Niche PATIENT SAFETY

NHS Midlands and East

An Independent Investigation into the Care and Treatment of a Mental Health Service User in Hertfordshire

Completed 18th September 2012

CONTENTS

1.0 INTRODUCTION

Niche Health & Social Care Consulting was commissioned by NHS East of England Strategic Health Authority (now part of NHS Midlands and East), to conduct an independent investigation to examine the care and treatment of a mental health service user who will be referred to for the purposes of this report as the SU. Under Department of Health guidance[1] Strategic Health Authorities (SHA) are required to undertake an independent investigation:

"*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.*

When it is necessary to comply with the State's obligation 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 for 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.

Where the SHA 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."

2.0 PURPOSE AND SCOPE OF INVESTIGATION

Independent investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of the SU, but to assess the quality of the internal investigation that took place following the incident and the implementation of subsequent learning and to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF INCIDENT

The SU was first referred to the Hertsmere Community Mental Health Team (CMHT) of Hertfordshire Partnership NHS Foundation Trust in February 2005 by a locum General Practitioner (GP). She had been treated for depression by her GPs since November 2004.

She did not attend two initial appointments with mental health services, but she was referred a second time by her GP in March 2005 and she was offered another appointment.

She did not attend this appointment and, following a third referral from her GP saying that her home life had become 'explosive', an urgent assessment was arranged by the CMHT. She was finally seen by the CMHT team on the 11th April 2005.

[1] Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended in 2005 by Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

At this assessment the SU was found to have a reactive depression related to her family and social situation, which was exacerbated by longstanding personality traits and the use of illicit drugs.

She was referred to the dual diagnosis service as she was experiencing mental ill health and was using recreational illicit drugs, but did not attend the appointment there.

She moved to the Welwyn Garden City YMCA in May 2005 and was well supported by the staff there and was allocated a YMCA key-worker, with a view to helping her with her drug abuse.

On 17th May 2005 the Hertsmere CMHT closed the case due to the SU's move from their catchment area to the YMCA.

On 25th July 2005 the SU was found at the local railway station contemplating suicide and she was admitted to Chase Farm Hospital as a result of this. This seemed to be precipitated by an argument with her sister over items she had stolen from her family to feed her drug habit and that of her boyfriend.

On 27th July 2005 she was transferred to the Dennis Scott Unit at Edgware General Hospital. She was discharged on 30th August 2005. The discharge summary from the Senior House Officer at the hospital suggests that she was to be referred back to the CMHT and also to the psychology service within the CMHT. Consideration had also been given to a referral to the Assertive Outreach Team, but this does not appear to have happened. Whilst the reason for this is not clear it would appear from the information available that this could have been because she did not fit the criteria.

After the admission she was discharged to live with her father but failed to attend her follow-up appointment with the Psychiatrist. During this admission she was given the diagnosis of 'Unstable Personality Disorder – Borderline, with Alcohol and Drug abuse' by the medical team.

There are no records of any contact between the SU and mental health services during 2006.

In June 2007 the SU presented at Barnet Accident and Emergency (A&E) Department, and the CMHT were informed of this by fax. Apparently she had moved back home but had been asked to leave by her sister and this precipitated the presentation at A&E. She was assessed as depressed with significant drug problems and had apparently been asked to leave the family home again because she had been stealing to fund her drug habit.

In this fax it stated that the SU did not wish to be referred to mental health services again, however a referral was made. Because of this, and because of her previous poor responses to appointments, she was written to by the CMHT asking if she wanted an appointment.

The SU responded to this letter in August and was offered an appointment on the 23rd August; however she did not attend this appointment. On that same day her mother

phoned the CMHT duty desk saying she was concerned about her daughter as she was consuming large amounts of alcohol and drugs. The CMHT Deputy Team Manager attempted to contact the SU but was unable to. Eventually the SU's sister was contacted by the Duty Worker and advised to take her to the A&E Department if she was concerned about her.

On Tuesday 28th August 2007 the Trust was informed that the SU has been arrested on 26th August 2007 on suspicion of involvement in the murder of her ex-boyfriend JR. He had been stabbed by her then current boyfriend. She was subsequently charged with murder.

The SU and her then boyfriend were convicted of this offence at St Albans Crown Court. Her initial mandatory sentence of three years was later raised to ten years after appeal by the victims' family.

