. Assessing a service user's mental state involves judging their psychological health. This requires experience, a degree of intelligence, insight, social skills, objectivity and the ability to deal with cognitive complexities. Assessment leads to care planning where an individuals needs are clearly defined and plans put in place as to how to meet those needs. It is

[238] DPT CPA Policy
[239] Clinical Statements
[240] AT 4 pg 15
[241] AT 4 pg 15

evident that Mr. Z did not receive a full CPA which consisted of both assessment and care planning.

Case management skills were identified nationally in the early 1990's with the introduction of the CPA process[242] and were reiterated and refined in later guidelines[243] and incorporated into the Trust policy. Many expensive and specialist resources were allocated to Mr. Z's case but these were reactive rather than proactive, well-thought through, considered options. It would have been appropriate for the CPN's to have worked in a more collaborative and therapeutic manner with the Clinical Psychologist and Mr. Z at a practical level through the implementation of basic CBT interventions such as a mood diary or an alcohol diary to support the more in-depth work that was being addressed by the Clinical Psychologist. The Occupational Therapist could have conducted an assessment at home to increase Mr. Z's confidence with day to day activities, but no assessment was completed, instead the Occupational Therapist appeared to have only been used to accompany Mr. Z to other agencies.

The referral to CAB for housing advice was not appropriate for a vulnerable man in private rented accommodation with another alcoholic and advocacy services could have been used to help and support Mr. Z explore further options.

There was evidence to support a lack of understanding at an individual and team level about the importance and role of the Care Coordinator and the CPA as a process.

What was most concerning, when viewed through the lens of this single case, is that the governance arrangements, in terms of monitoring, supervision and audit were not robust and therefore failed to pick up on the lack of CPA process over a seven-year period. This in part can be mitigated by the frequent changes in local management which would have unsettled the team, but not to the extent that is evident in this case.

The Independent Investigation Team therefore concluded that the CPA process was not robustly embedded or understood within the Trust and that there were a series of missed opportunities to fully assess and understand Mr. Z's complex and changing needs over time. A holistic health and social care needs assessment should have been conducted leading to the

[242] Care Management and Assessment-Practitioners Guide 1991 DoH
[243] Effective Care coordination in Mental Health- Modernising the CPA 1999 DoH

development of a care plan to meet the identified needs. The Independent Investigation Team could not conclude that this directly caused the death of Mr. N in February 2007 but maintains it contributed to the ineffectual route that Mr. Z's care pathway took.

Contributory Factor Number 3

The CPA policy was poorly implemented and understood. Consequently Mr. Z did not receive a comprehensive and holistic assessment or care plan. As a result Mr. Z did not receive all of the care, support and treatment that he could have benefited from if he had had a comprehensive assessment of his health and social care needs on which to base a care plan.

Service Issue 5

Robust systems were not in place to monitor the standards and implementation of the CPA policy.

13.6 Other considerations under CPA

Whilst the main concerns regarding CPA have been highlighted in detail in section 13.5 the Independent Investigation Team would like to draw attention to two other areas that are included in the CPA policy that impacted on the care and treatment received by Mr. Z. They are:

- discharge planning;
- transfers of care.

13.6.1 Discharge planning

Context

Discharge planning involves collaboration between inpatient and community teams at a multidisciplinary level.

Standards for discharge planning were laid out in the Trust CPA policy as set out below.[244]

- Care co-ordinators will remain fully involved with inpatients on their caseload and take responsibility for convening the discharge meeting.

[244] DPT CPA Policy 2006 pg 23

- A formal discharge meeting will take place involving the community care co-ordinator, service user, appropriate carer, inpatient and appropriate others including the crisis resolution team prior to discharge to ensure that the conditions for discharge are optimised. The discharge meeting will include a re-assessment of risk.
- A clear statement of responsibilities should be agreed, recorded and disseminated. This should include detailed arrangements for support in the first week and provisions for at least the next three months.
- No patient should be discharged without a community care co-ordinator and without arrangements being in place for their care unless valid reasons are recorded.
- Discharge letters to GPs will be copied to the care co-ordinator, service user and carer if appropriate.
- The care co-ordinator or delegated crisis resolution worker will have face to face contact with the service user within seven days of discharge from hospital.
- In cases where the service user has been a high risk, follow up should occur within 48 hours.
- Where there is an unplanned discharge, a CPA 6 form (emergency discharge) will be completed, a discharge letter completed and a post discharge meeting (if indicated) will take place.
- All discharge paperwork should be clearly and easily identified in the file.

Description of events

Mr. Z had three admissions to DPT mental health inpatient units across two sites, Wonford House and the Psychiatric Department at North Devon District Hospital.

At the point of his first contact with DPT Mr. Z was treated out of his catchment area as his wife was a member of staff within his catchment area team.

Admission 1: 10 August 2002 until 27 August 2002 Mr. Z took his own discharge against medical advice and was discharged into the care of his wife[245]. Mr. Z had not been started on any treatment as he refused this.[246] Mr. Z's wife has made a clear statement about the relationship being irretrievable and that she would only accept Mr. Z back to the family home as

[245] Clinical Records Volume 2 pg 277
[246] Clinical Records Volume 2 pg 14

a short term measure. CPN 1 contacted Mr. Z the day after he had taken his own discharge and visited him six days later when it was noted that he was not coping and was experiencing some suicidal thoughts but not acting on them although he was unsure why this was. No action was taken at this point beyond an appointment being made for a month's time.[247] Mr. Z was not seen for a medical review prior to his next admission.

Admission 2: 21 November 2002 until 24 January 2003 Mr. Z was discharged to a shared house. 27 December 2002 Consultant 2 (locum cover for Consultant 1) requested that Consultant 3 took over the medical care of Mr. Z at the point of discharge as Mr. Z had separated from his wife ad therefore no longer had 'out of area staff status'. Consultant 2 noted that Mr. Z had a recurrent depressive disorder and a possible dependent personality disorder as he had poor coping strategies.[248]

On 23 January 2003 Consultant 2's Secretary forwarded the community referral letter to Consultant 4 as Mr. Z's new accommodation was in his catchment area.[249]

Mr. Z remained on the ward until accommodation was secured being discharged on 24 January 2003 on Cipramil 20 mg daily. Mr. Z had secured a room in a shared house.[250]

Consultant 4 replied to Consultant 2's referral letter on 29 January 2003 asking for Mr. Z's key worker to negotiate a handover to his team so he could take over responsibility.[251]

On 30 January 2003 Consultant 2 wrote again to Consultant 4 asking him to urgently take over Mr. Z's case stating that he had a very dependent personality with a tendency to harmfully use alcohol with repeated acts of deliberate self harm through serious overdose.[252]

On 12 March 2003 Consultant 4 offered Mr. Z an appointment for 24 March 2003.[253] Mr. Z did not keep the appointment as a close family member worked with Consultant 4 on the inpatient ward.[254]

[247] Clinical Records Volume 3 pg 64
[248] Clinical Records Volume 2 pg 144
[249] Clinical Records Volume 2 pg 114
[250] Clinical Records Volume 2 pg 208
[251] Clinical Records Volume 2 pg 113
[252] Clinical Records Volume 2 pg 111
[253]Clinical Records Volume 2 pg 106
[254] Clinical Records Volume 2 pg 105

On 2 April 2003 Consultant 4 wrote to Consultant 3 asking him if he could take over the care of Mr. Z and stated that CPN 2 was happy to remain as his key worker.[255] On 18 May Mr. Z wrote to Consultant 3 requesting an appointment and a change of CPN as CPN 2 had regular professional contact with his daughter.[256] Consultant 3 initially agreed to take over[257] but had to withdraw this offer due to organisational change and suggested that Consultant 4 approached Consultant 5.[258] Consultant 4 wrote to Consultant 5 on 20 May 2003.[259]

Admission 3: 22 August 2005 until 30 August 2005 Mr. Z was admitted for detoxification.

Findings

Discharge 1: 27 August 2002

Despite a negotiated increasing plan of leave it was agreed that Mr. Z could take his own discharge against medical advice on 27 August 2002. At this point no date had been set for discharge and there was no aftercare plan in place. There are no indications in the clinical records as to what options were discussed with Mr. Z and his wife prior to the discharge, such as overnight leave or returning to the ward for a review to evaluate how the leave was progressing. In effect this was an unplanned discharge.

Discharge 2: 24 January 2003

Mr. Z's social circumstances had changed significantly at this time as his marriage had broken down and his alcohol intake had significantly increased. This was the first time that he had lived away from his family for a significant number of years. There was no evidence of discharge planning beyond assisting Mr. Z with his housing needs. There was no evidence of an occupational therapy assessment for Mr R to assess his activities of daily living despite his estranged wife raising concerns about his ability to manage on a day to day basis. It took six months for Mr. Z to receive any follow up from a psychiatrist. There was no CPN contact during this time although this was attempted from the Exeter Team and declined by Mr. Z due to the working relationship his estranged wife had with the team.

Discharge 3: 30 August 2005

[255] Clinical Records Volume 2 pg 105
[256] Clinical Records Volume 2 pg 101
[257] Clinical records Volume 2 pg 99
[258] Clinical Records Volume 2 pg 103
[259] Clinical Records Volume 2 pg 100

Mr. Z was discharged to a team that he was already engaged with, but again this opportunity was not used to plan Mr. Z's care. Although he had been admitted for a detoxification programme, follow up with alcohol services was not arranged, nor were any of the possible social Factors that had led to Mr. Z being admitted addressed.

Conclusion

In effect no formal discharge planning took place in that Mr. Z was discharged from two separate areas involving three CHMT's across the same organisation with no appropriate aftercare plan in place. This represents a series of serious omissions and would support the view that the CPA process and policy were not embedded across the organisation.

In fairness to CPN 1 the case had been closed for the previous five months yet she did make immediate contact and visited within seven days of Mr. Z leaving hospital in 2002. However it was not acceptable to then make an appointment for a month's time when Mr. Z was presenting with suicidal thoughts and had a history of life threatening suicide attempts. In 2002 DPT did not have the service structures that are in place now, such as the crisis team which is able to provide a more intense follow up than the CMHT following an unplanned discharge.

It is understandable that Mr. Z did not want to be seen by someone with a connection to his estranged wife but it is not understandable why the Consultant 1 follow up could not be provided by Consultant 4. The issue of the family member working on the inpatient unit should have been addressed if and when Mr. Z required admission. It would have been more sensible to have moved the family member if and when Mr. Z required admission rather than delay follow up arrangements.

Following hospital discharge, or for outpatients started on anti depressants, initial follow up should be regular (every two-four weeks) to monitor progress and to ensure treatment response is maintained[260] It is totally unacceptable to place a service user at risk with no follow up at all from a Consultant Psychiatrist or a CMHT following a serious overdose and a major change in social circumstances.

In conclusion there was a prolonged and protracted series of letters between all the consultants as to who should accept responsibility and the matter should have been referred to the Medical

[260] D. Semple et al 2005 Oxford Handbook of Psychiatry. OUP

Director for a decision about allocation. The discharge standards set by the Trust were not met. There appeared to be a widespread standard of poor practice across inpatient and community teams regarding the importance and relevance of multi disciplinary discharge planning.

13.6.2 Transfer of Care

Context

The standards for the transfer of care are detailed in the Trust's CPA policy 2006.

- Where possible, a transfer should be part of a planned process allowing time for a new care co-ordinator to be appointed and a handover completed.
- Transfer of patients to another CMHT should involve a joint CPA handover meeting.
- Disengagement should not occur before the new team has established a relationship.
- Consultants should liaise with their counterpart in the new area prior to transfer of care and begin handover to the new consultant within three months.
- Transfers should follow a full review.

Findings

Mr. Z's care moved from the Honiton CMHT to the Exeter CMHT in January 2003 when he was discharged from Hospital. There were no records to indicate that a formal handover occurred between CPN 1 and CPN 2.

In July 2005 the Social Worker allocated to Mr. Z noted that he had moved and wrote to the GP accordingly. No attempt was made to transfer the case to the appropriate team nor is there any closure summary available in the records.

Conclusion

In July 2005 there was a missed opportunity to hand over the care of Mr. Z to the Okehampton CMHT. There was no evidence to support the Trust's transfer standards being adhered to when Mr. Z moved between CMH teams.

Summary

Mr. Z had three admission episodes and contact with three CMHT's during his seven year contact with DPT.

The point of discharge and transfer is a vulnerable time for patients as they move from high support to low support. Discharge from hospital is a recognised time of potentially increased risk for a patient hence the development of national policies such as the seven day follow up as set out in the National Suicide Prevention Strategy for England 2005. Transfer between services is also a vulnerable time as there are risks in terms of continuity of care and communication failures between practitioners. These two areas are pivotal within that national and local CPA policies.

The Independent Investigation Team therefore concluded that there were six missed opportunities to thoroughly review and plan Mr. Z's care at vulnerable times throughout his care pathway. This resulted in the care offered being delayed, unplanned, fragmented, and reactive. The findings in this section of the report would further support the view of the Independent Investigation Team that adherence to Trust CPA policy was poor. The view of the Independent Investigation Team was that the wide spread lack of adherence to the guidelines for discharge planning and transfer of care contributed to the ineffectual route that Mr. Z's care pathway took.

Contributory Factor 4

Mr. Z's discharges from hospital and transfers of care fell below the expected standard as they were not planned in accordance with best practice or trust policy leading to serious delays in follow-up and missed opportunities to plan care. The poor practice appears to be wide spread across the inpatient and community teams that provided care and treatment to Mr. Z.

13.7 Risk Assessment and Management

Context

Safety is at the heart of all good healthcare. There has been an implied requirement under the Health and Safety at Work Act for clinical risk assessments to be carried out since 1974[261]. No mental health organisation can afford not to have a programme that actively seeks to reduce and eliminate risk, not only because of financial consequences, but more importantly, solid risk management programmes can significantly improve patient care.

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, well being and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users past and current clinical presentation to allow an informed professional opinion about assisting the service users recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

[261] Health and Safety at Work Act; HSE;1974

Best Practice in Managing Risk (DH June 2007) states that 'positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:

- it conforms with relevant guidelines;
- it is based on the best information available;
- it is documented; and
- the relevant people are informed[262].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult and unclear.

Both the crisis resolution team and the psychiatric liaison team form the Trust's mental health emergency response service and will therefore be considered under risk management.

Local Policy

The Trust Clinical Risk Management Policy was ratified in January 2004 and March 2006 and due for review in 2008 so cover the majority of the time that Mr. Z was in receipt of services

DPT policy states that clinical risk management is a whole systems approach to identifying, assessing, evaluating, controlling and communicating risks associated with clinical activities in order to maximise safety for all parties. It is an integral part of clinical practice and is subject to rigorous audit.

[262] Best Practice in Managing Risk; DH; 2007

The risk assessment and management process in place at the time Mr. Z was receiving his care and treatment included four steps:

1) Risk screening. This determined whether a significant level of risk was present. (The Trust form was taken from the Sainsbury Centre for Mental Health)[263][264]

2) In depth risk assessment. This examined the extent and level of risk. (The Trust form was taken from the Sainsbury Centre for Mental Health)[265]

3) Risk management. This the process of maximising benefits while balancing risk within acceptable limits, by intervention before or after an event taking place.

4) Risk review. This was a continuous process of revisiting the risk assessment and the management plan. Reviews should have occurred at agreed set time intervals or following changes in the individual's presentation and/or circumstances prior to making significant decisions about care

The Trust Risk Screening process stated

- *Risk screening must be carried out as part of an overall assessment of presentation for new and re-referred service users to determine current level of risk and the need for an in-depth risk assessment.*
- *Risk Screening will be carried out using the Trust-wide Risk Screening Tool however, other risk screening tools may be used according to service/directorate area agreement, following authorisation by the Clinical Cabinet.*
- *Risk screening will identify the need for:*
    - *An immediate action plan to ensure safety of the patient and others must also be put in place. (where there are imminent risks);*
    - *A short-term care plan;*
    - *No further action at this stage.*

The Trust In-depth Risk Assessment Process stated

- *When significant or serious/complex risks are identified an in-depth risk assessment will be carried out using agreed protocols which have been ratified by Devon Partnership*

[263] Morgan, S. (2000) Clinical Risk Management: A Clinical Tool and Practitioner Manual. London: Sainsbury Centre for Mental Health
[264] DPT Clinical Risk Management Policy pg 8
[265] Clinical Risk Management Policy pg 9

NHS Trust. These protocols may vary according to service area following authorisation by the Clinical Cabinet.

- *All available sources of information including; current treatment records, full history, previous presentations should be referred to.*
- *Particular attention needs to be paid to the place of patient history in the assessment of risk and the Factors and actuarial indicators which would identify an increased level of risk*
- *Service users, relatives and carers, other informants and agencies will be consulted as part of this process.*
- *Feedback, including consideration of risk Factors, must be communicated by clinicians undertaking assessments/interventions to nursing staff at the end of each assessment.*
- *In-depth risk assessment will inform a risk management plan.*

The Trust Risk Management process stated

The clinical risk management plan must be based on the outcome of the risk assessment and clinicians have responsibility for ensuring that risk is minimised and managed effectively. The management plan should form part of the CPA care plan or other relevant care planning tools, in which service user's physical and social needs are addressed. The plan must also change the balance between risk and safety and aim to ensure the service user feel safer and less distressed.

- *When significant or serious/ complex risks are identified, a meeting to review and manage the risk should be held with all involved parties. This may be a specific meeting or part of an existing team or multi-agency meeting. Any team member can request a risk management meeting.*
- *The risk management plan will be agreed, documented and communicated to all involved parties. The plan will include:*

1. *action to be taken / who is responsible for specific actions;*
2. *a timeframe;*
3. *co-ordination of the plan;*
4. *set review interval;*
5. *contingency plan.*

Risk must be considered and documented during care plan/ CPA reviews, Section 117

meetings, at all pre-discharge and discharge meetings.

