Independent Investigation

into the

Care and Treatment Provided to Mr. RD

by the

Devon Partnership NHS Trust

Commissioned by

NHS South West

Strategic Health Authority

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INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF MR RD

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr RD 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 Mrs. D.

Mr. RD received care and treatment for his mental health issues from the Devon Partnership NHS Trust. It is the care and treatment that Mr. RD 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 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. 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 Independent Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

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

2. Condolences to the family of Mrs D

The Independent Investigation Team would like to extend their sincere condolences to the family and friends of Mrs D. Her family did contribute to the Investigation and were interviewed. The information they provided was extremely helpful in providing a picture of Mr RD and the role Mrs D had in helping and supporting him during his mental health problems.

Mr RD declined to meet the Independent Investigation Panel but did write a short letter giving his view on some of the mental health services he had received.

3. Executive Summary

3.1 Incident Description and Consequences

Mr RD had a history of severe and enduring mental ill health since 2001 when he was first diagnosed as having paranoid schizophrenia. Mr RD never accepted that he was suffering from a mental health condition, was reluctant to engage fully with mental health services and was often not complying with his prescribed medication.

On 22 May 2007 Mr RD told his care coordinator that he was not going to attend the Depot Clinic for his medication as he thought it was slowing him down and he wanted to get on with the rest of his life. His last Depot medication had been given on 24 April. Mr RD did not keep any appointments with the mental health service from 22 May, and only visited the Community Mental Health Team office once, on 18 June 2007, when he wished to see his care coordinator but he was not available being at another service user's home. Mr RD did speak to his care coordinator by telephone, which was the last contact he had with him.

The Care Coordinator spoke to Mr RD's paternal grandmother who had been his main source of care, help and support throughout his life. She informed the care coordinator that she thought the Mr RD was displaying signs of relapse. The community mental health team
held a meeting to decide what they should do, and agreed that they would contact the members of the family to discover how ill Mr RD was, and wrote to him offering him a review meeting with his care coordinator and his consultant psychiatrist on 04 July 2007. This meeting was on 21 June 2007.

On 23 June Mrs D (Mr RD's paternal grandmother) was found in Shaldon with serious head injuries lying on the wall of a bungalow she had visited. Mrs D was airlifted to Derriford Hospital in Plymouth, where she died on 24 June from her injuries.

Mr RD pleaded guilty to manslaughter by reason of diminished responsibility and was made subject to a Section 37/41 Order under the Mental Health Act 1983 and is currently detained in a medium secure unit.

The consequences of the homicide are that a family has been deprived of a loving wife, mother and grandmother who had to a large extent held the family together through both good and bad times.

3.2 Background to the Independent Investigation

HASCAS The 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 service user 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 this Independent Investigation were set by the NHS South West stated that the Investigation Team should:

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 RD already undertaken by Devon Partnership 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 Trust, NHS South West and any other relevant bodies.

3.4 The Investigation Team

Investigation Team Leader and Chair

Mr Ian Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service

Investigation Team Members

Dr Louise Guest	Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust
Ms Margaret Togher	Former Associate Director of Nursing, North East London Mental Health NHS Trust

Support to the Investigation Team

Mrs Lesley Porter	Fiona Shipley Transcription Ltd.

Independent Advice to Team

Mr Ashley Irons	Solicitor Capsticks
Tina Coldham	Service User Consultant HASCAS Health and Social Care Advisory Service

3.5 Findings

Key Causal Factor

Key Causal Factor 1: Mr RD and his failure to engage with services and his regular use of alcohol, illicit drugs and occasional steroids, combined with the lack of assertive action to assess Mr RD's mental health by the Community Mental Health Team.

Mr RD was difficult to engage with services and did not accept that he had a severe and enduring mental illness. Throughout his contact with mental health services he regularly failed to comply with his medication, and also used cannabis and alcohol to excess thereby making a relapse in his mental health more likely. He also used body-building steroids on occasions. The mental health services provided him with considerable help and support but he did not really make a personal commitment to heed their advice. Mr RD always pushed for a faster route to greater independence and to continue with his habitual lifestyle.

This lack of adherence to his care plan and the prescribed medication was a key causal factor in his relapse. This also needed to be seen within the context of the Community Mental Health Team having been alerted to the possibility that Mr RD had started to relapse in a telephone call from his grandmother made to Care Coordinator 2 on 15 June 2007, eight days before the fatal attack.

The Independent Investigation Team concluded that the murder of Mrs D could have been prevented. The second element of this Key Causal Factor to the homicide of Mrs D was the decision of the Community Mental Health Team not to instigate an urgent Mental Act Assessment of Mr RD on the evening of 21 June 2007 or on 22 June 2007.

Contributory Factors

The Independent Investigation Panel identified five contributory factors.

Contributory Factor 1

The Care Coordination Role and the Role of Different Teams

Contributory Factor 2

The Care Programme Approach and Risk Assessment and Risk Management

Contributory Factor 3

Transfer of Care Arrangements between Inpatient and Community Mental Health Services

Contributory Factor 4

Lack of Provision of a Carers Assessment

Contributory Factor 5

Clinical Governance Systems

Service Issues

The Independent Investigation Panel identified seven Service Issues

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping.

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

The Workload of Consultant Psychiatrists

Service Issue 7

Peer Support and Supervision for Consultant Psychiatrists

3.6 Conclusions

The Independent Investigation Panel having examined all the case records relating to Mr RD and the relevant policies and procedures within the Devon Partnership NHS Trust concluded that during the five and a half years from November 2001 to June 2007 Mr RD provided an example of the difficulty in providing care and treatment to people who do not accept that they are suffering from a mental illness and do not engage with the services that are trying to help them.

Such a service user presents challenges to mental health services and difficult choices have to be made by staff as to how far they alter their overall treatment plan including medication and ongoing support in the community to meet the demands of the service user. The aim is often to show that they are listening to the service user and do understand their viewpoint, but this has to be achieved without compromising their health and wellbeing, and the duty of care mental health staff have to their service users.

Mental Health Legislation is available to help in situations where there are concerns about the health and safety of a service user and where there is also anxiety that they may present a risk to others. Where there is strong evidence that the service user is showing signs of relapse, it is of the utmost importance that the appropriate part of the available legislation is used to provide a legitimate way forward to protect the service user, the general public and staff.

3.7 Recommendations

Recommendation 1

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 2

It is strongly recommended that there should be a single and well identified place within the case record of every service user where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months.

Recommendation 3

It is strongly recommended that when the RiO Electronic Record System is installed that the Trust identifies a well identified place within the RiO System where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months. The location must be Trust- wide and in the same place for all case records.

Recommendation 4

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 5

The Clinical Team Leaders and Team Managers must as a matter of urgency ensure that all staff are aware that, under the remit of the Mental Health Act 1983 (as amended 2007), if there is concern about a service user relapsing they are legitimately able to undertake / refer for an emergency Mental Health Act Assessment.

Recommendation 6

When a service user is being discharged from the inpatient service, especially after a lengthy period in hospital, the community psychiatrist who will be taking over the care and treatment should be invited, and should attend, the meeting so that they have direct knowledge of the situation and can plan their future involvement.

Recommendation 7

The workload of consultant psychiatrists should be regularly monitored to ensure that they are not being spread too thinly across too many areas of responsibility. This should be linked to the Clinical Audit Programme and routinely reviewed.

Recommendation 8

The Co-Medical Directors should ensure that consultant psychiatrists have a well identified pathway to help and advice should they need assistance in any aspect of their work.

Recommendation 9

The Devon Partnership NHS Trust must ensure that there are clear care pathways within and between mental health services. This should be based on:

- **clear operational policies for each service;**
- **unambiguous acceptance criteria for referrals which make it absolutely clear who the service is for;**
- **a named manager within the service who will deal with any questions a referrer may have about the service**

- **an overall care pathway analysis to ensure that there are no gaps created by the acceptance criteria which leave some eligible service users without an appropriate service.**

The Care Pathways should be regularly audited and any complaints or plaudits from service users used as part of the audit.

Recommendation 10

The carers of service users must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The Devon Partnership NHS Trust and Devon County Council should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

Recommendation 11

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.*

Recommendation 12

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 13

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 14

The Trust need to review the Serious Untoward Incident (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.*
- *Providing staff with support through the internal investigation process and an early sight of the resultant report and its recommendations.*

4. Incident Description and Consequences

Mr RD had a history of severe and enduring mental ill health since 2001 when he was first diagnosed as having paranoid schizophrenia. Mr RD never accepted that he was suffering from a mental health condition, was reluctant to engage fully with mental health services and was often not complying with his prescribed medication.

On 22 May 2007 Mr RD told his care coordinator that he was not going to attend the Depot Clinic for his medication as he thought it was slowing him down and he wanted to get on with the rest of his life. His last Depot medication had been given on 24 April. Mr RD did not keep any appointments with the mental health service from 22 May, and only visited the Community Mental Health Team office once, on 18 June 2007, when he wished to see his care coordinator but he was not available being at another service user's home. Mr RD did speak to his care coordinator by telephone, which was the last contact he had with him.

The Care Coordinator spoke to Mr RD's paternal grandmother who had been his main source of care, help and support throughout his life. She informed the care coordinator that she thought the Mr RD was displaying signs of relapse. The community mental health team
held a meeting to decide what they should do, and agreed that they would contact the members of the family to discover how ill Mr RD was, and wrote to him offering him a review meeting with his care coordinator and his consultant psychiatrist on 04 July 2007. This meeting was on 21 June 2007.

On 23 June Mrs D (Mr RD's paternal grandmother) was found in Shaldon with serious head injuries lying on the wall of a bungalow she had visited. Mrs D was airlifted to Derriford Hospital in Plymouth, where she died on 24 June from her injuries.

Mr RD pleaded guilty to manslaughter by reason of diminished responsibility and was made subject to a Section 37/41 Order under the Mental Health Act 1983 and is currently detained in a medium secure unit.

The consequences of the homicide are that a family has been deprived of a loving wife, mother and grandmother who had to a large extent held the family together through both good and bad times.

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) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing „when things go wrong' the guidance states:

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

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

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

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

iii) Where the 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 this Independent Investigation were set by the NHS South West and stated that the Investigation Team should:

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 RD already undertaken by Devon Partnership 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 Trust, NHS South West and any other relevant bodies.

7. The Investigation Team

Investigation Team Leader and Chair

Mr Ian Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service

Investigation Team Members

Dr Louise Guest	Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust
Ms Margaret Togher	Former Associate Director of Nursing, North East London Mental Health NHS Trust

Support to the Investigation Team

Mrs Lesley Porter	Fiona Shipley Transcription Ltd.

Independent Advice to Team

Mr Ashley Irons	Solicitor Capsticks
Tina Coldham	Service User Consultant HASCAS Health and Social Care Advisory Service

8. Investigation Methodology

Consent

Mr RD refused to give consent to the release of his health and social care records. The NHS South West worked with the Caldicott Guardian to have the records released on the grounds of the Investigation being held in the public interest as the lessons from the homicide needed to be identified and used to improve services. The dispensation of his consent was received on 19 April 2010.

Communication with the Family of Mr. RD

Mr D was contacted by the Devon Partnership NHS Trust sending him a letter from the Panel Chair asking him to contact HASCAS should he wish to be involved in the investigation. Mr D accepted the invitation and the Independent Investigation Panel met him with his daughter and son-in-law on 22 September 2010.

Communication with Mr. RD

The Chair of the Independent Investigation Panel wrote to Mr RD via his social worker at the medium secure unit where he is currently detained. He declined to meet the Panel but did write a short note to highlight some features of his treatment and care.

Initial Communication with the Devon Partnership Trust

The Chief Executive of Devon Partnership 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 on 20 April 2010 with the Trust Chief Executive Officer, 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. 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 and 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

A day was set aside for the four Independent Investigation Panels to meet and interview the senior manager of the Devon Partnership NHS Trust on corporate issues such as Clinical Governance, Medical and Nursing issues, Organisation and Pattern of Mental Health Services across Devon and Torbay and their Commissioning.

The staff interviewed are shown in the Table below:

Date	Witness	Interviewers
14 July 2010	NHS Devon and Torbay Health Trust (PCT) Co-Medical Directors 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)

The Independent Investigation Panel into the Care and Treatment of Mr RD interviewed 24 people including Mr D and his sister and brother in law. Mr RD was offered a visit so that he could tell the Panel Chair how he viewed the care and treatment he had received, he declined an interview, but wrote a short letter to the Panel. Care Coordinator 2, who had retired, was offered an interview with the Independent Investigation Panel and declined to attend but was interviewed by the Panel Chair by telephone.

The list of all the staff and others interviewed is shown in the table below:

Date	Witness	Interviewers
21 July 2010	Consultant 4	Ian Allured, Louise Guest and Margaret Togher
23 July 2010	Consultant 1	Ian Allured, Louise Guest and Margaret Togher
	Social Worker 1	Ian Allured, Louise Guest and Margaret Togher
26 July 2010	Care Coordinator 4	Ian Allured, Louise Guest and Margaret Togher
	Consultant 3	Ian Allured, Louise Guest and Margaret Togher
27 July 2010	Community Psychiatric Nurse 1	Ian Allured, Louise Guest and Margaret Togher
	Residential Manager 1	Ian Allured, Louise Guest and Margaret Togher
17 August 2010	Consultant 6	Ian Allured, Louise Guest and Margaret Togher
	Care Coordinator 1	Ian Allured, Louise Guest and Margaret Togher
	Internal Investigation Panel Members 1 and 2	Ian Allured, Louise Guest and Margaret Togher
18 August 2010	Co Medical Director	Ian Allured, Louise Guest and Margaret Togher
	Team Manager 2	Ian Allured, Louise Guest and Margaret Togher
	Care Coordinator 3	Ian Allured, Louise Guest and Margaret Togher
	Ward Manager 1	Ian Allured, Louise Guest and Margaret Togher
	Team Manager 1	Ian Allured, Louise Guest and Margaret Togher
22 September 2010	Internal Investigation Panel Member 3	Ian Allured and Margaret Togher
	Named Nurse 1	Ian Allured and Margaret Togher
	Ward Manager 2	Ian Allured and Margaret Togher
	Named Nurse 2	Ian Allured and Margaret Togher
	Mr D and other Family	Ian Allured and Margaret Togher

	Members	
08 October 2010	Care Coordinator 2	Ian Allured (on the telephone)

Independent Investigation Team Meetings:

The Independent Investigation Panel met on 12 July 2010, 22 July 2010, Tuesday 27 July and 05 October 2010

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:

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. These are 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 their interviews to refresh their memory.

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 identities of all clinical witnesses have been made anonymous. All have been identified by their designation and an identifying number as appropriate. Consultant Psychiatrists are referred to as: Consultant 1, Consultant 2, Consultant 3 and so forth and the same for Community Psychiatric Nurses, Community Psychiatric Nurse 1, 2 etc.. All other individuals have been identified by their designation. The patient is referred to as Mr RD and the victim Mrs L. Mr RD's parents are referred to as Mr D and Mrs L.

9. Information and evidence gathered (documentation)

1. Mr. RD's Devon Partnership Trust records (Volumes 1 to 8)
2. Mr. RD's GP records
3. Mr RD's Plymouth Community Services NHS Trust records
4. The Devon Partnership NHS Trust Internal Investigation Report
5. Pre-sentence medical reports and addendums
6. Exeter court report (prosecution opening, mitigation, sentencing remarks)
7. The Independent Investigation witness statements
8. The Independent Investigation witness transcriptions
9. Trust policies and procedures in operation both in 2004 to 2007, and where different, those currently in place.
   - 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 and current
   - 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

10. Crisis Team Operational Policy

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

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

13. Governance Reporting Structure

14. Clinical Directorate Governance Arrangements 2010

15. Care Quality Commission Investigation Report 2010

16. Public Health Report 2006

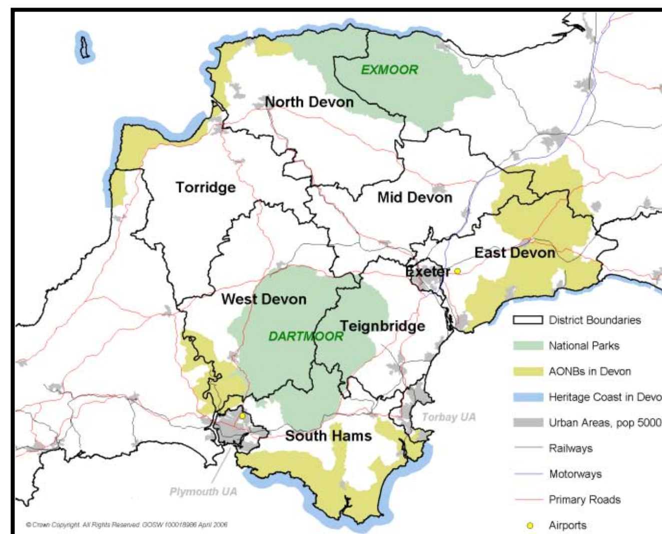
17. Devon Primary Care Trust Annual Report 2007 and 2008

10. Profile of Devon Partnership 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.[2] 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

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

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 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 Trust (DPT)

DPT was established in 2001. It serves the whole of Devon (except Plymouth) 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 people's services.

The Local Authority led Learning Disability Services and the Devon Partnership Trust provided and managed clinical services. Forensic Services were based at the Langdon Hospital with Medium Secure Services, Low Secure Services and Rehabilitation Services. The Trust also had responsibility for Child and Adolescent Mental Health Services.

Services in Torbay

The Adult Mental Health Services in Torbay up to 2006 were based on a sector division based on the geographical distribution of GP practices. In Torbay there were four consultant psychiatrists providing outpatient and inpatient services for the population.
There were two consultant psychiatrists covering Torquay with a community mental health team based at Waverley House , and two psychiatrists with another community mental health team based in Paignton (Culverhay) and covering Brixham as well.
The services available for the population of Torbay were:

- **Community Mental Health Teams** based at Waverley House and Culverhay
- **An Assertive Outreach Team** at Waverley House
- **A Crisis Resolution and Home Treatment Team** at Waverley House.
- **The STEP Team** providing a service for younger service users facing an early onset of a psychotic mental illness. This team had a psychiatrist but he was based in Totnes but assumed responsibility for the generally running of the team, but relied on the Torbay Psychiatrists to provide treatment for the services users in Torbay. The STEP Team psychiatrist being available to offer any specialist advice. The other members of the STEP Team based in Torbay were able to obtain advice and support from the Torbay psychiatrists. This was based at Culverhay.
- **The Primary Mental Health Team** which worked closely with GPs and provided assessment, treatment and support for those service users with common mental health issues. The team was based at Waverley House.

- **Watcombe Hall** a Devon Partnership NHS Trust service providing an inpatient rehabilitation service.

There was also an **Alcohol Service** and a **Substance Misuse Service** based at Shrublands House in Torbay.

The Inpatient Hospital Services comprised two wards at Torbay Hospital. These were:

The Haytor Unit, an unlocked acute admission ward and **Riverside Ward**, a Psychiatric Intensive Care Unit which offered support to the Haytor Unit for those service users with complex needs who challenged the resources of the general psychiatric ward environment. It also offered this service to the acute admission ward, St Michael's at Newton Abbot Hospital.
After July 2006 the community teams remained as described above, but the consultant psychiatrists were allocated on a functional basis with one being responsible for all the inpatient services and the Crisis Resolution and Home Treatment Team.

Additional Services

Riviera Court
Riviera Court is a residential care home and with staff available for 24 hours each day. It also had a sister establishment, The Braddons, which provided supported living with staff available during the day but not overnight.

Cypress House (provided by the Community Care Trust) provided independent accommodation which was registered as a hospital thus allowing it to provide accommodation and support for service users subject to Sections of the Mental Health Act 1983.

Lee Mill
Lee Mill was a low secure rehabilitation facility with 12 beds which was established to enable the Plymouth Primary Care NHS Trust to bring service users who had required placements in medium secure units back to Devon when they no longer needed this level of security. The 12 beds were originally allocated with seven for Plymouth and five of Torbay and Teignbridge.

Services in Teignbridge

Teignbridge is north of Torbay and is covers the area including Newton Abbot, Teignmouth, and Dawlish. South Hams and West Devon, covers Totnes, Dartmouth, Ivybridge really being the area, together with Torbay, which lies South West of Exeter.

The Adult Mental Health Service in Teignbridge servicing Newton Abbot comprised:
a Community Mental Health Team, a **Crisis Resolution and Home Treatment Team** and a small Assertive Outreach Team. The area was able to access the STEP Team from Totnes. The Community Mental Health Services were based at The Laurels in Newton Abbot.

The **Inpatient Ward was St Michael's** at Newton Abbot Hospital. As mentioned above this ward could call upon the Torbay Psychiatric Intensive Care Unit at Torbay Hospital, Riverside Ward, and was also able to use the same facility, Harvest Ward, at Bodmin Hospital within the Cornwall Partnership NHS Trust.

Transition

2006 onwards was a time of major change for the Devon Partnership NHS Trust:

- 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 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 (suspended)
    - 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 (suspended)

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*[3]
- Crisis Resolution and Home Treatment Teams came into being during the period from 2002 onwards.

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

[3] New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts 2005 DoH

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*[4]**

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:

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

[4] DPT web site August 2010

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.

Each Directorate has a Clinical Director, a Head of Practice and a Managing Partner.

Commissioning

How services were commissioned

Prior to October 2006 work was initiated by the CEO of Teignbridge PCT to bring together a Devon wide (excluding Plymouth) 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 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 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. RS and on his care and treatment from mental health services.

Background Information

Mr RD was born on 12 February 1982. He was the first child of his parents, but subsequently had two brothers who were two and eight years younger than him.

Soon after the second brother was born Mr RD's parents separated and Mr RD and the older of his two younger brothers lived with their father and the baby brother lived with Mrs D. When Mr RD was 10 years old his parents decided to alter the care arrangements and Mr RD and his brother moved to live with their mother and the two year old brother living with his father.

Mr RD's paternal grandmother reported great rivalry between his mother and father over the three children but neither parent provided a great deal of attention to them. The paternal grandmother gave Mr RD the most stable relationship he enjoyed within his family and was assisted by her husband, Mr RD's grandfather.

Roughly two years later when Mr RD was aged 10, his parents arranged to swap the parenting arrangements so he and his brother went to live with their mother and the youngest son moved to be cared for by his father.

Mr RD got into trouble at school (Knowles Hill) aged 12 was expelled when he was 15 for fighting and left school with no qualifications. Mr RD lived with his father, but lived independently in a caravan in the garden because his mother was unable to cope with him.

Mr RD was employed for six months at a factory where he sorted parcels. He was reported to have enjoyed this work. He then applied to join the army but was not recruited because he suffered from asthma.

Mr RD lived in a bedsit in Torquay for six months looking after himself. He had an interest in sport, particularly surfing and body building, which he took very seriously. Mr RD was also said to have had an interest in some aspects of the occult. During his time in Torbay Mr RD admitted that he drank heavily intermittently, and that he had used cannabis and ecstasy.

Mr RD also used steroids to assist with his body building but admitted that this had become out of hand and that he had abused his use of steroids.

Forensic history

As a young teenager Mr RD was cautioned by the police for being drunk and disorderly and for starting fires out of doors which were considered to be episodes of minor arson.

At the age of 15 Mr RD was sentenced to six months imprisonment in Portland Young Offenders Institution having been found guilty of causing actual bodily harm to a man on a bus when he was drunk.

At age 17 Mr RD drove a car when he was drunk after a beach party. He had no car insurance and had an accident which resulted in a friend of his being seriously injured. During the period Mr RD was bailed in the community waiting for the trial for the incident with the car he was involved in an unsuccessful burglary at a jewellers shop in Newton Abbot. Mr RD was sentenced to a further 18 months in Portland Young Offenders Institution.

It was during the second time in custody that Mr RD became withdrawn and refused to let his family visit him. It appeared that the other young people involved in the attempted burglary had not received a custodial sentence from the court because they had been successful in joining the Army. Mr RD was very angry that he had been singled out for punishment and this appears to have been a factor in his withdrawn attitude during this period in custody.

Mr RD was released on licence in April 2001. Mr RDs family reported that he did not appear to be his usual self when he returned home and described him as being withdrawn and morose. Mr RDs behaviour continued to cause his family concern and they reported that during the previous few months he had become isolated and antagonistic. He also appeared to be responding to auditory hallucinations. During this period he had accused his mother of stealing

his body building chemicals. He had cut his arm and had delusions about the Devil and being an emperor. His parents told him he needed help but since then Mr RD had rejected them.[5]

Mr RD's parents had referred him to the GP who in turn had referred him to the CAP service. His grandmother took him to the Accident and Emergency Department on the advice of CAP but he felt unable to cope with the environment and left.[6]

[5] Case Records Vol. 1 Part 1Pages 187 to 191
[6] Case Records Vol. 1 Part 1 Page 187

Mental Health Chronology

First Admission to Hospital (07 November 2001 to 11 June 2002)

On **07 November 2001** Mr RD was admitted to Torbay Hospital under Section 2 of the Mental Health Act 1983. He was placed on the Riverside Psychiatric Intensive Care Unit. The reason for this was that his family reported that he had contacted a cousin's partner, asking him if he could borrow a gun as he wanted to shoot his parents which he believed were not his real parents. He had also claimed that he was an Imperial Emperor who owned the hospital. Madonna was his mother and Kylie Minogue his sister or girlfriend. He said he was not Mr RD but was really the brother of Jason Donovan.[7]

On admission to the Riverside Unit Mr RD appeared hostile and was posturing and showing off his muscles. Despite this he was reasonably cooperative. His speech was normal in rate and form but he was not always coherent and his eye contact was intense. He appeared euthymic, denied suicidal thoughts and had a superior grandiose manner. He was orientated but lacked insight into the fact that he was ill.

Mr RD was assessed and given a differential diagnosis of drug induced psychosis, other psychotic illness or a personality disorder. A risk assessment stated that he had many risk factors for violence in that he was a young man with a history of violence, drug abuse, had made threats to kill specific people and showed poor insight into his situation.[8] Consultant Psychiatrist 1 found Mr RD to be fixed in his ideas about his parents including that his mother stole him at birth. He displayed very concrete thinking. Consultant 1 changed his medication to Risperidone BD.

Consultant 1 thought that Mr RD had settled on the ward by **16 November 2001** and thought he still had some delusional features but that they were poorly formed and he had agreed to take oral medication and would take this in the community. On **19 November 2001** Mr RD was allowed some Section 17 Leave with which he complied apart from drinking some alcohol.[9] Consultant 1 telephoned Mr RDs paternal grandmother who confirmed the history given by his

[7] Case Records Vol. 1 Part 1 Pages 1-5
[8] Case Records Vol. 1 Part 1 Page 4
[9] Case Records Vol. 1 Part 1 Page 11

mother and stated he had displayed distorted behaviour and that rejecting her and his grandfather was very significant.[10]

On **22 November 2001** a Mental Health Act Tribunal was held. Mr RDs parents refused to allow any of the family history or how their son had behaved to be used as they were frightened of their son. At the Tribunal Mr RD presented as psychotic and his application was rejected.

During the next few days Mr RD showed that he was still firmly holding his delusional beliefs. He refused to agree that he had had a gun and had threatened to kill his parents. Mr RD telephoned the police to report his father for telling the police about the gun. He had also told his cousin that he was not taking the medication.

On **23 November 2001** Mr RD appeared very delusional. He had laid himself on the floor of the ward near the nursing office and had refused to move. Staff had to physically lift him to a chair. Consultant 1 spoke to Mr RD and explained that he had to take his medication and if he refused he would have to have injections instead. The medication was altered to Risperidone liquid 3mg BD. The nursing record shows that if he did not take the Risperidone liquid he would be given a Haloperidol injection.[11]

On **30 November 2001** Mr RD was described as being settled but he did not really interact with others on the ward. It was planned for Consultant 2 to visit Mr RD's paternal grandmother the following week in preparation for a Section 3 of the Mental Health Act 1983 to be completed. The Section 3 was completed on **04 December 2001.**

Two days later Mr RD complained that he was being controlled and that he was not switched on. He thought that others were controlling his mouth and eyes. Consultant 1 decided to add regular Procyclidine to his medication. On **10 December 2001** the duty doctor was called to the ward because the staff were concerned about Mr RD's blood results from the test the month before which showed urea and electolytes being abnormal. The staff requested another physical examination due to Mr RD's weight loss and poor appetite. There were concerns about the effects of past anabolic steroid abuse and any possible side-effects or rebound effects.[12]

[10] Case Records Vol. 1 Part 1 Page 12
[11] Case Records Vol. 1 Part 1 Pages 12/13
[12] Case Records Vol. 1 Part 2 Page 432

A week later Consultant 1 described Mr RD as being much more lively in his interactions on the ward since the Procyclidine had been prescribed. Staff stated that he was talking freely and he had showed Consultant 1 some of his art work. It was planned for Mr RD to leave the Psychiatric Intensive Care Unit and to transfer to St Michaels Hospital in Newton Abbot and to have Section 17 Leave with his family over the Christmas period. He was transferred on **19 December 2001.**[13]

The Section 17 Leave over Christmas was from **24 December to 27 December 2001.** The Leave was reported to have gone well but Mr RD did return to St Michaels Hospital on **26 December 2001** asking for an inhaler for his asthma which was duly provided.[14]

On **27 December 2001** Mr RD returned from his Section 17 Leave over the Christmas period, inebriated when seen by the Senior House Officer at 21.00. It was also thought that he had not complied with his medication whilst at home. The same day Mr RD's family phoned Consultant 2 and reported that he had not been taking his medication and that he had been seeing spiders and had expressed serious delusions. Mr RD quickly settled on the ward but refused the offer of a Depot injection.[15]

The next day Mr RD also refused a Depot injection but Consultant 1 explained that she did not believe that he was taking his medication and that this had to be done. Consultant 1 also said that when he was at home and self medicating he must allow a relative to supervise his taking of medication.