4.0 CONDOLENCES TO THE FAMILY OF JR

The Independent Investigation Team would like to offer their deepest sympathies to the family and friends of JR. It is our sincere wish that this report provides no further pain and distress and addresses any outstanding issues and questions raised by his relatives regarding the care and treatment of the SU up to the point of the offence.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

This investigation involved the interviewing of twelve clinical staff and managers and we would like to acknowledge the helpful contributions of staff members from Hertfordshire NHS Foundation Trust and Hertfordshire Primary Care Trust.

In particular we would like to especially thank the Patient Safety Manager and administration staff from Hertfordshire NHS Foundation Trust for their valuable and helpful assistance throughout this investigation.

6.0 TERMS OF REFERENCE

The following Terms of Reference were agreed between NHS East of England and Niche Health & Social Care Consulting:

- *Review the assessment, treatment and care that the SU received from Hertfordshire Partnership NHS Foundation Trust*
- *Review the care planning and risk assessment policy and procedures*
- *Review the communication between agencies, services, friends and family, including the transfer of relevant information to inform risk assessment*
- *Review documentation and recording of key information*
- *Review Trust internal investigation of the incident to include timeliness and methodology to identify whether:*

- *All key issues and lessons learnt have been identified*
- *Recommendations are appropriate and comprehensive and flow from the lessons learnt*

- *Review progress and against any action plan*
- *Review processes in place to embed any lessons learnt*
- *Review any communication and work with families of victim and perpetrator*
- *Establish appropriate contacts and communications with families/carers to ensure their appropriate engagement in the independent investigation process*

6.1 Approach

The Independent Investigation Team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.

The Independent Investigation Team will conduct its work in private and will take as its starting point the Trust internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

As well as key staff, the Independent Investigation Team is encouraged to engage actively with the relatives of the victim and the SU so as to help ensure that as far as possible, the investigation is informed by a thorough understanding of the incident from the perspective of those directly affected, and will provide appropriate support to relatives throughout the investigation process.

The Independent Investigation Team will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and be able to comment of the factual accuracy of their transcript of evidence.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS East of England.

6.2 Publication

The outcome of the investigation will be made public. NHS East of England will determine the nature and form of publication. The decision on publication will take into account the views of the Independent Investigation Team, those directly involved in the incident and other interested parties. The published report will comply with the NHS East of England anonymisation policy.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS East of England.

6.3 Timescales

The Independent Investigation Team will complete its investigation within six months of starting work. The six months will start once the team is in receipt of the SU's records and sufficient documents are available to the team for interviews to start. The Investigation

Manager will discuss any delay to the timetable with NHS East of England and will also identify and report any difficulties with meeting any of the Terms of Reference to NHS East of England. A bi-monthly progress report will be provided to the SHA along with a bi-monthly detailed update report suitable for all stakeholders.

7.0 THE INDEPENDENT INVESTIGATION TEAM

This investigation was undertaken by the following healthcare professionals who are independent of the healthcare services provided by Hertfordshire NHS Foundation Trust:

Nicola Cooper — Investigation Manager and Report Author, Registered Mental Health Nurse and Senior Patient Safety Lead of Niche Health & Social Care Consulting Ltd

Dr Mark Potter — Consultant Psychiatrist

8.0 INVESTIGATION METHODOLOGY

This investigation follows national guidance[2]. The investigation commenced in June 2011.

8.1 Communication with Victims Family

A meeting was held with the victim's nearest relatives in order to explain the process and methodology of the investigation and discuss their concerns and support needs.

8.2 Consent

Written consent permitting access to her medical records was provided by the SU to the Strategic Health Authority in advance of the commissioning of the investigation.

8.3 Communication with the Perpetrator and the Perpetrator's Family

The Independent Investigation Team met with the SU in prison, and separately with her next of kin, to discuss the investigation and their views on the clinical care received by the SU prior to her offence.

8.4 Witnesses called by the Independent Investigation Team

The Independent Investigation Team interviewed the staff involved making reference to the National Patient Safety Agency *Investigation interview guidance*[3]. Niche Health & Social Care Consulting adheres to the Salmon Principles[4] in all investigations.