CPA Policy (2006)

All people referred to secondary adult mental health services will receive a screening assessment (CPA2c) as an integral part of the CPA assessment. If the risk screening reveals areas of concern the clinician may discuss this with their clinical supervisor and a more detailed risk assessment (CPA 2d) should be completed. The risk assessment process should be repeated if circumstances change considerably and should be discussed at review Contingency planning is noted to be a vital tool in the management of risk and that such a plan should identify in particular indicators of relapse or crisis, the service users strengths and personal coping mechanisms and abilities. [266]

Crisis Team

In October 2006 the Crisis Team had an operational policy that was based on the National Policy Directives

- *The National Service Framework for Mental Health: Modern Standards and Service Models (1999), outlines the case for access to services round the clock.*
- *The Department of Health Policy Implementation Guide (2001) outlines the properties expected of Crisis Resolution / Home Treatment Teams.*
- *The Sainsbury Centre for Mental Health (2001) has published guidelines for the development of Crisis Resolution Teams.*

The principles of service delivery were those outlined by the Sainsbury Centre for Mental Health (2001)

- *Crisis management, to the point of resolution.*
- *Engagement with users, families and carers.*
- *A holistic approach.*
- *Approach work with user's strengths rather than 'illness' model.*
- *Improvement and maintenance of mental health through psycho-education.*
- *A collaborative approach.*

[266] Care Programme Approach Policy 2006 pg 11

The main target group was people between the ages of 16 and 65 years of age (as determined by the Policy Implementation Guidance), whose mental illness is of such severity that they are at risk of requiring acute inpatient care.[267]

Psychiatric Liaison Team

The psychiatric Liaison Team is based within the Royal Devon and Exeter Hospital and is a stand alone team comprise 4 senior mental health nurses one of whom acted as a manager. Their remit is to assess people that come into the RD&E who have issues around their mental health. The team has access a variety of doctors ranging from F1s(qualified doctors in training) up to Consultant Psychiatrist and operates on a Monday to Friday, nine to five basis working closely with other mental health services, including the crisis team, and General Practitioners. Outside of these hours the duties are divided between up the crisis resolution team and the on call psychiatrist. [268]

[267] Crisis Team Operational Policy
[268] AT 1 pg 3

Description of Events

Mr. Z took an overdose of 28 Dothiepin tablets and was admitted to the RD&E hospital on 14 November 2000. The discharge summary noted a long standing history of depression and anxiety, with occasional binge drinking. The impression was that this constituted a serious overdose and there was a significant risk of further self harm due to work-related stress. Mr. Z was discharged home to the care of his wife and an urgent referral was made to Honiton CMHT.[269]

Mr. Z took a second over dose of 56 tablets Dothiepin with half a bottle of vodka on 2 August 2002 and was admitted to the Intensive Care Unit of RD&E hospital where he required ventilator support for respiratory arrest. The precursor to the overdose was recorded as his wife having discussed separating; they had been married for 25 years. He was detained under Section 5/2 of the Mental Health Act (1983) as he did not wish to stay in Hospital. Mr. Z agreed to be transferred to the Mental Health Hospital on 11 August and was again detained under Section 5/2 of the Mental Health Act (1983) as he did not wish to stay in Hospital. Mr. Z discharged himself against medical advice on 27 August 2002.[270]

On 18 November 2002 Mr. Z took a third over dose of Paracetamol and Aspirin and was admitted to RD&E hospital.[271] He transferred to the Mental Health Unit on 21 November 2002. The reason given for the overdose was that Mr. Z and his wife were separating, he was not working at this time and his alcohol intake had increased.[272] Mr. Z was discharged on 24 January 2003 to a rented room in a shared house.[273]

The Specialist CPN (drugs and alcohol) assessed Mr. Z on 22 September 2004 and noted that Mr. Z was consuming 20 units of alcohol a day. During the assessment Mr. Z disclosed that he had made two attempts to harm himself over the previous two weeks.[274]

On the 10 August 2005 Mr. Z took an overdose of 60 tablets of Dothiepin. He was found collapsed by his housemate on the morning of 11 August when an ambulance was called. He

[269] Clinical Records Volume 2 pg 169
[270] Clinical Records Volume 2 pg 128
[271] Clinical Records Volume 2 pg 273
[272] Clinical Records Volume 2 pg 221
[273] Clinical Records Volume 2 pg 208
[274] Clinical Records Volume 2 pg 74

was admitted to RD&E Hospital. He was seen and assessed on the 15 and 16 August by a nurse from the Psychiatric Liaison Team. The impression formed was that Mr. Z took an intentional, planned, overdose with the intent of ending his life. Mr. Z refused admission to a mental health hospital, refused to see a psychiatrist, and actively disengaged when this was talked about as he thought that he would be sectioned (detained under the Mental Health Act).[275] The Psychiatric Liaison Nurse thought that Mr. Z's symptoms of low mood, poor appetite, no hope for the future, chronic low self esteem, anxiety, low mood in the context of the breakdown of his marriage were indicative of issues relating to his personality, lack of coping skills and chronic alcohol misuse rather than a severe clinical depression. It was felt that initiating a Mental Health Act Assessment would have been counter productive to Mr. Z's future engagement with mental health services. In the report of the assessment the Psychiatric Liaison Nurse stated that "*Mr. Z was at high risk of completed intentional suicide in the short, medium and long term…..and was experiencing ongoing suicidal ideas*".[276] It was agreed with Mr. Z that the Crisis Team would provide intervention in the short term and that he should be urgently referred to the CMHT (Okehampton). The decision was discussed in detail with the GP, medical staff at DRD&E hospital, the Mental Health Manager and the Consultant Psychiatrist within the liaison team. Mr. Z was discharged home on 17 August 2005.[277]

The response from the GP was that Mr. Z should not leave hospital until it had been established that he did not need a Mental Health Act Assessment and that it would be totally unacceptable if he were to leave hospital and something serious happen to him.[278]

A level 1 risk screening was completed on 18 August 2005 following a home visit by the Crisis Team. They were unable to ascertain if Mr. Z was at risk: *from* others, a risk *to* others or children, of physical impairment, of wandering, or of memory or cognitive impairment. It was noted that Mr. Z was at risk of self harm having taken four recent overdoses and of self neglect due to drinking heavily. The known history was documented as a high intent suicide attempt with low discovery having left a suicide note and a will. It was also noted that Mr. Z had made previous attempts to jab himself in the heart with acupuncture needles to induce a heart attack. The initial assessment of risk was that Mr. Z "*always felt low*"[279]. A level 2 risk assessment was not thought to be necessary. The assessment detailed that Mr. Z stated that he did not wish the

[275] Clinical Records Volume 1 pg 104
[276] Clinical records Volume 1 pg 105/6
[277] Clinical Records Volume 1 pg 106
[278] GP records pg 54
[279] Clinical Records Volume 1 pg 14

Crisis Team to visit on the 19 August as he would be in the local pub.[280] The Crisis Team negotiated to visit again on 22 August 2005 with Consultant 6 after which Mr. Z was admitted to the Mental Health Unit for alcohol detoxification.

On 7 July 2005 the CMHT Social Worker informed the GP that Mr. Z was consuming 120 unit of alcohol a week.[281]

At the point of admission to the Mental Health Unit on 22 August 2005 a level 1 risk assessment was completed identifying the risk to himself from previous overdoses and a risk of neglect due to drinking heavily. The known history was documented as depressive illness compounded by heavy alcohol consumption. The management plan was identified as a detoxification plan whilst an inpatient. No further action was recommended at this stage.[282]

At a meeting with the Clinical Psychologist on 12 May 2006 Mr. Z reported that he had damaged his hand in anger when dealing with his housemate.[283]

The GP wrote to the Clinical Psychologist on 25 May 2006 stating that Mr. Z had recently had two admissions for alcohol related gastritis and pancreatitis.[284]

On 19 September 2006 Mr. Z was unable to attend his appointment with the Clinical Psychologist. The Clinical Psychologist visited Mr. Z at home, "*as he was aware of the risk*" where he presented as very distressed and tearful. Although stating that he would not harm himself the Clinical Psychologist was unconvinced as he witnessed Mr. Z conceal his despair when talking to his daughter on the telephone.[285] The Clinical Psychologist referred Mr. Z to the Crisis Team who agreed to do an assessment on 20 September as Mr. Z had been drinking. On 21 September the Crisis Team did an assessment the outcome of which noted significant evidence of alcohol withdrawal with mild to moderate depressive features, Mr. Z was experiencing suicidal thoughts and cited his children as protective Factors. The Crisis Team

[280] Clinical records Volume 1 pg 9
[281] Clinical records Volume 3 pg 78
[282] Clinical records Volume 4 pg 60
[283] Clinical Records volume 1 pg 43
[284] Clinical Records volume 1 pg 88
[285] Clinical Records Volume 1 pg 45

concluded that there was no evidence of serious mental illness and did not take Mr. Z onto their case load.[286]

On 26 September 2006 the Clinical Psychologist completed a notification of serious concern after a home visit on 19 September when Mr. Z had disclosed a high level of risk. Initially the Crisis Team had refused to assess him as he was under the influence of alcohol and when they did assess him on the 21 September Mr. Z concealed the level of risk. The circumstances noted that would increase the risk were increased alcohol consumption and decreased contact with his children. The plan was for a joint assessment by CPN 5 and the Occupational Therapist.[287] Mr. Z was removed from the serious concern list on 10 October 2006 by the Team Manager following discussion at the MDT meeting. The risk management plan was to continue to offer engagement and encourage Mr. Z to attend ENDAS.[288]

Mr. Z cancelled his appointment with the Clinical Psychologist on 8 February 2007 as he stated that he had been in a fight with his housemate and had hurt his ribs and his nose and that his breathing was poor.[289]

Findings

Mr. Z took four serious overdoses, all requiring admission to a general hospital over a period of five years between November 2000 and August 2005. Mr. Z was using alcohol in a harmful manner that was impacting on his physical health.

Risk Assessment

Throughout Mr. Z's seven-year contact with mental health services following the first overdose only two level 1 risk assessments were completed, both in 2005. Both risk assessments identified the risk of potential overdose and self neglect due to his high alcohol consumption. Despite the seriousness of the overdoses neither assessment proceeded to a level 2 assessment. However that is not to say that clinicians involved were not aware of the risks associated with Mr. Z as it was reported at interview with the Independent Investigation Team

[286] Clinical Records Volume 1 pg 16
[287] Clinical records Volume 1 pg 4
[288] Clinical Records Volume 1 pg 50
[289] Clinical Records Volume 1 pg 63

"*our perspective was that the risk was very much to himself...we never considered him to be a risk to anybody else",*[290] *"we never found him threatening or throwing up any concerns".* [291]

There were two reported incidents of violence with Mr. Z's housemate (13 May 2006 and 8 February 2007) neither of which appeared to have been discussed in detail with Mr. Z or seen in the wider context of his relationship with his housemate and how this might impact upon his mental health. In fact the housemate was noted to be "*supportive*" of Mr. Z. From the chronology it is clear that Mr. Z's housemate also had a problem with excessive alcohol consumption and that on occasions there were disputes about money. However there was no indication that violence was routine or significant until February 2007. It is unknown if Mr. N sustained any injuries on these occasions. It is noted that there was no opportunity to discuss the incident on 8 February with Mr. Z although further details could have been obtained when Mr. Z telephoned to cancel the appointment with the Clinical Psychologist.

Risk assessment is a dynamic and ongoing process. Risk Factors that were known about Mr. Z at the time of the incident were:

- his alcohol consumption was intermittently dangerously high;
- he had a history of serious overdoses;
- he had a recent change in anti depressant medication;
- he was depressed;
- he had an ambivalent relationship with his house mate that was a source if stress to him;
- he was socially isolated.

Whilst the teams did identify the risk of overdose and the risk of neglect no further consideration was given to them. The other risk areas identified above are noted within the clinical record. The risk of self neglect was noted to be in association with the high alcohol intake. Despite the seriousness of the overdoses an in-depth, level 2, risk assessment was not triggered for either of the risk areas identified by any of the teams involved with Mr. Z's care and treatment.

Mr. Z was not seen as presenting with a significant serious/complex risk that required an in depth assessment and therefore did not receive a level 2 risk assessment.

[290] AT 4 pg 6
[291] AT 4 pg 8

Risk Management

The risk management plan for 18 August 2005 was for alcohol detoxification. The action from the risk assessment on 22 August was for further assessment. The risk management plan in 2006 put Mr. Z's alcohol consumption firmly in the centre of the care and treatment to be provided for him as it appeared to be thought that it was not possible to help him in any other way. At interview a witness said "*I remember looking very carefully with him at his alcohol use and it will sound strange in retrospect but he was quite convincing about how in his case it was reducing his risk of self harm, of actually killing himself. We were very alert to the role that alcohol played in risk management*".[292]

Psychiatric Liaison Service Intervention

The Psychiatric Liaison Nurse assessed Mr. Z over a period of two days whilst he was in hospital following an overdose in August 2005. At interview with the Independent Investigation Team it was reported that approximately seventy percent of the Team's work was centred on people who had attempted suicide or self harm and had come through as an emergency.[293] The assessment was based on the RD&E medical notes, Mr. Z's mental health notes, discussion with the GP and two interviews with Mr. Z.

A high and imminent risk of suicide in the near future was identified as a risk Factor. Despite this the Psychiatric Liaison Nurse was reluctant to go down the Mental Health Act route it would alienate him from services even more "*there was the issue about his resistance and his reluctance…. he was pretty resistant and reluctant to actually engage in thinking about any hospital admission".*[294]

At interview with the Independent Investigation Team the Psychiatric Liaison Nurse discussed the dilemma of engagement with Mr. Z: *"I was wanting to actually try and get him engaged with services and he was fairly scathing of services anyway and so I didn't want to really upset him even more because I thought that would increase the risk."*[295]

[292] AT 4 pg 10
[293] AT 1 pg 3
[294] AT 1 pg 7
[295] AT 1 pg 5

"*I think that putting him in hospital at this time would have not reduced his level of risk. It would have just served to have annoyed him, alienated him and just interfered with any opportunity that the services might have had to be able to grab him".*[296]

The report was detailed in terms of risk Factors and protective Factors. It must be noted that the risk Factors outnumber the protective Factors.

It was agreed with Mr. Z that he would be discharged and receive Crisis Team support in the short term. Mr. Z reported at the assessment that his housemate had his own difficulties and that they did not get on very well. There was no liaison with Mr. Z's housemate as to his views about Mr. Z being discharged, whether he was able to cope with Mr. Z and no record exists of advice regarding who to contact should Mr. Z deteriorate.

Crisis Team Intervention

Mr. Z had two contacts with the Crisis Team.

The first contact was in August 2005 when Mr. Z was discharged from hospital. He was seen at home the day after he was discharged. A mental state assessment was documented stating that Mr. Z was labile, his speech was slow and low, he was subjectively and objectively depressed, was experiencing poor sleep and had recently lost two stones in weight due to a poor appetite. Although being aware that Mr. Z had taken a serious overdose they agreed not to see him on a daily basis due to his being in the pub this is in conflict with the clinical record that stated Mr. Z was agreeable to cutting down his alcohol intake. The fact that Mr. Z made a clear statement of intent to drink did not alter the plan of care and did not trigger a reassessment of his risks or the plan of care.

The second contact was in 2006. There is no record of the assessment from the Crisis Team within the clinical records submitted to this Investigation. Detail of this contact has been taken by the Independent Investigation Team from records kept by other practitioners. There is an assessment outcome and care plan that appears to have been faxed to the Clinical Psychologist.[297] Despite noting that there was significant evidence of alcohol withdrawal the only recommendation was for the GP to prescribe Vitamin B compound. Their view was that the

[296] AT 1 pg 8
[297] Clinical Records Volume 1 pg 16

depressive symptoms that Mr. Z presented with were secondary to excessive alcohol consumption.

Response to Violent Incident 8 February 2007

The extent of the injuries sustained by Mr. Z in the altercation he had with his housemate was not fully known to the Clinical Psychologist. Mr. Z suffered extensive bruising to his face (20 cm on the bridge of his nose, 15 cms on the left side of his chin and a small split in his lip), bruising and scratching to his left arm with swelling of his wrist, bruising, abrasions and swelling to his right arm, bruising to his back (60-70 cms with scratch marks and further significant bruising (40-60 cms) and scratches to his lower limbs.[298] At interview with the Independent Investigation Team witnesses reported that Mr. Z had not sounded as though he was under the influence of alcohol and that he had seemed calm and reasonable creating the impression that he just needed time to recover. He had conveyed his message of non attendance in a matter of fact manner. As Mr. Z had presented as calm and lucid it was assumed that the incident had resolved itself. Consideration was given to the fact that there was no history of violence and there did not appear to be any reason to engage other services.[299]

Conclusions

Risk assessment and management are fundamental and integrated components of the CPA process. The Independent Investigation Team conclude that the lack of a level 2 risk assessment in the light of the level of concern expressed by the clinicians is that this was an error on the part of the clinical team. This was due in part to the lack of awareness and understanding around the treatment approach used to treat and manage people who present with dual diagnosis and reflective of the lack of overall management of the case. If a level-two risk assessment had been conducted in accordance with Trust policy expectation then this could have focused some of the risks that were being referred to in the risk screen and in the clinical record and therefore guided a more appropriate and focused management plan directed at Mr. Z's low self esteem and depressive symptoms. However all these issues were not integrated or assimilated into a comprehensive risk management plan.

[298] Police records pg 26
[299] Addendum to AT 4

Psychiatric Liaison Service

The assessment conducted by the Psychiatric Liaison Service was comprehensive and thorough. The assessment appropriately linked past and present dynamic Factors (of separation) and concluded with a recommendation for long term psychotherapy for "*historical issues*".

However in terms of risk management there were two areas that the Independent Investigation Team deliberated on. The first of these was the reference to Mr. Z's behaviour and attitude being personality driven as opposed to depression driven. Mr. Z's behaviour was not seen as being psychodynamically driven in the context of a long-term untreated depression and there is no substantiated evidence within the assessment to indicate any personality driven traits. For example. Mr. Z did not overdose on a regular basis, all overdoses had been serious and potentially life threatening and Mr. Z had developed independent living skills since he separated from his wife. The second issue was that of not pursuing a Mental Health Act Assessment. The view of the Independent Investigation Team was that the notion of engagement with mental health services was a red herring as Mr. Z's immediate need was for somewhere safe to detoxify from alcohol and have an ongoing in-depth assessment of his mental state and treatment for his depression after the initial crisis period was over and that he should have been assessed under the Mental Health Act (1983) as he was unwilling to engage on an informal basis. In terms of risk management when these two issues were considered together the view of the Independent Investigation Team was that this incident constituted a near miss and an opportunity to assess and treat Mr. Z was lost. Further, not consulting Mr. Z's housemate about what support he would be able to offer Mr. Z was an omission.

Crisis Team

The assessment by the Crisis Team was comprehensive although appeared to rely heavily on the information contained in the Psychiatric Liaison Services assessment of Mr. Z. At the assessment in August 2005 Mr. Z was clearly depressed and although stating that he was going to cut down on his drinking he also stated that he would be spending the day in the pub and not be available to see the Crisis Team. The fact that there was no response to Mr. Z stating that he was going to be participating in a known precursor to previous overdoses coupled with the fact that there was no evidence to support any arrangements to see him on the 20th and 21st calls into question the operational functioning of the team as they were not meeting their stated principle of "*crisis management, to the point of resolution*". Again there was no reference to Mr.

Z's housemate and the role he may or may not have had in supporting/antagonising the situation. The view of the Independent Investigation Team was that the crisis was not managed and that Mr. Z was left at home in a vulnerable and distressed state.

It is unclear what the Crisis Team based their decisions on during the contact in 2006. However it is the conclusion of the Independent Investigation Team that it was inappropriate to not intervene actively when someone was presenting with "*significant symptoms of alcohol withdrawal*". Alcohol withdrawal produces a wide range of symptoms including insomnia, anxiety and irritation. It also causes physical symptoms such as headache, gastrointestinal upset, mild fever, cold sweats, and rapid heart rate. Symptoms may range from mild to severe. Those who suffer from severe symptoms may experience 'the DTs' or *delirium tremens* often marked by hallucinations, tremors, nightmares, nausea and vomiting. Severe cases can last for days or even weeks, with intermittent lose of consciousness or seizures and possible risk of physical injury. Immediate medical attention may be called for in more severe cases, depending on related conditions, since rapid heart beat and high blood pressure often increase the risk of stroke or heart attack.[300] This was a potential medical emergency that was not noted or dealt with appropriately. However The Independent Investigation Team would go so far as to say that leaving someone with "*significant symptoms of alcohol withdrawal*" is a dereliction in their duty of care.

Response to Violent Incident 8 February 2007

The Clinical Psychologist based the decision to take no further action following the violent incident based on what was known at the time. There is evidence to support the Clinical Psychologist taking action such as a home visit or referral to the Crisis Team when it was perceived that the risk had increased. It is the conclusion of the Independent Investigation Team that it is only with hindsight that any significance can be attached to this incident as the severity was under reported.

Engagement with Housemate

Neither of the emergency services involved made any reference to asking Mr. Z if they could contact his housemate to ascertain if he was able to provide any support.

[300] http://www.chiff.com/health/disease/alcohol-withdrawal.htm

Summary

In essence there are two issues

1) Lack of adherence to Trust Risk Assessment and Management Policy in terms of practice and process.
2) Appropriate risk assessment and intervention with someone who is alcohol dependent and depressed by 'emergency services'.

As with the CPA policy what is most concerning, when viewed through the lens of single case, is that the governance arrangements, in terms of supervision, monitoring and audit were not robust and therefore failed to pick up on the lack of risk assessment and management plans over a seven-year period.There is evidence to the effect that the risk assessment and management policy had not been adhered to or implemented across all the services that had contact with Mr. Z as they had not been completed at the point of first contact within each of the services as directed by the Risk Management Policy nor were they reviewed or added to as incidents occurred.

A level 2 risk assessment should have been completed to address Mr. Z's alcohol abuse which had, on two occasions, been reported as 120 units a week. A detailed risk assessment in this area could and should have provoked further discussion and consideration of the approach to Mr. Z's care and treatment which could have altered the approach taken to his treatment and care. The fact that this did not occur contributed to Mr. Z following a care pathway that was less than effective. However based on the fact that Mr. Z did not have a significant history of violence or aggression the Independent Investigation Team does not believe that any risk assessment would have rendered this homicide as predictable.

Contributory Factor 5

There was a lack of adherence across inpatient, community, and emergency teams to the Risk Assessment and Management Policy. Mr. Z was not comprehensively risk assessed by any of the services that he had contact with resulting in his care pathway being less than effective.

Contributory Factor 6

The mental health 'emergency' services missed opportunities to intervene appropriately with Mr. Z as they did not understand his presentation: believing his depression was alcohol or personality driven rather than a severe untreated depression. Consequently there were missed opportunities to intervene at a more assertive level resulting in a lack of appropriate intervention and management of Mr. Z's co-morbidity.

13.8 Mental Health Act (1983)

"The Mental Health Act 1983 is an Act of the Parliament of the United Kingdom but applies only to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people suffering from a mental disorder can be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as Sectioning. Its use is reviewed and regulated by an NHS special health authority known as the Mental Health Act Commission (MHAC)." [301]

In order to place a person under a section of the Mental Health Act (83) two registered medical practitioners must make an application in writing stating why assessment and/or treatment are necessary. This statement also has to explain why other options for treating the patient cannot be used and why compulsory detention is required. A Section 5(2) is the power under the MHA that allows a responsible doctor or Approved Clinician to detain an in-patient for a maximum period of up to 72 hours in order to make arrangements for their assessment for detention under Section 2 or Section 3 of the MHA 1983. Although detention under Section 5 (2) cannot be renewed, once the patient is informal it could be used again for the same patient. Repeated use of Section .5 (2) would tend to indicate that the patient has been inadequately assessed or managed and should not normally arise. The Consent to Treatment provisions of Part 4 of the MHA do not apply to patients subject to Section 5(2). This means that they are in exactly the same position as patient who are not detained under MHA and cannot be given medication without their consent. Section 5(2) should not be used as an alternative to Section 2 or 3 even if it is thought the patient will only need to be detained for 72 hours or less.