On **04 January 2001** Mr RD was using his eight hours of Section 17 Leave well and there were no further instances of him having taken alcohol. Mr RD accepted the idea that when he was able to leave hospital he would need a hostel placement.

The same day Mr RD's mother and paternal grandmother were seen by Mr RD's Care Coordinator 1 who explained the nature of his illness and the need for medication. The family were reported to have been very supportive of Mr RD but to have thought that he should live independently.[16] Mr RD then agreed to visit a hostel the following week.

[13] Case Records Vol. 1 Part 1 Pages 14/15
[14] Case Records Vol. 1 Part 1 Page 15
[15] Case Records Vol. 1 Part 1 Page 16
[16] Case Records Vol. 1 Part 1 Page 18

Care Coordinator 1 discussed the Care Plan she was drawing up with Mr RD and he thought it was all about his family and not about him. He described a weakness in his vision in that he could see things which he looked at directly but described his peripheral vision as black and it felt like being controlled by a ghost. Mr RD still persisted with his belief that he was given away as a child.[17]

On **12 January 2002** Mr RD was offered a place at Riviera Court, a supported hostel for people with mental health problems. On **16 January 2002** Mr RD was taken by Care Coordinator 1 to Riviera Court for a three week trial period, and would be reviewed weekly by her. He was due to return to St Michael's Hospital on **12 February 2002** for a ward round review.

Mr RD attended the ward round review. He was reported to have settled at Riviera Court and to have occasional leave to his grandparents. The grandparents stated that Mr RD drank to excess on these visits. The staff at Riviera Court confirmed that he was mainly settled and polite, and was interacting well with staff and other residents and using his time well. Mr RD was already reported to be asking when he would be able to have a place of his own.

The decision of the ward round was to recommence leave at Riviera Court, to help Mr RD to start looking for accommodation and to review the leave in a month.

On **12 March 2002** at the ward round review it was reported that Mr RD had been deteriorating at Riviera Court. He had been swearing at staff and appeared unable to understand that he was on Section 17 Leave and still under the Mental Health Act 1983. His thinking had not been rational, but the meeting agreed that he should return to Riviera Court but be closely monitored for any further signs of deterioration in his mental state.

Having left the ward round meeting Mr RD did not return immediately to Riviera Court. The staff informed the ward of this at 17.30 and agreed they would contact his family to see if there knew his whereabouts. Mr RD returned to Riviera Court at 1900, just before the time it had been decided to start the Missing Persons Policy procedure. He gave no account of where he had been. Staff agreed to monitor him carefully that evening.[18]

[17] Case Records Vol. 1 Part 1 Page 19
[18] Case Records Vol. 1 Part 2 Pages 343/344

On **20 March 2002** Mr RD's grandmother phoned Care Coordinator 1 to discuss her concern at the lack of structure to her grandson's day and the fact that he was not socialising.[19]

Mr RD settled again at Riviera Court and it was agreed that a Section 117 meeting would be held on **16 April 2002.** At this meeting it was stated that Mr RD had been doing well. He understood that a Section 25 of the Mental Health Act 1983 was planned to ensure that he would be supervised in the community and was taking his medication and not deteriorating. Mr RD was placed on the Supervised Discharge (Section 25A Mental Health Act 1983) by **11 June 2002.**[20] At this time it was noted that he was less inhibited after two weeks of being allowed to administer his own medication which caused Consultant 1 to question if he had been taking this medication. Consultant 2 and Care Coordinator 1 agreed to follow Mr RD up in the community following his discharge from St Michaels Hospital on **11 June 2002.** His medication on discharge was Olanzapine 20mg nocte and inhalers for his asthma.

Second Admission to Hospital (06 August 2002 until 26 August 2002)

Mr RD was admitted to hospital under Section 3 of the Mental Health Act 1983 because he had been expressing paranoid ideas and delusional beliefs that he did not belong to his family. He was grandiose and hostile and had been verbally aggressive to the staff at Riviera Court who requested his assessment. He was noted to lack insight into the reality of his delusions and for the inappropriateness of his behaviour. Mr RD refused voluntary admission, and was admitted to Riverside Ward the Psychiatric Intensive Care Ward, with a plan to transfer to Newton Abbot Hospital when he had settled and when a bed was available. He was admitted because there was a fear that he could become a risk to others.

It was noted that his mother was due to marry her long-term partner in two weeks and staff wondered if this event had triggered Mr RD's deterioration.[21] It was thought that Mr RD had not been compliant with his medication ever since he had been allowed to self medicate. Staff at Riviera Court suspected that he had obtained some cannabis from another resident. Mr RD had presented as hostile to staff and had stared fixedly at one particular member of staff. He had stated that his grandfather had a dead body in his attic and that his grandmother had been harmful to him as a young child (It was noted that his grandmother had been a great support to

[19] Case Record Vol 5. Part 2 Page 276
[20] Case Records Vol. 1 Part 2 Pages 198/199
[21] Case Records Vol. 1 Part 1 Page 24

him as a child and was the main stabilising force in his life, and that he had been quite dependent on her and visited her frequently)

Mr RD was being involved in plans for his mother's marriage to her long-term partner, but family members were concerned about how he would cope with the wedding. His mother was keen that he should be there.

By **07 August 2002** Mr RD was still delusional about Kylie Minogue and retained his views about his parents not being his birth parents. The plan was for him to continue with Olanzapine 20mgs and continue a 72 hour assessment of his behaviour and how he acted on the ward.

The next week on **16 August 2002** Mr RDs mental state had improved sufficiently for permission to be given for him to attend his mother's wedding. It was noted that if the wedding went well and he had not suffered any negative after-effects then he could be discharged. The wedding did pass without incident and Mr RD was granted Section 17 Leave for 28 days at Riviera Court from **26/08/2002.**.[22] Mr RD was discharged with medication of Olanzapine 20mg nocte to be supervised by the Riviera Court staff. He was to be followed up by staff from The Laurels Community Mental Health Team in Newton Abbot until his community care could be handed over to Waverley House Community Mental Health Team in Torquay. This was necessary as Mr RD's GP was from a Torquay Practice.

A Section 117 Meeting was arranged for **10 September 2002.** At the meeting attended by Mr RD and his family it was reported that he continued to abuse alcohol, returning either withdrawn or being rude to staff at Riviera Court. Mr RD refused to agree to his Olanzapine being increased from 20mg to 30mg, saying that it should be reduced. The Care Plan agreed at the meeting was that Mr RD should remain on Section 17 Leave to Riviera Court.

The Section 3 Mental Health Act 1983 order was to be converted to a Section 25 Supervised Discharge when Mr RD moved to a flat offering more independence but still supervised by Riviera Court. Care Coordinator 1 would liaise with the Waverley House CMHT and identify a social worker and supervisor to complete the necessary paperwork. Social Worker 1 agreed to talk to the managers of Riviera Court as Mr RD was very keen to move into independent living and a referral had been made to Rydal Court, the flats linked to Riviera Court. Mr RD was

[22] Case Records Vol. 1 Part 1 Page 30

discharged with medication of Olanzapine Velotabs 20mg nocte and inhalers. Follow-up was to be provided by Consultant 2 and Care Coordinator 1.

On **25 September 2002** the staff at Riviera Court were concerned that Mr RD had shut himself in his room and was withdrawn and hostile. He had also stopped having contact with his family. He continued to be increasingly hostile and negative towards the staff whilst denying that he had any illness. Mr RD was offered an interview to consider his request for a flat at Rydal Court but he refused to attend the meeting. The deterioration persisted and on **01 October 2002** Mr RD was admitted to Ash Ward at Wonford House Hospital in Exeter.

Third Admission to Hospital (01 October 2002 until March 2003 [Transfer])

On arrival at Ash Ward Mr RD denied that he had any plans for deliberate self harm. He was placed on normal Level 3 Observation on the ward, with the plan being to transfer him to St Michaels Hospital in Newton Abbot when a bed was available.

Mr RD said he did not know why he was in hospital. He stayed in his room most of the time and did not interact with others. He did not want any visitors. He refused to see his family when they visited or to accept their gift of cigarettes and chocolate. He later accepted the cigarettes being told they were from his mother. In a one to one interview he was very tense with his hands clenched.

A JARAP Risk Assessment was carried out on **25 September 2002** and Mr RD was deemed to have a high risk of causing harm to others and was thought to present a medium risk of absconding. The warning signs of Mr RD becoming a risk were his mental health deteriorating, his becoming withdrawn and isolated and becoming hostile. It was noted that alcohol intake could increase the level of the risk.[23]

Mr RD absconded from Ash Ward at 17.15 on **29 September 2002** and managed to get himself to London where he handed himself in at Kentish Town Police Station. A Forensic Medical Examination was carried out while he was in police custody at Kentish Town. Mr RD was conscious, coherent and alert with no obvious evidence of acute psychosis. The decision was made to remove all potentially dangerous materials from his possession and from the cell. After discussion with the staff at Wonford House Hospital Mr RD had to wait until arrangements could

[23] Case Records Vol. 7 Pages 51/52

be made for his safe return to Newton Abbot Hospital. It was noted that the custody suite had no Olanzapine in its medical cupboard.

On **30 September 2002** Mr RD returned to Ash Ward with one of his care staff from Riviera Court. The following day he was transferred to St Michael's Hospital at Newton Abbot. On **02 October 2002** Mr RDs medication was reviewed and it was decided to alter the Olanzapine from 20mg to 30mg. Two days later on **04 October 2002** he refused to have 30mg but agreed that he would take 20 mg mane and a further 10mg nocte. The next day Mr RD's placement at Riviera Court was given up as there appeared to be little chance of him returning there in the foreseeable future.

On **07 October 2002** Mr RD refused to have his depot. He had been aggressive to his grandmother when she visited him on the ward, and when she had bent to kiss him he had pushed her away and in doing so had knocked her glasses off. She was shocked and upset as he had never acted like this to her before. On another occasion Mr RD had pulled his mother's hair.

In view of this aggressive behaviour Mr RD was transferred to the Psychiatric Intensive Care Unit (Riverside) at Torbay Hospital where he accepted Depot on Riverside Ward. He was thus transferred back to St Michael's Hospital the following day. On his return a new care plan was put in place which stated that his medication would be:

- Olanzapine 10mg (8am dose) discontinued
- Next Clopixol dose – date to be arranged
- Clopixol and Olanzapine to be used in conjunction with each other
- Olanzapine 20mg nocte to continue
- Observation Level 1
- Possible risk of absconding – review as necessary
- Issue of possible physical aggression.

A week later on **15 October 2002** Mr RD's belongings from Riviera Court were delivered to the ward. On inspection they were found to contain knives wrapped up in his clothes. Consultant 3 was to be advised as it was planned that Mr RD would be transferred to Lee Mill at Ivybridge, a low secure unit which was thought to be more appropriate for him. An earlier referral had been made but Mr RD had been assessed by the Unit as not being ready to benefit from the service there.

During the next week Mr RD deliberately flaunted the rules at St Michaels Hospital. He was observed spitting out his medication and had neglected his personal hygiene. In addition he had enjoyed a successful escorted leave outside the hospital, but returned from an unescorted leave to the local shop with an empty half bottle of whisky. He claimed to have shared it with others but eventually agreed with a nurse that he had drunk it all. The final infringement was when on **25 October 2002** he had gone off the ward with his brother to swap some CDs at 18.45. Mr RD did not return until 21.00 having had a few drinks.

On **28 October 2002** it was noted that there had been three episodes of drinking during the week. At the ward round it was decided that his two hours of escorted leave twice a week would be cancelled if he had been drinking alcohol. Mr RD did admit to Consultant 1 that he heard constant voices. He claimed to feel that he was in league with the devil to harm his mother.

The next day, **29 October 2002**, Mr RD was talkative to one of the nurses and explained that he had had mental health problems since a child and had sought help when he was in prison. He said he felt that antipsychotic medication did not help him and only Procyclidine had helped with his blurred vision and lack of concentration. Mr RD said he believed this was his problem and not the delusional problems.

On **30 October 2002** Mr RD was told that he had breached his Section 17 Leave arrangements twice in the last week by drinking alcohol and on the other occasion returning to the ward drunk. The next day he again returned to the ward drunk after having been absent without leave. He had earlier asked his mother to visit but only if she called herself Julie as she was not his mother. A Senior House Officer advised his mother not to comply and not to visit.

Mr RD had an occupational therapy assessment on **15 November 2002** the result of which identified that he needed structure and occupation within his week in order to maintain his mental state.

On **25 November 2002** Mr RD was observed as being clearly drunk on the ward. As a result he was from then on to only have escorted leave during the week and unescorted leave at weekends provided he did not get drunk. If his drinking was to persist. Mr RD would be transferred to the Psychiatric Intensive Care Unit.

It was clear that Mr RD still had delusions as he still thought that his aunt's body was in his grandfather's attic. The plan was for Mr RD to stay at St Michael's Hospital for the next few weeks and then to go to Lee Mill. Mr RD was insisting that he changed from Olanzapine to Procyclidine and emphasised that he was determined to have this change.

On **03 December 2002** Mr RD stated that he was taking steroids, and then changed the tense used to the „past' tense but he was smiling. Two weeks later it was agreed that Mr RD should be referred back to Lee Mill in January 2003. In early January 2003 there were suspicions that Mr RD had been smoking cannabis and a resultant urine scan proved positive. Mr RD's leave was suspended until the next day.

On **06 January 2003** Mr RD visited Lee Mill for his assessment. Consultant 3 considered that Mr RD he had improved since the first time she saw him, but she still had some reservations about the suitability of Lee Mill for him. He was offered a place at Lee Mill but he was by no means sure he wanted to go there. However he was informed that he might not have much choice in the matter.

On **16 January 2003** Mr RD became been agitated by his conversation with Consultant 3 the week before. He stated that he had hidden a gun in the garden of St Michaels Hospital but it was no longer there and someone had taken it away. He telephoned the police using 999 and asked them to visit in order to interview him. There was no evidence that Mr RD had ever had a gun at St Michaels Hospital. The nurses commented that he was upset at the thought of moving to Lee Mill. He took his Olanzapine early but refused to take his Lorazepam, although he did later agree. He again telephoned the police but the staff informed them that there was no need to visit.[24]

[24] Case Records Vol 1. Part 1 Page 56

The next day Mr RD requested Section 17 Leave so that he could help his father mend a fence. Consultant 1 agreed provided he did not drink alcohol or smoke cannabis. This was agreed. On **20 January 2003** Mr RD apologised to Consultant 1 for his behaviour the previous week and admitted he was upset.

On **25 February 2003** Mr RD was found drinking lager in his room. He denied it was alcohol but handed over the can when he was informed that his room would be searched.

Throughout the latter half of January and February 2003 Mr RD was truculent and appeared to be testing the boundaries prior to the planned move to Lee Mill. The date for his transfer had been fixed for **05 March 2003.** The day before (**04 March**) Mr RD purchased cannabis which was found in his room. The police were involved, in line with the ward and hospital policy and they visited and took the cannabis away for destruction, no further action was taken.

On **05 March 2003** Mr RD was transferred to Lee Mill where he would be under Consultant 3.

Third Hospital Admission at Lee Mill (05 March 2003 until 08 March 2004) [Transfer]

Mr RD was admitted initially for a six week assessment to see if he would be able to benefit from the rehabilitation programme at Lee Mill. Initially Mr RD was unhappy about the move from Newton Abbot but seemed resigned to it. Mr RD kept a low profile on the ward and did not really interact with the other people on the ward and only engaged with the staff when he had to. He did comply with his medication and eventually the low secure setting provided an environment where he accepted the structure.

At first Mr RD was not keen to get involved with activities, but slowly did start to engage with staff in different occupational activities that were planned for him. He was interested in the walking activities and other physical programmes, but was less involved in talking or discussion sessions. Mr RD enjoyed going swimming, visiting the gym and also participated in the gardening group and going to the cinema.

Mr RD's mental state revealed that he had some positive symptoms, but he remained very reluctant to discuss them. He avoided any discussions about his past psychotic symptoms and when they were mentioned to him he would claim that he did not know what the staff were talking about. It proved extremely hard to assess his actual mental state due to this guarded and protective attitude. The one area of his symptoms that he did discuss was his admission that he did sense a presence behind his shoulder which prevented him concentrating on things.

Mr RD remained reluctant to get up in the morning but could always be persuaded to, however he would quite quickly return to his bed as soon as he could. He would play pool on the ward but never really became particularly sociable with the other service users.

Despite these difficulties Mr RD's mood and demeanour appeared to improve while he was at Lee Mill, and by the end of his stay any positive symptoms were "certainly not affecting his daily life significantly."[25] Throughout his stay Mr RD became increasingly more sociable, warm and receptive, particularly in involving himself in Occupational Therapy activities. His social skills had improved and he was able to express his needs, although there was an edge of abruptness about his manner. There was no doubt that Mr RD was warmer than on admission and at times he had displayed a sense of humour.

During the second half of his period at Lee Mill, Mr RD had regular weekend leave with his family. There were no problems connected to these periods at home and he never returned to the ward intoxicated with alcohol or drugs and his drug screens were negative. It was clear that he had been compliant with his medication but the discharge letter to his GP states that he did not really appear to consent to the medication in principle.

His admission to Lee Mill had been because Consultant 1 felt that he needed further rehabilitation to a level greater than St Michaels Hospital could offer. A more structured risk assessment was also required within the low secure setting as in Newton Abbot there had been issues of absconding, returning late from Section 17 Leave and coming back to the ward intoxicated.

Mr RD had remained lacking insight into his mental health problems, but accepted support and the idea of medication although he did not accept he was mentally ill. He had told Consultant 3 that he took his medicine because it had been prescribed for him.

Consultant 3 was very concerned that throughout his time at Lee Mill he retained his belief that his parents were not his parents, and whilst this did not prevent him spending more and more time with his family the „delusion' remained with him. Consultant 3 took the unusual step of meeting Mr RD's family to explain the Capgras Syndrome to them as she was concerned that it could become significant should Mr RD relapse. In his first episode of psychosis Mr RD had

[25] Lee Mill Case File Page 302

sought to buy a gun and had intended to kill his parents, so Consultant 3 explained how Mr RD would be likely to show symptoms of relapse. These were described as being:

- grandiose ideas;
- capgras views about his parents;
- getting hold of a gun;
- isolating himself;
- spending a lot of time in his bedroom;
- responding to auditory hallucinations;
- paranoid ideation;
- becoming much less communicative;
- appearing cold and suspicious;
- feeling he is cursed;
- feeling a presence behind him.[26]

On **23 July 2003** Consultant 3 wrote to the anticipated Consultant 4 to outline his progress at Lee Mill and to provide an overview of the plan for him. She stated that Mr RD had made significant progress at Lee Mill when compared to the two assessments she had carried out at St Michaels Hospital. Consultant 3 specifically mentioned that Mr RD

"had a very complicated delusional system surrounding himself, Kylie Minogue and Jason Donovan. Ideas that he was an Australian, went to Australia at night and his mother was not his mother, but his mother was a dead aborigine, who was on his shoulder. There were capras symptoms about his grandmother. He categorically denied that she was she and, at one stage, there was an altercation in which her glasses were knocked off. He also refused to have any contact with his mother and grandmother during this time.

[26] Lee Mill Case File Page 304

There have also been issues in the past when he has wanted to get hold of guns in order to extricate himself in difficult situations, but this has not been a feature whilst he has been with us (Lee Mill)"

Consultant 3 continues to identify other characteristics of his time at Lee Mill:

"...he has no insight into his illness, but takes his medication whilst he is on the unit. This is a combination of high dose Depot neuroleptics and olanzapine. I was going to reduce his Olanzapine, but he has been making such consistent improvements that I have not touched it, particularly when those who have known him for some time feel there have been significant improvements. His family have also verified this.

I would be most grateful if you could see him before we agree a transfer to Riviera Court. I would be interested in your views of how you feel he is. I recently renewed his Section 3, particularly because we have not got an imminent discharge date. He is pretty reluctant to stay where he is at the moment and I am concerned, given his complete lack of insight into his illness, that we need to test him out in the community on Section 25 prior to a formal discharge. I have also, during the time he has been here, had full and frank discussions with his family, particularly about the capgras symptoms and their need to contact a community worker should these symptoms recur"[27]

In a Strengths and Needs Assessment Mental State Examination undertaken on **06 August 2003** Mr RD was reported as having one day been dressed like a boxer in the middle of the day and would not explain why. It was classified as an episode of deteriorating mental state with the strange clothes being the symptom. Mr RD had been referred to a cardiologist at Derriford hospital as he had complained of some pains in his chest and on one occasion this had for a short time moved to his arm. He refused a blood test to have a lipid profile done. (Mr RD attended a Cardiology Outpatient Appointment on **06 October 2003** and after an Electrocardiogram Test it was confirmed that he had no coronary problems and his discomfiture had been due to muscular pains.)[28]

[27] Lee Mill Case File Page 427/429
[28] Lee Mill Case File Page 244

In the Daily Living Skills section of the assessment it was stated that Mr RD stayed in bed until midday, does his own self-care, "granny does his laundry" although he is able to but preferred others to do it for him. He was also learning to play the guitar.

The plan for Mr RD following his time at Lee Mill was for him to have a placement at Riviera Court, where he had been before. His hobbies were described as surfing, playing the guitar, using the local gym and swimming pool and any outdoor activities.

The summary states that since the **13 May 2003** Strengths and Needs Assessment Mental State Examination there had been a marked change in Mr RDs presentation as he had fully participated in his Occupational Therapy Programme and had enjoyed the more physical activities such as swimming, walking and gardening. He had complied with both oral and depot medication. There was however in the May assessment a statement that *"at the moment there does not seem to be an issue about risk to others, but there could be, given his previous history should he not comply with further treatment."*

From **August 2003** Mr RDs Care Plan was for him to move to Riviera Court but there needed to be a vacancy and also the funding needed to be arranged. It was quite difficult for the staff in Ivybridge to provide support to Mr RD once he was at Riviera Court. The letter quoted from above, from Consultant 3 to Consultant 4 was attempting to pave the way for the care to transfer to the Torbay Community Mental Health Team based in Waverley House in Torquay.

On **08 October 2003** Care Coordinator 1 wrote to the Team Leader of Waverley Community Mental Health Team asking for a local care coordinator to be identified once Mr RD was transferred to Riviera Court. She invited the team Leader to nominate a member of staff to attend a multidisciplinary ward round meeting at Lee Mill on 28 October to learn about Mr RD at first hand.

On **21 October 2003** Lee Mill was informed that a place was available for Mr RD. The manager of Riviera Court would not be able to give Mr RD his Depot herself and suggested that he attend a Depot Clinic at Waverley House where the Community Mental Health Team operated from. Mr RD stated that he would have no difficulty with this arrangement.

Mr RD started a one month Section 17 Leave to Riviera Court on **23 October 2003**.

At the multidisciplinary ward round on **28 October 2003** it was reported that Mr RD continued to take his medication although he still insisted he did not need it. Consultant 3 was tasked to contact Consultant 4 and discuss Mr RDs Mental Health Section and the arrangements for his care and treatment to be passed to Torquay. Care Coordinator 1 agreed to prepare the care plans for the future following the Section 117 Meeting planned for 25 November 2003. A social worker from the Waverley Community Mental Health Team would be arranged. It was agreed that drug screens should be done on a random basis.

Mr RD was satisfied with the arrangements as he was given weekend leave to be with his mother. He would be visited weekly by Care Coordinator 1 and would receive his Depot from Lee Mill with Riviera Court providing the transport until the transfer to Waverley House.

Consultant 3 wrote a letter to the North Locality manager of The Laurels Community Mental Health Team asking if he could liaise with The Waverley House Community Mental Health Team as Mr RD was ready for discharge to Riviera Court, but that until his GP arrangements had been sorted out this appeared hard to implement. Consultant 3 had heard from Consultant 4 that the Waverley Community Mental Health Team did not have the capacity to accept Mr RD at the present time due to pressure of work. Consultant 3 concluded by saying that "There seems to be no question at all that Consultant 4s Team will take Mr RD eventually, it is just the timing and I do not think it is appropriate to keep him in hospital at Lee Mill or, indeed, under the extended limbo of Section 17 Leave whilst this is resolved.

On **14 November 2003** a senior occupational therapist visited Riviera Court but Mr RD was out utilising his four hour leave. She left a four week supply of medication for Mr RD and also agreed to see if the Lee Mill Unit could lend Riviera Court a urine drug testing kit.

The Section 117 Meeting on **25 November 2003** had to be altered to Clinical Review as Consultant 3 could not attend. Those attending were the manager of Riviera Court, Care Coordinator 1, the Approved Social Worker, a Senior House Officer and two other staff from Lee Mill as well as Mr RDs mother and grandmother. It was agreed that Mr RD would in future have his Depot Injections at The Abbey Club, and that he could start at the Torbay Day Services in the coming week. A Supervised Community Order would be in place once Mr RD was discharged from Lee Mill. In addition a new care Coordinator would be appointed as soon as practical.

Care Coordinator 2 telephoned Lee Mill to introduce himself on **28 November 2003**.

On **11 December 2003** the Lee Mill Senior House Officer visited Mr RD at Riviera Court. He reported that Mr RD appeared settled and had been experiencing no problems. He had spent his days appropriately doing shopping, swimming and visiting friends at the flats close to Riviera Court.

The Section 117 Meeting was held on **07 January 2004.** It was attended by Care Coordinators 1 and 2, Consultant 4, the Lee Mill Senior House Officer, an occupational therapy student and Mr RD with his mother and grandmother and a staff member from Riviera Court. It was agreed that Mr RD would be placed on a Section 25 Community Supervision Order and Consultant 1 would make application. Mr RD commented that his family felt he would do well with the boundaries and structure the S25 would provide. He has been compliant with his medication but did state that he would rather be on oral medication than have the Depot injection.

Concern was expressed about Mr RDs beliefs as they were still present but were not intrusive. He was trying to limit his alcohol intake as he reluctantly accepted that it might not be good for his mental health. He had complied with all drug screens and the results had all been negative. The Care Plan agreed was:

- Section 25A to be obtained;
- to increase leave to one extra night during the week;
- to increase his unescorted leave during the day to ten hours;
- to review the Care Plan in six months time;
- to progress to more independent living such as the Riviera Court less dependent flats at The Braddens;
- Care Coordinator 1 and the Torbay Day Services to explore an Art Group and a college course to obtain some NVQs.

Mr RDs Supervised Discharge was granted on **08 March 2004** for a period of six months when it could be renewed for a further six months and after that for up to a year at each renewal. The conditions of the Supervised Discharge were to:

- Reside at Riviera Court;

- attend outpatients clinics at Waverley House or any other designated venue for the purposes of medical treatment;
- accept supervision from his Community Responsible Medical Officer, Consultant 4;
- allow the Community Responsible Medical Officer, Consultant 4 and the S25 Supervisor, or anyone authorised by them, access to his place of residence.

The Section 25 Supervised Discharge designated an Approved Social Worker, Social Worker 1.

Time in the Community (08 March 2004 until 28 June 2006)

The Care programme Approach Care Plan agreed on **19 November 2003** stated that the primary aim was to help Mr RD develop independent living skills and for staff to liaise with all other professionals and his family in order to gauge how well he was coping in the community.

It was made clear that Mr RD did not see himself as having mental health problems. He could become unwell due to not taking medication, using drink and drugs and steroids. He could become suspicious of others. His grandmother, mother or father might report that he is deteriorating and if they did an urgent assessment of mental state would be required.

On **21 November 2003** Mr RD was referred to the Torbay Day Services as he was in effect in the community despite technically being a resident at Lee Mill on extended Section 17 Leave. The Treatment Plan from the Day Treatment Service was to interact closely with Mr RD and to provide continuity of staff. It was agreed that he should attend a one – to - one cookery session once a week. Mr RDs mental state would be monitored and all staff were to be made aware of his Risk Assessment. His care coordinator was to be contacted in the event of a change in his mental state.