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[2] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*
[3] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*
[4] The '*Salmon Process*' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon,

Twelve people who had been involved with the care and treatment of the SU or the management and commissioning of services were invited for interview in this investigation.

Eleven of these were from Hertfordshire NHS Foundation Trust and one was a GP working in the surgery where the SU received care. This GP was not in post when the SU was receiving care at the practice so was only able to answer very general questions about procedures and development rather than the SU's care. The GP who had provided care for the SU has now retired.

The CMHT Deputy Team Manager, who gave advice following the calls to the CMHT Duty Worker a few days before the offence, was due to retire at the point the interviews were arranged and refused to attend for interview. However, he did provide a statement to the Independent Investigation Team. The Independent Investigation Team are disappointed that this person did not attend for interview. He could have provided potentially valuable information to help this investigation.

Additionally, one of the managers who took part in the internal investigation team has moved on since the internal investigation took place. The Independent Investigation Team were provided with contact details for this individual but this manager was not contacted as the other two investigators on the internal investigation team were available to interview and were able to furnish us with the necessary information.

Every interview was recorded and transcribed and all the interviewees had the opportunity to check the factual accuracy of the transcripts and to add or clarify what they had said.

In addition to this, the Independent Investigation Team met and corresponded with the PCT and the GP practice she was registered with about the provision of GP counselling services at the time that the SU was receiving care, and since.

8.5 Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA) guidance[5]. The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened[6]. The Fish Bone analysis was used to assist in identifying the influencing factors which led to the incident. This is represented diagrammatically in Section 21.

Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

[5] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

[6] id p38

The Trust's Serious Untoward Incident Report was benchmarked against the National Patient Safety Agency's "investigation credibility & thoroughness criteria"[7] and the results analysed.

9.0 SOURCES OF INFORMATION

The Independent Investigation Team considered a diverse range of information during the course of the investigation. Unfortunately the SU's clinical records pertaining to the care provided to her by the CMHT and inpatient psychiatric services have been missing since the Trust's internal investigation took place. The team has, therefore, had to rely on the clinical chronology devised by the internal investigation to piece together details of the SU's clinical care. Later on in the investigation the Independent Investigation Team was provided with a copy of the SU's clinical records which had been retained by one of the Trust's investigators involved in the internal investigation team which went some way with assisting us to fill in some of the gaps in clinical information.

Other information provided and reviewed were the Trust's Internal Investigation Report[8], the SU's GP records, Trust policies and procedures and internal performance management information.

The Independent Investigation Team consulted policies, strategy documents and circulars on the care of people with depression and personality disorder, and the management of risk from the Department of Health. A complete bibliography is provided in the appendices at Appendix D.

[7]National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log* http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60183&type=full&servicetype=Attachment

[8] Hertfordshire Partnership NHS Trust (2008) *Confidential Internal Investigation Report. Serious Incidents. THE SU.* Hertfordshire Partnership NHS Foundation Trust

10.0 EXECUTIVE SUMMARY

The SU was first referred to the Hertsmere Community Mental Health Team (CMHT) of Hertfordshire Partnership NHS Foundation Trust in February 2005 by a locum General Practitioner (GP). She had been treated for depression by her GPs since November 2004.

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She did not attend this appointment and, following a third referral from her GP saying that her home life had become 'explosive', an urgent assessment was arranged by the CMHT. She was finally seen by the CMHT team on the 11th April 2005.

At this assessment the SU was found to have a reactive depression related to her family and social situation, which was exacerbated by longstanding personality traits and the use of illicit drugs.

She was referred to the dual diagnosis service as she was experiencing mental ill health and was using recreational illicit drugs, but did not attend the appointment there.

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On 25th July 2005 the SU was found at the local railway station contemplating suicide and she was admitted to Chase Farm Hospital as a result of this. This seemed to be precipitated by an argument with her sister over items she had stolen from her family to feed her drug habit and that of her boyfriend.

On 27th July 2005 she was transferred to the Dennis Scott Unit at Edgware General Hospital.

She was discharged on 30th August 2005. The discharge summary from the Senior House Officer at the hospital suggests that she was to be referred back to the CMHT and also to the psychology service within the CMHT. Consideration had also been given to a referral to the Assertive Outreach Team. The Independent Investigation Team found no evidence that either referral was made. Whilst not clear, it would appear from the information available that a referral not being made to the Assertive Outreach Team could have been because the SU did not fit the criteria.