[301] http://en.wikipedia.org/wiki/Mental_Health_Act_1983

A Section 2 is an assessment order only and lasts up to 28 days, it cannot be renewed. It can be put into place following a Mental Health Act (83) assessment by two doctors and an Approved Social Worker (ASW). At least one of these doctors must be a Section 12 approved doctor. The other must either have had previous acquaintance with the person under assessment, or also be a Section 12 approved doctor.

The terms of reference for this Investigation include a requirement '*to review the Mental Health Act (83) assessment process, where applicable*'.

Description of events

02 August 2002 Mr. Z took a second serious overdose requiring resuscitation. His wife had asked for a separation and Mr. Z's alcohol intake had been increasing.

On 5 August 2002 Mr. Z was referred to the Emergency Duty Team for a possible assessment under the Mental Heath Act (1983) as he was disinhibited, agitated and stating that he was going to leave the ward.[302]

Mr. Z was assessed under the Mental Health Act (1983) on 6 August 2002 whilst he was in Intensive Care at the RD&E by Consultant 1. The Mental Health Act was not applied as Mr. Z agreed to remain in hospital and to an informal admission to the mental health unit.[303]

Notes in the clinical record (undated and unsigned) recorded a consultation with Mr. Z's wife and CPN1 who both stated that Mr. Z underplayed his depression. CPN 1 reported that Mr. Z did not really engage, tended to drop off his medication and backed out of therapy. They also state '*5/2 by physician*'.[304]

Mr. Z was transferred to Wonford House Hospital on 10 August 2002. [305] A document in the clinical records noted that Mr. Z was detained on a Section 5/2 of the Mental Health Act (1983) on 8 August 2002 and that this was allowed to lapse. It is also recorded that a Section 5/2 was

[302] Clinical Records Volume 3 pg 52
[303] Clinical records Volume 3 pg 18
[304] Clinical Records Volume 3 pg 50
[305] Clinical records Volume 2 pg 292

applied on 10 August 2002 at 18.30.[306] A reference in the medical records stated '*Section 5/2 yesterday as did not wish to stay*'.[307]

The discharge letter to the GP dated 27 August 2002 stated that Mr. Z was put under a Section 5/2 as he wanted to leave whilst still in EMU and that he was put under Section 5/2 again whilst on Delderfield Ward (mental health unit) again for wanting to leave.[308]

Mr. Z was re-assessed under the Mental Health (1983) Act on13 August 2002 and was not thought to be detainable as he was not suicidal, was willing to stay in hospital if he could have more freedom but was not willing to take any treatment. The outcome of the assessment was that Mr. Z was not thought to be detainable and that personality difficulties were more apparent than depression.[309]

Findings

Mr. Z's social circumstances had changed significantly in 2002 as his marriage had broken down and his alcohol intake had significantly increased.

From the various clinical records it is possible to piece together Mr. Z's care pathway under the Mental Health Act (1983) in August 2002:

- 6 August assessed but not detained
- Unknown date between 6 and 10 August assessed and detained on S5/2 by a physician in RD&E; this was allowed to lapse
- 10 August assessed and detained on S.5/2 on the Mental Health Unit
- 13 August assessed and S 5/2 rescinded, no other section of the Mental Health Act was applied as Mr. Z was not thought to be detainable

Of significance: there was an absence of formal documentation relating to the application of and discharge from the Section 5/2 that was applied on 10 August.

[306] Clinical Records Volume 2 pg 209
[307] Clinical Records Volume 2 pg 8
[308] Clinical Records Volume 2 pg 128
[309] Clinical Records Volume 2 pg 291 & 15

Of significance: the undated and unsigned records, noted that two people who knew Mr. Z well, namely his wife and CPN 1, reported that Mr. Z '*underplayed*' his depression.
The Independent Investigation Team made a calculated guess that these records related to the Mental Health Act Assessments whilst Mr. Z was a patient in the ITU and that they were probably the notes of the Approved Social Worker involved in the assessment. This assumption is based on the content of the records for example '*OD before referred to CPN1*', the reference to the fact that Mr. Z had already been placed on a S.5/2 by the physician and that this person met with Consultant 1 on ITU. There was no conclusion recorded in the notes.

Mr. Z was able to negotiate his own terms for remaining in hospital.

Conclusions

This was an appropriate use of Section 5/2 on both occasions that Mr. Z was detained under the Act.

There is a balance to be maintained when assessing people under the Mental Heath Act (1983) in keeping them safe whilst caring for them in the least restrictive environment possible. Mr. Z was assessed under the Mental Health Act (1983) on 13 August 2002 when he was able to negotiate the terms and conditions of his continued informal stay in hospital. One of these terms was that he did not wish to take any anti depressant medication, otherwise referred to as treatment, for his depression, the other was that he wanted greater freedom. Whilst the Independent Investigation Team respects that it was not present at the assessment and appreciates that on occasion there has to be negotiation whilst striking the balance between engagement and disengagement with services it cannot conclude that the decision not to apply for a section 2 was correct. Mr. Z was on this occasion clear that he was not going to engage with any care plan as he wanted greater freedom where he would not be able to be monitored and that he was not going to take any treatment, namely medication that had been helpful to him in the past. Further Mr. Z was allowed certain degree of choice that was not in keeping with patients who have recently committed a suicide attempt, such as being allowed access to his motor bike and indeed keeping this on hospital grounds.

Mr. Z may well have been presenting with personality difficultiesas he was heading towards a major life event (his separation). However it was known that he was suffering from a recurrent

depressive illness where he underplayed his symptoms and did not disclose the severity of his distress and that he had a history of not really engaging.

It is always a complicating Factor when a close member of the family is a healthcare professional within the service that someone requires help from and this, on occasion, may lead professionals to make decisions that they would not necessarily apply to the general public.

The Independent Investigation Team concluded that this was a difficult assessment for the professionals concerned and that they acted in the spirit of the Act in terms of the least restrictive environment, although not applying for a Section 2 was a missed opportunity to really understand and engage with Mr. Z. However the Independent Investigation Team cannot form the view that there was poor regard for the Mental Health Act as they were not in possession of all the facts that underpinned the decision not to apply for a Section 2.

There are no extant Approved Social Worker assessments within the medical records neither are there records in relation to the assessment and detention regarding the Section 5/2 that was applied on 10 August. The Independent Investigation Team therefore concludes that either the documentation was not completed or is missing from the clinical file. (Refer to section 13.1)

Service Issue 6
Mental Health Act assessment documentation was not available within the clinical record reflecting a poor standard of clinical record keeping.

13.9 Management of the Clinical Care that Mr. Z Received

This section examines the context in which the clinical care and treatment that Mr. Z received and was given and seeks to give an account of how services were managed during the period that Mr. Z was receiving his care and treatment. This section serves to provide a general summary of the total quality of the clinical care and treatment that Mr. Z received.

The above sections have examined all of the separate components of the care and treatment that Mr. Z received. It is important to bring all of these Factors together when examining Mr. Z's case in order to understand why his case was managed in the way that it was.

Case summary

Mr. Z had increasing contact with mental health services in both Exeter and latterly in Okehampton from 2000 until the offence in 2007. He suffered significant early negative life events but largely overcame teenage delinquency and poly drug misuse. He married and had two children. He then developed a recurrent depressive disorder and intermittent alcohol misuse. He overdosed seriously four times over a seven-year period during which he was assessed by generic, liaison and crisis mental health teams from different areas of the DPT. His complex diagnosis of recurrent depressive disorder and alcohol dependency presented significant challenges for integrated assessment, successful treatment and containment of risk for himself and others. These challenges were compounded by Mr. Z's ambivalence to certain clinical interventions, most notably those directed at his alcohol consumption.

Findings

There are five headings under which the findings in this section are examined. They are as follows**:**

Case Formulation

A case formulation is a theoretically-based explanation or conceptualisation of the information obtained from a clinical assessment. It offers a hypothesis about the cause and nature of the presenting problems and is considered an alternative approach to the more categorical approach of psychiatric diagnosis.[·] In clinical practice, formulations are used to communicate a hypothesis and provide a framework to developing the most suitable treatment approach. Despite the number of experienced professionals involved in the care and treatment of Mr. Z there is no evidence to support a clear case formulation outside any medical diagnosis and even case formulation within the diagnoses was an either or situation, depression vs. alcohol, rather than joined up into dual diagnosis.

Case management

Case management is the coordination of community services for mental health patients by allocating a professional to be responsible for the assessment of need and implementation of care plans. It is usually most appropriate for people who, as a result of a serious mental illness,

have ongoing support needs in areas such as housing, employment, social relationships, and community participation.[310] Mr. Z's case was difficult to manage whilst he was receiving services from the Exeter CMHT due to the complication of his family working within the service and his concerns about compromising their professional integrity consequently the case was allowed to drift and was not managed.

The Okehampton CMHT did attempt to manage Mr. Z's case and but this ceased when CPN 5 closed the episode of care, leaving the Clinical Psychologist as a lone practitioner to manage the case. The Clinical Psychologist was focused on working through loss and reaction to loss but this was compromised as the support structures necessary to do this work were not in place, namely a care coordinator to pursue a more assertive level of engagement with ENDAS and possibly a support worker to encourage alternative activities and address practical concerns.

At no point throughout Mr. Z's care pathway was there a joint meeting with ENDAS to discuss joint working or assertive management of the case.

It is clear from the previous sections on CPA and risk that Mr. Z's case was not managed in a robust manner at any level by any of the services that he had contact with. This was evidenced through the lack of a comprehensive assessment, care planning and review and the fact that this was not noted by any managers. The level of assertion needed to manage the case was underestimated due to a lack of case formulation within a dual diagnosis framework.

Multidisciplinary working

Interviews by the Independent Investigation Team with staff, from all services, demonstrated a committed but silo approach to the care of Mr. Z. This resulted in suboptimal intervention into both the treatment of his depression and alcohol dependency. Although a detailed case discussion could have taken place at any time with regard to Mr. Z's treatment plan the Independent Investigation Team could see no record of it in any clinical record. Even when Mr. Z's case was discussed within Okehampton CMHT, as a serious concern, this did not result in a full multidisciplinary plan.

[310] Onyett, Steve (1998). Case management in mental health. Cheltenham: Stanley Thornes.

Clinical leadership

There were several changes of Team Manager during the time Mr. Z was in contact with the Trust, leading to gaps in the supervision process and it appears that Consultant 6 had an unmanageable case load only being able to respond to staff requests for intervention as and when required (although it was reported at interview with the Independent Investigation Team that there was regular attendance at team meetings and that Consultant 6 was available on a formal and informal basis for advice). The clinical leadership was at best disjointed or ineffective despite an awareness of the risks that Mr. Z was capable of presenting with and the fact that there was intermittent concern about him.

Lack of Effective Operational Management

The Trust had in place clinical Polices and procedures throughout the time that Mr. Z was receiving services and these were not adhered to at any time nor was this detected by any of the governance system in operation at this time. There was no operational policy for the CMHT's that would have guided their core function and provided time frames for the implementation of Trust wide clinical policies.

Conclusion

Mr. Z received care and treatment over a seven-year period from three different CMHT's, two inpatient units, the Crisis Team and the Psychiatric Liaison Team. His clinical presentation did not change hugely over this time although his social circumstances did.

Issue 1

Mr. Z was complex with a diagnosis of recurrent depressive disorder and alcohol dependency and this presented significant challenges in terms of case formulation as the two issues were not considered together by any of the teams that Mr. Z had contact with.

Issue 2

Effective case management requires effective clinical leadership which can come from any professional with the knowledge and skill to question, challenge, step back and assimilate information or what is being presented with an open mind to actually look at the facts. This was not evident at an individual or team level.

Issue 3

Multi disciplinary working is about using the combined strengths and knowledge of all professionals to the benefit of the patient. Other professionals were co-opted in to the care of Mr. Z but their roles were not optimised. For example a CPN could have monitored Mr. Z's mental state and medication concordance on a regular basis, an OT could have completed an ADL assessment and developed a plan around independence and managing the relationship with his housemate. Increased activity does not equate to effectiveness and what appears to have occurred were anxiety based responses based on a perceived level of risk rather than integrated considered multidisciplinary working.

Issue 4

There was an issue about the culture of practice in relation to dual diagnosis and possibly personality disorder. Mental health teams are often under pressure due to the nature of the work as it is unpredictable in terms of quantity and priorities are constantly shifting. This can often produce *post hoc* rationalisations. This case provides a good example of how teams demure from Mental Health Act assessment or engagement due to alcohol abuse. The rationale being that: you can't assess someone when they are under the influence of alcohol. The alternative reason is that intoxicated people are difficult to assess, they are unpredictable and maybe dangerous, difficult to engage, and inconsistent in their presentation, also, the Mental Health Act cannot be applied for substance misuse alone which means that risk containment is difficult. The real Catch 22 situation is that as soon as it is possible to rationalise that alcohol is the main problem and the depression 'appears' minor, professionals can stand back in the belief that they have discharged any presumed responsibility. The same can be applied to the notion of personality disorder as Mr. Z's behaviors in relation to his risk taking were, on occasion, seen to be personality driven.

Issue 5

Practitioners did not adhere to the Trust Clinical Policies. Clinical Teams did not manage or monitor the implementation of Trust policy. The Trust did not have a robust system of clinical audit that would have been able to detect these wide spread failings over a significant period of time.

In conclusion all these issues in combination led to a series of serious omissions and missed opportunities for robust intervention over a seven-year period. The Trust safety framework of the CPA was not used to assist in case formulation, case management or multidisciplinary working. There was no evidence of any clinical leadership within the CMHT. The services providing care and treatment to Mr. Z had in their possession sufficient information to indicate that his needs were of a complex nature although this was not managed in a coordinated manner.

A full Dual Diagnosis approach would have included encouragement for all involved workers to persist in the two arms of treatment, one for the depression and one for the alcohol dependency. These two arms should have been integrated with the ENDAS team giving support to the CMHT to think in terms of substance misuse objectives where the patient is encouraged to achieve abstinence and agree to a relapse prevention plan. This was not considered in the overall case management of Mr. Z and there is no way of knowing if Mr. Z would have engaged in or responded to such an approach.

However, even when considering the management of Mr. Z's depressive disorder it became apparent that he did not receive the level of case management and care coordination that could have been provided through the safety net of the CPA policy. His care and treatment were not challenged at a clinical or managerial level in relation to either the symptomatology or recovery/well-being within the multi disciplinary team.

The Independent Investigation Team can therefore conclude that the lack of an overall coherent management plan, founded on CPA, and the lack of over all case management and clinical leadership of the care offered to Mr. Z were ineffective in enabling him to address his alcohol based life style and did little to ameliorate his depression.

Contributory Factor 7

The clinical leadership and management throughout Mr. Z's care pathway was weak resulting in the absence of an overall multi disciplinary management plan. Mr. Z continued an alcohol based life style and this did little to ameliorate his depression.

13.10 Clinical Governance Processes

Context

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish[311]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

National Service Framework self assessment

The self-assessment process is a validated process that includes both regional and national office. The DPT was scored as follows:

2005	
Primary/secondary interface	At or above SHA average
Assertive outreach	At or above SHA average
Dual diagnosis	At or above SHA average

2006	
Primary/secondary interface	Amber
Crisis resolution	Green
Dual diagnosis themed review	

2007	
Primary/secondary interface	Amber
Assertive outreach	Green
Dual diagnosis	Amber
Crisis resolution	Amber

The Care Quality Commission Annual Health Check gives all NHS organisations a two-part annual performance rating The Annual Health check performance rating for DPT in 2006/7

[311] http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

showed that the quality of the service was ‘excellent’ and that the use of resources was ‘fair’. In 2008/9 performance rating for DPT showed that the quality of the service was ‘fair’ and that the use of resources was ‘good’.

Action taken by the Trust

Devon Partnership NHS Trust readily acknowledged that there has been, and continues to be concerns around the Clinical Governance framework within the Trust. There have been three restructurings over the past four years.

In Early 2006 it was recognised that there was a need to improve clinical engagement, leadership and involvement with the design of services and the Trust worked with the Department of Health Clinical Governance Support Team to develop the Clinical Cabinet Model. The Clinical Cabinet was the overarching Clinical Governance Committee with a ‘plan, do and check’ approach. Professional groups set minimum standards and Professional Expert Groups designed some quality and implementation guides.

In 2009 this structure was reviewed and evaluated. The Clinical Cabinet was noted to be excellent in terms of an engagement mechanism but not effective in terms of the ‘closing the loop function’ and the provision of an ongoing assurance and was removed from the governance reporting arrangements in 2010.

In 2008 the Trust invested in patient safety and a small group of senior clinicians undertook advanced training. This has led to a redesign of the Clinical Governance structure and strategy with more emphasis on the engagement and involvement of all Trust employees.

From April 2010 the Trust set up a Trust Management Board which essentially is an extended executive team and that comprises the executive team and the clinical directors and their managing partners to ensure that Clinical Governance is incorporated in all areas of service delivery. Reporting into this are the four Clinical Directorates (adults of working age, older people, secure services and specialist services) and the Professions Directorate (medical, nursing, psychology, social work, occupational therapy, pharmacy). The Clinical Directors are supported by a network of associate clinical directors with responsibilities across the governance framework. It has to be noted that this new structure is embryonic.

The Trust has introduced a wide range of systems and processes to enhance and promote quality and safety across the organisation. These include systems are set out below.

- A major programme of work to improve all aspects of medicines management.
- A programme of regular peer reviews and executive 'walk around' audits of frontline services.
- Active participation in the local multi-agency safeguarding forum and the appointment of safeguarding officers within the organisation.
- Investment in leading-edge Patient Safety Officer training with the Institute of Health Improvement and Leadership for Patient Safety training and the appointment of a dedicated, Trust-wide lead with responsibility for patient safety.
- The introduction of a programme of Practice Quality Audits at ward level to be rolled out to all clinical teams.
- The introduction of the team and corporate level Quality Dashboard. This monitors, on a monthly basis, key performance indicators that have been prioritised by the Trust Board, across safety, timeliness, personalisation, recovery focus and sustainability.
- The development of Practice Quality Audits which monitor the implementation of the Clinical Practice Standards. This enables the Trust Board to have a more accurate picture of what is being achieved at an individual and team level.
- The Trust Board have also recently also introduced 'story telling' from experienced people using the services to enable a greater understanding of how services are operational in clinical practice.
- "*Services Good Enough for my Family*" standards have been introduced across all clinical areas.
- The Medical Director capacity has been strengthened though co working and taking lead responsibility for clinical governance (April 2010).
- The role of Director of Nursing has been strengthened in terms of broader professional practice.
- Patient Safety Officers have been introduced to provide practical hands on support for clinical teams.

Specific Issues raised by this Investigation in terms of Governance were:

- clinical records;
- adherence to Trust policy;

- local operational policies;
- engagement of clinical staff in clinical governance.

Clinical Records

The Trust has recognised and declared to its registering authority shortfalls in clinical recordkeeping in four areas:

1. the content of clinical records in relation to comprehensive care planning (including risk assessment);
2. the quality of the written records;
3. multiple records and inconsistent availability/use of electronic records;
4. the tracking and availability of archived records.

Action taken by the Trust

In early 2009 work began on designing and testing the use of a single clinical record to address the historic variations across the Trust. This will become redundant with the introduction of RiO (electronic clinical record system). The system, which has been implemented successfully in other Mental Health Trusts, is supported by intensive staff training and became operational in North Devon in May 2010. The system is currently being rolled-out across the rest of the organisation and this process will be completed by March 2011.

A programme of audit of the record keeping standards, overseen by the Information Governance Group, commenced in 2008/9 and was rolled out across the Trust in 2009/10.

From March 2009 all staff were required to undertake Information Governance Training by way of e-learning and 85% of staff had completed this by March 2010.

The Trust acknowledged the difficulty that the Independent Investigation Team experienced around tracking and archiving of records.[312] A process had been established for the collation of records required for Internal and Independent Investigations and other enquiries. The Trust took immediate action following concerns highlighted by the Independent Investigation Team and refined this process incorporating it into the Records Management Policy that was ratified by the Trust Board in July 2010**.**

[312] CT 1 pg 8

Adherence to Policy

At the time of the incident there was a clear breach in adherence to clinical policy, specifically CPA and Risk Assessment and Management. What became clear during the course of the Independent Investigation was that this was not an isolated incident but widespread practice across the Trust in inpatient settings as well as community settings.