Mr RD attended some of the sessions agreed but at a review with the organiser on **19 January 2004** to consider the future treatment programme he wanted more one – to - one cookery sessions but this could not be arranged although there were group cooking sessions. Mr RD refused any groups and therefore he was discharged from the Day Treatment Service.

Two days later the Day Services Organiser wrote to Mr RD explaining that he had been discharged from the service. This was because he had made it plain that he did not wish to engage with the service and be with people with mental health problems. He refused to discuss his mental state other than to state that he had done some "wacky" things two years previously. Mr RD had attended the one – to – one cookery sessions on five occasions and had appeared to enjoy these and had acted appropriately.

Approved Social Worker 2 from the Plymouth Teaching Primary Care Trust wrote to Approved Social Worker 3 at Waverley House about the recommendation she had made for Mr RD to be made the subject to Section 25 of the mental Health Act 1983. She was concerned that ASW 3 was nominally the supervisor for all people under Section 25 in the Torbay area, and wanted to emphasise that

"it is fairly crucial that there is regular information flowing between yourself and the care coordinator so that you are always aware of any concerns or untoward incidents. The recommendation was made on a health and safety basis and also for the protection of others. I am told and have also seen documented that [Mr RD's] mental health can deteriorate very rapidly, also that he is liable to act on paranoid impulses and has in the past become quite threatening"[29].

On **15 April 2004** Mr RD attended an assessment session for the Day Treatment Services at his own request. A residential worker from Riviera Court and Care Coordinator 2 attended with him. Mr RD reported that he would be attending a first stage life saving course through „Bridge'. He did agree to take part in the pottery group and the lunch cookery group.

On **18/04/2004** Mr RD attended the pottery group but as he did not feel well he apologised and left early. Five days later he attended the lunch cookery group and he appeared to be confident and interacted well with the other participants. At the end he surprised the leader as he invited his mother into the room to see what he had prepared.

At the second session of the cookery group on **30 April 2004 Mr** RD was not as well as the time before and did not interact in the same way. He told bizarre stories about camping with friends and playing „manhunt', a game where if you are found you are tortured.

[29] Case Records Vol. 4 Part 1 Page 156

Mr RD continued to attend the groups and started to interact with the female members of them. He also started to challenge the leader of the pottery group by asking lots of questions. On **12 May 2004** Mr RD attended the pottery group but did not engage and needed encouragement to start another project, having finished his first one the session before. He took lunch early and left.

The nurse at Riviera Court explained that Mr RD had had a session with Consultant 4 and Care Coordinator 2 and had disliked the way the discussion had been about his illness and the past. He had wanted them all to move forward as he had and as a result he was considering asking to have a change of Consultant and Care Coordinator.

The next day, **13 May 2004**, there was a Review Meeting at Riviera Court. Mr RD stated that he would like to move to more independent accommodation. On **26 June 2004** Care Coordinator 2 saw Mr RD at Riviera Court with the nurse when he received his depot. Mr RD appeared settled and reported no problems. He had decided not to pursue the life-saving course at present. There had been a vacancy at The Braddons so an application form had been completed with Mr RD. His application was successful and Mr RD ended the placement at Riviera Court on **12 July 2004** and moved into The Braddons.

On **17 August 2004** there was a Section 25 Review Meeting. It was reported that Mr RD had been at The Braddens for about six weeks and that he liked it there. A side effect of medication was raised which caused his eye to roll. Mr RD was taking Clopizol 600mg two weekly, Olanzapine 20mg daily and Procyclidine 5mg BD.

On **22 October 2004** Care Coordinator 2 telephoned The Braddens and was informed by staff that Mr RD was doing very well. The Care Coordinator explained that he would see Mr RD regularly at his Depot appointments and asked the staff at The Braddens to telephone him should they have any concerns.

At a Review Meeting on **11 February 2005** Mr RD said that he wanted to come off the Section 25 because he felt that he had very much improved. He was supported in this by his mother and his grandmother. Mr RD discussed riding his motor bike and getting a provisional licence from DVLA. Following discussion Consultant 4 and care Coordinator 2 agreed not to renew the Section 25. They both agreed that Mr RD had increased confidence and was able to express

emotions and was talking things through with people. Their thoughts were echoed by his mother.[30]

The next Review Meeting was held on **03 May 2005.** Mr RD felt that he was doing really well, and had decided he would like to move on to more independent accommodation. He was clear that he did not want any support. He had started working part-time with his father when he has work and was also attending the gym at Newton Abbot. It was agreed that if he was to live independently he would require outreach support from The Braddens for at least a month. He would ideally prefer a studio flat.[31]

On **27 May 2005** a further Review Meeting was held with Mr RD, Consultant 4, Care Coordinator 2, a support worker from The Braddens and Mr RDs mother. Mr RD had found a flat at 2 Warren Hill. It was agreed that a Community Care Grant would be applied for and a referral made to MASH, a local charity providing furniture and other items needed to equip a home.

Mr RD stated that he wanted to reduce his medication, but Care Coordinator 2 thought it would be better for him to get settled in his new home first and then to review the situation. His medication was Clopixol 1000g every four weeks, Olanzapine 20mg daily and Procylidine 5mg bd.[32]

A month later, on **22 June 2005** Care Coordinator 2 visited Mr RD at his new address. It was evident that he and his family plus the care support worker had worked very hard to make the flat comfortable and close to what Mr RD had ideally wanted. No particular concerns were noted.

On **22 July 2005** Care Coordinator 2 visited Mr RD at his home. He had just returned from a week's holiday in Tunisia with his brother. He had had a good holiday but there was no night life. It was necessary to complete renewal forms for the Disability Living Allowance, but Mr RD did not want to say too much about his past history.[33]

A Review Meeting was held on **26 August 2005** which was informed that Mr RD was now living at Flat 1, 2 Warren Hill, Torquay. He was working with his father and brother and also fishing. It was agreed to reduce the Olanzapine to 15mg daily and to review the situation again on 16

[30] Case Records Vol. 4 Part 1 Page 204
[31] Case Records Vol. 4 Part 1 Page 205
[32] Case Records Vol. 4 Part 1 Page 206
[33] Case Records Vol. 4 Part 1 Page 207

December 2005. Mr RD was also keen to wean himself off the Procyclidine but he was warned that this should be done slowly.[34]

On **08 November 2005** Care Coordinator 2 visited Mr RD at his home. Mr RD was progressing well and remained physically and mentally well. The Disability Living Allowance would end in December and Mr RD wanted to apply for Income Support. His grandmother had obtained all the details.

There was one issue which needed to be addressed as Mr RD had been involved in an exchange with a traffic warden in Teignmouth about a tax disc. Mr RD was alleged to have assaulted the traffic warden and had already appeared in court once. The case was due to be heard on **06 December 2005**. Mr RD said he had found a solicitor.

Mr RD did not attend the next review meeting with Consultant 4 and care Coordinator 2 on **16 December 2005.** Care Coordinator 2 was ill so Consultant 4 telephoned Mr RD who said he knew he had a meeting but had not remembered the time. He was advised that care Coordinator 2 would arrange another appointment, Mr RD said he was alright.[35]

The next contact was a home visit arranged for **04 January 2006**. Mr RD explained that the court case had been postponed and the next hearing was for reports on 6 February with the trial the next month on 14 March. Mr RD asked Care Coordinator 2 to write a letter to the court about his mental health. It was noted that Mr RD was well.

Care Coordinator 2 did write to the Newton Abbot Magistrates Court on **25 January 2006.** He explained that Mr RD had a diagnosis of schizophrenia and that he had worked hard over the past three years and had reached "a point of relative mental health wellness which was aided by a monthly Depot injection plus reviews from Care Coordinator 2 and Consultant 4."[36]

On **03 March 2006** Mr RD attended another review Meeting with Consultant 4 and Care Coordinator 2. He reported himself to be well and to be attending the gym when he had the money. He was seeing a lot of his family. His flat was described as lovely and he had altered the furniture round as he was going to have a party. He said his mental health was fine but he was a bit stressed due to the court case. The Depot date was altered to 16 March so as not to

[34] Case Records Vol. 4 Part 1 Page 208
[35] Case Records Vol. 4 Part 1 Page 209
[36] Case Records Vol. 4 Part 1 Page 112

clash with the court. Mr RD had weaned himself off the Procyclidine. Mr RD said the Depot "knocks him out" so it was agreed that it should be reduced to 800mg every four weeks with 15mg Olanzapine daily. The next review was fixed for 02 June 2006.

The next Depot was given at Waverley House on **16 March 2006.** Mr RD explained that he had received a fine for the assault and was very relieved not to have been sent down. He attributed the court's leniency to the letter written by Care Coordinator 2. Mr RD asked for assistance in filling in his Disability Living Allowance form as he had difficulties writing so Care Coordinator 2 arranged for a worker at The Abbey Club to help him on 28 March 2006.

The next Medical Review Meeting was on **16 June 2006.** Mr RD arrived and said he had a job as a builder and he had to go quickly and would prefer "not to keep in contact."

His mother arrived a short time later and explained that Mr RD would not go for his Depot. He had never liked it and now wanted to see how he was without it. He had also stopped his oral medication about two months previously.

Mr RD had also taken a six week course of steroids. His mother said she had had to be vigilant all the time looking for any signs of change in him. There had been some changes in his attitude, and he had neglected his mother because she had insisted on attending the meeting. She stated that she had worked a 13 hour shift the other day and when she had got home the letter box was half burnt and she was sure it was Mr RD. He had said to a friend of his mother's "I'm not talking to that bitch she shopped me." Mrs D had been afraid and had stayed at her sister's home. Mr RD had appeared to be alright with his friends.

Mr RD had asked his grandfather for a hacksaw – last time he was ill it was a gun and he had in the past threatened her with a knife. When ill the first time he had rejected her and his grandmother and his behaviour was again rude and awful.

It appeared that Mr RD was worried about sex as he was not able to have an erection and had blamed the medication. He had stated that he wanted to go to South America.

Mrs L (mother) said the signs of relapse were:

- a change in his attitude;
- using abuse;

- rejecting his mother and calling her "The Devil."
- Holding back from her
- "When he is well he's really a pleasure to be with, now the pleasantries seem to be disappearing day by day."
- "Last time he was ill I was not his mother and his grandmother had raped him."

Mrs L also said that Mr RD had been to see her parents, which is something he has never done before.

A plan was agreed with Mrs L and she was asked to consider how soon a Mental Health Act Assessment would be needed. She agreed to phone again later that day to request it. She later left a message for Consultant 4 saying he should write a letter to Mr RD stating that his mother had attended the meeting and he needs to take his medication and if he did not he needed to be sectioned. A letter was hand delivered to Mr RD that day with a copy sent to his mother.[37]

(It appears that an appointment was made for Mr RD to visit Waverley House on **19 June 2006** but there is no mention of it in the continuous record.) There is an entry for that date stating that Mr RD did not attend the meeting.

Consultant 4 telephoned Mrs L and left a message saying that Mr RD had not attended the meeting and asking her to contact him about what the next steps might be. Mrs L did ring back and reported that Mr RD had been with his grandmother the previous night and had said he would not be attending the meeting at Waverley House, but when he went to his father's he had said he would go the meeting with Mr RD.

Consultant 4 advised Mrs L to telephone if there were any further incidents or concerns and that it was likely that there would be a Mental Health Act Assessment carried out later in the week. Consultant 4 also telephoned ASW 1 to make him aware that there was likely to be a Mental Health Act Assessment in the next few days.[38]

[37] Case Records Vol. 4 Part 1 Pages 211/215
[38] Case Records Vol. 4 Part 1 Pages 215/216

On **21 June 2006** Care Coordinator 2 telephoned Mrs L – her ex-husband and his mother felt that Mr RD should not be sectioned at present and that the police should not be involved. His grandmother had been feeding him and was therefore the nearest relative and she would not agree to a Section under the Mental Health Act 1983. Mrs L said she was sure that it had been Mr RD who had tried to burn down her flat as he had told a friend that he intended to do this.

Care Coordinator 2 also telephoned Mr RD's grandmother. She said that he was definitely suffering from thought disorder and that she thought that the assault on the traffic warden might have been the trigger to his deteriorating mental health. It appeared to her that since his Disability Living Allowance had been stopped he considered that he was no longer ill and therefore did not need medication or mental health services.

Mrs D (grandmother) stated that the whole family was disappointed in the level of support Mr RD had received from the mental health services and that more could have been done to prevent a relapse. Mr RD had told her that he was going camping and she thought he would be back on Friday to go out for a drink with his brother in the evening as usual. If he did not return she would agree to a Mental Health Act Assessment with a view to Mr RD being admitted to hospital. Mr RD had often gone camping and had survival skills for being in the open air for several days.

Later that day Mrs D telephoned again to report that Mr RD had given up his flat and had wanted the deposit, which he could not have until 17 July. He had asked her to ring the Waverley Team and say he was in prison in order to "get them off his back."

ASW 1 telephoned Mrs D and explained that on the evidence he already had he would report Mr RD as missing and arrange a Mental Health Act Assessment as soon as he was available. ASW 1 reported him as missing at 12.45 that day. It was noted that Mrs D did not object and referred him to Mrs L (Mr RDs mother) if a Mental Health Section was required.

On **23 June 2006** a referral was sent by the Crisis Resolution Service to the Torbay Emergency Duty Service as Mr RD had been at the Accident and Emergency Department but had left before they could see him. The police had tried to arrest him but he had assaulted a police officer and had left the hospital. The police were likely to place him on a Section 136 of the mental Health Act 1983 in order to take him to a place of safety.

The next day, **24 June 2006**, Mrs D made a referral to the Torbay Emergency Duty Service as Mr RD had been seen in some woods and was reported to be using illegal drugs and mixing with inappropriate people and was not taking his prescribed medication. She wanted a Mental Health Act Assessment to be initiated as quickly as possible.

On **27 June 2006** Mr RD was sectioned under the Mental Health Act 1983 whilst in the police custody suite. He had stopped taking his medication and his mental health had deteriorated. It was reported that Mr RD was assumed to have tried to burn down his mother's flat as she had found her Age Concern bag in her letter box half burned and was sure Mr RD was responsible.

The police reported that Mr RD had threatened a mother and her young child with scissors earlier that day. During the personal search when he was arrested a five to six inch bladed knife had been found in his waistband. He had presented as extremely hostile and had been arrested at 12.05. He had assaulted the police officers who arrested him and searched him.

Consultant 4 and Care Coordinator 2 saw Mr RD in the Custody Suite, but he was not prepared to speak to them and they agreed that he needed a secure setting such as Harvest Ward at Bodmin Hospital.

Fourth Admission to Hospital (28 June until 06 November 2006)

a) At Bodmin Hospital – Harvest Ward (28 June until 14 July 2006)

On **28 June 2006** Mr RD was taken by ambulance to Bodmin Hospital with three staff and Care Coordinator 2 who was anxious to explain the context to Mr RDs admission so that they were fully conversant with his situation. Care Coordinator 2 also telephoned Harvest Ward the following day to explain about Mr RD who was still in seclusion at his own request.

Mr RD was very delusional about having killed many people including Sir Francis Drake and David Beckham on **29 June 2006**. He claimed that he had been seeing Victoria Beckham. Mr RD was still in the de-escalation area. The plan was for him to have the routine blood tests, to discuss medication and give PRN medication if required.

On **08 July 2006** Mrs D provided information about the circumstances leading up to Mr RD being admitted to Harvest Ward at Bodmin Hospital as she thought it important that the staff understood. Mr RD was assessed as requiring a Psychiatric Intensive Care Unit and therefore Harvest Ward was approached where there was a vacancy.

Mrs D explained that Mr RD had dressed in his army clothes and taken the keys of his flat to the agent and requested his deposit back as he was going to join the army. He was then missing for 10 days. He then went to her house with a large cut on his arm (on risk assessment of 13/07/2006 cut is mentioned and needed stitches – cause not known) He had called his mother The Devil and would not speak to her. Mrs D took him to Torquay as he asked and when in the car two police officers appeared to arrest him on a Section136. Mr RD tried to run away but was caught.

By **09 July 2006 i**t was felt that Mr RD no longer needed to be on 5 minute checks. At the ward round the following week on **13 July 2006** his Clopixol was increased to 300mg weekly. He was considered to be a risk to his mother and grandmother and to others, to himself and of self neglect, relapse and hazards in the delivery of care. A return to St Michaels Hospital was discussed.[39]

The following day, **14 July 2006** Mr RD was admitted to the Haytor Unit at Torbay Hospital from Harvest Ward at Bodmin Hospital.

b) Haytor Unit – Torbay Hospital (14 July until 15 August 2006)

Mr RD took some time to settle on Haytor Ward. On **20 July 2006** he talked of his mother as though she was dead and said he had seen the corpse. He said that he had tried to burn his mother's house down and had managed to smuggle vodka into Bodmin Hospital.[40] He claimed to be a hitman and had seen a field full of the bodies of the people who he had shot.

Mr RD had bought a half bottle of vodka whilst out shopping on leave. On **23 July 2006** Mr RD said he would prefer his depot orally as it made him feel like a zombie. The next day his Depot was altered to oral Clopixol 20 mg. He was generally isolative on the ward.

[39] Case Records Vol. 6 Part 3 Page 368
[40] Case Records Vol. 6 Part 1 Page 170 and 173

On **02 August 2006** Mr RD reported that he had had a good leave at home over the weekend. He would like to move into assisted accommodation, but he realised that he would have to wait for Disability Living Allowance and to find suitable accommodation. The plan for him was that he was not stable enough for discharge, but that he could have weekend leave and unescorted leave of four hours a day.

A week later on **07 August 2006** Mr RD had bought two bottles of beer and tried to bring them into the ward. He was told that he would lose leave if he did not hand them over which he duly did. At 23.55 a female service user was seen coming out of Mr RDs bedroom and she had admitted having had unprotected consensual sex with him. Mr RD and the other service user were warned about the dangers of sexually transmitted diseases and the Haytor Ward Policy about sexual matters.

The next day Mr RD had barricaded himself in his room by moving his bed against the door. Staff had managed to push their way into his room to ensure that he was safe. Undeterred he had barricaded himself in his room having disabled the lock. Staff had again been able to force an entry into his bedroom and found him safe. Mr RD had caused significant damage to the lock which had had to be replaced. He was verbally hostile as staff examined his room for damage.

A referral was made to Accommodation Plus for accommodation for Mr RD when he was deemed able to leave the hospital. This was completed on **8 August 2006.** The next day one of the staff noted that Mr RD had been awake all through the night. He had also overheard a telephone conversation where he was claiming to be the brother of Kylie and Dannie Minogue but had been forcibly separated from them at birth.

After his weekend leave, on **14 August 2006**, his family contacted the ward to report serious problems over the weekend. Mr RD had been drinking 15 pints of beer a day. He had talked about buying a knife and again spoke of how people were buried in various places. He claimed that he had spent the weekend with a girlfriend rather than with his parents. He said that he had written off his parents and they do not exist. He said he would not cooperate with treatment. There had been problems at home during a Bar-B-Que at home when he lit it before everyone was ready and ate all the food.[41] Mr RD had had a row with his father over this selfish behaviour and also because he had been talking about disgusting delusions in front of his younger brother. His father had told him to clear off and not come home.

[41] Case Records Vol. 6 Part 1 Pages 186 and 187

Following discussion with his family over the telephone it was decided to implement the Missing Persons Policy and to inform the police about Mr RD's behaviour. This was done at 21.30 and Mr RD returned under his own steam at approximately 22.30. In the morning, **14 August 2006**, Mr RD could not be roused and he refused to allow staff to assess his mental state. Mr RD did attend the ward round that afternoon but ripped up a number of prescription charts in temper and stormed off after all Section 17 Leave was suspended. He continued to be aggressive and threatening to staff.

On **15 August 2006** Mr RD approached nursing staff and asked for an electrician to be called immediately to check his goods. When told that it had been requested and he would have to wait he was unable to accept this and threatened to hit the staff nurse. He was described as being "angry, posturing with threatening body language and he appears to be intimidating staff by staring."[42]

Mr RD was interviewed by the police in connection with a fire on the ward a couple of days earlier. He denied having done this but there was a high probability that it had been him as the other people were accounted for. It was noted that Mr RD had a history of fire raising and it was noted that this should be added to his risk assessment.

Mr RD remained very agitated, to such an extent that he was given Haloperidol and Lorazapam. In view of his escalating behaviour he was transferred to the Psychiatric Intensive Care Unit (Harvest Ward) at Bodmin Hospital.

c) At Harvest Ward, Bodmin Hospital (15 August until 18 September 2006)

On admission to Harvest Ward Mr RD was unwilling to leave the de-escalation area as he felt safe there, as he had on his previous admission in June.

The Discharge Summary from this admission provides a good overview of the antecedents to the admission. "He is currently admitted following relapse secondary to non-compliance with his medication. He had been maintained on Clopixol Depot however a couple of months prior to

[42] Case Records Vol. 6 Part 1 Pages 188 and 189

admission he had asked to have this reduced and it was switched to oral Clopixol after which he became non-compliant resulting in his current relapse. When unwell Mr RD tends to increase his alcohol intake and also abuse cannabis which has an exacerbating effect on his mental state and also increases risk to others. His illness is characterised by repeated themes of grandiose and persecutory beliefs, intimidating manner and rapid delusions of identification that involve his parents and his grandmother and associated threats and they are considered to be at high risk when he is unwell. Mr RD also tends to isolate himself and also increase use of illicit substances, mainly alcohol and cannabis. He also has fascination with military or combat type wear and gear and dresses in like manner, exposing his upper body and flexing his muscles. Usually he has poor insight when he is unwell."[43]

On admission a risk assessment was undertaken using the Cornwall Partnership NHS Trust documentation. The relapse "Alerting Factors/Triggers" were cited as:

- use of illicit substances;
- non-concordance with medication;
- grandiose;
- Capgras about parents and grandparents;
- isolating himself;
- responding to auditory hallucinations;
- paranoid ideation;
- presents as cold and suspicious;
- believes he is cursed;
- talking of having a presence behind him or on his shoulder.

During the first few days of this admission Mr RD quickly settled and there were no management issues with him. It was noted that his appearance and movement could be interpreted as intimidating. Mr RD said he was ready for a transfer back to the Haytor Unit. He

[43] Case Records Vol. 6 Part 1 Page 99

admitted he had felt threatened on the Psychiatric Intensive Care Ward. He acknowledged that he felt the benefit of medication but had refused to accept depot. In the event Mr RD finally accepted that he would have Depot of 600mg every fortnight.

On **02 September 2006** Mr RD was visited by his brother who tried to pass him a cigarette lighter which was hidden in the pocket of a jacket he had brought him. Later the same day he was visited by his brother and his „girlfriend'. Staff thought that they had taken some money from Mr RD and had bought alcohol and had given him some. When they were observed they quickly drank their drink and no smell of alcohol was noticed. Mr RD's room was searched and scissors, a safety pin and a cigarette lighter were discovered concealed in his pillow. Throughout the evening Mr RD was challenging to staff.

A further risk assessment was completed on **13 September 2006** prior to Mr RD being transferred back to Haytor Ward at Torbay Hospital. The main points of the risk assessment were that Mr RD had a forensic history including attempted robbery and driving whilst uninsured and under the influence of alcohol. He had also been aggressive to his family, nursing staff and the police. He was assessed as being at risk of:

- harm to others;
- harm to self;
- neglect;
- relapse;
- hazards in the delivery of care.[44]

During the time on Harvest Ward Mr RD had shown interest in some of the female service users. At the Clinical Meeting held on **12 September 2006** with Consultant 5 and a social worker Mr RD was described as being compliant with medication. He had also agreed to comply with the wishes of staff if he was interested in a female service user they thought was vulnerable.

[44] Case Records Vol. 6 Part 2 Page327

Depot of 600mg Clopixol was given to Mr RD on **14 September 2006** and should be administered every two weeks.

Mr RD was transferred back to Haytor Ward on **18 September 2006.**

d) Haytor Ward (18 September until 06 November 2006)

The next day, **19 September 2006**, Mr RD challenged the absence of unescorted leave but this was refused. He was able to have his hour of escorted leave changed so that he could be escorted by a member of his family. He then took leave with a member of his family at 10.23 and was reminded he needed to return by 11.23. Mr RD returned at 12.45.

On **20 September 2006** at the Ward Round some possible transfers were discussed including Cypress Lodge and Watercombe. Mr RD stated that he would not wish to be further away than Torquay because his family would have a long way to travel to visit him. He said that he would like a flat and showed no insight into the fact that he had recently relapsed and currently required hospital and would need a supported placement in the community.

Mr RD asked if he could have escorted leave to be with his girlfriend who would be the escort. Consultant 5 agreed that he could have four hours Section 17 Leave but that the girlfriend must introduce herself to the ward staff before they left the ward. Mr RD returned from the four hour leave with his brother 45 minutes late. He told nursing staff that he had been very angry and had been punching the walls and showed them grazes on his knuckles to prove the point. He was given PRN medication and he appeared to have had a settled night.[45]

On **26 September 2006** Mr RD left the ward with his brother at 19.00 0n Section 17 Leave and was due to return at 20.30. At 21.00 Mr RD's brother telephoned the ward and reported that he had dropped Mr RD at a friend's house in Union Street in Torquay and an ex-service user would drop him off at the hospital later. The nurse asked the caller for his name and he gave a false name. The nurse knew it was Mr RD's brother and that he had been told that he had to stay with him for the whole period of the escorted leave.

The ward staff telephoned Mr RD and left a message on his mobile, his father was also trying to contact him. The Absent Without Leave Policy was implemented at 21.50 but at about this time

[45] Case Records Vol. 6 Part 1 Page 194

Mrs D (grandmother) telephoned the ward to inform the staff that Mr RD was on his way back. He arrived back at 22.05 and was visibly staggering, he agreed that he had been drinking but refused to say how much he had consumed.

The next morning Mr RD refused to attend the ward round with Consultant 6. The discussion about Mr RD concluded that his leave would be suspended and that Coordinator 2 would refer him for a placement at Cypress Lodge and Riviera Court.[46] Two days later, **28 September 2006** Consultant 6 agreed to restore Section 17 Leave at six hours a day to be escorted by staff or a family member.

On **05 October 2006** the ward staff received information that Mr RD had told a lady that he had a penknife and a 10 inch blade and was intent on „blood-letting'. As a result his room was searched but nothing was discovered.

Mr RD told the technical instructor running a gym session on **11 October 2006** that he had taken some steroids, namely Sustenon 250 and Decca Aurobolin. The technical instructor sent a note to care Coordinator 2 that Mr RD had said that "he had been using anabolic steroids for some time and that he was aware they caused him some mental health problems, but that he would not stop using them. After further conversation it was plainly obvious that he did not know the purpose of steroids and how they react with the body. I got the distinct feeling that he would use any drug if convinced „it would make me big' (His words). With this in mind, be aware steroids specifically testerone and a product called sustenon 250, if abused can cause increased aggression and a condition called roid rage."

The next day Mr RD had returned to the ward with his brother at 21.10 and his brother had stayed until 22.00. He was asked to leave and Mr RD asked if he could just go outside with his brother which was agreed provided he returned immediately. Mr RD did not return until 23.45 and provided no explanation for his actions.

On **13 October 2006** the ward staff suspected that there had been illicit drug use on the ward and a drug screen was undertaken. Mr RD proved positive for amphetamine.

The applications for accommodation at Cypress Lodge were being considered and on **16 October 2006** staff from Cypress Lodge telephoned the ward staff asking for more information. At the ward round on **18 October 2006** the possible placement at Cypress Lodge was

[46] Case Records Vol. 6 Part 1 Page 197

discussed. Mr RD stated that he did not think the regime there would be suitable for him. The meeting agreed that the application would proceed while other options were also pursued, one option being Parkview which had a single bedroom flat available and would have a double bedroom flat free in a few weeks.

On **19 October 2006** an application was sent to Parkview and Cypress Lodge was sent the additional information required. Mr RD was challenged about having been suspected of drinking the previous night whilst on Section 17 Leave. He denied this but was warned that if he did use alcohol when he was on Section 17 Leave he could jeopardise his being offered an accommodation placement.

One of the nurses had a one to one session with Mr RD whilst having a game of pool. The nurse mentioned that he might be leaving the ward in the near future. Mr RD had replied that the thought frightened him because he recognised that he had had a bad attitude. He said he would like to continue his work as a disc-jockey and in the future hoped to be able to visit Australia.

Mr RD appeared to be more amenable on the ward and was not abusing his Section 17 Leave by staying out for longer than agreed. On **25 October 2006** Mr RD was assessed as having a good mental state and that he appeared settled. In response to this improvement the plan was for his Clopixol Depot to be reduced to 800mg monthly. The same day a representative from Beacon Homes visited Mr RD to assess his suitability for accommodation in their housing schemes.