After the admission the SU was discharged to live with her father but failed to attend her follow-up appointment with the Psychiatrist. During this admission she was given the diagnosis of 'Unstable Personality Disorder – Borderline, with Alcohol and Drug abuse' by the medical team.

There are no records of any contact between the SU and mental health services during 2006.

In June 2007 the SU presented at Barnet A&E Department, and the CMHT were informed of this by fax. Apparently she had moved back home but had been asked to leave by her sister and this precipitated the presentation at A&E. She was assessed as depressed with significant drug problems and had apparently been asked to leave the family home again because she had been stealing to fund her drug habit.

In this fax it stated that the SU did not wish to be referred to mental health services again, however a referral was made. Because of this, and because of her previous poor responses to appointments, she was written to by the CMHT asking if she wanted an appointment.

The SU responded to this letter in August and was offered an appointment on the 23rd August; however she did not attend this appointment. On that same day her mother phoned the CMHT duty desk saying she was concerned about her daughter as she was consuming large amounts of alcohol and drugs. The CMHT Deputy Team Manager attempted to contact the SU but was unable to. Eventually the SU's sister was contacted by the Duty Worker and advised to take her to the A&E Department if she was concerned about her.

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The SU and her then boyfriend were convicted of this offence at St Albans Crown Court. Her initial mandatory sentence of three years was later raised to ten years after appeal by the victims' family.

From the outset of this investigation the Independent Investigation Team adopted a systems approach to analysing what happened and have been guarded against hindsight bias given that this has been a retrospective review of the care and treatment that the SU received.

The Independent Investigation Team considered a diverse range of information during the course of the investigation. Unfortunately the SU's clinical records pertaining to the care provided to her by the CMHT and inpatient psychiatric services have been missing since the Trust's internal investigation took place. The team have had therefore to rely on the clinical chronology devised by the internal investigation to piece together details of the SU's clinical care. Later on in the investigation the Independent Investigation Team were provided with a copy of the SU's clinical records which had been retained by one of the Trust's investigators involved in the internal investigation team which went some way with assisting us to fill in some of the gaps in clinical information.

The Independent Investigation Team have used a recognised framework and considered the following factors: patient factors, task factors, team and individual factors, work

environment, organisational and strategic factors[9]. It is recognised that patient factors have a direct influence on practice and outcome. The availability and utility of protocols and guidance influence the care process. This framework provides the conceptual basis for analysing the care and treatment of the SU and includes both the patient clinical factors as well as the high level organisational and strategic factors that may contribute to the final outcome.

Using this approach, the Independent Investigation Team have concluded that although there were some care and service delivery problems and opportunities to learn lessons, there were no clinical factors, other than the social factors of the service user, or organisational factors that contributed to the final outcome. The tragic death of JR was not predictable or preventable.

There were care and service delivery problems, and opportunities for the learning of lessons identified in this independent investigation. The Independent Investigation Team makes draft recommendations in ten key areas after carefully considering the issues that have been identified:

10.1 Communication with service users

The Trust should review the processes in place for ensuring that details of service users' addresses on Trust information systems are up to date.

Where alternative communication mechanisms and technologies are used to communicate with, and inform, service users of appointments, the efficacy of these should be evaluated.

The Trust should ensure that all eligible carers receive a carers assessment.

10.2 Care Programme Approach

The Trust should ensure that there are standards and a formal process in place to ensure the completion and retention of minutes of all meetings that take place in community teams, when current, past, or potential service users are discussed and agreements or clinical decisions made.

When a service user does not have a Care Co-ordinator identified, the Trust should ensure that there is a clinician identified at each CPA review or discharge planning meeting who will take responsibility for ensuring that all actions and referrals deemed necessary are acted upon and completed in full.

An audit of CPA reviews and discharge planning meetings, for service users currently receiving care under CPA, should take place to ascertain that all actions and referrals deemed necessary have been acted upon and completed in full.

[9] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

10.3 Discharge Procedures

The Trust should ensure there is guidance available to clinicians outlining criteria and standards that should apply for service users who are discharged from inpatient units in their absence, and ensure that compliance with this is audited within three months of receipt of this report.