Action taken by the Trust

Clinical practice standards have been developed across the Trust to address initial contact with the Trust, assessment and formulation, personal recovery planning, coordination and delivery of services and managing transition (all aspects of the CPA policy). Support has been provided to teams in the form of coaching to support implementation (14 teams engaged). This is supported by teams self monitoring their level of compliance (guidelines indicate 20 case files per month per team) through the implementation of the Practice Quality Audit Tool to provide independent verification of the self monitoring.

The clinical practice standards are detailed and specify that recovery plans are up to date and reviewed within a six month time scale. There is some evidence that this approach has began to impact on practice as it was reported at clinical and management interviews that case files were being scrutinised, for example:

"The managers of the teams will go through everybody's caseload on a monthly basis and more if necessary, but there will be a random check of people's cases as well and you will be asked to bring along a cretin amount of, say half a dozen cases to supervision. We do have peer audits of CPA and people's caseloads as well to check that systems and qualities there".[313]

The Practice Quality Audit (PQA) was re-launched in April 2009 against the background of the process of transformation for health and social care services towards becoming more person-centred and recovery orientated. The standards are those of the Recovery Co-ordination Policy Implementation Guide and the Trust's Care Programme Approach Policy CO5, December 2008. To date three audit cycles have been completed across some areas of the Trust covering approximately 50% of the clinical teams although the level of staff participation was very low at around 26%.

[313] AT 8 pg 14

Date	November 2009 (Phase 1)	April 2010 (Phase 2)	June 2010 (Phase 3)
Teams	Torquay R&IL, Waverley Torquay Assertive Outreach Team, Waverley Paignton and Brixham R&IL, Culverhay Torbay MW&A, Waverley	Exeter, East & Mid AOT Exeter, East & Mid Well Being and Access Exeter East and Mid Devon R&IL Exeter, East & Mid STEP North Devon AOT North Devon Well Being and Access North Devon R&IL North Devon STEP S Hams& W Devon AOS S Hams & W Devon R&IL S Hams &W Devon Well Being and Access S Hams/W Devon STEP Torbay AOS Torbay W&A Torquay R&IL	AOS/STEP CMHT Psychology and Psychological Therapies Psychotherapy Recovery and Independent Living Wellbeing and Access Addictions 10 inpatient wards, including some from each of Eating Disorders, OPMH, Adult Inpatients and Forensics
Total number of staff	**29**	**292**	**297**
Number of staff participating	**18**	**98**	**78**

Response rate

Response rate October 2009	Response rate April 2010	Response rate June 2010
18/29 (62%)	**138/292 (47.2%)**	**78/508 (15.4%)**

The response rate for the audit in June 2010 was very low, with only 15.4% of possible responses returned.

Assessment and formulation

Although the first phase of the PQA showed that 100% of the assessments were strengths based this dropped to 75% in phases 2 and 3. Just 26% of assessments in phase 3 included the person's desired outcomes**.**

Risk screening

Where people had had a risk screen and immediate risks identified action plans were put in place in 100% of cases

Personal recovery plan (care plan)

Only 32% of people in phase 3 had a personal recovery plan in place compared with 94% of people in phase 1 and 76% of people in phase 2. All of the recovery plans had been developed with the person. Where medication was part of the plan every person had had this reviewed but only 52% had a date set for the next review.

Review

75% of people who had been on a caseload for 6 months had had their personal recovery planned reviewed.

Record keeping and communication

The quality of the record keeping in phase 3 of the audit was generally high with above 90% of notes conforming to the standards.[314]

Clinical Record Self Monitoring (CRSM) survey results for June - July 2010 showed a return rate of between 22% and 100%. Data was available for 28 out of the 73 clinical teams.

There was an achievement rate of between 0 and 73% for recovery plans meeting the Clinical Standards.[315]

The quality dashboard was at the time of writing the report, unable to note performance against the following KPI's as data collection was still in progress:

(KPI-156) Experience of patients

(KPI-193) Clinical record keeping standards are met

(KPI-194) Each person has a recovery plan

(KPI-195) Recovery plans meet clinical standards

[314] 08_061_PQA_Phase_3_Trustwide_report
[315] CRSMS_Analysis_June-July_10

(KPI-196) Care follows agreed pathways
(KPI-197) Service compliant with registration standards
(KPI-198) Practice quality audits delivered on time
(KPI-201) Teams self improvement log up to date

However where data is available it does provide a very clear picture of achievement against targets, for example:

(KPI-209) Waiting times (referral to assessment) % less than 4 weeks[316]

Jan-09		Feb-10		Mar-10		Apr-10		May-10		Jun-10	
Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual	Min Std	Actual
72%	71%	72%	79%	72%	81%	72%	73%	72%	77%	72%	73%

The importance of participation and active engagement in clinical audit as a tool for the development of practice is clearly identified in *Services Good Enough for My Family* and in the strategic aims of Devon Partnership NHS Trust.

Operational Policies

At interview with the Independent Investigation Team those with a long corporate memory were able to recall operational policies being in place across the Trust in the early to mid 2000's just after the Trust was formed. None of the clinical staff interviewed were aware of a current operational policy for their clinical area. Instead there is a series of Policy Implementation Guides (PIG's) that have been developed through the Professional Expert Groups (PEG's). These in themselves are not operational policies and this was recognised at a corporate level by the Trust:

"We have not eschewed across the board the service specifications that underpin them (PIG'S). That's partly about us but it's also partly about continuing conversations with our commissioners

[316] Item_7_Performance_Report_Appendix_2

and exactly what the services commission to provide and for whom. We have policy implementation guides which are values, principles, aspirations and some of them are quite specific around standards but others are not, particularly the one for recovery and independent living."[317]

There is some awareness of the Policy Implementations Guides at a management level but not at a clinical level. This is an area of vulnerability for the Trust as it is unclear what staff are working to. It is unfortunate that the Clinical Practice Standards, under the heading *"Initial contact with Trust staff"* refers to '*practitioners will respond within the timeframe defined by the service operational policy*'[318]

Engagement across the Trust

The Trust Board had worked continuously to improve the level of engagement in the governance process and structure by clinical staff and at interview with the Independent Investigation Team it was noted:

"*think again that's improved for staff and they (the Trust Board) have made a great effort to come out and meet the teams early on in this process of change and got very engaged with that".*[319]

However there remains a very clear disconnect between the aspirations of the Board and what is occurring within the clinical teams as participation and adherence to the governance process remains weak and below what could be expected for a statutory organisation as evidenced by the lack of engagement and vey low return rates with the Quality Practice Audits.

[317] CT 1 pg 19
[318] Practice Standards Reference 210/05/10
[319] At4 pg 30

Conclusion

The Trust Board has worked hard and invested in their Clinical Governance arrangements through engagement with staff and governance reorganisation. Many of the everyday actions and decisions that take place in clinical practice fall 'sub audit' and governance systems often measure compliance and quantity rather than content and quality. What the Trust is aspiring to do is build in a quality monitoring system through the implementation of the Practice Standards and the Practice Quality Audits. What was clear to the Independent Investigation Team was that the Trust Board had a very clear vision and high aspirations about where they are going and what they wish to achieve for the people of Devon. However this is very much in the aspirational stage of development as there remains a disconnect between front line clinicians as they have yet to fully engage with the governance process. What needs to be understood across the Trust is that Clinical Governance is not an optional extra but the responsibility of all Trust employees. Clinical Governance is often seen as a complex process and needs to be kept simple and straightforward for busy clinical teams by incorporating it into systems and processes that are already in place. For example there is evidence that case notes are now being scrutinised in supervision, this time can also be used to complete the Practice Quality Audit thereby bringing it to life and promoting local ownership.

In the case of Mr. Z it was apparent that local policy and national guidance were not adhered to. It must be remembered that a single case cannot usually provide sweeping generalisations for an entire organisation however in this case poor practice was noted across several areas. Witnesses who gave evidence to the Independent Investigation Team described a service that could at times be pressured but that worked within reasonable resource allocations. Witnesses were not aware of the Trust's CPA policy and guidance although they all appeared to take their roles and responsibilities seriously. The Independent Investigation Team, whilst acknowledging that Mr. Z's case could have been managed differently, concluded that many acts of omission in terms of all aspect of the CPA process were due to poor clinical governance systems. The Independent Investigation Team based the conclusion on the fact that these omissions were over a seven-year period and across a range of services. However, as none of the omissions were noted to be causative. Nor could any of these short comings have rendered the homicide predictable. They did however contribute to Mr. Z receiving less than optimal care as the assurance mechanisms designed to ensure that the safety nets in clinical practice such as CPA

and risk assessment were not operationalised to the extent that they were able to detect and correct lack of adherence to Trust policy.

Contributory Factor 8

The Trust Clinical Governance systems were in a state of flux. There were no operational policies to provide guidance for teams, clinical policies were not understood implemented or monitored at a local level nor were the wider Trust governance structures robust enough to detect and correct these failings.

14. Findings and Conclusions

When conducting Investigations of this nature careful consideration is given to the notion of causality. Causality is the relationship between a series of events. In the case of HSG (94) 27 the care and treatment a service user received is examined to determine whether any acts of omission or commission provided the circumstances in which the serious untoward incident (the homicide), was likely to occur. Causality determines whether one series of events (the homicide) was a direct consequence of another series of events (the care and treatment received).

This report defines causality and contributory Factors in the following way:

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the events of 10 February 2007. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

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

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 10 February 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

Independent Investigations conducted under the auspices of HSG (94) 27 are frequently critical of services and how they were delivered to an individual. On these occasions it would be relatively easy to say that the services failed and that this caused the homicide. However in mental health and other areas of health and social care it is not always so straight forward as

there are many variables to consider not least of which is the changing presentation of an individual.

Aggression as a result of alcohol intoxification is a common phenomenon. Mr. Z had a long history of drinking to excess but had no history of being violent as a result. Both the forensic medical assessments and the Judge in the summing up noted this was a most unusual case of homicide and that Mr. Z's depression alone could not be connected with the index offence.

When examining the quality of the care and treatment a person receives the following four findings categories can be utilised:

1) Trusts can produce high standards of service delivery that are appropriate, effective and in keeping with best practice. Sometimes in this situation the Independent Investigation Team would be unable to identify any causal or contributory Factors to the homicide in question.

2) Trusts can produce high standards of service delivery that are appropriate, effective and in keeping with best practice. However a single act of omission or commission may have led to the circumstance in which a serious untoward incident is more likely to happen. In this case causality can sometimes be determined between the untreated mental state of the service user and the care and treatment provided.

3) Trusts can deliver less than perfect services where systems are chaotic and best practice standards have not been implemented. However there is *no* direct relationship between what the services actually did or did not do and the homicide. This may be because the mental state of the service user was stable at the time, the person may have been drunk or under the influence of non prescription drugs, which is not the responsibility of mental health services. Service users also have responsibilities within the health care system such as keeping appointments, taking medication as prescribed and making, where possible, healthy life style choices. The service user is recognised as central in the management of their mental health and where this does not occur there is a potential barrier to treatment.

4) Trusts can deliver less than perfect services where systems are chaotic and best practice standards have not been implemented. This can result in direct acts of negligence and poor practice resulting in an individual not receiving care and treatment or the wrong care and

treatment. In these circumstances there would be a high probability of identifying Factors that had a direct causal bearing on the incident.

Service users cannot be compelled to do things they do not wish to do unless detained under the Mental Health Act. Mr. Z was an independent person living in the community at the time of the homicide. He was not subject to any Section under the Mental Health Act and was free to make his own life style choices as he saw fit regardless of what others perceived as being in his best interests. In the case of Mr. Z category 3 applies as although the Trust could have done things differently the Independent Investigation Team found no direct causal Factors which connected the care and treatment Mr. Z received and the events of the 10 February 2007.

Causal Factors

The Independent Investigation Team concluded that there were no direct acts of omission or commission that could be positively identified to have had a direct causal bearing on the events of 10 February 2007.

Contributory Factors

The Independent Investigation Team found eight Factors that contributed to the less than effective care and treatment package that Mr. Z received.

Contributory Factor 1

Mr. Z was not treated in an integrated manner in terms of his co-morbidity as defined in the dual diagnosis good practice guide 2002.[320]

Contributory Factor 2

There was a lack of robust medical intervention and as a consequence Mr. Z was only ever partially treated.

[320] *Department of Health (2002)* Mental Health Policy Implementation Guide: Dual diagnosis good practice guide. *Department of Health, London.*

Contributory Factor Number 3

The CPA policy was poorly implemented and understood. Consequently Mr. Z did not receive a comprehensive and holistic assessment or care plan. As a result Mr. Z did not receive all of the care, support and treatment that he could have benefited from if he had had a comprehensive assessment of his health and social care needs on which to base a care plan.

Contributory Factor 4

Mr. Z's discharges from hospital and transfers of care fell below the expected standard as they were not planned in accordance with best practice or trust policy leading to serious delays in follow-up and missed opportunities to plan care. The poor practice appears to be wide spread across the inpatient and community teams that provided care and treatment to Mr. Z.

Contributory Factor 5

There was a lack of adherence across inpatient, community, and emergency teams to the Risk Assessment and Management Policy. Mr. Z was not comprehensively risk assessed by any of the services that he had contact with resulting in his care pathway being less than effective.

Contributory Factor 6

The mental health 'emergency' services missed opportunities to intervene appropriately with Mr. Z as they did not understand his presentation believing his depression was alcohol or personality driven rather than a severe untreated depression. Consequently there were missed opportunities to intervene at a more assertive level resulting in a lack of appropriate intervention and management of Mr. Z's co-morbidity.

Contributory Factor 7

The clinical leadership and management throughout Mr. Z's care pathway was weak resulting in the absence of an overall multi disciplinary management plan. Mr. Z continued an alcohol based life style and this did little to ameliorate his depression.

Contributory Factor 8

The Trust Clinical Governance systems were in a state of flux. There were no operational policies to provide guidance for teams, clinical policies were not understood implemented or monitored at a local level nor were the wider Trust governance structures robust enough to detect and correct these failings.

Service Issues

The Independent Investigation Team found six Service Issues

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping. This ensured that the personal data regarding Mr. Z was not appropriately shared in a timely manner with those providing his care and treatment over time.

Service Issue 2

The Trust failed to assure via clinical governance and audit processes the adherence by staff to basic record keeping standards.

Service Issue 3

The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

Service Issue 4

The approach to the treatment and care of people who have a dual diagnosis was under developed and not integrated leading to vulnerable people, with a mental illness being at risk and under treated.

Service Issue 5

Robust systems were not in place to monitor the standards and implementation of the CPA policy.

Service Issue 6

Mental Health Act assessment documentation was not available within the clinical record reflecting a poor standard of clinical record keeping.

Conclusions

Mr. Z had increasing contact with mental health services in both Exeter and latterly in Okehampton from 2000 until the death of Mr. N in 2007. He suffered significant early negative life events but largely overcame teenage delinquency and poly drug misuse. He married and had two children. He then developed a recurrent depressive disorder and intermittent alcohol misuse. He overdosed seriously four times over a seven-year period during which he was assessed by generic, liaison and crisis mental health teams from different areas of the DPT. His complex diagnosis of recurrent depressive disorder and alcohol dependency presented significant challenges for integrated assessment, successful treatment and containment of risk for himself and others. Mr. Z did not have a history of violent or aggressive behaviour.

Mr. Z's care and treatment as provided by the Devon Partnership NHS Trust did not adhere to local policy and procedure or fall within national guidance at an individual or team level. Mr. Z did not receive a comprehensive assessment, care or treatment plan. The approach that the Devon Partnership NHS Trust chose to pursue could not be seen as best practice especially in the light of the evidence based approach to treating those with a dual diagnosis.

The Independent Investigation Team would like to acknowledge that Mental Health Trusts face considerable challenges when faced with delivering care and treatment to service users who are ambivalent about their own well being and engaging with Trust services. Mr. Z was ambivalent about his alcohol dependency, as well as being a complex individual and was at times difficult to accurately assess as it was well documented that he was able to mask the severity of his depression. The Trust personnel did establish a rapport with Mr. Z and worked hard to support him however this was not within the framework of a clear management plan or understanding of dual diagnosis.

Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe. The Independent Investigation Team found that the governance systems and practice in operation throughout the time that Mr. Z was in their care were often largely

ineffective enabling practitioners to practice without the safety net of adhering policies and procedures.

The Independent Investigation Team could not make a causal link between the care and treatment that Mr. Z received and the events of February 2007. However the Team was able to identify eight contributory Factors which each played a part in management of Mr. Z's care and treatment. It is the view of the Independent Investigation Team that Mr. Z's mental health problems were not fully understood and therefore managed. As a result Mr. Z's condition was at best partially treated.

15. Devon Partnership NHS Trust's Response to the Incident and the Internal Investigation

The following section sets out the Trust response to the events of February 2007. 10 February 2007 was a Saturday. On Monday 12 February the CMHT were informed that Mr. Z had been taken into custody in relation to the death of his housemate and that the incident was being investigated as a potential murder. The Police requested the clinical records and spoke with the Clinical Psychologist and Consultant 6. Both clinicians raised their immediate concerns about the possibility of Mr. Z attempting suicide whilst in custody.

15.1 The Trust Serious Untoward Incident Process

The Trust does have an Incident Reporting Management and Review Policy that was due for review in May 2010 that makes reference to the guidance given in *Being Open* and incorporates the principles. The policy is designed as an electronic document with numerous hyper links to other documents for further explanation and detail.

15.2 The Trust Internal Investigation

In accordance with Trust procedures an incident report form was completed by the CMHT manager on 12 February 2007. The incident was graded as catastrophic in terms of consequence and moderate in terms of frequency

A three day report was completed on 2 March by the CMHT Manager which detailed a brief chronology reflecting the most recent contact and the action taken by the CMHT including a team debrief on 13 February 2007 and a support visit to Mr. Z on 14 March following liaison with the Health Care Team at Exeter Prison. No issues of concern were identified and no recommendations were made as no details were known about the incident.

In accordance with Trust procedure an Internal Review into the care and treatment of Mr. Z was commissioned. The purpose of this Review was:

"To consider aspects of the case as defined in the terms of reference and to report on the findings in order that changes to practice may be established"

The Internal Review Team consisted of:

- Service Development Manager, Trust HQ;
- Addictions Service Manager, North Devon;
- Consultant Psychiatrist, South Devon.

The Internal Review Team Terms of Reference

1. Consider reviewing prior clinical history and past events, including initial contact with mental health services if appropriate.
2. Consider any index offence e.g. violence, aggression, weapons, child protection, domestic violence, Police involvement.
3. Review the effectiveness of the action taken post incident, including the debriefing process for staff and relatives.
4. Consider requesting an incident report summary from the Risk Management Department.
5. Assess the adequacy, appropriateness of care plans, treatment plans and risk assessment documentation, including reviewing the dates of documentation.
6. Assess the actual care and treatment of the patient.
7. Review the multidisciplinary joint working in the provision of care.
8. Review the policies procedures and systems and include compliance with these.
9. Review their adequacy e.g. CPA engagement and supportive observation; risk assessment documentation.
10. Examine the adequacy of communication and sharing information between internal professionals, external agencies and family.
11. Consider environmental risk assessment if appropriate.
12. Identify areas of good practice.
13. Identify recommendations and learning points.
14. Provide feedback to the team involved as appropriate.

Findings of the Internal Review

The findings focused on the delivery of the Care Programme Approach and the role of the Care Coordinator and the Multidisciplinary Team:

- All areas of the CPA operational practice and documentation could have been more purposefully used to assist the patient and the Care Coordinator in augmenting and

strengthening the psychotherapy being provided. A number of entries were found to be unsigned.

- The personal care plan should be based on a comprehensive assessment and risk assessment which identifies goals of treatment, practical and occupational goals which are regularly reviewed noting achievements and progress.
- There was evidence that the overdose in August 2005 was risk assessed but that the recording of the outcomes and follow-up by the Team Manager was weak.
- There is no evaluation of risk based on self reporting of incidents of self harm (using acupuncture); of Mr. Z's previous history with Exeter services and of the regular expressions of discord including the two reported incidents of violence on 12 May 2006 and 8 February 2007.
- Throughout the case records from August 2005 to February 2007 there are references to Mr. Z being assessed as high risk of completed suicide but there do not appear to be any corresponding plans.
- The incident on 08 February is of particular concern since it did not appear to prompt an urgent risk assessment, joint visit or follow up visit either by team members or partner agencies.
- There is strong evidence of an over reliance on the information and recommendations contained in the Psychiatric Liaison report without further case history being retrospectively sought using that case transfer process to confirm and inform the work undertaken by the Okehampton team.
- Of particular concern is the reference in the letter from the Clinical Psychologist to CPN 5 dated October 2005 in which he stated that Mr. Z had no previous contact with mental health services.
- There is evidence that there was a lack of regular multidisciplinary holistic care planning and reviewing activity that may have led to separate and stand alone referrals being made to other colleagues within the CMHT, the crisis team, the GP, ENDAS and Rethink. It may have been preferable for the two professionals to have had an inclusive meeting with Mr. Z where a more accurate account could have been gleaned and the resulting paper work shared with Mr. Z to enable him to correct any errors.
- In the view of Mr. Z's significant physical, psychological and addiction problem it would have been preferable for regular case review to have involved his GP and any other professional involved in his care to clarify optimum use of resources and support.