In another one to one meeting with a nurse on **30 October 2006** Mr RD mentioned that he hoped that he would hear from Beacon Homes about a placement. Later that day a letter was received from Beacon Homes saying that Mr RD could not be offered a place due to him displaying too many high risk factors, and having a history of illicit drug use in the recent past. The Beacon Homes do not provide staff on the premises in the evening and they feel that due to the risks identified this accommodation would not be appropriate for Mr RD.

Mr RD was disappointed that he would not be going to Beacon Homes. He was annoyed later that day when his inability to sleep was thought by staff to be due to his taking amphetamines. Mr RD refused to provide a urine sample.

Mr RD had an argument with another service user in the Occupational Therapy Department which appeared to be over a female service user. The Modern Matron spoke to Mr RD about rumours that he had been using illegal substances on the ward. He had had Procyclidine 5mg for his eyes which had been looking strange all the day. The difficulties with the other service user lasted all day. Mr RD then accused the other service user of having assaulted him. He had spat at him and had thrown an apple at him. Mr RD said he did not feel safe on the ward and that the other person should be moved to a secure unit.

It appeared that Mr RD might take matters into his own hands, and the staff advised him against this and to stay away from the other service user. Later in the day Mr RD asked for some paper so that he could formally complain about the behaviour of the other service user. He told the ward staff that he had reported the incident to the police and that they would be coming to the ward to interview him. Mr RD did get close to the other service user and make as if to hit him, and on another occasion he made a rude gesture towards the other person with his hand. On both occasions the situation was contained by the ward staff.

On **31 October 2006** Mr RD telephoned the ward to inform the staff that he would not be returning from Section 17 Leave as arranged that evening. Staff spoke to him and his grandparents and his father but he could not be persuaded back. The Missing Persons Policy was implemented. His refusal to return was due to his being scared by the other service who had threatened to kill him. Mr RD took these threats seriously as the other man had carried out two previous threats. He stated that he would not feel safe on the ward until the other service user was removed. The staff contacted Mr RD’s father and grandmother but neither was able to persuade him to return to Haytor Ward.

The next morning Mr RD returned to the ward with his grandmother who discussed his treatment and care with the modern matron and said how disappointed she was by his ongoing treatment. The other service user apologised to Mr RD and he accepted the apology and the issue appeared to have been resolved.

Mr RD had his Section 117 Meeting on **03 November 2006.** Consultant 6, Care Coordinator 3, Mr RD and his grandmother attended the meeting. It was agreed that Care Coordinator 3 would try to find appropriate accommodation for Mr RD in the next few days. Mr RD agreed to work with Care Coordinator 3 on a regular basis once he was in the community, but he did not want

to talk about his illness or relapse indicators. His grandmother was concerned that Mr RD had been awarded the middle level of the Disability Living Allowance and care Coordinator 3 suggested how he could appeal against this decision.

It was noted on the discharge letter sent to Mr RD's GP that at the "discharge planning meeting Mr RD was able to engage in humourous chat with abstract thought process in evidence, which contrasted with the very concrete thoughts seen previously."[47]

Care Coordinator 3 completed a Care Programme Approach Personal Plan dated 03 November 2006. This was because care Coordinator 2 was absent on sick leave. Mr RD was placed on Enhanced Care Programme Approach.[48]

On **06 November 2006** Mr RD was offered a placement at Riviera Court for two weeks in the first instance. He accepted this placement and was discharged from the ward and his Section 3 under the Mental Health Act was rescinded.

e) In the Community (06 November 2006 until 23 June 2007)

Mr RD attended the Depot Clinic on **30 January 2007** and was seen by Care Coordinator 4. She visited Mr RD at Riviera Court as his placement there had been for three months and the period was coming to an end. Mr RD had not managed to find himself any accommodation and he was still adamant that he wished to live independently. He suggested that Care Coordinator 4 went with him to see a flat which was suitable.

The Care Coordinator observed that Mr RD appeared to know what he was doing and they went to „Cosy Lettings' where he gave them a holding deposit and completed several forms. Mr RD was a little concerned as he would need to find a guarantor which could prove difficult. A visit was also made to the Housing benefit office where further forms were collected and his claim for Housing benefit was started. The tenancy at Riviera Court was extended until **09 February 2007.**[49]

On **05 February 2007** Mr RD visited the Community Mental Health Team at Waverley House and saw Care Coordinator 4. He had still not found a guarantor and did not accept any of the

[47] Case Records Vol. 6 Part 1 Page 93
[48] Case Records Vol. 6 Part 1 Page 131
[49] Case Records Vol. 4 Part 1 Page 225

Care Coordinator's suggestions. She talked to him about the Assertive Outreach Team and the service they would be able to offer him, but he stated that he would not be needing them. Care Coordinator 4 told Mr RD that she would be referring him to the Assertive Outreach Team in any case. It was agreed that they should meet again in two days to review the situation.

On **07 February 2007** Care Coordinator 4 visited Mr RD at Riviera Court. The staff there informed her that Mr RD had not got up to meet the Assertive Outreach team when they had visited that morning. They had had to resort to talking to Mr RD through his door. He did agree to meet one of the Assertive Outreach Team the following day with Care Coordinator 4. It appeared that Mr RD was not taking the situation very seriously and insisted that he did not require any other input apart from that of the Care Coordinator 4. He was adamant to pursue the flat and said he would have enough money for the deposit in a few days. He said he would ask his grandmother to look after his belongings for a short time and that he would see if his father would let him stay with him until he had the flat.[50]

The next day, **08 February 2007**, Care Coordinator 4 reported in her notes that Mr RD had visited her in her office and informed her that he would not be able to see her properly as he „had to get off'. He would therefore not be able to meet the Assertive Outreach Team. He was going to be able to stay with his father and his grandmother had agreed to act as his guarantor. Care Coordinator 4 discussed the situation with Mr RD in the team meeting and suggested that a Care Programme Approach Review Meeting should be held with Consultant 4, Team manager 1 and Mr RD and his family.

Later that week Mr RD moved into his flat and Care Coordinator 4 visited him there. He appeared to be focused and in a good frame of mind. He was still adamant that he did not want contact with mental health services except for Care Coordinator 4.

The Care Programme Approach Review Meeting was held on **08 March 2007** with Mr RD, Consultant 4, Care Coordinator 2, Care Coordinator 4 and team Manager 1. Mr RD did not want his family to be present at this meeting nor in the future. Mr RD was quite combative in the meeting as he was insisting that he did not want care Coordinator 2 to give him his depot as when he had given the injection done it "stings". He also wanted to try and get a deal on reducing the amount of the depot by half in return for agreeing to see Care Coordinator 2. He

[50] Case Records Vol. 4 Part 1 Page 226

also claimed that he did not have any recollection of his breakdown and relapse in the last year, although later said things which belied this.

The meeting did reach some decisions which were that:

- Mr RD would attend the depot and that care Coordinator 2 would phone him in the morning on the day of the Clinic to remind him to attend and would arrange a female member of staff to give him the injection;
- No information would be divulged directly to Mr RD's family unless the staff had major concerns about him;
- Care Coordinator 2 would refer Mr RD to Day Opportunities as he was interested in mechanics and cooking;
- A further review would take place on 15 June 2007 with Mr RD, Consultant 4 and Care Coordinator 2.[51]

On **27 March 2007** Care Coordinator 2 telephoned Mr RD to remind him of the Depot Clinic and to arrange to meet in order to complete the forms for the Opportunities Courses. The meeting took place on **29 March 2007** at Mr RD's flat. The forms were duly completed and would be posted once Care Coordinator 2 had completed a current Care Plan. Mr RD stated that he did not do care plans and refused to participate.

Mr RD was telephoned again on **24 April 2007** to remind him of the Depot Clinic. There was no answer but a message was left. Mr RD was strident in attitude as if this was done reluctantly and he would prefer to self-administer.[52]

Care Coordinator 2 telephoned Mr RD on **22 May 2007** and eventually managed to speak to him rather than having to leave a message. Mr RD said that he was not going to have the Depot as it was slowing him down too much and was stopping him getting on with his life. Care Coordinator 2 responded by showing that he understood how Mr RD was feeling but that from previous experience by not having the depot he was at risk of relapsing as he had the year before.[53]

[51] Case Records Vol. 4 Part 1 Page 227
[52] Case Records Vol. 4 Part 1 Page 228/229
[53] Case Records Vol. 4 Part 1 Page 229

On **11 June 2007** the situation regarding Mr RD was discussed in the Team meeting. The plan was to reassess Mr RD at 15.00 at his home. A message was left on his mobile phone.

Care Coordinator 1 and Assertive Outreach Worker 1 visited Mr RD at home as previously arranged but he was not in. Care Coordinator 2 was telephoned and told of the situation. It was agreed that another worker from the Assertive Outreach Team should attend the Review Meeting arranged for 15 June 2007.

Care Coordinator 2 also spoke to Mr RD about the possibility of the Assertive Outreach Team making contact with him. He explained that the team worked with people like him and tried to get them to a position where they no longer needed their support. Mr RD did agree to the team contacting him.

On **15 June 2007** Care Coordinator 2 spoke to the organiser of the Opportunities Service to see if he had been able to arrange a course for Mr RD. This had not proved possible because Mr RD was so intractable about the location of the course. The organiser agreed that he would continue to try and arrange something suitable.

The same day Mr RD failed to attend for the Review Meeting with Consultant 4 and Care Coordinator 2. A member of the Assertive Outreach Team had also arranged to attend and reported that despite attempts to meet Mr RD they had not been able to make contact with him. It was agreed that the Assertive outreach team would „call cold' on Mr RD as another way of trying to make contact with him.

Care Coordinator 2 agreed to telephone Mrs D to inform her of Mr RD's non-involvement with the mental health services. Mrs D understood the actions of the mental health services. She then told Care Coordinator 2 in strictest confidence that she thought Mr RD was showing signs through his behaviour that he was relapsing.

On **18 June 2007** Care Coordinator 2 spoke to Team Leader 1 about the possible relapse of Mr RD. It was agreed that Care Coordinator 2 should try to contact Mr RD by sending him text messages. It was also agreed that the situation should be reviewed at the Thursday Supervision Meeting.

At 12.00 the same day Mr RD visited Waverley House and asked if he could speak to care Coordinator 2. This was not possible as Care Coordinator 2 was out of the office with another service user. Occupational Therapist 1 saw Mr RD and spoke with him and then managed to make telephone contact with Care Coordinator 2 and he was able to speak directly to Mr RD. Care Coordinator 2 explained that he had been trying to contact Mr RD and tried to arrange another Review Meeting. Mr RD said he wanted to see Consultant 4 on his own and to have his depot reduced saying that he "might take half the dose."

Mr RD continued to say that he was meeting the organiser from the Opportunities Service in Kingsteignton and was confident that they might find him work. Mr RD did agree that Care Coordinator 2 could telephone every month as before.

The Assertive Outreach Team discussed Mr RD at their team Meeting and it was agreed that Care Coordinator 1 and the Team Manager of the Assertive Outreach Team would visit Mr RD on 27 June 2007.[54]

Care Coordinator 2 spoke to Occupational Therapist 1 about how Mr RD had presented when he had visited Waverley House. She reported that he had spoken politely without any belligerence and that he had been dressed well and was not in his combat gear.

On **21 June 2007** the situation was discussed at the weekly team supervision meeting. The main contributors were Care Coordinator 2, Consultant 4, Team manager 1 and Occupational Therapist 1. The notes made in the continuous record by Care Coordinator 2 but written on 25 June after the homicide state:

"We looked at events especially those from the review on 8/3/7. Ascertained that he had thus far missed 2 depots (22/5/7) and this Tuesday (19/6/7)just gone. Whilst this was not ideal he would still be experiencing some positive degree (diminishing of course) from the last depot (given 24/4/7).

In relation to [Mr RD's] demand that he next meet [Consultant 4] individually to discuss medication [Consultant 4) view was that this was not advisable and that we should arrange to review him further (together with Assertive Outreach) – subsequently faxed appointment for 2.00pm on Wednesday July 4th.

[54] Case Records Vol. 2&3 Page 9

Discussed with [Consultant 4] my [Care Coordinator 2] documentation protocol for my conversation with [Mr RD's] nan last Friday (15/6/7). We agreed further that in view of the reality that we were approaching a time for the convening of a Mental Health Act Assessment that I would liaise with nan and mother by phone (prior to this rescheduled review). We balanced his recent behaviours with his appearance and demeanour when he presented at Waverley earlier this week (18/6/7) together with how he has presented in the past when relapsing (withdrawal into the woods, the wearing of combat gear and a general aura of hostility and paranoia.)

Subsequently spoke with [Consultant 4] as mentioned above:

- a) *Set new review date (Wednesday 4th July 2007)*
- b) *Protocol for recording information from relatives*
- c) *My future contact with his relatives especially his nan*
- d) *My liaison with Assertive Outreach Team about their continuing to try to make contact with [Mr RD] and their attendance at the next review*

***22/6/7** liaised, by phone, with Assertive Outreach especially about new review appointment and their cold calling on [Mr RD].*

11.00am Asked Waverley secretary to send [Mr RD] letter about the new review

(Mr RD assaulted his grandmother on 23 June 2007 and she died from the injuries sustained a few hours later in hospital early on 24 June 2007)

***25/6/7** Discussed situation further with [Consultant 4] in view of the weekend's events (in stark terms [Mrs D] was found with head injuries in Sheldon on Saturday which ultimately resulted in her death. {Mr RD] is currently in custody being questioned by police. [Team Manager 1] is currently writing a report."*[55]

[55] Case Records Vol. 4 Part 1 Page 233/235

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 nine overall critical issues and junctures that rose directly from the care and treatment that Mr. RD received from the Devon Partnership NHS Trust. These critical issues and junctures are set out below:

- 13.1 Documentation and Record Keeping
- 13.2 Diagnosis and Medication
- 13.3 Care Programme Approach and Risk Assessment and Risk Management
- 13.4 Use of the Mental Health Act
- 13.5 Management of the Clinical Care – Inpatient and Community Services
- 13.6 Role of Community Psychiatric Nurse and Care Coordinator
- 13.7 Referral from Community Mental Health Team to Assertive Outreach Team
- 13.8 Lack of a Carer's Assessment
- 13.9 Clinical Governance Processes

These four areas identified by the Independent Investigation Team are examined in detail in the next Section of the Report.

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 24 June 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. RS'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 24 June 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 and Record Keeping

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'*

The Department of Health has issue guidance on the management of clinical records: *Records Management: NHS Code of Practice* (2006, Part II Second Edition 2009). This guidance covers legislation pertinent to accessing health records, such as:

- Data Protection Act 1998
- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Access to Medical Reports Act 1988

All NHS Trusts are required to maintain and store clinical records in accordance with the requirement of the Data Protection Act (1998). 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.

Most health and social care professional groups have also developed guidelines for the management of and access to clinical records. For example the Royal College of Physicians (RCP) in partnership with NHS Connecting for Health has developed standards for hospital patient records, approved by the Academy of Medical Royal Colleges[56]

The General Medical Council (GMC) guidance 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 '

Devon Partnership Trust 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.*

[56] http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Pages/Overview.aspx

- *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'*.[57]

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.

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 Devon Partnership 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.

[57] CPA policy 2006 pg 26

Eight volumes of clinical records were submitted to the Independent Investigation Team from the Devon Partnership NHS Trust and one set of records from the Plymouth Community Services NHS Trust for the period Mr RD was at Lee Mill.

The quality of the content of Mr. RD's records from Lee Mill was good with the file full and well ordered.

The Records from the Devon Partnership NHS Trust

The eight volumes from the Devon Partnership NHS Trust were not of such good quality. The order in which papers were filed appeared at times random and there were countless instances of the same records appearing in more than one file and in the wrong order.

Care Programme Approach documentation was often incomplete or entirely missing. Risk assessment and care planning documentation was sometimes not present and not completed to the standard set out by both local and national policy expectation. The records were not in many places continuous, integrated or contemporaneous. Throughout the records there are examples of incomplete, unsigned and undated entries, but 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, and provided good information and a full account of the interventions and medication that had been provided during each hospital admission.

The records from 2001 and 2002 were generally good with clear summaries from the consultant psychiatrists, although the volume of duplicate notes for this period was appreciable. Otherwise the files were jumbled and it was difficult without going through the whole file several times to understand and extract a chronological order for all the contents of the record.

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. This was particularly evident in the records relating to the Trust's Internal Investigation.

The Trust was unable to retrieve Mr RD'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 the complete clinical record archive for use by this Investigation. 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.[58] This did not occur and it is probable that the clinical records became increasingly disrupted and jumbled at this point.

It did appear that within the majority of the records there was good recording of the Mental Health Act 1983 forms and papers concerning Mr RD's detention and the granting of Section 17 Leave.

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 most of the five year period during which Mr. RD 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. RD 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.

[58] Incident Reporting, Management and Review pg 6

First, the quality of contemporaneous Care Programme Approach 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. RD. The Trust had in operation sound policies and procedures outlining guidance to professional staff regarding these matters. These policies and procedures were not adhered to. At the time Mr RD 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.

In the findings section directly above it was noted that the different clinical teams working with Mr. RD 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. RD 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.

One of the recommendations made earlier in this Report was about the need for there to be a clear, recognised and standardised location within each service user’s notes and records where an up to date synopsis of the history is kept, together with the latest Care Plan and Risk Assessment with the Crisis plan and the relapse indicators. This is essential, and will be with RiO as well, to ensure that if a service user contacts the Trust in any location there will be a record of the salient factors in both his history and the current, or latest contacts available to whichever member of staff needs it.

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.

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 RD'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 Mrs. D. It was only after the initiation of the Independent Investigation that a review of the gaps in the records occurred and a far fuller set of files was located three weeks after the gaps had been identified. As far as the Independent Investigation Panel could tell an almost complete set of records was able to be consulted during the Investigation.

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. RD but it is impossible to know exactly how much was original and how much was photocopied.

The Independent Investigation Team considered the impact that the internal investigation might have had in this area. In order for the internal investigation to 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.

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 causal or contributory factor to the incident.

There were three service issues which arose from the examination of the records of Mr RD and which the Devon Partnership NHS Trust will need to address:

Service Issue 1

Professional staff did not maintain an appropriate standard of clinical record keeping. This ensured that the personal data regarding Mr. RD 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.

Recommendation 1

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.*

13.2 Diagnosis and Medication

Context

„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.[59]

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.

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

Description of events

Diagnosis

When first admitted to Torbay Hospital on 07 November 2001 Mr RD presented with hostility and delusional ideas and was given a differential diagnosis of drug induced psychosis, other psychotic illness or personality disorder. It was noted that he had a history of illicit substance misuse (hence the consideration that his symptoms could be drug induced), also that he had a long history of emotional and behavioural difficulties including offending behaviour (hence the consideration of a diagnosis of Personality Disorder.)[60]

Following this it is clear from the medical record that Mr RD presented with an enduring psychotic mental illness, having had numerous relapses presenting with agitation and delusional ideas. Inter episode, when well, there is evidence in the record that he could be a pleasant person, and on interview some staff members admitted a fondness for him. Unfortunately and highly significantly, Mr RD never achieved insight into his symptoms or mental illness, and even when considered well he probably retained some delusional ideas. He was therefore given a diagnosis of Paranoid Schizophrenia. Schizophrenia is a severe and enduring mental illness characterised by distortions of thinking and perception; Paranoid Schizophrenia is dominated by delusions and often accompanied by hallucinations. There is evidence that ongoing substance misuse worsens the course and outcome of the disorder.

Unfortunately it is also evident that Mr RD continued to abuse illicit substances, and this had a deleterious effect on his mental state. Of particular note is his use of anabolic steroids to assist with body building. Side effects of anabolic steroids include sexual dysfunction, which is significant in this case as Mr RD complained of this, but attributed it to his prescribed medication, which had a negative impact on his compliance. Additionally steroids are known to have a direct deleterious effect on mental health, with aggression, violence, mania and psychosis all associated with their use. It is also noted that Mr RD abused amphetamines. This would also have had an adverse effect on his mental health, being associated with hyperactivity, irritability, paranoia and aggression, and also with amphetamine psychosis.

[60] Case Records Vol 1 Part 1, page 4

Medication

The mainstay of treatment for paranoid schizophrenia is antipsychotic medication, of which there are two main classes. The first of these, „typical' antipsychotics, include drugs such as haloperidol and depot preparations such as clopixol. Recognised side effects of typical neuroleptics include extra pyramidal side effects (EPSE), which are typified by abnormal involuntary movements and dystonia. It is likely that the „eye rolling' that Mr RD complained of was due to EPSE. Other side effects include sedation and sexual dysfunction, which also troubled Mr RD.

The second class is the „atypical antipscyhotics' and includes medicines such as risperidone and olanzapine. These are so called because they carry a reduced risk of the occurrence of EPSE. Side effects include weight gain, sedation and sexual dysfunction. Clozapine is an atypical antipsychotic that has greater efficacy than the other antipsychotics, and is used to treat treatment resistant schizophrenia. Unfortunately it does not come in an injectable form or as a long acting preparation.

Mr RDs Medication

On admission on 07 November 2001 Mr RD presented as acutely psychotic and was treated with haloperidol and lorazepam[61] which is appropriate initial treatment for acute psychosis. This was changed to risperidone, an atypical antipsychotic with an alleged lower side effect profile, on the 09 November 2001.[62] It was clear from this point that medication compliance was an issue, as it is noted that Mr RD was suspected of not taking the prescribed medication, and it was changed to liquid form.[63] He appeared to respond to this, with a noted improvement in mental state by the 17th December 2001, although delusional symptoms still persisted. Mr RD's more challenging behaviour, in terms of not complying with the conditions of Section 17 leave and substance misuse, were also evident from this initial admission.

His medication was changed to Olanzapine velotabs 20mg by 18th January 2002 (it is not clear exactly what the date and reason for this were.) He had already been offered and refused a depot injection.[64] The olanzapine was continued for some time, until following suspicion of non compliance and an incident of aggression towards his grandmother, clopixol depot was initiated

[61] As above, page 7
[62] Ibid page 9
[63] Ibid page 13.
[64] Ibid page 18.

in October 2002.[65] Following this Mr RD was maintained on a combination of clopixol depot and olanzapine. The clopixol was prescribed at a dose of 600mg every two weeks during inpatient stays, and it would appear that this was the dose Mr RD required to stabilize his mental state. However he suffered from side effects, and due to this the dose was usually reduced following discharge. The reason for combination therapy with two antipsychotics is not clear from the record, and may have increased the incidence of adverse side effects.

It is noted that Mr RD suffered from EPSE, as he described his „eyes rolling'. It is common practice for anticholinergic medication to be prescribed as an antidote for this, as happened in this case with the prescription of procyclidine. It was also reported by his mother that Mr RD suffered from sexual dysfunction and attributed this to his prescribed medication.[66] It is not clear whether this was discussed with Mr RD, although it is also possible that this was a side effect of steroid abuse.

The depot clopixol was reduced to 800mgs every four weeks on the 25th October 2006 at Mr RDs request, despite the fact that he remained liable to be detained under section 3 of the Mental Health Act 1983. This is a relative reduction of a third in the dose, and may have contributed to the early relapse following non compliance with the depot.

Due to partial response to two different anti-psychotics Mr RD could be considered treatment resistant, and as such consideration of clozapine would have been appropriate. We were informed during the witness interviews that clozapine therapy had been discussed, but that it had not been considered appropriate in this case due to Mr RD's reluctance to take oral medication and long term poor compliance. For this reason a depot preparation was preferred, so that at least if Mr RD did default on his medication the team would be aware.

[65] Ibid page 43.
[66] Case records Vol 4, page 212.

Conclusion

It is the Independent Investigation Panel's view that the overall medication strategy with Mr RD was appropriate. His high risk and poor compliance necessitated depot medication and precluded clozapine; his ongoing substance misuse increased his treatment resistance and necessitated higher dose prescribing, leading to increased adverse side effects.

13.3 Care Programme Approach and Risk Assessment and Risk Management

Context

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.[67] Since its introduction it has been reviewed twice by the Department of Health:[68] 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).[69]

"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".[70] (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. This is achieved by enabling effective co-ordination between

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

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 the Care Programme Approach 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:

- 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.[71]

Devon Partnership Trust 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.[72] The policy contained a section on general standards and specific standards in relation to:

- 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

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

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 Community Mental Health Teams during the time that Mr RD received his care and treatment.

Description of events

This Section of the report will examine all the Care Plans made about the care and treatment Mr RD needed to meet his health and social care needs.

From 07 January 2002 until 20 April 2007 there were 14 Care Programme Approach or similar care plans and risk assessments carried out in respect of Mr RD. It is noted that there are no records of Care Plans or Risk Assessments during 2004 and 2005, coinciding with a period from 08 March 2004 until 28 June 2006 when Mr RD was living in the community. In this two years and three months period Mr RD lived at Riviera Court, The Braddens and finally in an independent flat in Torquay.

The quality of the Care Programme Approach Care Plans and Risk Assessment and Risk Management Plans varies greatly, with a noticeable difference in those completed while Mr RD was an inpatient to those where he was living in the community. The dates of the 14 Care Planning and/or Risk Assessment Meetings were:

Care Plan 1 - 07 January 2002

Care Coordinator 1 completed the documentation for this Care programme Approach Care Plan. The aims stated for Mr RD were for him to transfer from St Michaels Hospital in Newton Abbot to a community setting. In particular the objectives were for Mr RD to:

- learn more living skills;
- be compliant with his prescribed medication
- build a therapeutic relationship with staff to promote the above and thereby to help Mr RD move to accommodation which allowed him more independence.

The Plan stressed that Mr RD might not comply with the need to regularly take his medication if he was not actually observed to ensure that he did. The failure to comply with medication was noted to be a relapse factor, the risk of which would be greatly increased should he use illicit drugs, steroids or alcohol to excess. The contingency plan should Mr RD relapse was to ensure that he was immediately seen by the mental health services.[73]

Care Plan 2 – 26 February 2002

Mr RD was on extended Section 17 Leave at Riviera Court at this time. The relapse indicators listed in this Care Plan were the use of illicit drugs, steroids or alcohol, being non-compliant with his prescribed medication, having grandiose ideas and/or paranoid ideation and the presence of fixed delusional views.

The backing of a concerned and supportive family was noted to be a positive factor as they would notice signs of mental health deterioration. In addition mention was made of the need for a Section 25 Supervised Discharge to be made to ensure that Mr RD did remain in touch with mental health services.[74]

Care Plan 3 (A Jarrop Risk Assessment) on 25 September 2002

This Jarrop Risk Assessment was conducted on Ash Ward (Acute Admission Ward) at Wonford House Hospital. Mr RD was admitted to Ash Ward following his deteriorating health at Riviera Court where he had become increasingly isolated and hostile to the staff, and they felt he was not taking his medication. Mr RD had shut himself in his room and had also stopped having contact with his family. He continued to be increasingly hostile and negative towards the staff whilst denying that he had any illness. Mr RD was offered an interview to consider his request for a flat at Rydal Court but he refused to attend the meeting.

[73] Case Records Vol. 5 Pages 99/102
[74] Case Records Vol. 5 Pages 33/35

Mr RD was deemed to have a high risk of causing harm to others and was thought to present a medium risk of absconding. The warning signs of Mr RD becoming a risk were his mental health deteriorating, his becoming withdrawn and isolated and becoming hostile. It was noted that alcohol intake could increase the level of the risk.[75]

Care Plan 4 – 01 October 2002

The Care Plan was very brief and was carried out at St Michaels Hospital soon after Mr RD had been returned from London following his absconding from Ash Ward. The plan was to settle Mr RD on the ward and the signs of relapse were noted as not taking his medication so vigilance was the message for all staff in observing him.

Care Plan 5 – 13 May 2003 (A Case Conference Assessment)

Mr RD was at Lee Mill but was described as still having active symptoms. The signs of relapse were listed as:

grandiose ideas;
Capgras symptoms;
getting a gun;
isolating himself;
spending much of his time in his bedroom;
responding to auditory hallucinations;
paranoid ideation;
being much less communicative;
appearing cold and suspicious;
feeling he is cursed;
feeling a presence behind himself.

[75] Case Records Vol. 7 Pages 51/52

In the Section on the Strengths and Needs Assessment Mental State Examination there had been a marked change in Mr RD's presentation as he had fully participated in his Occupational Therapy Programme and had enjoyed the more physical activities such as swimming, walking and gardening. He had complied with both oral and depot medication. There was however in the May assessment a statement that *"at the moment there does not seem to be an issue about risk to others, but there could be, given his previous history should he not comply with further treatment."*[76]

Care Plan 6 – 06 August 2003 (A Case Conference Assessment)

Mr RD was still at Lee Mill and was described as having little insight into his mental health problems, but that there were no signs of deterioration. The relapse indicators were exactly the same as those immediately above.[77]

Care Plan 7 – 19 November 2003

This was part of a formal Care Programme Approach Meeting.
Mr RD was on extended Section 17 Leave at Riviera Court, and a transfer from Lee Mill to Riviera Court was planned once the local Torquay Mental Health Services agreed to accept the referral.