10.4 Inter team and service communications and working procedures

The Trust should ensure that there is a formal, auditable process in place that ensures referrals from Crisis Assessment and Treatment Team (CATT) to CMHT's are forwarded, acknowledged and responded to on an urgent basis.

Clinicians working within CATT should be made aware of their responsibility to monitor service users, where a need has been identified for an alternative plan of care from a CMHT, until the CMHT have acknowledged receipt of the referral.

The Trust should review the processes in place for responding to service users and carers reporting crisis situations to the CMHT, and develop guidance and policy for clinicians detailing the appropriate care pathways that should be used to ensure risk is assessed and an appropriate response is made.

The Trust should ensure that communication and referral pathways between CATT's, CMHT's and inpatient services are clear and auditable and are understood by all relevant clinical staff.

The Trust should ensure that clinicians and managers are aware of the appropriate pathway and referral routes for inter team referrals, and develop interface agreements between services which will then clarify the movement of service users between teams.

The Trust should put processes in place to ensure that inter team and service referrals are acknowledged on receipt, and that any referrals not acknowledged are followed up by the referrer.

10.5 Personality Disorder Awareness

The Trust should ensure that all clinicians working in mainstream mental health services receive awareness training on the management of people with personality disorders and the thresholds for involvement of the specialist team.

10.6 Risk Assessment

The Trust should ensure that future risk assessment training for all clinicians must also include the exploration of 'near misses' or serious and violent incidents that could have led to severe harm as an outcome but didn't.

10.7 Records Management

The Trust should ensure that there is a robust process in place to ensure the appropriate retention and storage of records and ensure there is a tracking procedure in place so that the whereabouts of original paper clinical records and any copies taken is known. This process should be tested by a process of regular audit.

The Trust should ensure that all clinical and admisistrative staff have received training in their responsibilities regarding the administration of clinical records and that the content of such training contains all aspects contained within the NHS Code of Practice and Information Governance Toolkit.

10.8 Liaison with the police

A high level discussion between the Trust and local police needs to take place to agree to implement the components outlined within the Memorandum of Understanding[10].

The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding[11] and these should be made explicit within Trust policy.

10.9 Investigations and learning the lessons

The Trust should ensure that there are evidence based and auditable processes in place to quality check the outcome of Serious Untoward Incident Investigations.

The Trust Serious Untoward Incident Investigation should be robust and thorough with identified learning points, a robust action plan that is carefully monitored by the Trust Board.

The Trust Board should confirm and challenge the outputs from the reports and the actions arising.

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[10] Memorandum of Understanding for Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

[11] Memorandum of Understanding for Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy.

The Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

10.10 Psychological Therapies in primary care

Commissioners should undertake a review of the provison of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

11.0 PROFILE OF HERTFORDSHIRE NHS FOUNDATION TRUST

At the time of the incident, Hertfordshire Partnership NHS Foundation Trust provided mental health and learning disability services to the people of Hertfordshire, and learning disability services in north Essex and Norfolk. It employs around 3,300 staff over approximately 80 sites. The Trust organises its services into four streams:

- Acute and Rehabilitation
- Community Services
- Specialist Services
- Learning Disability and Forensic Services

The Trust obtained foundation trust status on 1st August 2007 under the National Health Service Act 2006 and is regulated by Monitor, the independent regulator of foundation trusts.

In 2006 reconfiguration of services took place that meant that all residents of Hertfordshire would now receive services from Hertfordshire Partnership NHS Foundation Trust. Under the previous arrangements some services were provided to the residents of Hertsmere and Potters Bar by Barnet, Enfield and Haringey Mental Health Services.

The SU was a resident of Potters Bar and she received services during these transitions so received services from both Hertfordshire NHS Foundation Trust and Barnet Enfield and Haringey Mental Health Services.

Currently Hertfordshire Partnership Foundation Trust state they provide specialist mental health and learning disability services for the people of Hertfordshire. It also has services in Norfolk and North Essex, comprising of both in-patient care and community services, with specialist community teams for Assertive Outreach, Early Intervention in Psychosis, Crisis Intervention, Child and Adolescent Mental Health Services. It employs approximately 3500 members of staff on over 100 sites.