- The lack of coordination may have contributed to the delay and the experience for the patient being passed for one person to another with little sense of working together on shared treatment goals.
- Practical arrangements may have been over looked and under provided for.
- Two files were found to have been used instead of one integrated community mental health file as per CPA policy.
- It should be noted that medical staff are co-located within the compact purpose built team base and that access to a single team file should be standard practice.
- Liaison psychiatry refers to lack of case transfer form the Exeter Team to Okehampton being due to miscommunication. There is no evidence that Okehampton acted appropriately and sought to rectify this by pursuing a retrospective case transfer.
- The papers found in the separate medical file were not comprehensive but they do show that arrangements for Mr. Z's care provision often reflected the fact that close family were members of staff within the adult mental health service.
- Mr. Z's care appears to go back to 1997 when he saw a Clinical Psychologist based in the Honiton Team. There are brief records held on this file relating to previous referrals to ENDAS and brief records of contact with a number of medical and community staff with Exeter and East Devon community services. There is also some reference to admission to Delderfield ward but a lack of detail about the purpose and outcome of the episode.
- The lack of case transfer process from Exeter, and the existence of a separate medical file was likely to have put the new care coordinator at a significant disadvantage in asserting the full picture of Mr. Z's mental health history.
- Where a full case transfer process appears not to have been implemented by the pervious service then the Care Coordinator in the new service will need to be assertive in ensuring that they receive a full history on which to base their own assessment and care planning activity as a pre-requite to proving an appropriate therapeutic service.
- The new Care Coordinator should be supported by their manager if problems arise in gaining access to records held by the team with previous Care Coordinator responsibility. Team Manager may need to take direct action by liaising and agreeing transfers if difficulties persist.
- Discussions about case transfer decisions commonly arise during management supervision sessions and are often referred to as work load management and documented using the agreed trust format and stored by the manager.

Members of the review panel found that that care provided to Mr. Z was offered in a way which tended to reflect an approach which was reactive to his difficulties rather than a proactively and regularly planned, providing and reviewing interventions and outcomes based on a comprehensive assessment of need.

Independent Investigation Team Analysis of the Internal Review

The internal review conducted by the Trust complied with the requirements of Trust policy and procedure although it is not known if it was completed with in the timescale as it is undated. The internal review team was comprised of a suitably qualified and experienced panel form other areas within the Trust.

It is the view of the Independent Investigation Team that the internal review did adequately explore all of the issues relating to the care and treatment of Mr. Z except for the issue of dual diagnosis and was thorough to the extent that the suggestion was made that further investigation should took place to check the missing case records to ascertain if there were further areas of concern.

15.3 Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[131]. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;

- receive a plan about what can be done medically to repair or redress the harm done[132].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

Two members of Mr. Z's family were employees of the Trust which is an unusual situation. They were supported on a regular basis by the Trust but were not involved in the Trust internal investigation.

No contact was made with the victim's family. The Internal Investigationdid not feel that it was part of their remit to liaise with the families concerned:

"We had no contact within this investigation and my reading and understanding of the terms of reference was that we were given very specific remit, which was to look at the quality of care". [321]

The Trust Chief Executive has acknowledged to the Independent Investigation Team that this is something that the Trust could have managed better and have worked in order to bring about change. For more recent serious incidents within the Trust liaison with the victims family is through a senior manager or board member.

15.5 Staff Support

A team debrief was held as part of the weekly clinical meeting within the CMHT. Staff reported at interview that they were not aware of any formal support being offered by the Trust nor was there any communication about the Internal Investigation which was described as:

"*pretty haphazard. They (Internal Investigation Team) turned up without notifying us first time round and they turned up at the team base and said we want to speak to you about this….we haven't had any preparation but then it was done by interview and we were interviewed individually. I'm not aware of any support at all.*[322]

[321] AT 3 pg 5
[322] AT 4 pg 31

There was conflicting evidence from the Internal Investigation team who reported that they:

"had a meeting with all the staff in the team prior to the investigation and we explained why we were conducting the investigation and the process and the aims of the investigation and explained that, a bit similar to the conversation we had at the start, that any critical points we raised were not personal, they were about improving care. We also had telephone contact with staff if they wished it during the course of the investigation".[323]

15.6 Trust Internal Review Recommendations

The internal review led to a number of recommendations:

1. DPT should ensure that staff adhere to the CPA policy. Particular attention should be paid to case transfer, risk management and the importance of thorough assessments, personal plans and reviews. Improvement in the quality of case records assists service users in developing confidence in their clinicians as well as proving support and clarity of job purpose to staff. An audit of case files was to be carried out and any remedial action required was to be implemented by June 2008.
2. All staff should receive supervision on a regular basis in a learning culture which positively but critically challenges their assumptions and practice.
3. Close family relationships. Where there are close family relationships between patients and staff particular attention should be paid by DPT to ensuring that care provided to the patient is not subject to the possibility of a conflict of interest. The Trust is to publish guidance advising staff of their responsibilities by July 2008.
4. Further investigation should take place onto the closed case files concerning Mr. Z being held by East Devon, Exeter, and ENDAS.
5. Investigation should take place into the care provided to the deceased person by DPT as a matter of urgency.

An addendum is attached to the initial investigation dated 11 August 2008 and concluded that the findings from a study of the Exeter team files supported the findings and recommendations in the initial review.

[323] AT 4 pg 12

15.7. Progress against the Trust Internal Review Action Plan

In 2007 there were four incidents involving a homicide and the Trust consolidated all the findings from each of the Internal Investigation into one action plan with 16 recommendations. The actions in relation to this case are detailed below:

1. The Trust will integrate service user clinical records to ensure there is a single clinical record for each person that receives care/treatment from our services.
   Action: the Trust will project manage the integration of service user records within inpatient services and community services.
   Position statement: 16 June 2010 RiO project in place to deliver an electronic integrated record system across the Trust. Implementation is underway and due for completion in November 2011
   Status: Amber

2. The Trust will create a robust system for tracking and retrieving clinical files.
   Action: the Trust will identify the best system for tracking and retrieving clinical files. The Trust will implement the system across the organisation.
   Position statement: 7 July 2010 systems were in place for tracking and retrieving clinical records across the Trust. These systems vary, the information Governance team will advise/assist in accessing records. The implementation of the RiO system will remove the need for tracking of files as they will be available on line; implementation commenced June 2010 and completes in March 2011
   Status: Amber

3. The Trust will ensure that staff adhere to the CPA policy: particular attention should be paid to case transfer, risk management issues and the importance of thorough assessments in personal plans and reviews
   Action:
   The role of the Care Coordinator to be clarified and communicated to all staff with care coordinator responsibilities.
   Adherence to CPA policy and principles in practice to be routinely monitored by practice quality audits across the Trust and any shortfalls addressed with individual practitioners.

An audit of all case files in Crediton/Okehampton CMHT was to be carried out to promote adherence to CPA policy and principles in practice; any shortfalls were to be addressed with individual practitioners.

Position statements:

On 23 September 2008 the Policy Implementation Guide for recovery coordination was approved; the associated implementation plan detailed how information, guidance, and training would be provided for services, users, carers and practitioners.

Status: Green

On 23 June 2010 the Practice Quality Audit was reviewed and aligned to fit with Recovery Coordination and revised CPA policies; this was implemented alongside the Recovery Coordination in agreed early adopter sites. This was to be rolled out through the main network functions and work undertaken to modify the tool for use in remaining services.

Status: Amber

30 September 2008 Local Audit completed

Status: Green

4. All staff should receive supervision on a regular basis in a learning culture that positively but critically challenged their assumptions and practice.

Action: Supervision policy and processes currently under review; this review will consider this recommendation and ensure that the supervision process is engaged in and recorded.

Position statements: 17 June 2010 the revised supervision policy was ratified and the supervision training plan agreed following a successful pilot scheme. Recording of supervision was through the online programme for all staff and reports were routinely produced (at the time of writing this report daily reports were produced for senior managers and a monthly reports were produced to inform the team dashboards). An implementation project led by the Safety Officers had supported Managers to input records of supervision had been carried out since September 2009 by working to identify and overcome barriers to carrying out supervision. Latest figures (October 2010) showed an increase in supervision levels to over 85% of staff receiving supervision in line with the supervision standards. **Status:** Amber

5. Where close family relationships are evident between patients and staff members particular care should be paid to ensuring that the care provided to the patient is not compromised and is appropriately and safely managed.

   Action: The Trust will develop guidance on managing patients who are staff members close relatives.

   Position statement: 23 June 2010 Guidance on managing those who are in contact with our services who are staff members, or who are closely related to staff members in under development

   Status: Amber

Staff Feedback

The Clinical Psychologist reported that his line manager had been given a copy of the Internal Investigation report and that this had been discussed with him. However all other team members reported that they had not seen the Internal Investigation report until it had been sent to them following the staff briefing session held by the Independent Investigation Team.

Findings

There is a balance when conducting investigations between scapegoating and objectively weighing up findings of fact and for that an Investigation Team needs to be robust, inquisitive and on occasion critical in their questioning and findings. The findings from the Internal Investigation are in keeping with the findings of the Independent Investigation Team although they failed to include dual diagnosis.

The Independent Investigation Team found that it appeared as though Mr. Z's relatives were supported by the Internal Investigation lead and the Trust. However consideration should have been given to contacting and supporting the victim's family who remained distressed by this incident.

Of concern to the Independent Investigation Team was the apparent lack of dissemination and leaning from the internal investigations. Most people interviewed were asked how they had found out about the incident and how the Internal Investigation findings were conveyed to them. What the Independent Investigation found was that on this occasion clinicians either did not receive any feedback or do not recall receiving any feedback. It was also found there was no

shared learning across the organisation in that if an incident had happened in one setting, for example the Crisis Team, any findings from an Internal Investigation would not be shared with, for example a CMHT the wider Trust. The process of the internal report going to the Serious Untoward Incident Group for acceptance prior to being submitted to the Trust Board is clear but it is not clear how this information is then disseminated, who has responsibility for this process and how lessons are learnt.

Conclusion

The Internal Investigationrecognised and addressed all the omissions in Mr. Z's care pathway but did not address dual diagnosis. This is concerning as this is a known contributor to incidents of this nature.

The action plan developed by the Trust addressed all the recommendations made by the Internal Investigation. Some of the actions are major projects in themselves such as the implementation of the RiO system and take years to implement, others such as a protocol for staff members relatives are relatively straightforward and should have been completed prior to the Independent Investigation. There were some notable slippages within the action plan, for example, the robust system for tracking and retrieving clinical records was due for completion in December 2008 but from the Independent Investigation's perspective this was clearly an ongoing issue.

Of note the action plan does contain a recommendation about the management of an individual with dual diagnosis but this was in relation to another case.

What had not been addressed in a robust manner was the dissemination of learning from incidents such as this to the team concerned or across the Trust and this needs to be developed.

16. Notable Practice

The Independent Investigation Team were not able to discern any areas of notable practice. However it is noted that the Mental Health Trust is continuing to develop and refine their systems to ensure the development of clinical practice and more robust systems of governance.

17. Lessons Learned

The examination into the care and treatment of Mr. Z raised three key points which could be considered useful for learning on a national basis. The points identified focus on basic and fundamental building blocks of care.

Whilst the Independent Investigation Team notes that the findings within this report conform to those of most other Independent Investigations conducted in recent years such as issues raised regarding the Care Programme Approach, assessment, the quality of documentation and so on these are the basic building blocks regarding an individual's care and the safety net in which practitioners practice. Systems and processes are in place for a reason and that is primarily to ensure that the best possible care is provided. Basics such as a comprehensive assessment and the CPA process cannot be omitted in any case and the onus is on the management and the governance structures within an organisation to ensure that this occurs. Complacency in this area is not acceptable.

Individual health and social care professionals form part of a multidisciplinary team. All service users should expect to receive the expert inputs of individuals with the diversity of skill and experience to meet their care and treatment needs. New ways of working and new service models of delivery should ensure that all cases receive the appropriate inputs from the required professional discipline on referral. All cases should receive regular monitoring and review with input from a multidisciplinary team

Co morbid substance use disorders increase the risk of homicide by people with mental illness.[324] As has already been stated, the literature suggests that clients in the UK with a Dual Diagnosis are associated with unmet need, poor treatment compliance, high rates of disengagement and an increased risk of offending behaviours.[325] [326] [327] Dual Diagnosis clients are also often perceived as the most complex clients to treat by service providers.[328] NIHCE are currently developing (due February 2011) guidelines for alcohol dependence and the harmful

[324] Comorbid Personality Disorders and Substance Use Disorders of Mentally Ill Homicide Offenders: A Structured Clinical Study on Dual and Triple DiagnosesSchizophrenia Bulletin 2004 30(1):59-72;
[325] T. Weaver et al. (2003) Co-morbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, **183**, 304-313.
[326] G. Strathdee et al. (2002) *Dual Diagnosis in a Primary Care Group*. London, Department of Health.
[327] N.M.J. Wright et al. (2003) Moving beyond single and dual diagnosis in general practice. *British Medical Journal*, **326**, 512-514.
[328] V. Crawford, (2001) Co-existing problems of mental health and substance misuse ('Dual Diagnosis'): A Review of Relevant Literature. *London, Royal College of Psychiatrists Research Unit.*

use of alcohol, the draft guidelines have been available from June 2010. They advise that all healthcare professionals, not just mental health professionals, in non-specialist settings should be able to correctly identify alcohol dependence and harmful drinking patterns and provide an initial assessment using formal assessment tools.

18. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Trust to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress and development had been taken into consideration and that the recommendations set below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

Each recommendation is set out below in combination with the relevant contributory Factor and the progress that the Trust has already made in the area. The relevant service issues and contributory Factors have been grouped into four themes in order to provide a cohesive approach.

Theme 1: Clinical Management

- ***Contributory Factor 1***

Mr. Z was not treated in an integrated manner in terms of his co-morbidity as defined in the dual diagnosis good practice guide 2002.[329]

- ***Contributory Factor 2***

There was a lack of robust medical intervention and as a consequence Mr. Z was only ever partially treated.

- ***Contributory Factor 6***

The mental health 'emergency' services missed opportunities to intervene appropriately with Mr. Z as they did not understand his presentation believing his depression was alcohol or personality driven rather than a severe untreated depression. Consequently there were missed

[329] *Department of Health (2002)* Mental Health Policy Implementation Guide: Dual diagnosis good practice guide. *Department of Health, London.*

opportunities to intervene at a more assertive level resulting in a lack of appropriate intervention and management of Mr. Z's co-morbidity.

- ***Contributory Factor 7***

The clinical leadership and management throughout Mr. Z's care pathway was weak resulting in the absence of an overall multi disciplinary management plan. This contributed to Mr. Z continuing an alcohol based life style and did little to ameliorate his depression.

- ***Service Issue Number 4***

The approach to the treatment and care of people who have a dual diagnosis was under developed and not integrated leading to vulnerable people, with a mental illness being at risk and under treated.

Since 2007 the Trust had done some work in relation to the development of a dual diagnosis approach to care and treatment through the development of a dual diagnosis care pathway. However this was not found to be an informative document. The aspirations of the Trust are in keeping with the Dual Diagnosis Good Practice Guide (2002) in that care for individuals with Dual Diagnosis should be 'mainstreamed' within mental health services and the following recommendations have been compiled to address this area of development and to target those who are at the sharp edge when it comes to assessing peoples' needs.

A four- tier e-learning dual diagnosis training package is in place across the Trust. Tier 1, drug awareness had been completed by 29 employees including two drug and alcohol workers and five senior mental health practitioners. Seventeen staff have completed Tier 2 training including 5 members of staff from the prison service.

The Trust had strengthened the clinical leadership across the Trust through changes in the responsibilities through the roles of the Medical Director and the Director of Nursing. Each Clinical Directorate is now headed by a clinician, Clinical Director, with management support from a managing partner. These changes can be further supported through the development of care pathways based on National Guidance.

Recommendation 1

The Trust and the PCT need to develop and implement a dual diagnosis strategy based on their needs assessment, National Policy and best practice. This needs to include:

- *the appointment of a Clinical Lead who should be either a Team Leader or Consultant who is prepared to persevere and drive treatment on both the substance misuse and mental illness;*
- *the development of a Dual Diagnosis Steering Committee to include the key stakeholders from statutory, including the PCT, and voluntary sector to take this work forward;*
- *the development of a dual diagnosis network to provide protected time for case discussion and group supervision;*
- *develop the care pathway to include those presenting to accident and emergency;*
- *prioritise the need for effective training so that all staff members utilise evidence-based interventions when delivering treatment (assertive outreach, crisis team, liaison team and PICU staff);*
- *the committee should report directly to the Director of Operations and the PCT on progress and the work should be considered as "core" to adult services development;*
- *visits to nationally respected Dual Diagnosis services may be helpful (e.g. Haringey and Birmingham) in determining the model most appropriate for Devon.*

Recommendation 2

A care pathway, based on the 2009 NICE guidelines for treatment of depression, is developed across the well being and access, and recovery teams to incorporate the interface with primary care psychology/IAPT service.

- *Work in partnership with the PCT, GP's with special interest and the voluntary sector to develop the stepped care model for the treatment and management of depression.*
- *Introduce an evidenced based assessment such as Beck's Depression Inventory or the Hamilton Rating Scale for Depression for all adults presenting to mental health services with a low mood or depression.*

Recommendation 3

The 'emergency services' and those conducting on call services need to have priority for dual diagnosis training regarding assessment.

- *Research indicates that assertive outreach, crisis teams and PICU staff, will have the highest density of patients who have a dual diagnosis. They should therefore be expected and supported to undertake training at a minimum of level 3.*
- *Liaison psychiatry staff and home treatment/crisis staff are more likely to have contact with people in crisis. They need to be able to distinguish between those who have an underlying chronic problem as opposed to those who are using substances as a means of coping. They should therefore be expected and supported to undertake training at a minimum of level 2.*
- *In order to ensure that training is put into practice a supervision network needs to be developed.*

Recommendation 4

The Professions Directorate develop and put in place an action plan to strengthen, support and empower the role of the Clinical Team Leaders across the Trust to support the professional leadership structure at Board level through:

- *the creation of action learning sets;*
- *the use of executive coaching;*
- *clinical master classes;*
- *360 appraisals;*
- *considering the merits of developing an in-house leadership programme.*

Theme 2: Clinical Records

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping. This ensured that the personal data regarding Mr. Z was not appropriately shared in a timely manner with those providing his care and treatment over time.

Service Issue 2

The Trust failed to assure via clinical governance and audit processes the adherence by staff to basic record keeping standards.

Service Issue 3

The standard for the archiving and retrieval of clinical records fell below the standards required under the Data Protection Act.

The issue of documentation and records has been an ongoing one for the Trust. This has been notified to their regulatory authority. It has to be seen in the context of Devon being a widely dispersed rural area with 73 clinical terms. The Trust had explored the possibility of having a single integrated record for each service user but this has not been practical. It was reported by clinicians that access to clinical records has improved through the systems developed by the Information Governance Department although there remain concerns about storage and archiving.

The Trust have continued to refine their records management policy and process and improvements have been reported by clinical staff.

In June 2010 the Trust ratified the revised supervision policy and the supervision training plan was agreed following a successful pilot scheme. Recording of supervision was through an online programme for all staff. Reports were routinely produced (at the time of writing this report daily reports were produced for senior managers and monthly reports were produced to inform the team dashboards). An implementation project led by the Safety Officers had supported Managers to input records of supervision had been carried out since September 2009 by working to identify and overcome barriers to carrying out supervision. Latest figures showed an

increase in supervision levels to over 65% of staff receiving supervision in line with the supervision standards.

Recommendation 5

The Trust must commission/complete a review of clinical records and their storage against the standards cited in the Data Protection Act.

- *All clinical areas must ensure that records have been returned to the central archive when patients are discharged or move through services.*
- *An audit needs to be conducted in relation to the most recent 10 near misses or serious incidents to ensure that the clinical records have been correctly archived following an internal investigation.*
- *Trust personnel must be reminded of their duties and obligations to maintain clinical records to professional standards during clinical supervision.*
- *Random spot audits of clinical case files should be conducted across all clinical teams to ensure correct ordering and storage of clinical records.*

Recommendation 6

Following the introduction the electronic record system RiO, the Trust must, ensure using regular audit and supervision, that:

- *all relevant clinical information is stored in a manner that is readily accessible to all clinicians working with a client;*
- *that information is appropriately cross referenced;*
- *that the quality of clinical notes is of an acceptable standard and complies with best practice guidance and professional standards.*

Theme 3: Non adherence to Trust Policy and Procedure

Service Issue 4

A local, verbal protocol regarding the treatment of relatives of members of staff was in place but had not been approved of or ratified by the Trust Board. This placed clinical practice in a vulnerable position and also potentially placed patients at risk.