The signs of relapse were described as being:

- not taking his medication;
- illicit drug, steroid and alcohol abuse;
- being preoccupied with delusional beliefs;
- being arrogant, rude, threatening and suspicious of others;
- concern being expressed by staff at Riviera Court or a member of his family, Mother, Father or Grandmother.

If a relapse in Mr RD's mental health was thought to be occurring it was stated that an urgent mental state assessment should be carried out.[78]

[76] Lee Mill File Pages 861/871
[77] Lee Mill File Pages 807/817

Care Plan 8 – 13 July 2006.

Mr RD was an inpatient on Harvest Ward, the Psychiatric Intensive Care Unit at Bodmin Hospital. A Care Review Form was completed which listed all the relapse indicators as in Care Plan 5 above. The review noted that the Capgras Symptoms were still present and that as such he presented a risk to his mother and grandmother and others and the list was in all other respects the same as at 13 May 2003.

The goals for Mr RD were to establish a therapeutic medication regime by educating him about the benefits of medication, the importance of being compliant with the prescribed medication and to take it in the quantities prescribed.[79]

Care Plan 9 – 15 August 2006

Mr RD was still at the Haytor Unit but because of his disruptive and disturbed behaviour he was transferred to Harvest Ward by the end of the day.

This Care plan was prepared in the context of Mr RD having approached nursing staff and asking for an electrician to be called immediately to check his goods. When told that it had been requested and he would have to wait he was unable to accept this and threatened to hit the staff nurse. He was described as being "angry, posturing with threatening body language and he appears to be intimidating staff by staring."[80]

Mr RD was interviewed by the police in connection with a fire on the ward a couple of days earlier. He denied having done this but there was a high probability that it had been him as the other people on the ward were accounted for. It was noted that Mr RD had a history of fire raising and that this should be added to his risk assessment.

The current risks Mr RD presented were listed as harm to others, self-harm, neglect, relapse and hazards in the delivery of care [due to his non-engagement]. The current symptoms were

[78] Case Records Vol. 4 Part 1 Pages 19/22
[79] Case records Vol. 6 Part 3 Pages 367/373
[80] Case Records Vol. 6 Part 1 Pages 188 and 189

the Capgras Symptoms and the use of illicit substances. The current triggers for relapse were the use of illicit substances, not taking his prescribed medication, isolating himself and becoming non-communicative.

Mr RD remained very agitated, to such an extent that he was given Haloperidol and Lorazapam.[81]

Care Plan 10 – 21 August 2005

This was essentially the same as that for Care Plan 9 above. Mr RD was on Harvest Ward at Bodmin Hospital.[82]

Care Plan 11 – 13 September 2006

This was also essentially the same as that for Care Plan 9 above. Mr RD was on Harvest Ward at Bodmin Hospital.[83]

Care Plan 12 – 17 October 2006

Mr RD was on the Haytor Unit at Torquay Hospital.

This Care Plan was a risk assessment using the Sainsbury Centre for Mental Health Risk Assessment Level 1. This showed that Mr RD presented a risk to others and challenges to mental health services. The identified risks were:

- violence to others;
- threats to others

[81] Case Records Vol. 6 Part 2 Pages 283/288
[82] Case Records Vol. 6 Part 2 Pages 289/301
[83] Case Records Vol. 6 Part 2 Pages 307/311

- fire setting;
- non-compliance with medication;
- use of illicit drugs.

The plan was to monitor his compliance with medication, assess his mental state, review his observation level and offer him PRN if he was showing signs of aggression or restlessness.[84]

Care Plan 13 – 03 November 2006

Care Coordinator 3 prepared this Care Programme Approach CPA 3 Personal Plan within the context of Mr RD being ready for discharge to Riviera Court and his Section 3 of the Mental Health Act 1983 being rescinded.

The Care Plan stated that Mr RD wanted accommodation but with limited support from the Care Coordinator and he refused to talk about his mental ill health or the relapse indicators. It was agreed that Mr RD should have regular contact with his Community Psychiatric Nurse and move to Riviera Court as a step towards more independent living arrangements. The triggers showing possible relapse were listed as:

- isolating himself;
- grandiose ideas;
- paranoid ideation;
- becoming less communicative;
- dressing in Commando gear;
- camping out and isolating himself in woods.

Positive and helpful factors were described as being:

- the monthly Depot injection;

[84] Case Records Vol. 6 Part 1 Pages 134/141

- the relationship with the Community Psychiatric Nurse;
- good communication between services about the relapse indicators;
- liaison with his family and their support;
- regular monitoring of his mental state.

It was identified that in a crisis there should be an immediate assessment and a possible Mental Health Act assessment with the Crisis Team being contacted immediately.[85]

Care Plan 14 – 20 April 2007

It is difficult to be sure when this Care Plan was done as although it states that it was written on 20 April 2007 it also states that Mr RD is on a Section 48/49 of the Mental Health Act from 10 July 2007 [after the homicide of Mrs D]

CPA3 Personal Plan

As this is the last CPA3 Personal Plan and CPA2c Risk Assessment & Management (Level1) completed it will be detailed in full. Mr RD was on Enhanced CPA. Care Coordinator 2 completed the forms.

"Important information/contingency plan summary

CLIENT HAS 117 RIGHTS

Prior to becoming known to mental health services (October 2001) Mr RD has previously engaged in behaviour whereby he had a forensic history.

Mr RD's diagnosis is „paranoid schizophrenia' and it is important to note that Mr RD does not, in any meaningful sense, accept this diagnosis and if we try to talk about his particular thoughts/symptoms he refuses to engage.

His family, especially his grandmother, are very supportive of Mr RD: his relationship with them is usually positive but sometimes not so.

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[85] Case records Vol. 8 Pages 4/11

Relapse indicators are:-

a) marked suspicion of others
b) withdrawal from accepting prescribed medication (depot)
c) increased isolation and dressing predominantly in combat gear
d) alcohol and/or street drugs may be associated with relapse.

Mr RD's response to my suggestion that we collaborate on writing this document was "I don't do care plans". Mr RD wants to "get on with his life" – he would like to live independently (currently OK) and work (not employed at present)

Difficulties, as perceived by Mr RD, centre around the mental health services insistence that he has and maintains contact. He has a marked interest in:

1) cooking
2) car/bike engine repair and maintenance; he has requested referral to Opportunities to pursue these. {the forms have been filled out with Mr RD and his grandmother is supportive of this]

What do the care coordinator/other people think would help?

If Mr RD's actions/thoughts give rise to concern (this will predominantly be from others) and/or he stops consistently accepting the need for prescribed medication (depot) care coordinator (or another) will intervene by

1) liaising with Consultant 4
2) liaising with Emergency Duty Team, Crisis Resolution Team and GP
3) liaising with family
4) possibly liaising with the police.

Contingency Planning

As implied/indicated earlier Mr RD will NOT actively engage in the answering of these questions.

Mr RD's relationship with his family, may, at the point of relapse, be more negative than positive – in consequence, from a consensual viewpoint he may be hesitant/reluctant to give the OK for family contact - professional concerns and responsibilities may have to override this.

Current Medication

Clopixol 800mg (depot) every four weeks. Provides maintenance of mental health.

What steps have been agreed with you to meet your needs?

- Mr RD will be referred to Opportunities –Care Coordinator to action;
- Mr RD will be telephoned the morning when his depot medication is due to be given – Care Coordinator to action;
- Mr RD will be given his depot by a professional (preferably female) other than his care coordinator;
- Mr RD will, with some reluctance, attend regular reviews with psychiatrist, care coordinator and interested others.

Urgent Contacts

Duty/ „back up' worker at Waverley House [Community Mental Health Team base]
GP and Emergency Duty Team.

The Plan was to be reviewed on 01 November 2007.

[The rest of this section of the form is not completed – presumably as Mr RD would not sign it and did not accept the need for any further assistance. It was not signed by either Mr RD or Care Coordinator 2]

CPA2c Risk Assessment & Management (Level1)

The above CPA3 Personal Plan and the CPA2c Risk Assessment & Management (Level1) was completed by Care Coordinator 2.

The CPA2c Risk Assessment & Management (Level1) was less detailed and is summarised here. Care Coordinator 2 identified a risk to other people but thought it unlikely that Mr RD was

at risk from others. He stated that at a time of relapse, due to Mr RD's thoughts, his behaviour may lead to risk to self and/or others. It was indicated that Mr RD was a challenge to services due to his reluctance to engage.

The section of the form titled Initial Assessment of Risk states that "when well Mr RD does not pose a risk. When unwell he will isolate himself and perhaps develop psychotic ideas for example „being a hit man'. His risk history has been related by significant professionals and his family.

The Initial Risk Management Plan states that mental health services would monitor Mr RD's mental health and especially concordance with medication, and notes that liaison with his family was useful.

This is the last Care Plan and Risk Assessment on the files.[86]

Findings

In general terms the care planning and case records in the inpatient units was quite good and there was clearly a sense of the service user being assessed and plans made from day to day about activities and the ability to be granted escorted or unescorted Section 17 Leave.

The file from Lee Mill was well put together and it was relatively easy to find the information one was seeking. The Case Conference Assessments were well constructed and appeared to be thorough.

It was evident that not all the risk assessments and resultant plans to manage the risk were as full as they could have been. The early risk assessments in 2001 and 2002 included in the discharge letters to the GP provided a good account of all the significant events during the inpatient stays and also good reasons for the admissions. A full list of relapse indicators was included and a management plan should they appear.

The Care Programme Approach Risk Assessments were less comprehensive and did not always indicate whether Mr RD was on standard or enhanced status, but with his psychosis and

[86] Case Records Vol. 7 Pages 91 to 95.

the level of support he required he should at all times have been on the Enhanced Care Programme Approach. Some of the Risk Assessments did not include the Level 2 assessment, and Mr RD would certainly require this level of risk assessment given his forensic history and the relapse history he had during the years 2002 to 2006.

An example to illustrate this point is the difference between the CPA3 Personal Plan and the Risk Assessment completed by Care Coordinator 3 on 03 November 2006 and the one done on 13 May 2003.(Care Plan 5) The latter highlighted the Capgras symptoms whereas the 03 November 2006 Risk Assessment appears to use only the evidence from the June 2006 relapse rather than the full history from 2001.

The 03 November 2006 Personal Plan and Risk Assessment was developed within the context of Mr RD being ready for discharge to Riviera Court. Mr RD had had a period of just over five months in hospital between 28 June and 06 November which required two periods in Harvest Ward, the Psychiatric Intensive Care Unit because he exhibited behaviour the Haytor Unit found difficult to manage. Mr RD returned to the Haytor Unit from his second period there on 18 September 2006. The 03 November 2006 Care Programme Approach documentation was therefore completed just over six weeks later.

The Care Plan stated that Mr RD ***wanted accommodation but with limited support from the Care Coordinator and he refused to talk about his mental ill health or the relapse indicators.*** It was agreed that Mr RD should have regular contact with his Community Psychiatric Nurse and move to Riviera Court as a step towards more independent living arrangements. The triggers showing possible relapse were listed as:

- isolating himself;
- grandiose ideas;
- paranoid ideation;
- becoming less communicative;
- dressing in Commando gear;
- camping out and isolating himself in woods.

Positive and helpful factors were described as being:

- the monthly Depot injection;

- the relationship with the Community Psychiatric Nurse;
- good communication between services about the relapse indicators;
- liaison with his family and their support;
- regular monitoring of his mental state.

It was identified that in a crisis there should be an immediate assessment and a possible Mental Health Act Assessment with the Crisis Team being contacted immediately.

This Assessment did not include the Capgras Symptoms displayed by Mr RD at periods throughout his mental illness which were seen to be extremely serious earlier in his illness from 2001 until August 2006 in Care Plan 10 where they were noted to be current in his overall presentation at that time. In 2003 Consultant 3 had said that the best indicator of relapse was the change in his personality and the fact that his family were saying that he was different.

Mr RD had a clear forensic history yet this was not highlighted in the 03 November 2006 Care Programme Approach Assessment. The relapse symptoms appear to have been taken from his previous admission and not from his total history. There was no mention of his shunning his parents and becoming distant from them, nor that his family, and in particular his grandmother, were reliable judges of when Mr RD was beginning to relapse and show signs of mental health deterioration. The Risk Assessment did not include the Level 2 risk assessment, despite all the difficulties there had been during the previous admission. In answer to the question, "Need for Risk Assessment & Management (Level2)?" the Care Coordinator had typed "No".

In his interview with the Independent Investigation Panel Care Coordinator 3 stated that he did not have any concerns about Mr RD and therefore decided that a level 1 Risk Assessment was in order. He recalled that that the only slight concern was his bullish attitude towards the services.[87]

By January 2007 Mr RD was looking for a flat as his three months at Riviera Court was nearly over. At this point Care Coordinator 4 became responsible for helping him find accommodation. She, in her interview with the Independent Investigation Panel, stated that although she was surprised that Mr RD had been discharged without extended Section 17 Leave or a renewal of the Section 25, "when he's well, he does manage very well independently."[88] She supported him

[87] Transcript 2 Page 2
[88] Transcript 8 Page 5

as he negotiated the rental of a new flat and thought that he handled the administration well and did not appear to need much help other than moral support.

The Independent Investigation Panel considered that this was surprising given all Mr RD's history and in particular the violent way he relapsed in 2006. In addition the staff on the Haytor Unit had found Mr RD difficult to manage during his time on the ward. One key message the Panel would wish to make is that throughout the notes, all 2901 pages, there was no clear place where a member of staff could identify where to access a clear current history of Mr RD and his mental ill health nor the current risk assessment and the care plan and risk management plan to offset the risks. Several of the Risk Assessments did not have a crisis action plan should Mr RD relapse.

Recommendation 2

It is strongly recommended that there should be a single and well identified place within the case record of every service user where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months.

The Independent Investigation Panel understands that the Devon Partnership NHS Trust is implementing the installation of RiO, the electronic record system, but there will still need to be a recognised place for the same information on this system. It is accepted that the lessons from the parts of the NHS Trust which already have access to RiO will be used to inform the training of those not yet having access and this issue will be contained within all future new training and refresher training.

Recommendation 3

It is strongly recommended that when the RiO Electronic Record System is installed that the Trust identifies a well identified place within the RiO System where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months. The location must be Trust- wide and in the same place for all case records.

Risk Assessment and Risk Management

Mental Health Services do need to be reminded about the nature of risk assessment and its management. One person interviewed when asked about risk assessment stated that "level 1 is your basic risk pathway; Level 2, indicators for that would have been past history of risk towards self or others. Obviously any serious untoward incidents would put somebody on Level 2. Any serious thoughts towards either self or others would put someone on Level 2. Generally someone who is considered to be at higher risk than the morbidity of the normal population that we serve would generally go on to Level 2"[89]

It is evident from this member of staff and others who were interviewed that the Risk Assessment process was not well understood, and this was not helped by the forms in use with their level 1/Level 2 emphasis. As has been observed before, it is absolutely clear that with his forensic history and the nature of his previous relapse history Mr RD should have been on Level 2 for the whole time he was with the mental health services, especially as he could not be trusted to comply with medication, and also his frequent failure to engage with the services.

Recommendation 4

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.*

[89] Transcript 7 Page 2

- *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.*

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 individual's needs are clearly defined and plans put in place to best meet those needs. It is evident that Mr. RD did not receive consistently a full Care Programme Approach which consisted of assessment, care planning, risk assessment and risk management.

Case management skills were identified nationally in the early 1990's with the introduction of the Care Programme Approach process[90] and were reiterated and refined in later guidelines[91] and incorporated into the Devon Partnership NHS Trust policy. Many expensive and specialist resources were allocated to Mr RD's case but these were sometimes reactive rather than proactive, well-thought through, considered options. It is accepted that Mr RD was not an easy man to work with as he never accepted that he had a mental illness. This made him reluctant to work with staff when they wanted to talk about his illness and the signs of relapse. Such action made him even more likely to disengage and to fail to attend meetings.

At times during the period 06 November 2006 to June 2007 it almost appears that Mr RD is running the care and treatment care plan he is to receive. The Independent Investigation Panel understands that in the treatment of mental illness there is always a balance to be drawn between pushing a service user too far against their wishes to make them withdraw from the service, and needing to keep in control of the prescribed medication to ensure that the psychosis is being treated.

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

Mr RD did at times try to bargain with Consultant 4, as when on 18 June 2007 Care Coordinator 2 was trying to arrange another review meeting with Dr 4 and himself, to which Mr RD retorted that he wanted to see Consultant 4 on his own and to have his depot reduced. He added that he "might take half the dose." In the event Consultant 4 at the Team Supervision Meeting on 21 June 2007 refused to accept that he would see Mr RD on his own but with Care Coordinator 2 and a member of the Assertive Outreach Team.

It is significant that Mr RD was not engaging with the Opportunities Service either, as whatever employment or courses they suggested he claimed that he could not get to the place where they were to be held. This, when linked to the lack of a structured day and Mr RD living in a flat with no support, led to his not having much to do with his time other than spend time with his family. It was also clear that Mr RD would not comply with any suggestions the mental health services might make to provide more structure.

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. Care Coordinator 2 mentioned as much in his interview with the chair of the Independent Investigation Panel when he stated that risk assessments "were not the be all and end all of the work. Working with patients was more important than the paperwork."[92] This is true in certain circumstances if one is dealing with an emergency, but the emergency has to be written up so that it can help other staff to appreciate the nature of the specific „case' should they have to deal with it. The lack of adequate information in a specific place in the documentation or on RiO has already been mentioned.

It was very clear from the investigation of Mr RD's treatment and care that all was not right within the Devon Partnership NHS Trust. The governance arrangements, in terms of monitoring, supervision and audit were not robust and therefore failed to pick up on the lack of a robust Care Programme Approach process over the period from 2001 to 2007. 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.

[92] Transcript 4 Page 2

Nearly all of the staff interviewed stated that whilst they had had supervision throughout the period they had been employed by the Devon Partnership NHS Trust, it had been somewhat “ad hoc”, prior to the introduction of the relatively new computer based system for recording that it had actually happened. Staff had been able to discuss any worries or concerns that they had about service users and their work in general, but the actual supervision sessions had often not taken place or were not made. They all confirmed that the situation had now improved, but the Trust should confirm this through an audit of the current arrangements.

The Independent Investigation Team therefore concluded that the CPA process was not firmly embedded or understood within the Trust.

Service Issue 4

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

13.4 Use of Mental Health Act 1983

Context

The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

Section 1 - Definition of Mental Disorder

A patient must be suffering from mental disorder as defined by the Act before compulsory admission to hospital can be considered. This definition, however, is open to broad interpretation; 'mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. Nevertheless a person

may not be regarded as suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Section 2 - Admission for Assessment

This allows for admission for assessment (which may be followed by medical treatment) for up to 28 days. Application may be made by the nearest relative or an approved social worker (in practice it is usually the latter) and must be supported by two medical recommendations, at least one of which must be from a doctor approved under Section 12 as having special experience in the diagnosis or treatment of mental disorder.

The patient has the right to apply to a Mental Health Review Tribunal within 14 days of admission. The nearest relative, the managers or the responsible medical officer can discharge the patient although the RMO can bar discharge by the nearest relative.

Section 3 - Admission for Treatment

This Section provides for the admission of a patient to hospital and his detention for a maximum period of 6 months (unless the order is renewed). Application may be made by the nearest relative or an approved social worker supported by two medical recommendations, at least one of which must be from a doctor approved under Section 12.

The patient has a right to apply to a Mental Health Review Tribunal within the first 6 months and once during each subsequent period for which the detention is renewed.

Section 4 - Admission for Assessment in Cases of Emergency

An emergency application for admission for assessment may be made by the nearest relative or an approved social worker supported by one medical recommendation, preferably from a doctor acquainted with the patient. The application should state that it is of urgent necessity to admit the patient and that admission under Section 2 or 3 would involve undesirable delay. The order ceases to have effect after 72 hours unless the second medical recommendation under Section 2 is given and received by the managers within that period.

Section 25A (Supervised Discharge)

This additional power was introduced on the 01 April 1996 following the implementation of the Mental Health (Patients in the Community Act) 1995, and provided a legal framework for supervising after-care in the community of certain patients who had been detained in hospital for treatment under the Mental Health Act 1983. It aimed to ensure that those patients receive after-care services provided under section 117, and was specifically aimed at revolving door patients whose care needed special supervision due to the level of risk. It had the power to require the patient to reside in a specific place, to attend for treatment, occupation, education or training (though no power to enforce treatment without consent), and to provide access to the supervisor or other authorised person. It also gave the power to convey to hospital for a meeting, but no power to detain. It has since been repealed by the Mental Health Act 2007, which provided instead Supervised Community Treatment (Community Treatment Orders).

Findings

This Section of the Report brings all the evidence about Mr RD's mental health and his relapses from his first admission to hospital in November 2001 to his arrest for the murder of his grandmother in June 2007. The evidence is taken from the Clinical Records and the documentation examined by the Independent investigation Team together with evidence presented by the staff at their interviews, and altered where necessary by them when their transcript was sent for checking for its accuracy, and also for them to add anything further they considered important and relevant.

Mr RD was first admitted to Torbay Hospital under Section 2 of the Mental Health Act 1983 on 07 November 2001. He was placed in the Riverside Psychiatric Intensive Care Unit. The reason was that his family reported that he had contacted a cousin's partner asking him if he could borrow a gun as he wanted to shoot his parents because he believed they were not his real parents. He had also claimed that he was he was an Imperial Emperor who owned the hospital. Madonna was his mother and Kylie Minogue his sister or girlfriend. He said he was not Mr RD but was really the brother of Jason Donovan.

It was noted that Mr RD had a forensic history which comprised being cautioned by the police for being drunk and disorderly and for starting fires out of doors which were considered to be episodes of minor arson. This offence had occurred on three occasions.

At the age of 15 Mr RD was sentenced to six months imprisonment in Portland Young Offenders Institution having been guilty of causing actual bodily harm to a man on a bus when he was drunk. At age 17 Mr RD drove a car when he was drunk after a beach party. He had no car insurance and had an accident which resulted in a friend of his being seriously injured. During the period Mr RD was bailed in the community waiting for the trial for the incident with the car he was involved in an unsuccessful burglary at a jewellers shop in Newton Abbot. Mr RD was sentenced to a further 18 months in Portland Young Offenders Institution.

Mr RD was assessed and given a differential diagnosis of drug induced psychosis, other psychotic illness or a personality disorder by Consultant 1. A risk assessment stated that he had many risk factors for violence in that he was a young man with a history of violence, drug abuse, had made threats to kill specific people and showed poor insight into his situation.[93] Mr RD was noted to be fixed in his ideas about his parents and that his mother stole him at birth. He displayed very concrete thinking and was given Risperidone BD for his medication.

By 19 November 2001 Mr RD was allowed some Section 17 Leave with which he complied apart from drinking some alcohol.[94] Consultant 1 telephoned Mr RDs paternal grandmother who confirmed the history given by his mother and stated he that had displayed distorted behaviour and that rejecting her and his grandfather was very significant.[95]

A Mental Health Act Tribunal was held on 22 November 2001 but Mr RDs parents refused to allow any of the family history or how their son had behaved to be used as they were frightened of their son. At the Tribunal Mr RD presented as psychotic and his application was rescinded.

Mr RD had improved and was allowed Section 17 Leave for the Christmas Holiday period. He returned to the ward on 27 December 2001, inebriated when seen by the Senior House Officer at 21.00. It was also thought that he had not complied with his medication whilst at home. The

[93] Case Records Vol. 1 Part 1 Page 4
[94] Case Records Vol. 1 Part 1 Page 11
[95] Case Records Vol. 1 Part 1 Page 12

same day Mr RD's family phoned Consultant 2 and reported that he had not been taking his medication and that he had been seeing spiders and had expressed serious delusions. Mr RD had quickly settled on the ward but refused the offer of a Depot injection.[96] The next day Mr RD also refused a Depot injection but Consultant 1 explained that she did not believe that he was taking his medication and that this had to be done. When at home he was told he must allow a relative to supervise his taking his medication.
Such behaviour was to become the hallmark of Mr RD's mental ill health. He never really acknowledged that he was ill, and on the few occasions when he did discuss his symptoms he immediately denied having mentioned them at the next interview with a clinician.

On 04 January 2002 Mr RD's mother and paternal grandmother were seen by Care Coordinator 1 who explained the nature of his illness and his need for medication. The family were reported to have been very supportive of Mr RD but to have thought that he should live independently.[97] Mr RD then agreed to visit a hostel the following week.

On 12 January 2002 Mr RD was offered a place at Riviera Court, a supported hostel for people with mental health problems, and he moved there for a three week trial period on 16 January 2002. Mr RD attended the ward round review on 12 February 2002 and was reported to have settled at Riviera Court and to have occasional leave to his grandparents who stated that Mr RD drinks to excess on these visits.

A Care Programme Approach Risk assessment was carried out between 18 December 2001 and 26 February 2002. The findings were summarised as follows:

"Mr RD has a forensic history and an ongoing use of drugs and alcohol which makes him present a risk to others and himself. Deterioration in mental state compounds these issues. The Risk Indicators were:

- previous use of illicit drugs, steroids and alcohol;
- as a body builder he has an extremely well developed musculature;
- has done judo and boxing;

[96] Case Records Vol. 1 Part 1 Page 16
[97] Case Records Vol. 1 Part 1 Page 18

- previous offences (drunk and disorderly, three setting fires outdoors, Actual Bodily Harm, drove car without driving licence when drunk and seriously, injured a friend, smash and grab raid at jewellers in Newton Abbot, sought to obtain shotgun from friends to kill both parents and self, threatening behaviour (verbal), Cap Gras beliefs, being given away by mother at an early age, claim of being raped by grandmother age two.
- no insight into his mental state
- non-compliance with medication
- grandiose ideas,
- paranoid ideas, very fixed delusional state.

The overall assessment was that Mr RD did not pose a significant threat to himself but did pose a greater risk to others.

The staff at Riviera Court confirmed that he was mainly settled and polite, and was interacting well with staff and other residents and using his time well. Mr RD was already reported to be asking when he would be able to have a place of his own. The decision of the ward round was to recommence leave at Riviera Court, to help Mr RD to start looking for accommodation and to review the leave in a month.

There were concerns in March 2002 that Mr RD was showing some signs of his mental health deteriorating, but he appeared to improve but it was agreed by the clinical team that he should be made subject to Section 25 of the Mental Health Act 1983. This allowed for Mr RD to be supervised in the community and provided a structure for his care and treatment, and prescribed where he was to live and that he had to regularly see the mental health staff supervising him. The Section 25 was effective from 11 June 2002.

On 06 August 2002 Mr RD was admitted to hospital under Section 3 of the Mental Health Act 1983 because he had been expressing paranoid ideas and delusional beliefs that he does not belong to his family. He was grandiose and hostile and had been verbally aggressive to the staff at Riviera Court who requested his assessment. He was noted to lack insight into the reality of his delusions and the inappropriateness of his behaviour. Mr RD refused voluntary admission, and was admitted to Riverside Ward the Psychiatric Intensive Care Ward, with a plan to transfer

to Newton Abbot Hospital when he had settled and a bed was available. He was admitted because there was a fear that he could become a risk to others.

Mr RD was considered well enough to return to Riviera Court by 26 August 2002 on extended Section 17 Leave. A Section 117 Meeting was arranged for 10 September 2002. At the meeting attended by Mr RD and his family it was reported that he continued to abuse alcohol, returning either withdrawn or being rude to staff at Riviera Court. Mr RD refused to agree to his Olanzapine being increased from 20mg to 30mg, saying that it should be reduced. The Care Plan agreed at the meeting was that Mr RD should remain on Section 17 Leave to Riviera Court.

On 25 September 2002 the staff at Riviera Court were concerned that Mr RD had shut himself in his room and was withdrawn and hostile. He had also stopped having contact with his family. He continued to be increasingly hostile and negative towards the staff whilst denying that he had any illness. He was admitted to Ash Ward, the Psychiatric Intensive Care Unit at Wonford House Hospital on 01 October 2002.

A JARAP Risk Assessment was carried out on 25 September 2002 and Mr RD was deemed to have a high risk of causing harm to others and was thought to present a medium risk of absconding. The warning signs of Mr RD becoming a risk were his mental health deteriorating, him becoming withdrawn and isolated and becoming hostile. It was noted that alcohol intake could increase the level of the risk.[98]

On 07 October 2002 Mr RD refused to have his depot. He had been aggressive to his grandmother when she visited him on the ward, and when she had bent to kiss him he had pushed her away and in doing so had knocked her glasses off. She was shocked and upset as he had never acted like this to her before. On another occasion Mr RD had pulled his mothers hair.