Hertfordshire Partnership NHS Foundation Trust organises its services into three geographical business streams:

1. Learning Disability and Forensic Services in Hertfordshire, Norfolk and Essex
2. West Hertfordshire
3. East and North Hertfordshire

Community Services comprises a range of different teams working with identified service user groups. Community Services includes Child and Adolescent Mental Health Services, (which includes in-patient services) and also the Early Intervention in Psychosis Service.

12.0 CHRONOLOGY

Background and early life

The following information has been gleaned from clinical notes, assessments and reports contained within the SU's clinical records.

The SU was born on 5th June 1986. In the clinical notes she is reported to have told clinicians that she had learning problems at school and had difficulties with spelling but that she did not go to a special school as she was embarrassed about her abilities. She achieved three GCSE's in maths, science and English in 2002 but states that she always felt that her sisters were higher achievers than her and that her parents were more proud of them. After leaving school the SU worked as a hairdresser and later in a cafeteria, a sports shop and pubs.

The SU has three older sisters.

The SU is recorded to have reported that she experienced emotional difficulties when her mother left the family home to live with another man and that she began to adopt some self harming behaviours at this time. The SU describes a long history of low mood and self harm since she was a teenager. She is recorded to have reported she was burning her hands, walking into things and hitting herself. She also described homicidal nightmares and hearing voices which sounded like her own voice and said these were worse when she 'did bad things'.

In 2004 the SU became involved in a relationship, which resulted in her having a miscarriage in January 2005. It is understood that this boyfriend used illegal drugs and that the SU sometimes stole to help him support his drug habit.

Criminal History

In August 2003 the SU is recorded to have stated that she smashed a glass into a girls face after the girl poured a drink over her following a disagreement. She says she was arrested by police and was reprimanded but not charged.

There is no evidence that the SU has any other forensic history until the offence occurred in August 2007.

Medical and Psychiatric History

24th November 2004: The SU visited her GP and reported that she had felt low since her mother left the family home five months earlier. She described feeling tearful and aggressive and not sleeping well. She was prescribed Venlafaxine, an antidepressant, 75mgs per day.

***14th December 2004*:** The SU visited her GP stating she was pregnant and was feeling tearful. She had split up with her boyfriend who was a heroin user.

10th January 2005: The SU miscarried the child she was expecting. She reported she had missed some doses of her Venlafaxine and was advised not to do this. She reported feeling more positive.

27th January 2005: The SU was referred to the GP Practice Counsellor for counselling by her GP.

Comment
National guidance[12] says

"In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered."

The Independent Investigation Team conclude that referral of the SU to counseling services was appropriate and in line with recommended practice at the time. There was no evidence, in the clinical records however, that this referral was actioned or followed through or that the SU was offered an appointment.

23rd February 2005: The SU attended the GP surgery and reported she had hurt her knuckles after hitting the wall. She reported feeling low in mood, particularly in the mornings. Venlafaxine increased to 150mgs per day as a trial to see if it helped to reduce her depressive symptoms.

A mental health review took place in the GP surgery. The GP decided to refer the SU to the CMHT as the increase in dosage of medication had not made any improvement to her depressive symptoms.

The SU was referred to the CMHT by the GP. The GP reported that the SU had a history of depression since 2004, had experienced a family break up and a miscarriage and was having severe nightmares.

[12] NICE (2004) *Depression: Management of depression in primary and secondary care* [CG23] this has been replaced by NICE (2009) *Depression: The treatment and management of depression in adults (update)* [CG90]

3rd March 2005: The CMHT sent a letter to the SU offering her an appointment with a psychiatrist as an outpatient for 10th March 2005. The SU did not attend this appointment.

23rd March 2005: The SU was re-referred by her GP to the CMHT as she told him that her sister had not informed her about the letter detailing her appointment on 10th March 2005.

31st March 2005: The CMHT sent a letter to the SU offering her an appointment with a psychiatrist as an outpatient for 6th May 2005.

8th April 2005: The SU's GP faxed the CMHT informing them that the SU was having a crisis at home and was wanting to leave and live somewhere else. The GP was helping her by trying to find her an emergency hostel. He requested that her appointment with the CMHT team was made as soon as possible.