Contributory Factor Number 3

The CPA policy was poorly implemented and understood, consequently Mr. Z did not receive a comprehensive and holistic CPA. As a result Mr. Z did not receive all of the care, support and treatment that he could have benefited from if he had had a comprehensive assessment of his health and social care needs on which to base a care plan.

Contributory Factor Number 4

Mr. Z's discharges from hospital and transfers of care fell below the expected standard as they were not planned in accordance with best practice or Trust policy, leading to serious delays in follow-up and missed opportunities to plan care. The poor practice appears to be widespread across inpatient and community teams.

Contributory Factor Number 5

There was a lack of adherence across inpatient, community and emergency teams to the Risk Assessment and Management Policy. Mr. Z was not comprehensively risk assessed by any of the services that he had contact with.

The Trust has policies in place that are clear about the roles and responsibilities of clinicians and managers in relation to CPA and risk assessment. Up to date policies are available in an electronic format. As the non adherence to policy was widespread the issue was considered under clinical governance.

Recommendation 7

The Trust CPA policy is clear about the roles and responsibilities of professionals and managers. These responsibilities should be restated at all staff development reviews and appraisals. These responsibilities should be presented to all new members of staff as part of the formal induction process. The CPA process should be a standing item within management supervision with case files being checked for:

- *up to date holistic assessment of health and social care needs;*
- *a CPA care plan that is reflective of the identified needs;*
- *a review date has been set;*
- *supervisors and managers need to complete the Practice Audit during supervision and be able to demonstrate adherence to the CPA policy;*
- *the Trust needs to ensure that the current policy is compliant with the Refocusing the CPA guidance 2008.*

Recommendation 8

The risk policy needs to be reviewed to more closely align the risk screening tool (level 1) with the in depth risk assessment (level 2). The policy needs to specify that where a risk is identified at the screening stage then an in-depth assessment focusing on that particular risk needs to be conducted and a management plan developed.

- *Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services (Department of Health, 2007) should be used as guidance to underpin the revised risk assessment and management policy.*
- *The policy should be structured to reflect the functions of the various teams e.g. Crisis Team, CMHT etc.*
- *The Trust needs to ensure that risk management plans are drawn up following risk assessments where either significant risk is identified or where current trigger Factors, which might increase risk, are present.*
- *Random spot audits need to be carried out to support the annual audit plan.*

- *Risk assessment is a component of the CPA process and is to be included in management and clinical supervision.*
- *A service audit needs to be completed six months after the implementation of the revised policy to ensure that it has been acted upon.*

Recommendation 9

The Trust must issue a short protocol, within six months of the publication of this report, clarifying how relatives of staff will be treated within the Trust. This recommendation was made following the Internal Investigation but had at the time of writing the report not been actioned: it is therefore repeated.

Theme 4: Clinical Governance and Clinical Audit

Service Issue 6

Robust systems were not in place to monitor the standards and implementation of the CPA policy.

Contributory Factor 8

The Trusts Clinical Governance systems were in a state of flux. There were no operational policies to provide guidance for teams, clinical policies were not understood implemented or monitored at a local level nor were the wider Trust governance structures robust enough to detect and correct these failings over a period of seven years.

The developments undertaken by the Trust have been noted in Section 13.10 Clinical Governance. In summary Devon Partnership NHS Trust readily acknowledged that there had been, and continued to be concerns around the Clinical Governance Framework within the Trust. There have been three restructurings over the past four years. What the Trust is aspiring to do is build in a quality monitoring system through the implementation of the Practice Standards and the Practice Quality Audits. What was clear to the Independent Investigation Team was that the Trust Board has a very clear vision and high aspirations about where they are going and what they wish to achieve for the people of Devon. However this is very much in

the aspirational stage of development as there remains a disconnect between front line clinicians as they have yet to engage with the governance process.

The following recommendations have been developed with the Trust in order to facilitate a higher degree of engagement in the Clinical Governance process.

Recommendation 10

Clear concise Operational Policies are developed to enable staff to understand their core function and responsibilities. These should include reference to core policies such as CPA and the key Clinical Practice Standards.

- *Operational service managers need to develop a core operational policy for the area they manage highlighting the area of practice such as age range, geographical area covered, services available.*
- *Clinical team leaders need to plot out the systems and processes that operate within their team such as referral criteria, assessment method, liaison with primary care/specialist services, allocation, supervision, discharge criteria, team meetings.*
- *Operational policies must be consonant with best practice guidelines such as the national Policy Implementation Guides, CPA policy or NIHCE guidelines*
- *A mechanism for the disseminating policies and policy revisions needs to devised and implemented by the Clinical Governance Committee.*
- *Adherence to operational policies needs to be regularly monitored as part of an on-going audit programme.*

This will in effect create a service map and the beginnings of a service care pathway.

Recommendation 11

The implementation of the Clinical Practice Standards and the Practice Quality Audit needs to be strengthened across the Trust. Clinical audit participation needs to be developed through:

- *being a standing item on all clinical team meeting agendas;*
- *being included in individual annual appraisal and personal development plans;*
- *being monitored through supervision;*

- *forming part of all employees core job description.*

Recommendation 12

A robust annual audit plan, reflecting the Clinical Practice Standards and the standards specified in 'Services Good Enough for My Family', needs to be developed and widely disseminated. This will need to detail the roles and responsibilities of team leaders and managers not just in terms of data collection but also their involvement in action planning to rectify short falls.

- *The support services that are available across the Trust, such as coaching and Patient Safety Officers need to be targeted at those teams that struggle to complete the audit cycle.*
- *Clear time scales need to be incorporated into the annual audit plan to enable individual practitioners and teams to manage their time.*

Recommendation 13

The Trust need to review the SUI Policy to include:

- *the introduction of reflective feedback sessions following serious incidents and near misses;*
- *the involvement of clinical teams in the development of recommendations;*
- *how learning and recommendations are to be shared across the Trust;*
- *greater clarity about the involvement of victim and perpetrator family in Internal Investigations and how they will be supported thorough out the process.*

19. Glossary

Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner
Case management	The process within the Trust where a patient is allocated to a Care Coordinator that is based within a Community Mental Health Team
Cipramil	Type of antidepressant known as a selective serotonin re-uptake inhibitor (SSRI)
CMHT	Community Mental Health Team are a team professionals and support staff who provide specialist mental health services to people within their community
CPN	Community Psychiatric Nurse
DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up.
DLA	Disability Living Allowance is a benefit paid to people aged under 65 who need to help to look after themselves and/or to get around because of a long-term health problem or disability
Dothiepin	A Tricyclic antidepressant and one of the oldest classes of antidepressants. Used to treat depressive

	illness, particularly where sedation is required
DPT	Devon Partnership NHS Trust
Escitalopram	An oral drug that is used for treating depression and generalized anxiety disorder. Chemically, escitalopram is similar to citalopram
ENDAS	Exeter East and Mid Devon Substance Misuse Team
Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support
GP	A General Practitioner is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
Mirtazepine	Mirtazapine is a tetracyclic antidepressant
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment
RD&E Hospital	Royal Devon and Exeter Hospital

Section 2 Mental Health Act (1983)	Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.
Section 12 Approved Doctors	A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.
SHO (Senior House Officer)	A grade of junior doctor between House officer and Specialist registrar in the United Kingdom
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant
SSRI	Selective Serotonin Reuptake Inhibitor: are a group of antidepressant drugs that are used to treat depression and have largely replaced older Tricyclic antidepressants
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Standard CPA	Denotes a lower level than enhanced CPA that requires lower levels of input from the Care Coordinator

Independent Investigation Time Line

Mr. Z DoB 8 August 1954

Devon Partnership NHS Trust

Date	Content	
05/11/1992	Mr. Z was referred by his GP to a psychiatrist at his own request. At this time he was unemployed and drinking ¾ bottle vodka a day to help him sleep. He was started on Prozac 20 mg.	
12/12/96	Mr. Z was referred by his GP to a Clinical Psychologist. The referral noted that his wife was a mental health professional. He had been prescribed Dothiapin 150 mg daily and was noted not to be suicidal.	
14/02/1997-28/10/97	Mr. Z was seeing a Clinical Psychologist within the CMHT. Mr. Z disclosed a long standing experience of depressive episodes and a history of periodic alcohol abuse stemming from his early teens. His mother died when he was aged 7, his father remarried and Mr. Z had a poor relationship with his step mother leading to a history of petty criminal activity, drug abuse and self harm behaviours. He presented with a profound sense of little self worth and strong feeling of inadequacy developing a significant dependency on alcohol in his teens. At the end of the sessions Mr. Z had responded well to psychological intervention, remained abstinent from alcohol, resolved work related stress issues and improved the relationship with his wife.	
15/11/00	Referral to CMHT from SHO liaison for urgent contact: overdose of Dothiapin when he knew his wife would be out of the house. Noted long standing history of depression and anxiety, occasional binge drinking. The impression was that this was serious overdose and a significant risk of further self harm due to work related stress.	
17/11/00 13/12/00	Letter to GP: assessed by CPN 1 work stressors identified. CPN 1 saw Mr. Z on a monthly basis to monitor his mental state and medication whilst providing practical advice and support.	
19/03/01	CPN 1 referred Mr. Z to Consultant 1 and he was seen on 19 March 20001 A full assessment was completed from which extra information including the nature of relationship with his father. Father took him shop lifting and when they were caught father asked him to take blame. Mr. Z offended again and after Probation was sent to Borstal for fraudulent use of cheques. Also noted to have spelling difficulties. He initially worked as a brick layer then a wood machinist. He and wife moved to Norfolk later returning to Exeter as his wife undertook a course. During this time he was a house husband which he disliked intensely and when, more recently when threatened with redundancy and a return to that role he had become depressed. Consultant 1 noted that he had been referred by Probation to child psychologist. Consultant 1 decided to increase the Dothiapin by increments of 25 mg to 200mg.	

	He was reviewed a month later and disclosed that he was experiencing impulsive suicidal thoughts (Volume 2 pg 155), he had reduced the medication to 100 mg and did not wish to increase this as he was working. By June CPN 1 had persuaded Mr. Z to increase the medication to 150 mg and is was noted that he was coping well (Volume 2 pg 154) In early September Mr. Z was again under increasing stress form work and becoming increasingly depressed. The Dothiapin was decreased to 150 mg and Seroxat 20 mg added.	
28/09/01	Mr. Z's employers requested a medical report. Consultant 1 review 31 October 2001 Mr. Z reported that he felt relieved to have left his job, he appeared to be responding well to the treatment regime.	
06/1101	CPN 1 visit anxiety and stress symptoms	
04/12/01	CPN 1 referred Mr. and Mrs. Z to the couples clinic for counselling and continued to see monthly	
15/02/02	Consultant 1: continues to be seen by CPN weekly; agreed gradual reduction of Dothiapin by 25 mg every 3/12 and a maintenance dose of Seroxat.	
19/03/02	Occupational health letter replied to on 24/04/04 fit for return to work. CPN 1 reviewed the progress made by Mr. Z noting that his mood was stable and that he was not suicidal. Relapse indicators were noted and the case was closed.	
12/06/02	Consultant 1: at work doing well. Advised to reduce Dothiapin to 25 mg in 2/52 time and then stop after a month.	
02/08/02 05/08/02	Admitted EMU OD 56 tabs Dothiapin and 1/3 rd bottle vodka. Mr. Z continued to remain in ITU requiring "numerous" resuscitations and continued intubation. His family refused to have him home if he were to self discharge due to his wanting to die at home.	
06/08/02	Referral to mental health services: currently on ITU going to a medical ward when stable and arrangements were being made to transfer Mr. Z to a mental health ward. Mr. Z had been placed on S.5/2 as he had refused to remain in hospital but he agreed to informal mental health admission. The overdose had been the response to his wife informing him that she was leaving him. Further information had been obtained: Mr. Z was born from an unexpected pregnancy after which his mother had Post Natal Depression and he was brought up by his maternal Grand parents' for three years. Mr. Z also admitted to cutting as a teenager.	
10/08/02	Transferred to Wonford Hospital. Risk assessment: low mood, hopeless re the future unwilling to talk about feelings; off work, marital problems; excessive alcohol intake. Assessment: relaxed, no anxiety O/D triggered by breakdown of marriage, found by wife unconscious, wished overdose had worked, flat affect, felt as though depression would never improve, binge drinks, poor sleep, memory and concentration.	

11/08/02	In patient notes: settled on the ward, collapsed pm and admitted EMU back later in the evening.	
12/08/02	Review: remain on Section 5/2 further MHA assessment booked for the following day, not happy about being in hospital but realised that he has to be.	
13/08/02	Settled, visited by wife, 1 hour unescorted leave in the grounds; Mr. Z was reassessed under the Mental Health Act and found not to be detainable. His wife had been willing to have him back for a short period until he could find accommodation. Mental Health Act assessment; unreasonably optimistic about his future, denied suicidal ideation dose no want anti depressants. Consultant 1 thought that personality difficulties were more apparent than severe depression.	
14/08/02	In patient notes: visited by wife and daughter to discuss treatment and past problems; son visiting soon as is brother from Cardiff. Care plan: wife has asked him to leave after 25 years of marriage. Reacted by taking an overdose. Long history of depression. Initiate therapeutic relationship; engage in OT activities twice weekly 1:1.	
16/08/02	Review Consultant 1: can have 2 hours leave unescorted. Can have access to motor bike staff to hold keys. Wife to attend ward round. Consultant review: seen with wife feels that Mr. Z pushing boundaries and she is worried about upsetting him further and was feeling bruised having found him following the over dose.	
16/08/02	Daughter visiting daily; settled on the ward.	
19/08/02	Issue of Mr. Z having twine in his room to practice tying knots; seen as a potential risk to him and other patients; given to staff to keep in the office.	
23/08/02	Care plan: mental state and adjustment to change in circumstances has improved and a plan was in place to increase his leave to work towards discharge from hospital. Mrs. Z attended the ward round.	
27/08/02	Wonford Hospital disclaimer: Mr. Z took his own discharge against medical advise, he denied any suicidal thinking and had clear plans for his future. He was not on any medication at the time of discharge. His wife was on the ward at the time and took him home. CPN 1 to follow up. CPN letter. noted Mr. Z was not sleeping well and objectively he appeared low.	
	No coherent plan of care was put in place when Mr. Z took his own discharge against medical advise	
28/08/02	CPN 1 called Mr. Z and made an appointment for 02/09/02. She saw him on 02/09/02 where he was not coping and was experiencing some suicidal thoughts but not acting on them although he was unsure why this was. The records indicate that a further appointment was made for 02/10/02 but there are no further entries in the clinical records.	

18/1102	Devon Doctors on call records: overdose 8 boxes of paracetamol around 3 pm, ambulance called. Wife wishes to speak to an ASW. Noted that Mr. Z had a borderline personality disorder and that he wanted to die in his own home	
21/11/02	Admission assessment: Mr. Z took overdose on 18/11/02; at this time he was unemployed and going through a separation with his wife.	
20/11/02	Mr. Z took an overdose of paracetamol and aspirin and was admitted to the general hospital as medically unfit for a mental health admission.	
22-14/11/02	Nursing records indicate that Mr. Z was settled on the ward looking after himself, tearful at times when discussing his lost relationship. SHO review cited the reason for the overdose as failure to cope with his wife leaving, not working and an increase in his alcohol intake.	
25/11/02	72 hour evaluation: Mr. Z was superficially settled, interactive and motivated. He would become upset and tearful when encouraged to focus on circumstances leading to his admission. Suicidal thoughts had abated and he was making plans for his future.	
26/11/02	MDT review: settled on the ward, tended to displace his feelings and decision making with activities. Stated that he did not want to continue to live. Planned on attending mediation with his wife about practical issues, use of car, house etc.	
02/12/02	MDT review: Settled on the ward although reported as being negative about his future. Was accepting of day leave. The plan was to review his treatment and accommodation problems.	
03/12/02	Letter from Mr. Z's wife to Consultant 2 (Consultant 1 was on a six month sabbatical) regarding her view on Mr. Z's dependency and the need for the team to pickup where she has left off managing him e.g. his money and housing needs.	
10/12/02	MDT review: pro-active in dealing with his housing problems. Mediation appointment went well. Day leave only.	
16/12/02	MDT review: trying to solve his accommodation problems. CMHT, Meadow House, had been asked to allocate the case. Mood reported as being superficially bright. A discharge date to be set and given to HAG (housing advise) and housing. Handover to Exeter Dr P was to write to Dr AB.	
24/12/02	MDT review: going out most days having a few pints, staying at friends as no accommodation.	
27/12/02	Request for medical handover as Mr. Z moved areas to Meadow House CMHT Consultant 2 referred Mr. Z to Consultant 3 because of RS's marriage breakdown there was no longer a complication of spouse being in local mental health services. First mention of diagnosis of dependent personality disorder. Consultant 2 noted the increased risk that Personality Disorder infused into the clinical state. CPN 1 continued to see Mr. Z consistently.	

31/12/02	MDT review: remained on the ward as no accommodation. Warned by the medical team that drinking whilst an inpatient would result in him being placed on a contract which could result in his discharge. Low and isolated at times. Spent Christmas with his daughter.	
15/01/03	Mr. Z disclosed that he had been drinking half a bottle of vodka and 2 pints of larger a day since his admission.	
21/01/03	MDT review: Mr. Z had found accommodation in a shared house and had identified a GP he could register with. He had complied with the alcohol contract. The plan was for discharge on the 24 January as this was when the accommodation became available.	
22/01/03	Referred to Meadow House CMHT. Issues to be considered were identified as high risk of dependency although he had the skills to do tasks but that he was unable to cope combined with marriage break-up and increased risk of overdose 23/01/03 Consultant 2's secretary forwarded the referral letter for community follow up to Consultant 4.	
24/01/03	Discharged. Medication Cipramil 20 mg Lansoprazole 15 mg Living away from the family home.	
	Follow up arrangements following two serious overdoses Issues: • CPA, risk management • Protocol re family member as service user • CMHT transfer of patients	
30/01/03 29/01/03 30/01/03	Discharge summary to GP. Further information had been gained during the admission: Mr. Z had been a long term user of amphetamines, LSD, cocaine and marihuana until approximetly1998. The discharge summary also reiterated an early period of significant recidivism which, because it appears to have stopped reflected a long episode of acting out behaviour resulting from dynamic issues from childhood. Also at this time he is noted to have threatened wife with suicide and blaming her if she left him. Consultant 4 wrote to Consultant 2 asking for Mr. Z key worker to negotiate with a relevant member of the team regarding a handover so that he could take over responsibility. Consultant 2 wrote to consultant 4 asking him to take over consultant responsibility as a matter of urgency Reiterating diagnosis of Personality Disorder (dependent type with harmful acting out e.g. alcohol , self harm etc).	
Undated risk assessment 05/02/03	Completed by CPN 1 as part of a handover summary. Mr. Z had been experiencing periods of acute anxiety and panic. Warning signs identified as increased anxiety, sleep disturbance and increased alcohol consumption. Was noted to be living in a one bed flat on benefits and had been working on his daughters flat. Letter from Consultant 4 to Consultant 2 his community team were still waiting to hear from Consultant 2's community team regarding a handover so consultant responsibility has not yet transferred and that he would not be able to admit him to Bucknill ward as an immediate member of staff was a close relative. (assumed to be catchment area ward)	

19/02/03	Arrangements for transfer of case to another CMHT.	
12/03/03	Consultant 4 offered Mr. Z his first appointment for 24/03/03.	
02/04/03 20/05/03 21/05/03	Letters regarding problematic handover as close family worked on catchment area ward. CPN 2 identified as key worker Consultant 4 referred to Consultant 3 as an alternative consultant, who was willing to take on the case but it seemed as though Mr. Z did not wish to be seen by him as he worked with his family. Consultant 4 referred to Consultant 5 apparently at Consultant 3 suggestion asking him to take over the case Mr. Z wrote to Consultant 3 requesting services from the South Team consultant and key worker.	
11/04/03	The GP prescribed Dothiapin 150 mg.	
30/06/03	Mr. Z was reviewed by Consultant 5 where he showed some signs of a depressive illness with sleep disturbance, anxiety and depressed mood It was noted that there was s slight scent of alcohol. Citalopram had been changed back to Dothiapin.	
	Eventually seen approx 6/12 after discharge	
15/08/03	Letter to Mr. Z from CPN 3 cancelled appointment for the previous day as Mr. Z did not want any one from mental health services at Meadow House to have any contact with him. Mr. Z was discharged from the case load although the duty system was made available.	
15/10/03	Consultant 5: Mr. Z did not attend his appointment and no further appointments were offered at this time.	
28/11/03	Mr. Z wrote to Consultant 5 apologising for missing his appointment and to say that he wanted to be seen. Offered an appointment for January 2004.	
14/04/04	Consultant 5 review: strong smell of alcohol, binge drinking 4/5 days a week GP had referred to ENDAS; no medication due to alcohol; advised to work with CPN 3.	
26/05/04	Consultant 5 review: had one pint prior to appointment, stopped drinking spirits, still drinking larger, had an appointment at ENDAS (this is all that is written no GP letter no mental state or risk assessment) Review possibility of anti depressants after assessment at ENDAS; underlying depressive illness.	
10/06/04	CPN 3 wrote to the GP: the plan was to refer Mr. Z to counselling and the GP was requested to refer to heart fit programme. Mr. Z was not willing to look at Bell Industries (craft).	
05/08/04	Appointment offered with CPN 3 (Meadow House) for 16/08/04.	