In view of this aggressive behaviour Mr RD was transferred to the Psychiatric Intensive Care Unit (Riverside) at Torbay Hospital where he accepted Depot on Riverside Ward. He was thus transferred back to Newton Abbot Hospital the following day. A week later on 15 October 2002

[98] Case Records Vol. 7 Pages 51/52

Mr RDs belongings from Riviera Court were delivered to the ward. On inspection they were found to contain knives wrapped up in his clothes.

The period from mid-October 2002 to the beginning of March 2003 when Mr RD was transferred to Lee Mill were punctuated with episodes when he would abuse his Section 17 Leave and return to the ward late and often after having drunk alcohol. This culminated with Mr RD purchasing cannabis which was found in his room. The police were involved in line with the ward and hospital policy and they visited and took the cannabis away for destruction and no further action was taken. This was on 04 March 2003 the day before he moved to Lee Mill. Mr RD was transferred on 05 March.

Lee Mill in 2003 was a 12 bed low secure unit for male service users with very chronic mental health problems, mainly with treatment resistant schizophrenia, who required a structured environment in which to receive a rehabilitation programme to help them learn skills for less secure placements. It also had service users who had drug-related problems and substance misuse, particularly cannabis misuse in addition to their schizophrenia.[99]

Consultant 3 described the Lee Mill Unit as being very structured, and it was locked in terms of security....it had quite a lot of staff which enabled the staff to do the rehabilitation, so people were out participating in a lot of activity with the emphasis being on recovery.[100]

Initially Mr RD was reluctant to engage in much of the activity at Lee Mill but after a couple of months or so he slowly did start to engage with staff in different occupational activities that were planned for him. He was interested in the walking activities and other physical programmes, but was less involved in talking or discussion sessions. Mr RD enjoyed going swimming, visiting the gym and also participated in the gardening group and going to the cinema. In his letter to the Independent Investigation Team Mr RD stated that he had found his time at Lee Mill the best in terms of activities and helpful activity.

Consultant 3 stated in her interview that she thought that Mr RD had been getting too much leave and that he needed to be in hospital more than he had been and that he would be better

[99] Transcript T1 Page 1/2
[100] Transcript T2 Page 2

on Depot injections.[101] She also said that she felt that if Mr RD was not supervised and was not taking his medication, with his past history he was a risky young man. This was not in terms of self harm but about the risk he posed to others, particularly if he developed the Capgras symptoms again. She also stated that she would have been concerned if he was going to live in a flat on his own as the Lee Mill Unit saw him as someone you would want to keep a rein on, which is why the Section 25 Supervision in the Community was obtained when he moved back to Riviera Court in October 2003.

Consultant 3 was very concerned that throughout his time at Lee Mill Mr RD retained his belief that his parents were not his parents, and whilst this did not prevent him spending more and more time with his family the „delusion' remained with him. Consultant 3 took the unusual step of meeting Mr RD's family to explain the Capgras Syndrome to them as she was concerned that it could become significant should Mr RD relapse. In his first episode of psychosis Mr RD had sought to buy a gun and had intended to kill his parents, so Consultant 3 explained how Mr RD would be likely to show symptoms of relapse. These were described as being:

- grandiose ideas;
- capgras views about his parents;
- getting hold of a gun;
- isolating himself;
- spending a lot of time in his bedroom;
- responding to auditory hallucinations;
- paranoid ideation;
- becoming much less communicative;
- appearing cold and suspicious;
- feeling he is cursed;
- feeling a presence behind him.[102]

The Section 25 order gave the mental health services some ability to ensure Mr RD complied with medication and remained in contact with the service at Waverley House. It stated that Mr RD had to:

- reside at Riviera Court;

[101] Transcript 2 Page 2
[102] Lee Mill Case File Page 304

- attend outpatients clinics at Waverley House or any other designated venue for the purposes of medical treatment;
- accept supervision from his Community Responsible Medical Officer, Consultant 4;
- allow the Community Responsible Medical Officer, Consultant 4 and the S25 Supervisor, or anyone authorised by them, access to his place of residence.

The Care Programme Approach Care Plan dated 19 November 2003 stated that as "Mr RD did not see himself as having mental health problems he could become unwell due to not taking medication, using drink and drugs and steroids. He could become suspicious of others. His grandmother, mother or father may report that he is deteriorating and if they did an urgent assessment of mental state would be required."

From November 2003 until June 2004 Mr RD appeared to stay reasonably well although he only spasmodically engaged with the Day Opportunities Programme and did not settle with any of the various groups he had tried. In July 2004 Mr RD was allocated a place at The Braddons, moving in on 12 July.

At his Review Meeting on 11 February 2005 Mr RD said that he wanted to come off the Section 25 order because he felt that he has very much improved. He was supported in this by his mother and his grandmother. Mr RD discussed riding his motor bike and getting a provisional licence from DVLA. Following discussion Consultant 4 and Care Coordinator 2 agreed not to renew the Section 25 order. They both agreed that Mr RD had increased confidence and was able to express emotions and was talking things through with people. Their thoughts were echoed by his mother.[103]

Further positive progress was made by Mr RD and he decided that he would like to move into a flat and live independently. Mr RD had found a flat at 2 Warren Hill. It was agreed that a Community Care Grant would be applied for and a referral made to MASH, a local charity providing furniture and other items needed to equip a home.

Mr RD stated that he wanted to reduce his medication, but Care Coordinator 2 thought it would be better for him to get settled in his new home first and then to review the situation. His

[103] Case Records Vol. 4 Part 1 Page 204

medication was Clopixol 1000g every four weeks, Olanzapine 20mg daily and Procylidine 5mg bd.[104]

A Review Meeting was held on 26 August 2005 which was informed that Mr RD was now living at Flat 1, 2 Warren Hill, Torquay. He was working with his father and brother and also fishing. It was agreed to reduce the Olanzapine to 15mg daily and to review the situation again on 16 December 2005. Mr RD was also keen to wean himself off the Procyclidine but he was warned that this should be done slowly.[105]

On 08 November 2005 Care Coordinator 2 visited Mr RD at his flat. Mr RD explained that he was alleged to have assaulted a traffic warden and had already appeared in court once. The case was due to be heard on 06 December 2005. Mr RD said he had found a solicitor. Care Coordinator 2 agreed to write a supportive letter to the Court outlining Mr RD's mental health history.

On 03 March 2006 Mr RD attended another review Meeting with Consultant 4 and Care Coordinator 2. He reported himself to be well and to be attending the gym when he had the money. He was seeing a lot of his family. His flat was described as lovely and he had altered the furniture round as he was going to have a party. He said his mental health was fine but he was a bit stressed due to the court case. Depot date was altered to 16 March so as not to clash with the court. Mr RD had weaned himself off the Procyclidine. Mr RD said the Depot "knocks him out" so it was agreed that it should be reduced to 800mg every four weeks with 15mg Olanzapine daily. The next review was fixed for 02 June 2006.

The next Depot was given at Waverley House on 16 March 2006. Mr RD explained that he had received a fine for the assault and was very relieved not to have been sent down. He attributed the courts leniency to the letter written by Care Coordinator 2.

The next Medical Review Meeting was on 16 June 2006. Mr RD arrived and said he had a job as a builder and he had to go quickly and would prefer "not to keep contact."

[104] Case Records Vol. 4 Part 1 Page 206
[105] Case Records Vol. 4 Part 1 Page 208

His mother arrived a short time later and explained that Mr RD would not go for his Depot. He had never liked it and now wanted to see how he was without it. He had also stopped his oral medication about two months previously.

Mr RD had also taken a six week course of steroids. His mother said she had had to be vigilant all the time looking for any signs of change in him. There had been some changes in his attitude, and he had avoided his mother because she had insisted on attending the meeting. She stated that she had worked a 13 hour shift the other day and when she had got home the letter box was half burnt and she was sure it was Mr RD. He had said to a friend of his mother's "I'm not talking to that bitch she shopped me." Mrs D had been afraid and had stayed at her sister's home. Mr RD had appeared to be alright with his friends.

Mr RD had asked his grandfather for a hacksaw – last time he was ill it was a gun and he had in the past threatened her with a knife. When ill the first time he had rejected her and his grandmother and his behaviour was again rude and awful.

Mrs L (mother) said the signs of relapse were:

- a change in his attitude;
- using abuse;
- rejecting his mother and calling her "The Devil."
- Holding back from her
- "When he is well he's really a pleasure to be with, now the pleasantries seem to be disappearing day by day."
- "Last time he was ill I was not his mother and his grandmother had raped him."

Mrs L also said that Mr RD had been to see her parents, which is something he had never done before.

A plan was agreed with Mrs L and she was asked to consider how soon a Mental Health Act Assessment would be needed. She agreed to phone again later that day to request it. She later left a message for Consultant 4 saying he should write a letter to Mr RD stating that his mother

had attended the meeting and he needs to take his medication and if he did not he needed to be sectioned. A letter was hand delivered to Mr RD that day with a copy sent to his mother.[106]

Consultant 4 telephoned Mrs L and left a message saying that Mr RD had not attended the meeting and asking her to contact him about what the next steps might be. Mrs L did ring back and reported that Mr RD had been with his grandmother the previous day and had said he would not be attending the meeting at Waverley House, but when he went to his father's he had said he would go the meeting with Mr RD.

Consultant 4 advised Mrs L to telephone if there were any further incidents or concerns and that it was likely that there would be a Mental Health Act Assessment carried out later in the week. Consultant 4 also telephoned ASW 1 to make him aware that there was likely to be a Mental Health Act Assessment in the next few days.[107]

Care Coordinator 2 also telephoned Mr RDs grandmother. She said that he was definitely suffering from thought disorder and that she thought that the assault on the traffic warden might have been the trigger to his deteriorating mental health. It appeared to her that since his Disability Living Allowance had been stopped he considered that he was no longer ill and did not therefore need medication or mental health services.

Mrs D (grandmother) stated that the whole family was disappointed in the level of support Mr RD had received from the mental health services and that more could have been done to prevent a relapse. Mr RD had told her that he was going camping and she thought he would be back on Friday to go out for a drink with his brother in the evening as usual. If he did not return she would agree to a Mental Health Act Assessment with a view to Mr RD being admitted to hospital. Mr RD had often gone camping and had survival skills for being in the open air for several days.

Later that day Mrs D telephoned again to report that Mr RD had given up his flat and had wanted the deposit, which he could not have until 17 July. He had asked her to ring the Waverley Team and say he was in prison in order to "get them off his back."

[106] Case Records Vol. 4 Part 1 Pages 211/215
[107] Case Records Vol. 4 Part 1 Pages 215/216

ASW 1 telephoned Mrs D and explained that on the evidence he already had he would report Mr RD as missing and arrange a Mental Health Act Assessment as soon as he was available. ASW 1 reported him as missing at 12.45 that day. It was noted that Mrs D did not object and referred him to Mrs L (Mr RDs mother) if a Mental Health Section was required.
On **23 June 2006** a referral was sent by the Crisis Resolution Service to the Torbay Emergency Duty Service as Mr RD had been at the Accident and Emergency Department but had left they could see him. The police had tried to arrest him but he had assaulted a police officer and had left the hospital. The police were likely to place him on a Section 136 of the mental Health Act 1983 in order to take him to a place of safety.

The next day, **24 June 2006**, Mrs D made a referral to the Torbay Emergency Duty Service as Mr RD had been seen in some woods and was reported to be using illegal drugs and mixing with inappropriate people and was not taking his prescribed medication. She wanted a Mental Health Act Assessment to be initiated as quickly as possible.

On **27 June 2006** Mr RD was sectioned under the Mental Health Act 1983 whilst in the police custody suite. He had stopped taking his medication and his mental health had deteriorated. It was reported that Mr RD was assumed to have tried to burn down his mother's flat as she had found her Age Concern bag in her letter box half burned and was sure Mr RD was responsible.

The police reported that Mr RD had threatened a mother and her young child with scissors earlier that day. During the personal search when he was arrested a five to six inch bladed knife had been found in his waistband. He had presented as extremely hostile and had been arrested at 12.05. He had assaulted the police officers who arrested, and searched him.
Consultant 4 and Care Coordinator 2 saw Mr RD in the Custody Suite, but he was not prepared to speak to them and they agreed that he needed a secure setting such as Harvest Ward at Bodmin Hospital.

On 08 July 2006 Mrs D provided information about the circumstances leading up to Mr RD being admitted to Harvest Ward at Bodmin Hospital as she thought it important that the staff understood. Mr RD was assessed as requiring a Psychiatric Intensive Care Unit and therefore Harvest Ward was approached and had a vacancy.

Mrs D explained that Mr RD had dressed in his army clothes and had taken the keys of his flat to the agent and requested his deposit back as he was going to join the army. He was then missing for 10 days. He then went to her house with a large cut on his arm (on risk assessment of 13/07/2006 the cut is mentioned and needed stitches – cause not known) He had called his mother The Devil and would not speak to her. Mrs D took him to Torquay as he asked and when in the car two police officers appeared to arrest him on a Section136. Mr RD tried to run away but was caught.

By 14 July 2006 Mr RD was calmer and it was felt appropriate to transfer him from Harvest Ward to Haytor Ward at Torbay Hospital. Mr RD took some time to settle on Haytor Ward On **20 July 2006** he talked of his mother as though she was dead and said he had seen the corpse. He said that he had tried to burn his mother's house down and had managed to smuggle vodka into Bodmin Hospital.[108] He claimed to be a hitman and had seen a field full of the bodies of the people who he had shot.

Consultant 6 in his interview wondered whether Mr RD had been transferred back from the Psychiatric Intensive Care Unit a little too soon as he was severely deluded on his return to Haytor Ward. This was the first time Consultant 6 had met Mr RD and he proved very difficult to manage on the ward and within a month he was again referred to Harvest Ward at Bodmin Hospital. He had:

- abused his Section 17 Leave by coming back late and having used alcohol;
- tried to smuggle alcohol on to the ward;
- barricaded himself into his bedroom and seriously damaged the lock on the door;
- his Capgras symptoms returned;
- after his weekend leave, on 14 August 2006, his family contacted the ward to report serious problems over the weekend. Mr RD had been drinking 15 pints of beer a day. He had talked about buying a knife and again spoke of how people were buried in various places. He claimed that he had spent the weekend with a girlfriend rather than with his parents. He said that he had written off his parents and they do not exist;
- he continued to be aggressive and threatening to staff;
- on 15 August 2006 Mr RD threatened to hit a staff nurse;

[108] Case Records Vol. 6 Part 1 Page 170 and 173

- he was described as being “angry, posturing with threatening body language and he appeared to be intimidating staff by staring.”[109]
- Mr RD was interviewed by the police in connection with a fire on the ward a couple of days earlier. He denied having caused this but there was a high probability that it had been him as other people on the ward were accounted for.

Mr RD was transferred to Harvest Ward on 15 August and quickly settled. There was an incident with his brother trying to smuggle a cigarette lighter onto the ward in a jacket he brought for Mr RD. The brother and his girlfriend were also suspected of having brought alcohol onto the ward and when Mr RD’s bedroom was searched a knife, a pair of scissors and a cigarette lighter were discovered hidden in his pillow.

The Discharge Summary from this admission provides a good overview of the antecedents to the admission. “He is currently admitted following relapse secondary to non-compliance with his medication. He had been maintained on Clopixol Depot however a couple of months prior to admission he had asked to have this reduced and it was switched to oral Clopixol after which he became non-compliant resulting in his current relapse. When unwell Mr RD tends to increase his alcohol intake and also abuse cannabis which has an exacerbating effect on his mental state and also increases risk to others. His illness is characterised by repeated themes of grandiose and persecutory beliefs, intimidating manner and rapid delusions of identification that involve his parents and his grandmother and associated threats and they are considered to be at high risk when he is unwell. Mr RD also tends to isolate himself and also to increase his use of illicit substances, mainly alcohol and cannabis. He also has fascination with military or combat type wear and gear and dresses in like manner, exposing his upper body and flexing his muscles. Usually he has poor insight when he is unwell.”[110]

On admission a risk assessment was undertaken using the Cornwall Partnership NHS Trust documentation. The relapse “Alerting Factors/Triggers” were cited as:

- use of illicit substances;
- non-concordance with medication;
- grandiose;

[109] Case Records Vol. 6 Part 1 Pages 188 and 189
[110] Case Records Vol. 6 Part 1 Page 99

- Capgras about parents and grandparents;
- isolating himself;
- responding to auditory hallucinations;
- paranoid ideation;
- presents as cold and suspicious;
- believes he is cursed;
- talking of having a presence behind him or on his shoulder.

Mr RD returned to Haytor Ward on 18 September 2006. He continued to abuse his Section 17 Leave by returning after the agreed time and often having obviously consumed quantities of alcohol. All leave was suspended for a short period and then it was restarted.

Mr RD told the technical instructor running a gym session on 11 October 2006 that he had taken some steroids, namely Sustenon 250 and Decca Aurobolin. The technical instructor sent a note to Care Coordinator 2 that Mr RD had said that "he had been using anabolic steroids for some time and that he was aware they caused him some mental health problems, but that he would not stop using them. After further conversation it was plainly obvious that he did not know the purpose of steroids and how they react with the body. I got the distinct feeling that he would use any drug if convinced „it would make me big' (His words).

On 13 October 2006 the ward staff suspected that there had been illicit drug use on the ward and a drug screen was undertaken. Mr RD proved positive for amphetamine. After this Mr RD's behaviour improved and he was looking forward to being discharged and to having his own accommodation in the community.

On 06 November 2006 Mr RD was offered a placement at Riviera Court for two weeks in the first instance. He accepted this placement and was discharged from the ward and his Section 3 under the Mental Health Act was rescinded.

Early in February 2007 Mr RD moved into his flat and Care Coordinator 4 visited him there. He appeared to be focused and in a good frame of mind. He was still adamant that he did not want contact with mental health services except for Care Coordinator 4.

On 02 February 2007 Care Coordinator 1 referred Mr RD to the Assertive Outreach Team. The referral was marked „urgent' and explained that Mr RD quickly disengages from the service and becomes non-concordant with his medication which in turn soon deteriorates into a crisis and a hospital admission. The risk factors were described as "sometimes feels intimidated by others but acts in a bravado manner. He may neglect himself when unwell. When acutely unwell Mr RD has in the past put up a fight when going through the hospitalisation process. He has set fires during his last relapse (2006) whilst in an inpatient unit. He may neglect himself, loses sense of reality and has in the past gone into the woods commando style. Even when well Mr RD denies having any mental health problems, and is unwilling to discuss the subject. The purpose of the referral was to keep Mr RD engaged with services" [111]

The Care Programme Approach Review Meeting was held on 08 February 2007 with Mr RD, Consultant 4, Coordinator 2, Coordinator 4 and Team Manager 1. Mr RD did not want his family to be present at this meeting nor in the future. Mr RD was quite combative in the meeting as he was insisting that he did not want care Coordinator 2 to give him his depot as when he had given the injection done it "stings". He also wanted to try and get a deal on reducing the amount of the depot by half in return for agreeing to see Care Coordinator 2. He also claimed that he did not have any recollection of his breakdown and relapse in the last year, although later said things which belied this.

The level of contact mental health services had with Mr RD appeared to reduce after he had moved into his flat. He was challenging the dose of his Depot and was refusing to see his Care Coordinator. He did agree to see Care Coordinator 2 and to allow him to send him text messages to remind him when his depot was due.

Mr RD was telephoned on 24 April 2007 to remind him of the Depot Clinic. There was no answer but a message was left. Mr RD was strident in attitude as if this was done reluctantly and he would prefer to self-administer.[112]

Care Coordinator 2 telephoned Mr RD on 22 May 2007 and eventually managed to speak to him rather than having to leave a message. Mr RD said that he was not going to have the Depot

[111] Case Records Vol. 8 Pages 8/9
[112] Case Records Vol. 4 Part 1 Page 228/229

as it was slowing him down too much and was stopping him getting on with his life. Care Coordinator 2 responded by showing that he understood how Mr RD was feeling but that from previous experience by not having the depot he was at risk of relapsing as he had the year before.[113] He also told Mr RD that he had spoken to the Assertive Outreach Team with a view to them working with him as they specialised in helping people reach a point of stability where disengagement from the service could be the goal. Mr RD agreed that they could contact him.

Care Coordinator 2 also contacted the manager of the Work Opportunities to see if Mr RD had found a suitable programme. The manager was still trying to meet Mr RD's needs but he was very limited in the places he could do the work in.

Mr RD did not attend the review with Consultant 4 and Care Coordinator 2 on 15 June 2007. A representative from the Assertive outreach Team had also attended in order to tell Mr RD a little about the service and to arrange to meet him. Despite having made a time to visit Mr RD at his flat he was not there when they had called. It was agreed that the Assertive Outreach Team would make cold visits in the hope of catching him in so they could meet him.

On 15 June Care Coordinator 2 spoke to Mrs D about her grandson. He outlined the lack of contact and the fact that he had refused to have his Depot injection on 22 May. Mrs D then informed Care Coordinator 2 that Mr RD appeared to be relapsing and was showing the symptoms which had indicated this in the past. This information was given in strictest confidence. The information was that she and her husband had overheard Mr RD talking to someone on the telephone asking for "one five all Wellows" and then "How much". He then immediately went out. Mr and Mrs D think this was to buy street drugs.

"Mrs D also mentioned that Mr RD and his mother had had no recent contact. In addition Mr RD had recently gone to his father's house to do some work for him in the property. His father had remonstrated with him when he came back home to find that the work had not been done. Mr RD abruptly left, and later Mr D found his tyres on the van slashed by some scissors. Mrs D was convinced that Mr RD had done this as he was the only person with sufficient strength. When

[113] Case Records Vol. 4 Part 1 Page 229

Mr RD asked her to do something for him she refused saying she was not going to help someone who had done what he had done to his father's van. Mr RD left."

On 18 June 2007 Care Coordinator 2 discussed the Mr RD situation with Team Manager 1. It was agreed that the situation would be discussed by the team on 21 June in the Team Supervision Meeting. Care Coordinator 2 had also agreed to make efforts to contact Mr RD via text messages. Care Coordinator 2 then went to meet another service user and while he was there he was telephoned by Community Psychiatric Nurse 1 to inform him that Mr RD was at Waverley House and would speak to him on the phone. Mr RD told Care Coordinator 2 that he did not want a review meeting with Consultant 4 but with care Coordinator 2 alone so that he could discuss his medication and have his Depot reduced, saying he "might take half the dose."

In her interview with the Independent Investigation Panel Community Psychiatric Nurse 1 stated that when she had met Mr RD at Waverley House on 18 June 2007 he hadn't been any different from how he had presented at the Depot Clinic when she had seen him there. She added that he "didn't look any different, he was quite polite towards me. He was quite happy to stand and talk to [Care Coordinator 2] on the phone out in reception, and there wasn't anything that was concerning me."

Community Psychiatric Nurse 1 also said in her interview that she was aware of Mr RD's relapse symptoms and knew that "he had a forensic history and that he presented as more macho......and there was a lot more posturing." She thought that Mr RD had been wearing his combat trousers but that was his usual dress. In his account of a conversation with Community Psychiatric Nurse 1 soon after her meeting with Mr RD, Care Coordinator 2 noted in the continuous record that she had said that he was dressed well and not in combat gear and had spoken politely without the belligerent combative edge with which he sometimes presented.

On 21 June 2007 Mr RD was discussed by the team in the Team Supervision Meeting which ten people attended.[114] It was confirmed that Mr RD had missed two Depot injections on 22 May and on 19 June, so his last injection had been on 24 April. The team had thought that Mr RD might still be receiving some measure of benefit from his April Depot. Consultant 4 thought that

[114] Case Records Vol. 4 Part 1 Page 233/234

it was not appropriate for him to agree to meet Mr RD on his own about medication. It was agreed that Consultant 4 and care Coordinator 2 with someone from the Assertive Outreach Team would meet with Mr RD on 04 July 2007.
Care Coordinator 2 and Consultant 4 discussed Mr RD and the way forward after the Supervision Meeting. It was agreed that the time for an assessment under the Mental Health Act 1983 was approaching and the timing of this was discussed. Care Coordinator 2 said he would liaise with Mrs L (Mr RD's mother) and Mrs D (his grandmother) to discover how they felt he was prior to the re-scheduled review on 04 July. His behaviour in the past when he relapsed was contrasted with the way he had presented on his short visit to Waverley House three days earlier.

The steps to be taken were listed in the continuous record as:

a. to set the new review date for Wednesday 04 July;
b. to have a protocol for recording information from relatives;
c. future contact by Care Coordinator 2 with Mr RD's relatives, especially his nan;
d. liaison with Assertive Outreach Team and their continuing to try and make contact with Mr RD and their attendance at the next review.

On 22 June 2007 Care Coordinator 2 did liaise with the Assertive Outreach Team about the review and the continued cold calling, and also asked the Waverley Secretary to send the letter to Mr RD informing him about his new review date on 04 July.

Over the weekend of 23/24 June 2007 Mr RD was arrested for the murder of his grandmother who had suffered serious head injuries and had died later on 24 June in hospital.

Conclusions

As can be seen from the lengthy section above describing the relapse signature of Mr RD there were some key elements to be aware of:

- Mr RD would refuse his Depot and usually had a fairly swift deterioration in his mental health;

- The need to heed carefully the warnings from his family and especially his grandmother who was very protective of Mr RD but if she said he was relapsing then this should be taken seriously;
- The relapse could be exacerbated by Mr RD using alcohol or drugs.

During Mr RD's last admission to psychiatric hospital in June 2006 the Cornwall Partnership NHS Foundation Trust completed a risk assessment which had the following relapse "Alerting Factors/Triggers" listed.

- use of illicit substances;
- non-concordance with medication;
- grandiose;
- Capgras about parents and grandparents;
- isolating himself;
- responding to auditory hallucinations;
- paranoid ideation;
- presents as cold and suspicious;
- believes he is cursed;
- talking of having a presence behind him or on his shoulder.

The Table below identifies the relapse behaviour present in each of his admissions to hospital following a Mental Health Act 1983 Assessment:

Table : Signs of Relapse in the behaviour of Mr RD prior to his admissions to hospital

Signs of Relapse	**November 2001**	**August 2002**	**October 2002**	**June 2006**	**June 2007**	**When known**
family see signs of relapse	✔	✔	✔	✔	✔	15 June
use of illicit substances;		✔	✔		✔	Always probable
non-concordance with medication		✔		✔	✔	22May
grandiose;	✔	✔		✔		
Capgras about parents and grandparents	✔	✔		✔		
isolating himself;	✔		✔	✔	✔	15 June
responding to auditory hallucinations;	✔					
paranoid ideation;	✔	✔				

presents as cold and suspicious;*						
believes he is cursed;*						
talking of having a presence behind him or on his shoulder*						

* these symptoms were more usually present when Mr RD was in hospital,

It was clear that Consultant 3 was extremely concerned about the Capgras Symptoms and took the precautionary step of meeting with Mr RD's parents and grandmother to warn them that he could easily act upon his delusion that they were not his parents. The Independent Investigation Panel felt that this relapse symptom was the most worrying, and that if his family, who were quite supportive of him, noticed that he was showing signs of relapse then they should be listened to.

Mr D in his interview with the Independent Investigation Panel stated that when Mr RD was sectioned for the first time he was admitted to hospital. but once he was discharged he was soon involved in taking drugs and alcohol and quite rapidly relapsed. After his second admission to Harvest Ward at Bodmin Hospital and his discharge from Newton Abbot to Riviera Court Mr RD quickly stopped taking his medication and he rapidly deteriorated and was readmitted to hospital.

Mr D also reported that about six weeks before the homicide Mr RD had threatened him with a pair of scissors but had stopped short of stabbing him in the neck. Mr D told his son that he had better leave and he did not want him back in his house. When Mr D went outside he saw the scissors pushed into the side of his van's tyres. Mr D did not report the incident but he did tell his mother about it (Mrs D, grandmother of Mr RD).

The Table above shows the relapse signs Mr RD displayed according to the medical records prior to his four hospital admissions and before the homicide. The Independent Investigation consider that the homicide of Mrs D was preventable as the relapse indicators were present for at least four weeks since his refusal to take the Depot injection on 22 May 2007. The signs of relapse displayed by Mr RD during these four weeks were the refusal to take his depot injection on 22 May and exacerbated by also missing the depot clinic on 19 June. Mrs D had informed Care Coordinator 2 that she felt Mr RD was showing signs of relapse on 15 June. Mr RD had

only been seen by Community Psychiatric Nurse 1 on 18 June when he appeared to exhibit no obvious signs of psychosis. He had however not attended any meetings with the mental health services, had refused to let the Assertive Outreach Team into his room and had avoided one pre-arranged meeting with them. The misuse of drugs and alcohol was an ever present possibility.