11th April 2005: As a result of the fax from the GP, the SU was assessed by a Staff Grade Psychiatrist and a Social Worker as they were functioning as the Locality Response Team who responded to urgent referrals to the CMHT. The SU told them that her mother had left the family home one year earlier and that she was self harming more as a result of this. She described a long history of low mood and self harm since she was a teenager. She said she was burning her hands, walking into things and hitting herself. She also described homicidal nightmares and hearing voices which sounded like her own voice and said these were worse when she 'did bad things'. The agreed plan of care as a result of this consultation was:

- Referral to be made for psychological assessment with the CMHT Clinical Psychologist
- CMHT Social Worker allocation to help with housing issues
- Appointment made for 25th April 2005 with local drug services
- The SU awaiting GP counselling following recent referral
- Care to be transferred to the geographically appropriate CMHT if the SU moved to another area
- Crisis plan agreed
- The SU advised to cut down and stop her cannabis use

A provisional diagnosis was made of Depressive Symptoms with Long Standing Personality Traits for the SU.

Comment
The Independent Investigation Team found no evidence that a referral to the CMHT Clinical Psychologist was made as a result of this.

12th April 2005: The CMHT Social Worker called the SU at the Young Homeless Centre and agreed to meet with her to assist her to deal with her benefits and housing issues.

14th April 2005: The SU spoke to her GP. Said she was back at home and awaiting a place at the YMCA.

18th April 2005: A letter was sent from the Social Worker to the SU saying that she had been unsuccessful in her attempts to contact the SU on her mobile phone and offering her an appointment on 22th April 2005. It is unclear from the clinical records whether this appointment was kept.

25th April 2005: The SU did not attend the appointment made for her with drug services.

26th April 2005: The Social Worker called the SU on the telephone. The SU said she was unaware of the appointment that she had missed. The Social Worker agreed to contact local drug services and arrange a further appointment. Appointment made for the Social Worker to meet the SU at her temporary accommodation.

Comment

It is apparent throughout the SU's care that she regularly moved between various family and other addresses. As the Independent Investigation Team have not had access to all of the clinical records it has been impossible to review all appointment letters sent to the SU and the addresses to which they were all sent.

2nd May 2005: The SU taken to the A&E Department by ambulance services where she was assessed by the Community Assessment and Treatment Team (CATT). This was precipitated by the SU complaining of abdominal pain that day and constipation, nausea and vomiting for the previous two months. She was given Omeprazole, a drug which reduces gastric acid secretion, to treat this.

The SU was not taken on by the CATT. A clinical risk assessment was completed and the risks assessed as: aggression to family and others, suicide, self harm, substance misuse. An appointment with the CMHT was arranged for the SU for 6th May 2005.

3rd May 2005: The SU spoke to her GP and said that she felt a bit better apart from the argument that she'd had with her sister the previous day. She stated that she was due to see the Psychiatrist in a few days.

On the same day, the SU contacted the Social Worker stating she was feeling low following the events of the previous day. A meeting for the following day was arranged. The SU's mother told the Social Worker on the telephone that the events had been precipitated by family arguments.

4th May 2005: The SU and her sister were seen by the Social Worker at the CMHT base. The SU reported feeling positive and supported.

6th May 2005: The SU did not attend her scheduled outpatient appointment with the Psychiatrist and the Social Worker.

9th May 2005: The SU moved into YMCA, which was outside of the CMHT catchment area. The clinical notes state that the CMHT were aware of the SU's plans to move there and that they would refer her to the appropriate local CMHT when she moved.

17th May 2005: The Social Worker telephoned the SU. The SU stated that there was 24-hour support and a key worker system at the YMCA. She reported feeling supported, getting assistance with her drug problem and that she was planning to register with a new GP. The Social Worker noted that she had discussed the SU in supervision with her manager and was to close the SU's case after discussion and agreement with the Consultant Psychiatrist.

9th June 2005: The SU was discharged from the CMHT with her agreement. No GP informed, as the SU hadn't yet registered with one in her new locality.

Comment
Trust policy[13] states:

"If a service user is due to move out of the geographical area for which the Care Co-ordinator and the multidisciplinary team has responsibility, the Care Co-ordinator will be responsible for initiating and setting up a review and handover meeting. This will need to specifically address the transfer of medical responsibility to the identified mental health team accepting the case. In such a situation responsibility for an individual service user's care plan remains with the host service until such time as the receiving team have formally accepted responsibility."