07/09/04	CPN 3: Summary letter to new GP after meeting Mr. Z was awaiting allocation at ENDAS although he was reluctant to participate in group work as he thought this might compromise his family He stated that he wanted to make his death look like an accident although he did not reveal any plans as to how he might do this. Mr. Z shared a house with other tenants and was worried that he might end up like them.	
	Level of contact with CPN minimal and no handover arrangements.	
22/09/04	Letter from Specialist CPN (drugs and alcohol) Mr. Z was consuming 20 units of alcohol a day and did not see this as a big issue. He disclosed self harm/suicide attempt in past two weeks but refused to clarify what these were, agreed that the case would close as Mr. Z was not willing to do any work around his alcohol consumption.	
24/09/04	Change of key worker no contact detailed in clinical records.	
	Case records and care delivery fragmented (4 month gap).	
26/11/04	Meadow House duty received a phone call from Mr. Z's counsellor at the Victory Centre: Mr. Z had been missing his sessions and often appeared under the influence of alcohol; his presentation was increasingly morbid and he would state that he wished he was dead. Support was requested with his management.	
06/12/04	CPN 4 offered an assessment appointment for 14/12/04.	
28/01/05	CPA initial assessment by CPN 4 at GP surgery: excessive alcohol consumption/depression: impression was that Mr. Z turned to alcohol as a means of coping with family breakdown. Heavy use of alcohol resulting in physical dependence. Plan: discussed with alcohol services; see again in a week to check motivation to change.	
17/02/05	CPN 4 completed an assessment. Mr. Z remained unmotivated to tackle his drinking despite the offer of an out of area placement at the Cedars. Clear symptoms of alcohol dependency.	
	No care plan to address other symptoms/needs/risks addressed in assessment.	
22/02/05	Letter from CPN 4 to GP: completed an assessment based on two meetings: Mr. Z showed signs of being physically dependent on alcohol and was unmotivated to address his alcohol intake.	
13/03/05	CMHT Social Worker was asked to make contact with Mr. Z to help with his DLA application.	
14/03/05	Meadow House offered an initial appointment for 07/04/05.	
08/04/05	Letter from CMHT social worker to Mr. Z; confusion re an appointment and request for Mr. Z to call him if he wished to be seen.	
27/04/05	Mr. Z cancelled the appointment with CMHT Social Worker.	
16/05/05	Letter from CMHT social worker to Mr. Z requesting contact on his return from holiday.	

07/07/05	Letter to GP from CMHT social worker: drinking over 120 units per week, case closed as moved areas to Crediton/Okhampton area.	
	The case was not handed over to Okehampton CMHT.	
11/08/05	Mr. Z took an overdose of 60x75 mg Dothiapin on 10/08/05. He was found collapsed by his house mate the following morning and taken to the Royal Devon and Exeter Hospital where he was admitted.	
16/08/05	Discharged from Royal Devon and Exeter Hospital. Liaison Psychiatric Nurse: hand written notes for assessment summarised in letter to GP below. Hand written records indicate that he was seen by liaison psychiatry on the 15 and 16. The plan on the 16 was that mid Devon crisis team would follow up Mr. Z on the Thursday morning, he was to be referred to the Okehampton CMHT for allocation, referred to Psychiatrist 6 for further mental state and review of medication. CMHT (unclear which one) agree to an initial assessment for 18/08/05.	
18/08/05	Letter to GP from liaison psychiatric nurse: re: overnight admission following intentional planned overdose Dothiapin 75 mg x 60 found unconscious by house mate; 3 months earlier had been inserting acupuncture needles into his chest cavity in order to induce a heart attack and die. Thought to be high risk of completed intentional suicide in short and long term. Thought that symptoms were related to his personality rather that severe clinical depression. Refused admission or to see a psychiatrist, seen by liaison nurse. Crisis team to work with him in the short term and refer to CMHT. Thought that admission would increase the risk and promote further disengagement with services. Plan: • left message with Dr Y secretary to discuss on Monday • Mr. Z agreed to see his GP and cut down on his drinking • Arranged to see on 22 did not want a visit on 19 as stated that he would be in the local pub • Was given all the help line numbers but stated that he had no desire to use them • MHT assessment not thought necessary. Further background information had been obtained of past dynamic insults and included possible sexual assault by teacher, grieving for loss of caring sister when he wasn't allowed to follow her when she emigrated to Australia when he was14 years old. Risk features notes and the letter concludes with a recommendation for long term psychotherapy for "historical issues" This assessment appropriately linked past and present dynamic Factors (of separation).	
	Near miss. Recognised high risk of suicide not admitted or assessed under MHA.	
22/08/05	Urgent home visit by Consultant 6 at the request of CRT: still very depressed asking for hospital admission; arranged at Coomb Haven.	
22/08/05	Admission: smelt strongly of alcohol not feeling safe at home.	

	Initially nursed on 1:1 due to being a high risk of suicide .	
30/08/05	Discharged: summary states that he completed a detoxification programme.	
02/09/05	CPN 5 called Mr. Z: informed that he was discharged from North Devon on 30/08; the admission had been of little benefit as no input and nothing to do. Arranged to visit at home on 7th September.	
07/09/05	Assessed at home by CPN 5 alcohol intake estimated as a couple of pints at lunch time and a couple of glasses of wine in the evening, prior to the overdose he had been drinking a bottle of whisky a day. He could not see the point of looking to the future due to not being in a family unit. Spoke positively about setting up a work shop to do furniture restoration and being able to explore the local country side as he had bought a car. Ruminating about the loss of his family, distressed. Agreed with the risk cited in LPN assessment. Advised to control his drinking. Discussed with team manager: urgent referral to Clinical Psychologist, CPN 6 asked to provide cover for leave.	
09/09/05	Appointment offered with Clinical Psychologist.	
16/09/05	Appointment offered with Clinical Psychologist.	
26/09/05	DNA, CPN 6 had time to make a home visit. In bed appeared physically unwell, vomiting. Has a car and felt that this had helped limit his alcohol use. Admitted to a desire not to be alive but denied any plans…	
06/10/05	Appointment offered with Clinical Psychologist.	
11/10/05	Appt offered with CPN 6.	
25/10/05	Letter from Clinical Psychologist to CPN 5: summarised that Mr. Z's difficulties pre date the marital break up and but no doubt contributed to it.	
27/10/05	Meeting with Clinical Psychologist: discussed marital difficulties and alcohol.	
08/11/05	Meeting with Clinical Psychologist: talked re children and perceived rejection after suicide attempt. To introduce stepping stones approach to grieving.	
10/11/05	CPN 5 called to arrange an appointment.	
10/11/05	Letter to Mr. Z offering contact from CPN 5 suggested Mr. Z contact him if he thinks this would be helpful.	
	The role of the care coordinator appears to have been terminated by CPN 5; no evidence of discussion, CPA etc.	
11/11/05	Mr. Z contacted the Clinical Psychologist in a drunken state; not suicidal, reminded about contact with the Samaritans.	
22/12/05	Meeting with Clinical Psychologist: Mr. Z described his hospitalisation a result of which was that his son had been in touch. He was to have his gall bladder removed in the near future and he hoped that he would die during the operation although he also had plans to move after the operation. Was having problems with his housemate who drank heavily. Loss reaction work sheets completed and coping over Christmas discussed.	

20/01/06	Meeting with Clinical Psychologist: major loss identified as his wife, self destructiveness evident but assertive bargaining in relation to plans to move to Exeter.	
	Lack of overall management plan.	
02/02/06	Meeting with Clinical Psychologist: operation successful; discussed loss reaction regarding his mother: • Insecure attachment • Early memory age 4 of mother not being there • Death of mother stated to father "you have killed my mother" • Blanks losses • Complex family network • Mother had breakdown and was hospitalised after Mr. Z born Made much of the "disaster" when his step mother arrived. House mate described as a "carer".	
16/02/06	Meeting with Clinical Psychologist: got drunk yesterday in order to be assertive with his house mate (not official career) continued with loss work. Always been depressed accepted anger turned on himself.	
02/03/06	Meeting with Clinical Psychologist: talked about the possibility of getting back together with his wife.	
28/04/06	Meeting with Clinical Psychologist: in pain to see GP; relatively jolly. Aware that he and his wife are poor at communicating, discussed the possibility of a letter but Mr. Z did not think that it was the right time.	
12/05/06	Meeting with Clinical Psychologist: Tearful, described himself as pathetic but felt that he was starting to come out of it. Damaged hand in anger when dealing with flat mate. Mr. Z talked about the trust he placed in the therapist who wrote "what now?".	
25/05/06	Letter from GP to Clinical Psychologist advising him that Mr. Z had had two recent admission for alcohol related gastritis/pancreatitis.	
06/06/06	Meeting with Clinical Psychologist: did not want to give up alcohol as this was his means of escaping thoughts and getting some sleep. Discussed problems of living with an alcoholic. Mr. Z was advised to make an appointment with the CAB regarding help with moving.	
26/06/06	Meeting with Clinical Psychologist: Good progress, completed workshop, returned to work, going to Ti Chi camp, sorted out belongings, reduced alcohol intake, increased contact with son.	

11/07/06	Meeting with Clinical Psychologist: had been drinking so meeting cut short; drinking as trying to block out problems caused by flat mate..	
18/07/06	Meeting with Clinical Psychologist: feeling low due to effects of living with an alcoholic who is causing financial problems. Reluctant to move as values workshop, chickens etc. CORE indicated very extreme responses. Not going to act on suicidal ideation. Return to stepping stones approach	
01/08/06	Meeting with Clinical Psychologist: Mr. Z had received literature on activation but had not applied it. Drank 2 bottles of whisky in 2 days as fed up with the situation-passive way of killing self. Believed that many problems would be solved if had transport or could move.	
31/08/06	Meeting with Clinical Psychologist: mixed picture many positives but continued to think of slow passive suicide. Contradictions evident youthful adventurous self vs old self destructive. Agreed to devise a care plan to focus on change.	
19/09/06	Meeting with Clinical Psychologist: unable to make his appointment sounded very down so home visit. Mr. Z presented as very distressed and tearful, denied self harm stated that he needed help. Daughter phoned and Mr. Z was able to put on an act to conceal the depth of his distress. Crisis team to complete an assessment.	
21/09/06	Crisis team assessment outcome plan: significant evidence of alcohol with drawl with mild to moderate depressive features, probable mal nutrition, expressed feelings and thoughts of suicide but cited children as protective Factors; no evidence of serious mental illness and was not taken on by the team.	
21/09/06	The Clinical Psychologist reviewed the medical notes.	
22/09/06	The Clinical Psychologist: no contact from crisis team, called Mr. Z and was informed that he had not been taken on by them (earlier assessment of 20/09 did not happen as he had been drinking) and he concealed the depth if his despair. Thought to be a high risk if he continued to drink.	
26/09/06	Following a CMHT MDT meeting of “urgent concern” the Clinical Psychologist made an urgent referral to ENDAS.; Mr. Z revealed extreme levels of suicidality that he usually worked hard to conceal. Assessment arranged with crisis team but not taken on. Discussed at Okehampton CMHT multi disciplinary team. Appointment offered by ENDAS for 30/10.	
	Why not taken on by the crisis team?	
27/09/06	CMHT Occupational Therapist and CPN 5 offer a joint appointment for 04/10.	
29/09/06	Meeting with Clinical Psychologist: Mr. Z down played the use of alcohol but agreed to attend an assessment with ENDAS. Continued to express suicidal ideation but no active plans. The Clinical Psychologist recorded that he was	

	confused about the lack of support that Mr. Z was receiving.	
04/10/06	Letter to GP: Home visit by OT and CPN 5: Mr. Z's. house was well ordered and he presented as kempt so thought that his living had not become chaotic, suicidality exacerbated when intoxicated; misuse of alcohol was identified as the most immediate problem.	
10/10/06	The Clinical Psychologist was informed by the specialist CPN (drugs and alcohol) from ENDAS that Mr. Z would not be seen until Mid November. Discussed in CMHT MDT clinical meeting, also present CPN 3 CRT previous care coordinator when he was living in Exeter. Acknowledgement given to ongoing risk of suicide being consistent throughout his involvement perpetuated by on going use of alcohol and inability to accept that his marriage had ended. The risk management plan was to continue to offer engagement and encourage appointment with ENDAS.	
12/10/06	Meeting with Clinical Psychologist: discussed alcohol and how this might put Mr. Z at greater risk. Agreed to return to the loss reaction worksheets at next session.	
19/10/06	Letter to GP: home visit by OT and CPN Mr. Z had been drinking but presented as more lucid and responsive; mood low but stated that his level of suicidality remained the same. Informed that the GP would not prescribe an anti depressant due to the risk of over dose. Mr. Z did not think that he would stop drinking but was prepared to see someone from ENDAS. Mr. Z did not see any benefit from ongoing contact with CPN 5 or the OT as the Clinical Psychologist was helping with his depression. Plan: arrange an introductory visit to Rethink.	
20/10/06	CPN 5: Discussed Mr. Z with the Rethink manager as their alcohol policy stated that service users must not be inebriated. Rethink requested a risk assessment.	
23/10/06	Appointment offered from ENDAS for 30/10.	
30/10/06	DNA appointment (assumed to be ENDAS) answer phone message left for the Clinical Psychologist. Confirmed with Colleague that Mr. Z had informed them that he did not want a service from them and that the case was closed (all in the same file ? reorganised).	
31/10/06	CPN 5 contacted ENDAS and informed them that Mr. Z DNA his appointment possibly due to transport difficulties.	
07/11/06	Meeting with Clinical Psychologist: very tearful explored relationship with wife. Keen to arrange anti depressants and the relate facility.	
10/11/06	The Clinical Psychologist liaised with GP re prescribing antidepressants.	
21/11/06	Meeting with Clinical Psychologist: tearful as brother dying of cancer, estranged wife being supportive, positive about the OT's input; seemed to be coping in difficult circumstances	

07/10/06	Clinical Psychologist: Mr. Z unable to keep his appointment tearful, drinking, brother deteriorated.	
08/12/06	Clinical Psychologist: phoned Mr. Z to clarify; he had been drinking stated that he felt as though he had been let down as services had not been there for him when he was travelling back from Exeter. Mr. Z asked the Clinical Psychologist not to contact him over the next week.	
11/12 06	OT: voice mail from Clinical Psychologist concerned about Mr. Z. Phoned Mr. Z, brother had died arranged to meet on the 18th or 20th.	
13/12/06	OT: following phone call of concern from GP arranged to see Mr. Z on the 14th.	
13/12/06	CPN 5: spoke with GP Mr. Z had not had a drink for the past 10 days and was requesting tranquilisers GP proposed SSRI's they were declined by Mr. Z as he wanted Dothiapin but the risk of overdose was thought to be too high by GP. Discussed with Consultant 6. CPN 5 would visit with the OT on 14/12/06.	
14/12/06	Meeting with Clinical Psychologist: distressed and incomprehensible phone message left. Home visit at 18.30. Mr. Z in bed, house mate answered the door but seemed drunk. The Clinical Psychologist reported an absurd conversation between the two of them where they each accused the other of being an alcoholic. Mr. Z was determined to attend his brother's funeral on 19th and was using this as strength to not drink. Reported that he appeared to be well supported by his house mate. Did not appear to be at risk of suicide.	
20/12/06	Letter to GP from CPN 5: following discussion with Dr Y about possible anti depressant SSRI if not drinking. Mr. Z coping with the death of his brother by increased alcohol. Increased support offered by CPN 5 and the Occupational Therapy.	
21/12/06	Meeting with Clinical Psychologist: funeral successful had not drank during any part of the day but had drank since. Spending Christmas with daughter. To see him again in the New Year.	
05/01/07	Meeting with Clinical Psychologist; appeared open to CBT and keen to attend Rethink. Coped over festive season, antidepressant not helping. All in all seems like there were signs of progress.	
09/01/07	OT: arranged to take Mr. Z to Rethink in Oakhampton.	
17/01/07	Consultant 6 review: chronic low self esteem, alcohol misuse and low mood. Was seeing Clinical Psychologist and due to see OT. Medication noted as Escitalopram for past 4/52 no improvement, change to Mirtazapine. (hand written entry dated 17/01/07. Noted that Mr. Z went to bed at 9pm to avoid his house mate who reportedly drank every evening.	
22/01/07	Letter to GP from Consultant 6: no reference to dynamic historical Factors. Very medication orientated and comment about alcohol. No reference to long term psychotherapy.	

24/01/07	OT met with Mr. Z in Oakhampton to attend Rethink, went well.	
25/01/06	Meeting with Clinical Psychologist: spent the session trying to convince the Clinical Psychologist that he has a realistic view of himself and that he will end his life by passive suicide. Rejected CBT reading on the grounds that he knew it all.	
05/02/07	Unplanned HV by OT no reply.	
08/02/07	Mr. Z cancelled his appointment with the Clinical Psychologist as he had been in a fight with his house mate and had hurt his ribs and nose and his breathing was poor. Reluctant to attend GP but wanted to meet with the Occupational Therapy on Monday.	
	Second recorded incidence of violence with house mate. Should this have triggered a home visit as new behaviour anger tuned out as opposed to in and overdose.	
10 February 2007	**Incident.**	
12/02/07	Consultant 6 entry: informed by CMHT admin and CPN 5 that there had been an incident involving Mr. Z; discussed with team manager. Concerns had been about depression, suicide and alcohol, no concerns about the possibility of him harming another.	