When Care Coordinator 2 spoke to Mr RD on the telephone he wanted to see Consultant 4 on his own with the aim being to reduce his medication. Mr RD was not displaying any motivation to work with the mental health services, and his grandmother had sounded the alarm which should have been heeded. The ten members of the Waverly House Community Mental Health Team sat through the Team Supervision Meeting on 21 June and all agreed to make another appointment for Mr RD to have a re-scheduled review meeting on 04 July, some 13 days away. Someone within the Team should have asked the question why arranging a Mental Health Act Assessment was not being done, and why was his family not being visited to provide up to date information on Mr RD's current mental state.

Care Coordinator 2 commented in his telephone conversation with the chair of the Independent Investigation Panel that it was not his decision alone, and in fact it was the decision of all 10 staff who attended the meeting. They had thought that Mr RD was on the cusp of requiring an admission but they decided they should uphold his rights until they had more information and provide him with as much liberty as possible under the Mental Health Act. This was based on the fact that he had seemed to be well when he had met Community Psychiatric Nurse 1.[115]

Care Coordinator 2 also stated in the same telephone conversation that the relapse signature was totally different from the 2006 relapse. The nature of it was different, but four key elements were apparent, his grandmother had noticed that he was behaving differently as in the past, he was refusing medication, he was isolating himself from the mental health services apart from the one visit to Waverley House, and he was in all probability abusing alcohol or drugs. The Waverley House Community Mental Health Team did not know about the threatening behaviour Mr D had shown to his father before he had slashed his tyres with the scissors he had almost stabbed his father with. This fact did demonstrate that Mr RD was suffering a deterioration of his mental health.

[115] Transcript 4 Page 2

The Team Supervision Meeting was on Thursday 21 June. Care Coordinator 2 did not make contact with Mrs D or Mrs L on the evening of Thursday 21 June. In his interview with the Independent Investigation Panel Consultant 4 did say that he had raised the question about whether the team was looking at a formal Mental Health Act assessment. After discussion it was agreed to make another review date for 4 July ("This was when both I and Care Coordinator 2 would be available.")

Consultant 4 continued to inform the Panel that the 4 July date was for "a planned review, but in the meantime there's a more urgent check on Mr RD's mental state and behaviour and to inform the urgency and the planning of a Mental Health Act assessment. I advised that we needed to speak to Mr RD's family members to obtain further third party information in terms of Mr RD's mental health. Care Coordinator 2 agreed to contact the family. I spoke separately after the meeting to Care Coordinator 2 about this in the office. I expected him to do this very urgently, and if the family raised concern if they thought Mr RD had signs of psychosis and risk we would then intervene urgently. My anticipation was that it was likely the Mental Health Act assessment would be before the planned meeting on 4 July and we could have had that information. I was aware that Mr RD can present quite well superficially himself, that's why I was seeking the family information because they knew him well and trying to get more information about how deteriorated he was."[116]

On Friday 22 June Care Coordinator 2 did make contact with the Assertive Outreach Team to alert them to the review meeting on 04 July and the need to continue with the cold calling. As no contact had been made with Mr RD on the Thursday or the Friday morning the Panel considered that a Mental Health Act Assessment should have been set up for that afternoon and the police informed that Mr RD was potentially dangerous and that he needed to be found so that an assessment could take place as soon as possible. It would have been preferable for this to have happened after the meeting on Thursday 21 June 2007.

Recommendation 5

[116] Transcript 6 Page 22

The Clinical Team Leaders and Team Managers must as a matter of urgency ensure that all staff are aware that, under the remit of the Mental Health Act 1983 (as amended 2007), if there is concern about a service user relapsing they are legitimately able to undertake / refer for an emergency Mental Health Act Assessment.

13.5 Management of the Clinical Care – Inpatient and Community Services

Context

During 2006 the Devon Partnership NHS Trust altered the way services were organised. The inpatient services had their own consultant and the community consultant psychiatrists adopted a functional model of working with specific teams which had not previously been the case.

At the time Mr RD was an inpatient on the Haytor Unit from 28 June to November 2006 Consultant 6 was the inpatient consultant. Whilst this „split' between community and inpatient work made ward management easier in that with all the service users being under the same consultant there was less upheaval from having several different ward rounds each week, there were potential difficulties in managing smooth discharges back to the community teams. At the time operational policies were being prepared but were not in place. Consultant 6 described the situation as being managed by "agreement, prior to instigating the model, that we [inpatient consultants and community consultants] would liaise closely about potential discharges from the ward."[117]

The staff attempted to facilitate daily meetings "which we continue to have", where community staff, particularly community staff with an interest in patients on the ward, attend to get a daily handover on that and to find out when there may be potential for discharge."[118]

Description of events

[117] Transcript 3 Page 3
[118] Transcript 3 Page 3

Mr RD in the community from 06 November 2006 and the homicide on 24 June 2007

Consultant 6 considered that when he was well Mr RD was quite resourceful and managed his self care well. It was known that those who knew Mr RD well would have said that "if there was any sense of breakdown or disengagement a rapid resort to the Mental Health Act and detention under the Mental Health Act would have been necessary because once his insight was impaired the chances of re-engaging with him were limited.""[119]

As mentioned above the period that Mr RD was an inpatient between 28 June and 06 November was a difficult time for staff because at times Mr RD was floridly psychotic and displayed aggressive and hostile behaviour. After his second return from Harvest Ward on 18 September 2006 Mr RD's mental state improved and he displayed no psychotic symptoms during the weeks prior to his discharge. Towards the end of the period when he was granted considerable Section 17 Leave he caused problems by returning to the ward late or when he had consumed alcohol. There were several examples of his brother attempting to bring in alcohol or cigarette lighters which were banned on the ward.

Despite these warning signs the speed in which Mr RD was moved from the Psychiatric Intensive Care Unit (18 September 2006) to being moved to an independent flat (mid February 2007) is surprising. In the early years of his mental ill health those consultants caring for Mr RD had identified that he responded to having a structure around his life which helped him to better comply with taking his medication and avoiding alcohol and illicit drugs. It was to assist this structure that Consultants 1 and 2 decided that a Section 25 of the Mental Health Act 1983 should be used. This Section, by providing supervised discharge, enabled the mental health services to determine where Mr RD should live and also ordered him to attend monthly for his depot injection.

On 06 November 2006 the Section 3 of the Mental Health Act was rescinded and no application for a Section 25 Supervised Discharge was made. Consultant 6 felt that Mr RD would engage and comply with services because he wanted to get into independent accommodation and that was the gist of the care plan for him. At the time of his discharge Mr RD had been settled on the ward since 13 October 2006 when he had tested positive for amphetamine use. As Consultant 6 explained without reference to the notes "I think at the time of his discharge we had a period of several weeks where he'd been going on unescorted leave with members of his family, all of

[119] Transcript 3 Page 5

whom were reporting him well. We had the family raising concerns his lack of progress, because I think what they saw was a young man who was frustrated by the lack of resources."[120]

Consultant 4 considered that the split between the inpatient services and the inpatient consultant worked reasonably well and the „Golden Hour Meetings' each weekday Monday to Friday where inpatient and appropriate community team members met ensured good communication. Minutes of the „Golden Hour Meetings' were issued daily so that the community consultants and the members of the various community mental health teams were kept abreast of what was happening and the current plans for their service users.

Consultant 4 stated that he had not been invited to the Section 117 Discharge Meeting although Care Coordinator 3 was present. It was Consultant 6 who, assessing that Mr RD was now well, decided to rescind the Section 3 of the Mental Health Act 1983 and to not apply for a Section 25.

On reflection Consultant 4 did think that having a Section 25 at that time might have made a difference. He added "when he was informal in the community we had less control over him. We could try and negotiate with him and persuade him, but as an informal patient, unless we use formal powers like a further mental Health Act assessment, our options we're limited. When he was on supervised discharge we would have more powers of agreeing where he lived."[121]

The staff interviewed and asked about the discharge of Mr RD to Riviera Court in November 2006 all commented on how well Mr RD had become. Consultant 3 in her interview had stated that when Mr RD was not displaying symptoms of serious mental illness he was a different man and was a pleasure to work with. She added that she was fond of him, but if he was relapsing that was a different matter and he appeared able to become ill very quickly.[122]

Findings

[120] Transcript 3 Page 6
[121] Transcript 6 Page 19
[122] Transcript 2 Pages 9/10

Consultant 6 thought that the split between inpatient mental health and community mental health was positive and that at the time Mr RD was moving from the inpatient service at the Haytor Unit to the Waverley House Community mental Health Team it worked well as it was new and agreements had been reached with all consultants and teams prior to its starting.

The staff interviewed by the Independent Investigation Panel thought the communication between the teams was good and that the „Golden Hour Minutes' meeting and the rapid issuing of emailed minutes did keep all staff up to date. The one reservation the Independent Investigation Panel identified was the potential for differences in opinion if the „receiving' consultant in the community was not at the meeting and it was the discharging consultant with a possibly different perspective on the situation that a colleague in the community.

Consultant 4 did feel that Mr RD would possible been more compliant if there had been a greater structure around him as this did appear to have worked well in the past. This message may not have been voiced as loudly with the community psychiatrist not present, and as it happened, a new care coordinator for Mr RD.

There are two views about the functional division of having separate consultants for inpatient work and community work. It undoubtedly makes the management of the ward easier and less disruptive for the nursing staff, but at the cost of splitting what would otherwise be continuous medical care from the same consultant. At present there is no overwhelming consensus on which is the best practice.

Conclusion

The Independent Investigation Panel would not seek to review the current configuration of inpatient and community services, but would make the recommendation that it is made common practice for the community psychiatrist who will be the Responsible Medical Officer for the service user to be invited to the discharge meeting. Such an action will enable the community views to be fully considered in the final discharge arrangements agreed.

Recommendation 6

When a service user is being discharged from the inpatient service, especially after a lengthy period in hospital, the community psychiatrist who will be taking over the care and treatment should be invited, and should attend, the meeting so that they have direct knowledge of the situation and can plan their future involvement.

Service Issue 6

The Workload of Consultant Psychiatrists

The Independent Investigation Panel considered that some of the psychiatrists they met appeared to have onerous responsibilities straddling across several different mental health teams. Such variety of role could have had an effect on the level of assistance and treatment given to Mr RD.

It was not considered to play a part in the murder of Mrs D, but could have meant that Mr RD did not receive an optimal care and treatment plan.

Recommendation 7

The workload of consultant psychiatrists should be regularly monitored to ensure that they are not being spread too thinly across too many areas of responsibility. This should be linked to the Clinical Audit Programme and routinely reviewed.

Service Issue 7

Peer Support and Supervision for Consultant Psychiatrists

It was apparent from the consultants the Independent Investigation Panel spoke to that the position with peer support and supervision for consultants had improved since 2007.

Another factor which was clear was the difficulty some consultants had experienced as a result of having to undertake a role in an Internal Investigation where staff had been criticised and their being partially ostracised as a result. In 2006/2007 there appeared to be no clear route to gaining help and assistance from peers or management.

Recommendation 8

The Co-Medical Directors should ensure that consultant psychiatrists have a well identified pathway to help and advice should they need assistance in any aspect of their work.

13.6 Role of the Community Psychiatric Nurse and the Care Coordinator

Context

The role of a Community Psychiatric Nurse and a Care Coordinator includes the following tasks:

- to work with people who are living in the community. This is most often in the person's own home but it can also be in clinics based, for example, in a GP's surgery or a community mental health team base;
- to remember that they have a duty of care to the service users they are working with;
- to develop with the service user an individual care plan based upon a robust assessment of their needs and a risk assessment to highlight risks that need to be managed;
- to provide support to people through difficult periods of their illness. They may also see patients who are currently well to check that they are still progressing and to be the first point of contact if the service user starts to become unwell again;
- to help service users with their medication and make sure that they understand what they should be taking and when;
- because community psychiatric nurses see service users in their own homes, they also play a valuable role in helping the service user's family and carers understand and cope with the illness;
- take referrals from a number of sources including psychiatrists, inpatient wards, GPs so that the community psychiatric nurse can help the service user transfer from hospital back into the community.

Findings

The care which Mr RD received after his 06 November 2006 discharge from hospital was largely to be monitored when he attended the Depot Clinic for his monthly injection. At the 30 January 2007 Depot Clinic Mr RD asked for assistance in finding some accommodation. Care Coordinator 4 provided him with considerable practical help and support during a few days in early February 2007 while his allocated Care Coordinator 2 was not at work due to illness. She had referred him to the Assertive Outreach Team but on 07 February 2007 Mr RD refused to get up to see the Assertive Outreach staff and they had a short conversation through the locked bedroom door. Care Coordinator 4 arranged with Mr RD that she would see the Assertive Outreach Team with him the following day.

Care Coordinator 4 saw Mr RD the next day but he was in a hurry and declined to see the Assertive Outreach Team. He said he would agree to see Care Coordinator 4 but did not need the help of any other mental health services. As a result of Care Coordinator 4's concerns Mr RD's case was discussed at the Community Mental Health Team meeting and it was agreed there should be a Review Meeting on 08 March 2007.

At the Review Meeting Mr RD did not want his family to be present at this meeting nor in the future. Mr RD was quite combative in the meeting as he was insisting that he did not want Care Coordinator 2 to give him his depot as when he had given the injection in hospital it "had stung". He also wanted to try and get a deal on reducing the amount of the depot by half in return for agreeing to see Care Coordinator 2.

From then on the plan appears to have been for Care Coordinator 2 to see Mr RD monthly at the Depot Clinic although he did visit to help arrange a meeting and some assistance in finding work with the Work Opportunities Manager. From the notes it appears that Mr RD was only seen face to face from 08 March on the following occasions:

Contacts with Mr RD between 08 March and 18 June 2007

Date 2007	Event	Seen	Not seen	Work Planned
March 08	Review Meeting	✔		
March 27	Depot Clinic	✔		
March 29	Care Coordinator 2 helped Mr RD fill in forms for Work Opportunities	✔		
April 24	Depot Clinic	✔		
May 22	Depot Clinic – Mr RD did not attend		**X**	
June 11	Appointment made to visit Mr RD at his home. Short notice with message left on his mobile telephone a few hours before		**X**	
15 June	Review Meeting		**X**	
18 June	Mr RD visited Waverley House but saw Community Psychiatric Nurse 1. Care Coordinator 2 spoke to him on the telephone as he was out with another service user.	✔		Review Meeting arranged for 04 July. Care Coordinator 1 and Manager of AOT would visit Mr RD on 27 June.

The Table above illustrates that Mr RD was seen face to face on five occasions between 08 March and 18 June 2007. On 08 March he was seen by Consultant 4 and Care Coordinator 2 so they would have been able to assess his mental state to a limited extent. Mr RD was „playing up' a little as he tried to bargain a drop in his medication. On 27 March Mr RD was seen at the Depot Clinic.

On 24 April Mr RD was showing off at the Depot Clinic and the inference was drawn that he was demonstrating that he would prefer to self administer his medication rather than have a Depot. He was not seen again by any member of the mental health services who was currently working with him again. Community Psychiatric Community Nurse 1 saw him on 18 June when he appeared to her to be showing no overt symptoms of psychosis.

Conclusions

With hindsight it would have been preferable had the Assertive Outreach Team been working with him as their role is to work hard to track people down and to engage them in services. Mr RD would have qualified as he was still young and had had several inpatient admissions under Section 3 of the Mental Health Act 1983. It does, however, have to be noted that the Assertive Outreach Team had been singularly unsuccessful in meeting him face to face and had just one conversation through a locked bedroom door at Riviera Court.

It appeared to the Independent Investigation Panel that the staff of the Community Mental Health Team were not assertive enough in trying to find Mr RD and to demonstrate that they were worried about his signs of relapse and his not taking medication. It had been noted several times in his time with psychiatric services that he responded to a structured environment. This was noted in the Psychiatric Intensive Care Units, the wards which had provided a structure, Lee Mill which had the advantage of being a locked ward, and to a certain extent during his second stay at Riviera Court, when he was subject to the Section 25 Supervised Discharge arrangements to which he responded well.

The Community Mental Health Team approach lacked a clear plan and was rather “hands-off” in its attempts to engage Mr RD. There appeared to be on the one hand a wish to check how Mr RD was by phoning his parents and his grandmother, whilst not being proactive in visiting them to find out directly how Mr RD appeared to them. The views of Mrs D were known but were not acted upon.

13.7 Referral from Community Mental Health Team to the Assertive Outreach Team

Context

Mr RD was proving difficult to engage for the Community Mental Health Team due to his wish to keep contact with the service at a minimum and his lack of insight into his mental ill health. Care Coordinator 4 made a referral to the Assertive Outreach Team as this team had a specialist role to try to engage and keep engaged service users like Mr RD who found it difficult to maintain contact and to comply with his prescribed medication.

Findings

The Community Mental Health Team working with Mr RD from 06 November 2006 until the time of the homicide on 24 June 2007 did not work very actively with him. This was because from the time he was discharged Mr RD made it clear that he did not wish to be involved with the mental health services to any great extent and agreed to have his monthly depot injections and to work with Care Coordinator 4. He stated that he did not wish to discuss his mental health nor his relapse indicators.

Contact with Mr RD from 30 January to 19 June 2007

Date 2007	What happened	RD seen	RD not seen
30 Jan	Seen at Riviera Court	✔	
05 Feb	Seen at Waverley House Assertive Outreach Team referral discussed	✔	
07 Feb	Seen at Riviera Court he had not allowed the Assertive Outreach Team staff into his room but agreed to see them the next day with Care Coordinator 4	✔	
08 Feb	Care Coordinator 4 was visited by Mr RD at Waverley House and said he would not be able to see her properly as he „had to get off'. He would therefore not be able to meet the Assertive	✔	

	Outreach Team.		
08 March	Care Programme Approach Review Meeting with Mr RD, Consultant 4, Care Coordinator 2, Care Coordinator 4 and Team Manager 1. Mr RD did not want his family to be present at this meeting nor in the future. Mr RD was insisting that he did not want care Coordinator 2 to give him his depot and wanted to get a deal on reducing the depot by half in return for agreeing to see Care Coordinator 2.	✔	
27 March	Care Coordinator 2 telephoned Mr RD to remind him of the Depot Clinic – he attended.	✔	
29 March	The forms for Opportunities courses were completed with Care Coordinator 2. Attempt to complete a current Care Plan. Mr RD stated that he did not do care plans and refused to participate.	✔	
24 April	Mr RD was telephoned to remind him of the Depot Clinic and a message was left. Mr RD was strident in attitude as if this was done reluctantly and he would prefer to self-administer.	✔	
22 May	Care Coordinator 2 telephoned Mr RD and spoke to him. Mr RD said that he was not going to have the Depot as it was slowing him down too much and was stopping him getting on with his life. Care Coordinator 2 said he knew how Mr RD was feeling if he did not have Depot would relapse as he had the year before.		✔
11 June	The CMHT Team Meeting discussed Mr RD and decided to arrange a visit that afternoon at 15.00. A message was left on his mobile phone. When Care Coordinator 1 and Assertive Outreach Worker 1 visited he was not at home.		✔
15 June	Case Review Meeting. Mr RD did not attend.		✔
18 June	Mr RD had a phone conversation with Care Coordinator 2 who explained that he wanted to arrange another Review Meeting. Mr RD retorted that he wanted to see Consultant 4 on his own and to	✔	

19 June	have his depot reduced. The AOT discussed Mr RD at their team meeting and agreed that Care Coordinator 1 and the Team Manager of AOT would visit Mr RD on 27 June. Mr RD did not attend the Depot clinic.		✔

It can be seen from the table above that Mr RD was seen only nine times from 06 November 2006 and 24 April 2007, almost six months. He was seen for the final time on 18 June by Community Psychiatric Nurse 1 who had not been involved with him for a considerable time.

Care Coordinator 2 wanted to transfer Mr RD to the Assertive Outreach Team because they had more experience in trying to engage service users who found this difficult. The referral was sent by ePEX, the email system, to the Assertive Outreach Team on 05 February 2007.

Community Psychiatric Nurse 2 explained the referral system to Assertive Outreach Team in his interview with the Independent Investigation Panel stating “The referrer would put a referral to Assertive Outreach on ePEX. They would then contact the team manager – we had a file for referrals. We had a caseload of 61, that was what we were funded for and that was what we were staffed for. We had a maximum caseload of 12 per care coordinator, with somebody carrying 13 – there was a budgetary reason we carried the extra one. At that time we had a caseload of 68 so we were over capacity. The CMHTs would come down to our planning meeting on the Monday, if they had a client they wanted to refer, or with other information they knew. For example, if Fred went to the football group on a Friday that wouldn’t necessarily be on ePEX, but they would drop him back home on Friday afternoon and that would be a good time to do the assessment, we’d stand a chance that he’d be in. Or if he went to the Cool House on a Monday and a Wednesday morning there was no point in turning up. They’d also look at the risk profile. I notice with [Mr RD] he only had a Risk Assessment 1, which was a bit of a surprise because most of our referrals have to have a Risk Assessment 2 completed.”

Team Manager 2 explained that due to staffing and the need to show the Strategic Health Authority that the Assertive Outreach Team had the requisite 61 service users some referrals were counted in the 61 but were awaiting assessment. They were being seen as the teams which referred them were continuing to work with them until the Assertive Outreach Team could formally accept them as a referral. Mr RD was in this category and his name was on a board in

the team room from February until June 2007. He would have been discussed during the weekly team meetings but no action other than trying to see him had been agreed.

The Assertive Outreach Team had tried to contact Mr RD at Riviera Court but he refused to meet with them, and they had never managed to find him at home despite cold calling on a few occasions. As shown in the Table and in the chronological timeline meetings to see Mr RD with Care Coordinators 1 and 2 had been tried as had being part of the scheduled Review Meeting on 15 June.

The referral to the Assertive Outreach Team was less urgent than it could genuinely have been as Mr RD was trying to dictate terms to the Community Mental Health Team about who he would meet, what he would discuss and the strength of his Depot. On 02 February 2007 Care Coordinator 1 referred Mr RD to the Assertive Outreach Team. The referral was:

> *"marked „urgent' and explained that Mr RD quickly disengages from the service and becomes non-concordant with his medication which in turn soon deteriorates into a crisis and a hospital admission. The risk factors were described as "sometimes feels intimidated by others but acts in a bravado manner. He may neglect himself when unwell. When acutely unwell Mr RD has in the past put up a fight when going through the hospitalisation process. He has set fires during his last relapse (2006) whilst in an inpatient unit. He may neglect himself, loses sense of reality and has in the past gone into the woods commando style. Even when well Mr RD denies having any mental health problems, and is unwilling to discuss the subject. The purpose of the referral was to keep Mr RD engaged with services"*[123]

In fact the referral was somewhat understated. Only the Level 1 Risk Assessment was used despite the forensic history and the four year history since Mr RD's first admission in November 2001. It is perhaps not surprising that the referral did not get priority until the Community Mental Health Team was really concerned that Mr RD was deteriorating and might require a Mental Health Act Assessment in June 2007.

[123] Case Records Vol. 8 Page 6

The Independent Investigation Panel can understand why in February 2007 it was decided to refer Mr RD to the Assertive Outreach Team as they had more experience in engaging people who did not really want to engage with mental health services. Mr RD was seldom visited after his last discharge from the Haytor Unit in early November 2006 as illustrated above. What does not quite add up was the attempt to still involve the Assertive Outreach Team after the middle of June 2007.

Conclusion

The Community Mental Health Team did not act with sufficient speed and urgency as discussed in Section 13.4. As it was clear that Mr RD was relapsing and that he would in all probability require urgent admission to hospital it would have been more appropriate to have involved the Crisis Team which had the responsibility of deciding which service users should be admitted to hospital and would undertake the necessary action under the Mental Health Act 1983. The continued use of the Assertive Outreach Team appeared to confuse matters and did not make any positive difference in the care and treatment of Mr RD as it never met him face to face.

The care pathways between services did not appear to be fully understood by the Community Mental Health Team during the latter half of June 2007.

Recommendation 9

The Devon Partnership NHS Trust must ensure that there are clear care pathways within and between mental health services. This should be based on:

- **clear operational policies for each service;**
- **unambiguous acceptance criteria for referrals which make it absolutely clear who the service is for;**
- **a named manager within the service who will deal with any questions a referrer may have about the service**

- **an overall care pathway analysis to ensure that there are no gaps created by the acceptance criteria which leave some eligible service users without an appropriate service.**

The Care Pathways should be regularly audited and any complaints or plaudits from service users used as part of the audit.

13.8 Lack of Provision of a Carer's Assessment

Context

Since the Carers Act (Equal Opportunities) 2005 and the Carers and Disabled Children Act 2000, all carers have a right to an assessment of their needs. This is mandatory and all Local Authorities have a duty to advise carers of their rights to an assessment.

The Devon County Council website has the following information about carer and their entitlement to an assessment in their own right separate from that of the person they are caring for:

"A carer is someone who provides, or intends to provide, a substantial amount of care on a regular basis for another individual. This can be for an adult or a child with special needs, and may be a family member, friend or neighbour.......If you are an unpaid carer as described above you are entitled to a **carers assessment**. An assessment is about you as a person rather than the person you care for and looks at **your** needs. It explores how your caring role is affecting you, and what might help to support you in your caring role and life.

An assessment may also consider the carer's leisure, education, training and work, where this is appropriate."[124]

[124] Devon County Council Website/Carers assessment

Description of events

Mr RD's parents and grandparents went to great lengths to support their son. However, throughout the five and a half years that Mr RD was receiving care and treatment from the Devon Partnership NHS Trust there is only one fleeting mention of Mrs D (paternal grandmother) being offered an independent carers' assessment.

Mrs D, and to a lesser extent, Mrs L did provide a great deal of care and support to Mr RD. Indeed Mrs D was viewed as the nearest relative as far as the Mental Health Act 1983 defined it as she was his „appointee' for financial matters. She was also providing him with a home for much of his Section 17 Leave except when he had his own rented flat, and even then she frequently made sure that he had proper meals at the weekend.

During the times Mr RD was in hospital Mrs D had frequent contact with him and as Care Coordinator 1 explained to the Independent Investigation Panel said "she was very doting on him, very caring, wouldn't hear a thing against him; she was very protective of him..... I knew his grandmother very well because I had a lot to do with her. A lot of my dealings were with her because she seemed to take the lead in caring for Mr RD, certainly in caring for things like his finances and benefits, so I would always be getting calls from her about help with filling in forms and supporting her in that."

Findings

Mrs D was within the definition given above a carer for Mr RD as she provided him with accommodation, and certainly undertook domestic tasks for him like washing and ironing his clothes and ensuring that he was properly fed.

Throughout all the records examined by the Independent Investigation Panel there was only one reference to a Carer's Assessment in relation Mrs D and none to any other members of his family. It is clear that Mrs D did provide a great deal of practical and emotional support to her grandson. In the interview the Panel had with Mr D he mentioned that if [the family] had known how much help his mother was giving to Mr RD they would have offered her more support but

they did not know how much she had been putting herself out to try and protect him. He also mentioned that he thought the Community Mental Health Team in Torquay relied on her too much when they could make no contact with Mr RD by asking her where he was and how he was.[125]

Conclusions

The Panel considers that Mrs D should have been offered a Carer's Assessment and if she had been reluctant to accept it should have been offered again when she was actively with her grandson. All health and social care staff should be fully aware of the rights of carers and be proactive in suggesting that any carers they are working with are fully aware of the help they can access.

Recommendation 10

The carers of service users must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The Devon Partnership NHS Trust and Devon County Council should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

[125] Transcript 5 Page 3

13.9 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[126]

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 offices. The Devon Partnership Trust 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	

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

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 Devon Partnership Trust in 2006/7 showed that the quality of the service was „excellent' and that the use of resources was „fair'. In 2008/9 the performance rating for the Trust showed that the quality of the service was „fair' and that the use of resources was „good'.

Findings

Devon Partnership NHS Trust readily acknowledged that there has been, and continue 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 and 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 which 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 the systems 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 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 the 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 Independent 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 in the tracking and archiving of records.[127] 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**.**

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 a widespread practice across the Trust in inpatient, 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 Care Programme Approach Policy).

[127] CT 1 pg 8

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). An independent audit will be conducted twice a year of a sample of all teams' compliance and self monitoring to ensure accuracy and consistency.

The clinical practice standards are detailed and specify that recovery plans are up to date and reviewed within a six month timescale. There is some evidence that this approach has begun 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 certain 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 are there".

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 O5, 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%.