The proforma below charts the events regarding Mr. Z in a chronological order

DoB 08/07/54

Date	Actual Care Pathway of Mr. Z	Met ✓ Partially Met? Unmet ✗	Agreed Formal Care Pathway
	1st contact with Exeter mental health services		
1997	Mr. Z had a long history stemming from 1982 of depression and alcohol misuse. In 1997, at the wife's request, the GP referred Mr. Z to the Department of	✓	Straight forward psychology contact. Query GP referral being the right place at the right time, put in the context of wife, who was a mental health

	Clinical Psychology due to a further relapse of anxiety and depression with alcohol misuse. The psychologist was based within CMHT (East Devon). Mr. Z responded well to psychological intervention, remained abstinent from alcohol, resolved work related stress issues and improved the relationship with his wife.		professional, suggesting that something else needed to be done. There was a good outcome.
	1st overdose **2nd contact with mental health services**		
23/06/00	Mr. Z consulted his GP in June 2000 for work related stress and anxiety and was prescribed Dothiepin.	✘	The GP should the have monitored him. Should have been referred for further psychological intervention. Missed opportunity.
14/11/00	Mr. Z took an overdose of 28 Dothiepin believing that this would kill him when he knew his wife would be out of the house. He was binge drinking at this time. He was seen by an SHO whilst an inpatient on a medical unit where he refused an admission to a mental health unit. It was felt that there was a significant risk of further self harm and an urgent referral was made to the CMHT (Meadows House). He was discharged home to the care of his wife. His medication was changed via the GP to Citalopram 20 mg.	**?**	Should have been seen by a consultant psychiatrist as he was actively suicidal. The Mental Health Act should have been considered. Wife was a mental health professional and able to cope. Presume no liaison psychiatry at this time or crisis/home treatment team. There is the issue of this incident being seen as self harm as opposed to a failed suicide attempt. Urgent referral to CMHT.
17/11/00	Mr. Z was seen and assessed at home by CPN 1(Honiton CMHT) who liaised with the GP.	**?**	Three days is not thought to be quick enough for a follow up after a serious overdose. Context was that his wife was a mental health professional and this may have influenced the response. Case passed to out of area team due to wife working within local team.
13/12/00	CPN 1 liaised with the GP as Citalopram reported to be unhelpful. The GP re-prescribed Dothiepin 75 mg	✘	Medication should have been overseen by a psychiatrist and an alternative to Dothiepin

	to be administered by Mr. Z's wife. CPN 1 referred Mr. Z for a consultant review by Consultant 1 (Honiton CMHT) as an 'out of area staff status' as his wife was an employee of the Trust (worked at Meadow House which would have been his catchment area CMHT).		considered due to toxicity in overdose.
27/02/01	Mr. Z was reviewed by Consultant 1. Further background information was obtained about his child hood traumas. The Dothiepin was increased incrementally to 200mg daily. He was being seen by CPN 1 on a monthly basis to monitor his mental state with supportive interventions.	✘	It took over three months to see a psychiatrist after a serious overdose, this is not acceptable. Monthly visits were not adequate to monitor his mental health.
27/04/01	Consultant 1 review noted that Mr. Z had reduced his Dothiepin to 100mg. He had been assessed by a psychologist and was placed on the waiting list for therapy. He did not receive therapy at this time. At the review on 01/06/01 CPN 1 had encouraged Mr. Z to increase the dose of Dothiepin to 150 mg and Mr. Z appeared to be coping well.	✓	Referral for psychological intervention appropriate as previous good response although placed on a waiting lists. CPN engaged in medication concordance also evidence of CBT style interventions around mood awareness.
12/06/01 onwards	CPN 1 continued to visit Mr. Z monthly and advice about medication and coping strategies. Consultant 1 reviewed in September 2001, noted increasing work stressors. Mr. Z had increased the Dothiepin by 50 mg and was advised to decrease this to 150 mg and start Seroxat 20mg. By October Mr. Z had left his employment and was doing well on the combination of medication. There was a further review in February 2002 where Mr. Z was keen to reduce the medication. Consultant 1 advised a reduction of 25 mg every month until he was just on Seroxat. In March 2002 CPN 1 closed the case. By April Mr. Z has reduced	✘	Not good practice to close the case whilst titrating a change in medication as if a relapse were to occur it would do so over the next few weeks. The situation with marriage and work would have lent itself to psychological intervention and can be regarded as a missed opportunity.

	the Dothiepin to 50 mg advised to increase to 75 mg while he settled into his new employment. In June Consultant 1 noted that Mr. Z was stable at work and advised he reduce the Dothiepin to 50 mg and then 25 mg in 2 weeks and stop after a month. He agreed to review in 3 months time. He and his wife were referred to couples counselling in December by CPN1.		
	2nd Overdose **1st Admission to a Mental Health Hospital**		
02/08/02	Mr. Z took an overdose of 56 Dothiepin with vodka following a discussion with his wife about a separation. He was found unconscious by his wife. This was a serious overdose requiring multiple resuscitations. He was placed on S.5/2 as he wished to leave and his family refused to have him home.	✓	Very serious overdose. Appropriate use of Section 5/2.
10/08/02	Mr. Z was transferred to Wonford House Hospital after agreeing to an informal admission noted that the overdose was triggered by the breakdown of his marriage and excess alcohol. He was again placed under S.5/2 as he wished to leave and was reassessed on 13 August and not thought to be detainable. As Mr. Z stay progressed there were references to his superficial engagement, his difficulty in talking about his problems and his refusal to take any medication.	**?**	Should have considered S. 2 or 3 in the light of his refusing treatment, from the discharge summary he was a "changed" man by the 27th, not suicidal, plans for the future. Mental Health Act assessments not available within the clinical records therefore unable to ascertain the rationale for not using a S.2. Poor standard of record keeping.
23/08/02	Mr. Z mental state had improved and a detailed plan was in place to increase his leave arrangements in preparation towards discharge.	✓	
27/08/02	Mr. Z took his own discharge against medical advice.	✘	This in effect is an unplanned discharge and the

	His wife was clear that they were going to separate and he could return to the family home on a short terms basis whilst he sought alternative accommodation.		dynamics that led to the overdose were unchanged and unaddressed.
28/08/02	CPN 1 called Mr. Z and made an appointment for 02/09/02. She saw him on 02/09/02 where he was not coping and had some suicidal thoughts but not acting on them although he was unsure why this was. He was advised to see his GP. The records indicate that a further appointment was made for 02/10/02 but there are no further entries in the clinical records.	✓ ✘	CPN 1 contacted Mr. Z the day after his discharge and visited 5 days after discharge. Not acceptable to make an appointment for a months time when suicidal; underlying problems not being addressed and no assessment or care plan in place. The advice to see his GP was inappropriate and an urgent appointment should have been made with a psychiatrist. This was the first serious omission and the case was lost to follow up as there was no further contact from services for three months.
	3rd Overdose **2nd admission to Mental Health Hospital**		
18/11/02	Mr. Z took an overdose of paracetamol and aspirin and was admitted to the general hospital as medically unfit for a mental health admission. He cited failure to cope with his wife leaving, not working and an increase in his alcohol intake as reasons for the overdose.		
20/11/02	Mr. Z was transferred to Wonford House Hospital, Delderfield Ward, where he settled onto the ward. He engaged with OT activities but remained negative about his future.	✘	Consideration should have been given to psychological intervention.
03/12/02	Mr. Z's estranged wife wrote to the locum associate specialist Consultant 2 (Consultant 1 had taken a six	✘	A multi disciplinary CPA assessment should have been commenced. A dual diagnosis approach and

	month sabbatical) stating that Mr. Z now needed to be considered as a single man and a vulnerable adult as he had few independent living skills and that he would not be returning to the marital home. Mr. Z remained settled on the ward going out most days, having a few pints and staying with friends as he had no accommodation. He was warned that drinking whilst an inpatient could result in his discharge.		interventions should have been considered. Use of the MHA (1983) should have been considered as Mr. Z was going drinking and suicidal. Staff were not acting in his best interests. Threatened discharge was not appropriate as he should have been monitored and not allowed leave as this was the third serious attempt on his life.
16/12/02	The CMHT at Meadow House were asked to allocate the case as Mr. Z was now separated from his wife. Mr. Z was proactive in seeking alternative accommodation.	**?**	Re-allocated to previous CPN at Honiton as not accepted at Meadow House.
27/12/02	Consultant 2 requested a medical handover to Consultant 3 (Meadow House) as there was no longer a complication of a spouse being in mental health services so his care could now be under his catchment area Consultant. Consultant 2 also noted that he believed that Mr. Z met the criteria for a dependent. personality disorder given the very poor coping strategies he had developed following a difficult childhood. Mr. Z was being treated with Citalopram 20 mg.	✘	There had not been any psychological or OT assessment of Mr. Z to confirm any notion of dependency in fact there is evidence to the contrary that Mr. Z had been proactive in addressing his accommodation problem. This diagnosis is misleading and detracts from the high alcohol intake that was masking the depressive symptoms. This was a missed opportunity to really get to grips with the case.
21/01/03	Mr. Z had identified some accommodation in a shared house and had identified a GP that he could register with. Mr. Z had continued to consume alcohol whilst an inpatient: half a bottle of vodka and two pints of beer a day. The referral was re-faxed to Meadow House as he would now come under this team as he was no longer a family member as a member of staff.	✘	This is a high alcohol intake and would have negated any potential positive effects of the anti depressant therapy. This was a missed opportunity to engage Mr. Z and proactive case management.

23/01/03 **24/01/03**	Consultant 2 (Honiton) forwarded the referral for community follow up to Consultant 4, (meadow House) locum consultant psychiatrist, requesting that he take over the care as Mr. Z had registered with a GP in Consultant 4's catchment area. Mr. Z was discharged.	✘	This was the second serious omission as Mr. Z was discharged without a discharge plan, there was no discharge CPA and no clear plan of how to manage Mr. Z or the potential risks that he could present with bearing in mind that he was for the first time moving to live by himself. The case was not allocated in a CMHT and there were no appointments for follow up.
	Follow up and handover arrangements		
29/01/03 **30/01/03** **Undated** **05/02/03**	Consultant 4 (Meadow House) wrote to Consultant 2 (Honiton) asking for Mr. Z's key worker to negotiate with a relevant member of the team regarding a handover so that he could take over responsibility. Consultant 2 (Honiton) wrote to Consultant 4 (Meadow House) asking him to take over consultant responsibility as a matter of urgency. Risk assessment completed by CPN 1(Honiton) indicated early warning signs as increased anxiety, sleep disturbance and increased alcohol consumption. And that he was a low risk of harm to others and self. Consultant 4 (Meadow House) wrote to Consultant 2 stating that the community teams had not transferred the case so he did not yet have Consultant responsibility. He added that he would be unable to admit him to his catchment area ward (Bucknill) as an immediate member of his family was working there.	**?**	A risk assessment was completed indicating early warning signs although this was not incorporated into a full needs assessment or care plan.

19/02/03	CPN 1 (Honiton) arranged to transfer the care to Meadow House CMHT.		
12/03/03	Consultant 4 (Meadow House)offered Mr. Z his first follow up appointment for 24 March 2003. He did not attend.		
02/04/03	Consultant 4 wrote to Consultant 3 asking if he would take over the case as Mr. Z did not want to see anyone who has contact with his family. He noted that CPN 2 was happy to remain involved in his care (there are no records of any involvement).	✘	It is understandable that Mr. Z did not want to be seen by someone with a connection to his estranged wife but it is not understandable why his consultant follow up could not be provided by Consultant 4. The issue of the family member working on the inpatient unit could have been addressed if and when Mr. Z required admission. It would have been more sensible to have moved the family member if and when Mr. Z required admission rather than delay follow up arrangements.
20/05/03	At Consultant 3's suggestion, due to a service reorganisation, Consultant 4 referred to Consultant 5 asking him to take on the case.		
21/05/03	Mr. Z wrote to Consultant 3 requesting follow-up from the South Team.		
30/06/03	Mr. Z was seen for his first follow up appointment by Consultant 5. it was noted that he had a moderate to severe reactive depression and that the GP had recommenced Dothiepin150 mg. It was suggested that this could be increased to 225mg. Mr. Z denied drinking heavily but smelt slightly of alcohol.	✘	A six month delay in follow-up is totally unacceptable. Follow up arrangements should have been agreed prior to discharge. Advise should have been sought from the Medical Director regarding the case allocation.
15/08/03	Mr. Z's case was closed to Meadow House as he did not want any contact from them. He was informed that the duty system was available to him should he require any assistance.		The needs of the service user were not a priority. Alternative arrangements for follow up should have been considered prior to this point. Required monitoring and supervision of mental state and medication did not occur, no were any forms of social support offered to Mr. Z. The CPA policy had not
5/10/03	Mr. Z did not attend his out patient appointment with		

	Consultant 5 and no further appointment was offered.		been adhered to.
	Beginning of increased alcohol consumption		
2004	In January Mr. Z requested consultant follow up. He was offered an appointment in January with Consultant 5 but appears to have been seen in April. Mr. Z smelt strongly of alcohol and admitted to binge drinking 4-5 times a week. The GP had referred him to ENDAS (Exeter drug and alcohol services).	**?**	Mr. Z had not have a needs assessment or a CPA, although an attempt was made to formulate some sort of care plan.
10/06/04	Joint meeting with Consultant 5 and CPN 3 (Meadow House) to try to construct a care plan and identified two short term goals. Mr. Z smelt of alcohol and stated that his anti depressants were not helping (Dothiepin). Consultant 5 was concerned about the mixture of alcohol and medication. Mr. Z agreed to work with CPN 3.	**?**	This meeting could and should have been used as a CPA assessment and planning meeting.
	CPN 3 saw Mr. Z on 7 September 2004, he was awaiting allocation at ENDAS and stated that he wanted to make his death look like an accident but did not reveal any plans as to how he might do this**.**	**✘**	A nine-month interval between Mr. Z asking for help and receiving an assessment for his alcohol problem is not acceptable especially with his history and the risk of associated over dose.
22/09/04	Mr. Z was seen and assessed by a specialist CPN (drugs and alcohol). Mr. Z was consuming 20 units of alcohol daily but did not view this as a problem. He was noted to be increasingly morbid and stated that he wished he was dead. Mr. Z stated that he had tried self harm/suicide attempt over the past two weeks but would not elaborate. He did not wish to work on his alcohol issue.		
	Mr. Z had been attending counselling at the Victory		

26/11/04 **28/01/05** **07/07/05**	Centre. The counsellor contacted the duty system at Meadow House saying that Mr. Z's presentation was increasingly morbid and that he was often under the influence of alcohol and he wished that he was dead. CPN 4 (duty worker) from Meadow House assessed Mr. Z and noted that he was showing signs of physical dependency on alcohol but was unmotivated to change this. Mr. Z was offered an out of area placement (due to concerns about confidentiality) to address his alcohol dependency but declined this. Mr. Z contacted Meadow House for assistance with his DLA application. After several failed appointments ASW 1 spoke with Mr. Z who's alcohol intake had increased to approximately 120 units a week. There was no further involvement from this team as Mr. Z had moved to private rented accommodation in another area.		By this stage Mr. Z clearly had a dual diagnosis of alcohol dependency and depression. Although attempts had been made to engage him with alcohol services these had been unsuccessful. The entwined relationship between alcohol and depression was not recognised. No attempt had been made to engage with Mr. Z on a therapeutic level through psychological interventions. A more assertive approach was required in terms of intervention and case management. There were no dual diagnosis services available within DPT at this time and there was and remains little awareness of this approach. The case was not transferred to Mr. Z's area. There had been a complete lack of adherence to any systematic approach to his care under CPA.
	4th Overdose		
10/08/05 **15/08/05**	Mr. Z took an overdose of 60 Dothiepin tablets and was admitted to hospital. Mr. Z was seen and assessed by the liaison psychiatric nurse (LPN) on the 15th and 16th. Mr. Z took the overdose so as not to be found by his flatmate and he had prepared his will and letters to his family. He described having chronic suicidal ideation and had attempted to pierce his heart with acupuncture needles. He was considered to be at	✘	The notion of engagement with mental health services was a red herring as Mr. Z's immediate need was for somewhere safe to detoxify from alcohol and have an ongoing in-depth assessment of his mental state after the initial crisis period was over. Mr. Z should have been assessed under the Mental Health Act.

	high risk of intentional completed suicide in the short and long term. It was thought that symptoms were related to his personality rather than severe clinical depression. Mr. Z refused admission or to be seen by a psychiatrist. It was thought that admission under the mental health act would increase the risk and promote further disengagement with services. Long term psychotherapy was recommended.		
16/08/05	Mr. Z was discharged from hospital (general). The plan was that the Mid Devon crisis team would follow up and that an urgent referral be made to Okehampton CMHT for allocation. A message was left for Consultant 6 (Consultant Okehampton and Crediton CMHT).		
18/08/05	Mr. Z was seen at home by the crisis team. He was noted to be depressed and was not taking any medication. Mr. Z declined a crisis team visit on the 19 stating that he would be in the local pub.	✘	This is an inconsistent approach, urgent for the catchment area Consultant but not for the crisis team Consultant. Mr. Z should have been seen by the crisis team Consultant. It is not acceptable to discharge or not see someone when they are clearly stating that they are going to indulge in risk taking behaviour i.e. drinking.
	3rd Admission to Mental Health Hospital		
22/08/05	An urgent home visit was conducted by Consultant 6. Mr. Z presented as very depressed and requested admission to hospital. Admission was arranged at Coombehaven who arranged his transfer to North Devon due to his family contacts.	**?**	This opportunity was not used to completely assess Mr. Z and his social circumstances as would be expected under CPA. There was a missed opportunity to link Mr. Z into alcohol services. There was no discharge CPA and no community care plan.
30/08/05	Mr. Z was discharged following a detoxification regime. He was not keen to take any anti depressant medication. Separation from his wife remained a		This was the third serious omission as Mr. Z was discharged without a discharge plan, there was no discharge CPA and no clear plan of how to manage

	large issue in his life. He had agreed to reduce his alcohol intake.		Mr. Z or the potential risks that he could present with.
	Okehampton CMHT follow up		
02/09/05	CPN 5 contacted Mr. Z by telephone at home and arranged to visit on the 7th. An urgent referral was made to the Clinical Psychologist.	✓	
23/09/05	CPN 6 completed a home visit, Mr. Z had been physically unwell.		
25/10/05	The Clinical Psychologist within the CMHT assessed Mr. Z and agreed to work with him.		
10/11/05	CPN 5 wrote to Mr. Z offering him contact.		
22/12/05 Onwards	The Clinical Psychologist engaged with Mr. Z on a two weekly basis. He described having problems with his house mate who drank heavily and that he would be having his gall bladder removed in the near future. The Clinical Psychologist assisted Mr. Z to work through some of his loss Factors.	✓	
25/05/06	The GP informed the Clinical Psychologist that Mr. Z had two recent admissions for alcohol related gastritis.		Again, despite the concerns that Mr. Z raised about his social situation no needs assessment was completed by the CMHT. This is a serious omission on behalf of the Trust who were in breach of both local and national best practice policy expectation.
11/07/06	Mr. Z attended his appointment but had been drinking so the meeting was cut short; also noted that he had hurt his hand after an altercation with his house mate and was advised to contact the CAB regarding advise to help move home. He continued to be seen about every two weeks.	✖	Alcohol had become a real issue and Mr. Z's physical health was clearly at risk. A holistic assessment as required under CPA would have highlighted areas of need. The diagnosis remained unframed and there was no identifiable care coordinator. A medical review should have been organised as Mr. Z's depression was untreated and he was at risk due to dangerous levels of alcohol
19/09/06	The Clinical Psychologist made a home visit after Mr.		

	Z did not attend his appointment as he had seemed "very down". He denied any harm ideation but stated that he needed help. Mr. Z was referred to the crisis team as he had expressed extreme levels of suicidality that he usually worked hard to conceal.	✓	consumption. Mr. Z should have been subject to robust care management and coordination of his mental and physical health needs as well as his social situation. An assertive dual diagnosis approach should have been taken.
21/09/06	Crisis team assessment. The crisis team could not assess on 19/09 as Mr. Z was intoxicated. He remained intoxicated on 20/09/06. He was seen on 21/09/06. Mr. Z stated that he had consumed 2 bottles of whisky and super strength larger over the past two days and that he had last abstained from alcohol 6 weeks ago. The impression was that there was evidence of alcohol withdrawal with mild to moderate depressive features. The crisis team did not take him onto their case load.	✘	No action was taken by the crisis team despite Mr. Z presenting with alcohol withdrawal symptoms. There are risks associated with the sudden cessation of alcohol and these were not recognised by the crisis team. Again this is a near miss. The crisis team should have offered to support Mr. Z through home detoxification or arranged an admission for detoxification.
	Increase in CMHT involvement		
26/09/06	The Clinical Psychologist discussed the case at the CMHT clinical meeting. It was agreed that there would be an urgent referral to ENDAS and that the team would continue to offer involvement.	✘	Mr. Z had been clear on previous occasions about not wanting to engage with ENDAS. An alternative intervention should have been considered.
04/10/06	A joint visit was carried out by CPN5 and an OT. Mr. Z recognised that his suicidality was increased when he was intoxicated and that his use of alcohol was the most immediate problem. His house was in good order. CPN 5 liaised with the GP who was unhappy about prescribing an anti depressant due to the risk of an overdose.	✘	This was a missed opportunity to conduct a full needs assessment. A Consultant Psychiatrist review should have been organised to discuss medical intervention for Mr. Z's untreated depression.
10/10/06	Mr. Z was discussed in the CMHT clinical meeting. Noted ongoing suicide risk perpetuated by ongoing alcohol misuse. The plan was to continue to offer engagement with ENDAS.	**?**	There was increasing concern about Mr. Z and increasing activity by the team but no real outcomes. Not thinking about dual diagnosis resulted in the team offering a set of interventions that were known

19/10/06	Home visit by CPN 5 and OT noted continued suicidality. Over the next few months the clinical psychologist continued to meet with Mr. Z and supported him through the death of his brother and his attendance at the funeral in December. Mr. Z appeared to cope well and had a period of abstinence from alcohol.	✓	not to be acceptable or advantageous to Mr. Z. There was a lack of reflection and case management resulting in the delivery of ad hoc reactive interventions. Mr. Z's care should have been challenged by the clinical lead within the team. The CPA process should have been monitored through the management and supervision structures within the CMHT.
13/12/06	Following a discussion with Consultant 6 CPN 5 suggested that the GP prescribe an SSRI, these were declined by Mr. Z.		
14/12/06	The Clinical Psychologist completed a home visit in response to a distressed phone call from Mr. Z. He was witness to a bizarre conversation between Mr. Z and his house mate, who were both intoxicated, about each other being alcoholics.	✓	
05/01/07	The OT continued to attempt to engage Mr. Z in activities outside the house.		This was the first Consultant Psychiatrist review in over a year. Mr. Z should have been reviewed on a regular basis
17/01/07	There was a review with Consultant 6 who suggested a change in medication. The Escitalopram was reduced to 10mg and Mirtazapine introduced at 15mg and increased to 30 mg after a week.	**?**	This was new behaviour. A home visit could have been conducted
08/02/07	Mr. Z contacted the clinical psychologist to cancel his appointment as he had been in a fight with his housemate and had hurt his ribs and his nose. He still wanted to meet with the OT on the following Monday	**?**	
10/02/07	**Incident**		