Most Recent Audit Cycles in the Devon Partnership NHS Trust

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.[128]

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.[129]

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

(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[130]

[128] 08_061_PQA_Phase_3_Trustwide_report
[129] CRSMS_Analysis_June-July_10
[130] Item_7_Performance_Report_Appendix_2

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 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 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."[131]

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*

[131] CT 1 pg 19

contact with Trust staff" refers to „*practitioners will respond within the timeframe defined by the service operational policy*'[132]

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 that the Trust Board had made a great effort meet the teams early on in the process of change.

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 very low return rates with the Quality Practice Audits.

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 at an aspirational stage of development as there remains a disconnection between front line clinicians as they have yet to 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 but it 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 being

[132] Practice Standards Reference 210/05/10

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. RD 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 Trust policy and guidance although they all appeared to take their roles and responsibilities seriously. The Independent Investigation Team, whilst acknowledging that Mr. RD'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 causal in origin the Independent Investigation Team did not conclude that poor Clinical Governance systems were causal to the events of 23 June 2007. They did however contribute to Mr RD 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.

Recommendation 11

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 12

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 13

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.*

14. Findings and Conclusions

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

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

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

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

Root Cause Analysis

The key question in any investigation into a homicide committed by a mental health service user is „why did they kill the victim'. In the situation with Mr RD it is a particularly relevant question as the person he murdered was his grandmother, and all the evidence available to the Independent Investigation Panel showed that she had been the one stable influence throughout his life. She had also taken the lead role in supporting him during the six years of his mental ill health.

The judge sentencing Mr RD on 20 May 2008 at Exeter Crown Court clearly saw Mr RD's actions in attacking and killing his grandmother as being due to him having "a mental disorder as defined by Section 1 of that Act [the Mental Health Act 1983]; you have a mental illness,

namely paranoid schizophrenia, and it is an illness of a nature and degree that warrants your detention in an appropriate hospital; that is for your own health, your own safety, and above all else for the protection of the public to whom you undoubtedly present a serious risk."

Using the Five Why's questioning technique the answer to the initial question:

Why did Mr RD attack his grandmother with a hammer and cause her such severe injuries that she died?

Because he suffered from paranoid schizophrenia and had delusions about his mother, father and grandmother not being his parents or grandmother (Capgras Syndrome)

Why was Mr RD psychotic?

The main factor was that he had stopped taking his prescribed medication.

Why had he stopped taking his prescribed medication?

Because he had always been reluctant to take it.

Why had he always been reluctant to take his medication?

Because he had never accepted that he was mentally ill and thought his medication prevented him from leading his life to the full as it slowed him up.

Why was he allowed to continue in this situation so that he became so acutely ill?

Because the Community Mental Health Team did not act decisively and assertively to confirm for themselves that he was relapsing and was psychotic and having delusions.

This Five Why's Technique does suggest that the Community Mental Health Team did not act quickly enough to organise a Mental Health Act Assessment. Having looked at all the evidence the Independent Investigation Panel considered that there was one key causal factor for the

homicide. This was that Mr RD and his failure to engage with services and his regular use of alcohol, illicit drugs and occasional steroids, combined with the lack of assertive action to assess Mr RD's mental health by the Community Mental Health Team probably led to the homicide.

The Independent Investigation Panel also identified eight contributory factors and five service issues.

Key Causal Factor

Key Causal Factor 1: Mr RD and his failure to engage with services and his regular use of alcohol, illicit drugs and occasional steroids, combined with the lack of assertive action to assess Mr RD's mental health by the Community Mental Health Team.

Mr RD was difficult to engage with services and did not accept that he had a severe and enduring mental illness. Throughout his contact with mental health services he regularly failed to comply with his medication, and also used cannabis and alcohol to excess thereby making a relapse in his mental health more likely. He also used body-building steroids on occasions. The mental health services provided him with considerable help and support but he did not really make a personal commitment to heed their advice. Mr RD always pushed for a faster route to greater independence and to continue with his habitual lifestyle.

This lack of adherence to his care plan and the prescribed medication was a key causal factor in his relapse. This also needed to be seen within the context of the Community Mental Health Team having been alerted to the possibility that Mr RD had started to relapse in a telephone his grandmother made to Care Coordinator 2 on 15 June 2007, eight days before the fatal attack.

The Independent Investigation Team concluded that the murder of Mrs D could have been prevented. The second element of this Key Causal Factor to the homicide of Mrs D was the decision of the Community Mental Health Team not to instigate an urgent Mental Act Assessment of Mr RD on the evening of 21 June 2007 or on 22 June 2007.

As is evident from the timeline Mr RD had a recognisable relapse signature and his family, especially his grandmother, were the best placed to recognise early signs of any deterioration in his mental health. Given that this was known and well documented the Independent

Investigation concluded that Consultant 4 and/or Care Coordinator 2 should have contacted the family of Mr RD by telephone or by visiting them, and if necessary enlisting the assistance of the police immediately after the Team Supervision Meeting on 21 June 2007, or during the following day.

This would have demonstrated that they were seriously concerned about Mr RD's mental health and accepted that he was a potential danger to others, and particularly to members of his family. The police would have been able to search for him and to alert the mental health services if they found him. The Community Mental Health Team had a duty of care to him to assess his mental health and prevent him relapsing thus rendering him likely to become psychotic and delusional.

The Mental Health Act Assessment, if undertaken, would have either confirmed that Mr RD was becoming psychotic again as the evidence already gathered suggested, or that he was not psychotic but did or did not require help under the Mental Health Act 1983 for his own safety or the safety of others. If he had been found and the Mental Health Act Assessment demonstrated that he was relapsing and did require admission to hospital under the Mental Health Act 1983 then the homicide would have in all probability been averted.

Contributory Factors

Contributory Factor 1 : The Care Coordination Role and the Role of Different Teams

Mr RD was seen face to face on five occasions between 08 March and 18 June 2007. It has to be seen within the context of Mr RD being hard to engage. This was very much the situation since his discharge from hospital in November 2006 since when he had been pushing for greater independence and less contact with mental health services.

Care Coordinator 4 had referred Mr RD to the Assertive Outreach Team but due to work pressures it was unable to immediately accept the referral. Mr RD seemed to be an appropriate referral for this team in February 2007 as he was hard to engage and this was the essence of the role of the Assertive Outreach Team. His referral was not seen as urgent until it was thought that Mr RD might be relapsing in May/June 2007 when they again tried to see him. At this stage it would have been more appropriate to have referred to the Crisis and Home Treatment Team.

There did not appear to be a clear care pathway between the various community based mental health services. As a result Mr RD did not have access to a specialist team which could have better addressed his needs. Again it is necessary to emphasise that he did not engage with the Assertive Outreach Team and refused to see them and appears to have deliberately avoided them.

The Independent Investigation Panel saw this as a contributory factor as it meant that Mr RD did not receive assistance aimed at helping him to engage with the mental health services. It could not be seen as a direct causal link.

Contributory Factor 2 : The Care Programme Approach and Risk Assessment and Risk Management

The Care Programme Approach Risk Assessments were less than comprehensive and did not always indicate whether Mr RD was on standard or enhanced status, but with his psychosis and the level of support he required he should at all times have been on the Enhanced Care Programme Approach. Some of the Risk Assessments did not include the Level 2 assessment, and Mr RD would certainly require this level of risk assessment given his forensic history and the relapse history he had during the years 2002 to 2006.

The referral to the Assertive Outreach Team in February 2007 did not include a Level 2 Risk Assessment although there should have been one given his mental health and forensic history.

The lack of full risk assessments was a contributory factor to Mr RD not being seen as an urgent referral to the Assertive Team , but did not directly lead to the homicide of Mrs D.

Contributory Factor 3 : Transfer of Care Arrangements between Inpatient and Community Mental Health Services

The division of the care of inpatients and the care of service users in the community did appear to the Independent Investigation Panel to have contributed to the lack of a robust and comprehensive care plan for Mr RD when he was discharged from the Haytor Unit for the final time on 06 November 2006.

In the past it had been noted that Mr RD had responded to a structure, but was less responsive to advice, care and treatment if the structure was missing. He had had his optimum good mental health whilst at Lee Mill and in the period following his discharge when he was subject first to

extended Section 117 Leave, and then made subject to a Supervised Discharge under Section 25A of the Mental Health Act 1983.

Mr RD had had an unsettled inpatient spell on Haytor Ward since 28 June 2006 to 06 November 2006 with two periods of care in the Psychiatric Intensive Care Unit at Bodmin Hospital (Harvest Ward).

The community Responsible Medical Officer did not attend the Section 117 Meeting to discuss discharge and the care coordinator was a temporary replacement for Care Coordinator 2. As a result the Section 3 of the Mental Health Act was rescinded and no Supervised Discharge was considered whereby Mr RD could have been forced to have medication or to return to hospital.

This was a contributory factor as it prevented the community mental health team having additional powers to treat Mr RD, but cannot be seen as a direct causal factor as there were too many other factors to be taken into consideration.

Contributory Factor 5 : Clinical Governance Systems

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.

No direct causal factor arising from the poor Clinical Governance Systems could be directly attributed to the homicide.

Service Issues

The Independent Investigation Team found seven 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. RD was not appropriately shared in a timely manner with those providing his care and treatment over time. There was no one place in the records where a current historic synopsis was stored along with the latest

care plan and risk assessment and risk management plan and a plan for what to do in a crisis.

<u>Service issue 2</u>

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

<u>Service Issue 3</u>

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

<u>Service Issue 4</u>

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

<u>Service Issue 5</u>

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

<u>Service Issue 6</u>

The Workload of Consultant Psychiatrists

<u>Service Issue 7</u>

Peer Support and Supervision for Consultant Psychiatrists

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

The following section sets out the Devon Partnership NHS Trust's response to the events of 23/24 June 2007. These days were a weekend. On Monday 25 June the Community Mental Health Team based at Waverley House was informed that Mr RD had been taken into custody in relation to the death of his grandmother. The matter was being investigated as a potential murder. The police requested the clinical records

15.1 The Trust Serious Untoward Incident Process

The Devon Partnership NHS 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 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.

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.

15.3 The Trust Internal Investigation

Membership of the Internal Investigation Panel

The Devon Partnership NHS Trust selected three members of staff who had had no contact with Mr RD to form the Internal Investigation Panel into the Care and Treatment he had received from the mental health services. The three staff were:

- A Nurse Manager (who had experience of such work and of Root Cause Analysis)
- A Community Mental Health Team Manager (with no previous experience)
- A Consultant Psychiatrist (with no previous experience)

The members of the Internal Investigation Panel did not know the outcome of their work and were not informed about how the recommendations were implemented. All three members had found the experience uncomfortable and had been shunned by the colleagues they had interviewed and those colleagues' friends.

The lack of a transcription service caused considerable difficulties as taking copious notes as there were two people for all the interviews. As it was Consultant 4 and Care Coordinator 4 refused to accept their transcripts and these were never agreed. The extra work caused by being part of the Internal Investigation was difficult to absorb as no additional time was allocated to help them avoid having to do their regular jobs at the same time.

Terms of Reference

The Terms of Reference for the Internal Investigation were to:

1. provide a brief synopsis of the incident.
2. produce a chronology of events.
3. review the clinical history and past events, including initial contacts with Mental Health services as appropriate.
4. consider any prior offences e.g. violence, aggression, weapons, child protection, domestic violence, police involvement.
5. review the effectiveness of the action taken post incident, including the debriefing process for staff and relatives.
6. consider requesting an incident report summary from Risk Management Department.
7. assess the adequacy, appropriateness of Care Plans, Treatment Plans and Risk Assessment documentation, including reviewing the dates of documentation.
8. assess the actual care and treatment received by Russell Deane.
9. review the multi-disciplinary joint working in the provision of care.
10. review policies, procedures and systems and include compliance with these. Review their adequacy e.g. CPA; Engagement and Supportive Observation; Risk Assessment documentation.
11. examine the adequacy of communication and sharing information between internal professionals, external agencies and family.
12. consider environmental risk assessment if applicable.
13. identify areas of good practice.
14. Identify recommendations and learning points, both local and Trust-wide.

15. Produce a Serious Untoward Incident Review Report within forty days of receipt of these terms of reference.
16. Provide feedback to the teams involved as appropriate.

Methodology

The Internal Investigation Panel examined the case records of Mr RD and used a root cause analysis approach in examining the relative weight of the evidence and how it led to the homicide of Mrs D. The following staff were interviewed (using the same nomenclature as in this Independent Investigation:

Consultant 4
Care Coordinator 2
Team Manager 1
Care Coordinator 3
Care Coordinator 4

Mr RD's father was telephoned by the Chair of the Internal Investigation Panel and asked if he would like to be seen by the Panel or have any other involvement. He declined the invitation.

The Internal Investigation started badly as the whole Community Mental Health Team wanted to be interviewed together. They were informed that this was not appropriate and that they would be able to be accompanied by a colleague. The individual members of the Community Mental Health Team came with another member of the Team. For example Consultant 4 had Care Coordinator 2 as his support and vice versa Consultant 2 acted as his support and both played an active role in both interviews.

There was no transcription service available so the members of the Internal Investigation Panel took turns in interviewing and in taking handwritten notes of the interviews. This proved difficult as the people being interviewed appeared very defensive and saw it as a joint exercise. The Serious untoward Incident Policy quite clearly said that staff "were allowed to bring anyone as

their professional representative or a friend. It didn't dictate that if that person was also part of the inquiry they couldn't do so."[133]

As all the staff interviewed had a close colleague who was also going to be interviewed the process was not easy for the Panel. The Independent Investigation Panel think that in the constrained circumstances in which it operated the findings and recommendations were very similar to those presented in this Report, but cover a much longer time frame in terms of Mr RD's involvement with mental health services. It was a direct result of the Internal Investigation that three members of the Community Mental Health Team were further investigated by the Devon Partnership NHS Trust.

15.4 Findings of the Internal investigation

There were seven separate findings following the Investigation. They were:

1) Lack of consistent review risk assessment throughout care coordination from Waverly house.
2) Lack of proactive and assertive decision making with the team.
3) Lack of proactive/assertive management and RMO/Consultant leadership with such a complex case.
4) Lack of multi agency risk sharing.
5) CPA issues especially no level two risk assessment or formal review in the Trust CPA format performed by the team at Waverly house.
6) Communication and record keeping.
7) Accountability as the incident could not have been predicted but could with more assertive action possibly have been prevented.

[133] Transcript 9 Page 2

15.5 Recommendations

There were seven recommendations designed to minimise the chance that the same mistakes and poor practice could happen again.

1) The Devon Partnership Trust serious and Untoward Incident Policy will preclude that any person who is to give a statement to an SUI investigation from acting as the professional/personal support for another individual giving evidence in the same or a related investigation.

2) A fact finding investigation into the professional conduct of Consultant 4, Care Coordinator 2 and Team Manager 1 into the care and treatment of Mr RD be undertaken, and action, if any, taken as appropriate.

3) A fact finding investigation into the professional conduct of Team Leader 1 into leadership of the care and treatment of Mr RD be undertaken, and action, if any, taken as appropriate.

4) A review of services at Waverly House Community Mental Health Team be undertaken with specific reference to:

    - examine and review thoroughly, the clinical practice and governance arrangements for clinical and practice supervision and leadership within the team.
    - review the assessment and management of risk and the compliance with Trust Policies and Procedures.
    - review how the team delivers care in a multi-disciplinary/multi-agency manner and in particular with complex cases.
    - review communication and information sharing between multi-disciplinary/multi-agency team members.

5) Make clinical staff aware that forensic history must be included and considered in assessment of risk.

6) All patients on enhanced CPA must have an individual clinical risk assessment review at least every six months or sooner if indicated, and following any significant change in circumstance such as; serious/untoward incident, adverse health event or near miss involving the patient, and that these must be clearly documented in the patient's notes.

7) Clinical cabinet to be asked to draft guidance on the quality of information written in patient notes by clinical staff.

An Action Plan was to implement the recommendations was prepared and details are shown in the table on the next page.

Action Plan

An Action Plan was developed to take forward the seven recommendations made by the Internal Investigation Panel. This is represented below:

Recommendation	Action	Lead Person	Timescale
1. The DPT Serious and Untoward Incident Policy will preclude any person who is to give a statement to an SUI investigation from acting as the professional or personal support for another individual giving evidence in the same or a related investigation.	1. The Trust will review the SUI policy in clinical cabinet and issue appropriate guidance.	Clinical Cabinet	May 2008
2. A fact finding investigation into the professional conduct of Consultant 4, Care Coordinator 2 into the care and treatment of RD be undertaken, and action –if any- taken as appropriate.	1. The Trust will hold separate fact finding reviews and take appropriate action on their findings.	Medical Director Nurse Consultant	End of March 2008 End of March 2008
3. A fact finding investigation into the professional conduct of Team Leader 1 into leadership of care and treatment of RD be undertaken, and action –if any- taken as appropriate.	1. The Trust will hold a fact finding review and take appropriate action on the findings	Nurse Consultant	End of March 2008
4. A review of services at Waverly House CMHT be undertaken	1. Examine and review thoroughly, the clinical practice and governance arrangements for clinical and practice supervision and leadership within the team.	Assistant Director of Nursing	End of March 2008

	2. Review the assessment and management of risk and the compliance with Trust Policies and Procedures. 3. Review how the team delivers care in a multi-disciplinary/multi-agency manner and in particular with complex cases. 4. Review communication and information sharing between multi-disciplinary/multi-agency team members.		
5. Clinical Staff to be made aware that forensic history must be included and considered in assessment of risk.	1. The Trust will issue guidance professional forums	Caldicott Guardian via Professional Forums	May 2008
6. All patients on enhanced CPA must have an individual clinical risk assessment review at least every six months or sooner if indicated, and following any significant change in circumstance such as; serious/untoward incident, adverse health event or near miss involving the patient, and that these must be clearly documented in the patient's notes.	1. The Trust will issue guidance through professional forums	Trust CPA lead via Professional Forums	May 2008
7. Clinical cabinet to be asked to draft guidance on the quality of information written in patient notes by clinical staff.	1. Clinical cabinet will draft guidance for policy formulation on the quality of information in patient notes by clinical staff.	Via Clinical cabinet	May 2008

15.6 Progress in Implementing the Recommendations

The Devon Partnership NHS Trust has developed a Consolidated Homicide Action Plan for four separate serious untoward incidents which happened in the space of 12 months.

The progress in implementing the seven recommendations from the Mr RD homicide is shown below:

Recommendation	Implementation Position
1. The DPT Serious and Untoward Incident Policy will preclude any person who is to give a statement to an SUI investigation from acting as the professional or personal support for another individual giving evidence in the same or a related investigation.	. ***Position : GREEN***
2. Fact finding investigation into conduct of two clinical staff	***Position : GREEN***
3. Fact finding investigation into conduct of one Team Manager	***Position : GREEN***
4. A review of services at Waverly House CMHT be undertaken	3/9/08 – Review completed. ***Position : GREEN***
5. A comprehensive risk assessment will be undertaken on admission to the service that includes historical factors (including forensic history) and current clinical presentation. Ongoing risk assessment needs to be a cumulative process which considers the dynamic between historical, current clinical and environmental/contextual factors (including issues such as non-engagement and non-compliance) ***Position : Green*** ***Position : Green***	23/06/10 – Clinical Risk Assessment and Management Policy revised November 2008. Process whereby Functions / Specialities will identify, and have approved, processes and utilisation of tools which ensure both static and dynamic factors are adequately considered given in this policy. This will be reviewed by September 2010, to reflect changes in roles, responsibilities and processes consequent to the implementation of Clinical Directorates and RiO 23/06/10 – Revised Clinical Risk Assessment and Management Policy sets explicit standards; Practice Standards have been developed which include the further setting of standards in relation to the assessment of risk 23/06/10 – Practice Standards developed,

Position : Green ***Position : Amber*** ***Position : Amber***	communicated and implemented that require the capturing and consideration of information relating to contact with children and risks to children both at initial assessment and subsequent review. 23/06/10 – Risk assessment and management processes revised, competency framework and training srategy developed. Fixed-term secondement/post for 36 days per year over three years has been agreed and funded. 23/06/10 - Practice quality audit reviewed and is now aligned to fit with Recovery Coordination and revised CPA policies; this was implemented alongside recovery coordination in agreed early adopter sites (five teams commencing 17/3/09). To be rolled out through main network functions (WB&A, RAIL and UIC) and work undertaken to modify tool for use in the remaining service areas and specialties.
6. All patients on enhanced CPA must have an individual clinical risk assessment review at least every six months or sooner if indicated, and following any significant change in circumstance such as; serious/untoward incident, adverse health event or near miss involving the patient, and that these must be clearly documented in the patient's notes.	23/9/08 – Policy Implementation Guide for Recovery Coordination approved; associated implementation plan details how information, guidance and training will be provided for services users, carers and practitioners. ***Position : Green*** 23/06/10 - Practice quality audit reviewed and is now aligned to fit with Recovery Coordination and revised CPA policies; this was implemented alongside recovery coordination in agreed early adopter sites (five teams commencing 17/3/09). To be rolled out through main network functions (WB&A, RAIL and UIC) and work undertaken to modify tool for use in the remaining service areas and specialties ***Position : Amber*** 30/9/08 - Local audit completed. ***Position : Green***

7. Clinical cabinet to be asked to draft guidance on the quality of information written in patient notes by clinical staff.	3/3/09 - Expectations regarding the standards for recording clinical information have been communicated to all clinical staff. 29/6/09 - ongoing assurance to be obtained via clinical audit programme; including peer and executive walkaround audits and Practice Quality Audit. ***Position : Green***

From the Table above it can be seen that of the 13 actions arising from the seven recommendations 10f are shown as green and have been implemented with the remaining three shown as amber. The amber recommendations have been implemented but still have an ongoing audit programme to demonstrate that they are being adhered to, and if the standards are not being maintained then remedial action will be taken.

15.7 Support for Staff

The staff interviewed as part of this Independent Investigation who had been involved in the Internal Investigation all complained that the process had been very stressful. This was made worse as there had been no feedback on the outcome of the Investigation.

All the staff interviewed stated independently that they had never seen the Internal Investigation Report until two weeks before their interviews when it was emailed to them following the workshop staff had attended to learn about the process for the Independent Investigation.

It appeared that no attempt had been made to help staff learn the lessons from the homicide of Mrs D, and neither had there been any support for those who had worked with the family. It was clear that some staff were affected having to remember the details of the incident three years later.

Recommendation 14

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.*
- *Providing staff with support through the internal investigation process and an early sight of the resultant report and its recommendations.*

16. Notable Practice

There were some examples of notable practice during the six years that Mr RD was a service user with the Devon Partnership NHS Trust and the 11 months he was at Lee Mill in the Plymouth Primary Care NHS Trust.

The examples selected by the Independent Investigation Panel were:

- The treatment and care provided in 2001 and 2002 by the staff in both the community teams in Torbay and Newton Abbot and in Newton Abbot Hospital;
- The treatment and care provided by the staff at Lee Mill and their following Mr RD into the community once he was placed at Riviera Court;
- The use of the Section 25A of the Mental Health Act 1983 (Supervised Discharge) following his discharge from Lee Mill which provided him with a structure and gave the Community Mental Health Team additional „power' to enable him to comply with his medication and his care plan.

17. Lessons Learned

The Independent Investigation into the Care and Treatment provided to Mr RD illustrates the difficulty of providing care and treatment to people who do not accept that they are suffering from a mental illness and do not engage with the services that are trying to help them.

Such service users present challenges to mental health services and difficult choices have to be made by staff as to how far they alter their overall treatment plan including medication and ongoing support in the community to meet the demands of the service user. The aim is often to show that they are listening to the service user and do understand their viewpoint, but this has to be achieved without compromising their health and wellbeing, and the duty of care mental health staff have to their service users.

Mental Health Legislation is available to help in situations where there are concerns about the health and safety of a service user and where there is also anxiety that they may present a risk to others. Where there is strong evidence that the service user is showing signs of relapse, it is crucially important that the appropriate part of the available legislation is used.

The other main lesson from the comprehensive review of Mr RD's contact with mental health services is that much information is gathered and collected by all staff. This needs to be recorded and stored in an orderly and contemporaneous manner. It would greatly assist future staff who may not know the service user if regular six monthly summaries of the main elements of the care and treatment could be stored in a clear and well signposted section of the notes. This six monthly updated summary should include:

- a synopsis of the history to date;
- the latest risk assessment and risk management plan;
- a list of the signs of relapse for the service user;
- an action plan highlighting what needs to be done in a crisis.

This lesson is encapsulated in Recommendations 2 and 3 which cover both paper records and the new RiO electronic service user records. The fact that this system will be available across the whole of the Devon Partnership NHS Trust in the next few months provides a golden opportunity to include this summary within the RiO system from the start.

18. Recommendations

Recommendation 1

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 2

It is strongly recommended that there should be a single and well identified place within the case record of every service user where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months.

Recommendation 3

It is strongly recommended that when the RiO Electronic Record System is installed that the Trust identifies a well identified place within the RiO System where the latest care plan and risk assessment and management plan is kept together with a brief synopsis of the history, this should be updated every six months. The location must be Trust- wide and in the same place for all case records.

Recommendation 4

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 5

The Clinical Team Leaders and Team Managers must as a matter of urgency ensure that all staff are aware that, under the remit of the Mental Health Act 1983 (as amended 2007), if there is concern about a service user relapsing they are legitimately able to undertake / refer for an emergency Mental Health Act Assessment.

Recommendation 6

When a service user is being discharged from the inpatient service, especially after a lengthy period in hospital, the community psychiatrist who will be taking over the care and treatment should be invited, and should attend, the meeting so that they have direct knowledge of the situation and can plan their future involvement.

Recommendation 7

The workload of consultant psychiatrists should be regularly monitored to ensure that they are not being spread too thinly across too many areas of responsibility. This should be linked to the Clinical Audit Programme and routinely reviewed.

Recommendation 8

The Co-Medical Directors should ensure that consultant psychiatrists have a well identified pathway to help and advice should they need assistance in any aspect of their work.

Recommendation 9

The Devon Partnership NHS Trust must ensure that there are clear care pathways within and between mental health services. This should be based on:

- **clear operational policies for each service;**
- **unambiguous acceptance criteria for referrals which make it absolutely clear who the service is for;**
- **a named manager within the service who will deal with any questions a referrer may have about the service**
- **an overall care pathway analysis to ensure that there are no gaps created by the acceptance criteria which leave some eligible service users without an appropriate service.**

The Care Pathways should be regularly audited and any complaints or plaudits from service users used as part of the audit.

Recommendation 10

The carers of service users must be offered an assessment of their own needs and any help that they may require in order to fulfil their caring role. The Devon Partnership NHS Trust and Devon County Council should undertake an audit of case records to determine whether Carers' Assessments are being offered and whether their identified needs are being met.

Recommendation 11

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.*

Recommendation 12

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 13

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 14

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.*
- *Providing staff with support through the internal investigation process and an early sight of the resultant report and its recommendations.*

19. Glossary

Anabolic Steroids	Anabolic steroids, officially known as anabolic-androgen steroids (AAS) or colloquially simply as "steroids", are drugs which mimic the effects of the male sex hormones testosterone and dihydrotestosterone. They increase protein synthesis within cells, which results in the buildup of cellular tissue (anabolism), especially in muscles. Used for body building.
Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders. Able to work to section people under the Mental Health Act 1983.
Assertive Outreach Team	A team of professionals working to help those with a severe and enduring mental illness to engage with services although they themselves do not wish to engage.
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 who is based within a Community Mental Health Team.

Caldicott Guardians	Senior members of staff in the NHS and Local Authorities are appointed to be Caldicott Guardians to protect patient and service user information and its confidentiality.
Clopixol Depot	This medicine acts as a combined absorption and conversion depot. Absorption depots retain the active substance, releasing it gradually. In conversion depots the active substance is made available as a derivative which is slowly converted to the active substance. A long lasting medication, usually given fortnightly or monthly.
Clozapine	This is an antipsychotic medication used in the treatment of schizophrenia. It tends to have greater efficacy than some other antipsychotics.
Community Mental Health Team	A team of professionals and support staff who provide specialist mental health services to people within their local community.
Risperidone	It is a second generation or atypical antipsychotic. It is used to treat schizophrenia (including adolescent schizophrenia).
Olanzapine	Olanzapine is an atypical antipsychotic for the treatment of schizophrenia.
Serious Untoward Incident (SUI)	An incident which causes a major problem, usually involving harm to an individual by accident, suicide or homicide. It also includes absconding from a secure ward. Any event which may cause harm to service users, the public or staff.

Services Good Enough for my Family	The aim of the Devon Partnership Trust is to deliver services to this standard.
Young Offenders Institution (YOI)	Primarily for young offenders aged between 18 and 20. Every YOI offers education classes as well as practical training courses that will improve skills and improve their chances of finding a job once they have been released. Pre-release courses, led by Prison Officers and contributed to by specialists from outside the prison, help young offenders tackle the issues that might face them when they leave such as accommodation, benefits, drugs and family.