There is no reference within the clinical records received by the Independent Investigation Team whether the SU's discharge from the service was discussed with the Consultant Psychiatrist. The Independent Investigation Team are therefore not able to be certain whether the SU's discharge was purely due to her change in geographical location or whether she was deemed to no longer need access to mental health services at that time due to an improvement in her clinical presentation. However, the Independent Investigation Team were told at the investigation interviews, that if the SU had not been moving localities at that time she would not have been discharged from the CMHT as there were ongoing issues that needed resolution. There is also no record of a CPA review taking place prior to discharge.

On interview the Independent Investigation Team were told that SU's discharge should have been handled differently and that she should have been '*handed over*' rather than '*cutting the ties*' and an interviewee described the difficulties encountered in doing this when the patient had not registered with a new GP in her new locality.

The Consultant Psychiatrist could not recall specifically whether he was involved in a conversation with the Social Worker about the discharge of the SU from the CMHT but said that he would normally be involved in such decisions if he was seeing the patient.

Current Trust policy[14] states:

"Service users will be discharged from CPA in the following circumstances:

[13] Hertfordshire Partnership NHS Trust. *Integrated Care Programme Approach and Care Management Policy* – Issue 4, July 2007
[14] Hertfordshire Partnership NHS Foundation Trust. *Care Co-ordination Policy (Incorporating the Care Programme Approach, Single Assessment Process and Models of Care)* – Version 3, November 2010

- *Where their care is transferred under CPA to another Trust*
- *Where they no longer meet criteria for CPA but will continue to be managed under other types of care co-ordination*
- *Where they are to be discharged back to primary care"*

And

"Discharge from CPA will not take place without:

- *Review and handover (e.g. to standard care co-ordinator or GP)*
- *Exchange of appropriate information with all concerned including carers, showing how the service user is advised to maintain and continue their recovery*
- *A clear statement about the action to take, and who to contact, in the event of relapse"*

Despite Trust policy no CPA meeting was held to plan the SU's discharge from the service prior to her discharge on 9th June 2005 and she was not referred to the CMHT in her new locality. On this occasion Trust policy was not complied with.

4th July 2005: The SU saw her GP and reported to be living back at her father's home and feeling better on Venlafaxine. She said that she was not talking to her mother.

25th July 2005: The SU was admitted informally to an inpatient unit at Chase Farm Hospital after being found sitting on a railway station contemplating jumping in front of a train. She had left the YMCA and had returned to her father's home where she was stealing from her family to fund her boyfriend's drug use. She reported feelings that her family hated her, a fight with her sister and dreams of wanting to kill her parents. The ward informed the previous Social Worker from the local CMHT about this admission who noted that she'd discuss this with the CMHT in the team meeting.

Comment
There are no records of whether this discussion took place or the outcome given. The current Community Mental Health Team Manager, who commenced their role in April 2007, informed the Independent Investigation Team that records of team meetings that took place prior to his commencement were not retained, to his knowledge. He did, however, state that records are now kept of discussions and decisions made at team and allocation meetings.

26th July 2005: The notes state that the SU reported to ward staff that she felt that her actions the previous day had been 'silly'.

27th July 2005: The SU was transferred to the Dennis Scott Unit at Edgware General Hospital.

28th July 2005: In a discharge summary written by one of the medical team the circumstances of the SU's admission to Chase Farm Hospital were described that the SU

tried to jump in front of a train and was admitted to hospital as a result of bystanders informing emergency services. She apparently sat on the edge of the platform after a fight with her sister and called her sister saying that she was going to die. She stated on admission, that she was prescribed Venlafaxine and hadn't taken it for a few days and that the argument started because she thought her sister had thrown her tablets away. She stated she felt silly now and was finding it difficult to think straight. It is reported in the summary that the SU told clinicians that she had a long history of cutting herself and banging her head against the wall and that she had attempted to kill herself a couple of months previously which resulted in her being seen by CATT and being sent home. The SU described binge drinking, smoking cannabis and taking cocaine. She also detailed smashing a glass into a girls face in a bar, which was followed by being arrested and then reprimanded by the police. She described hearing voices and seeing things moving in the room and dreams of killing people. The SU also spoke of feelings of not being part of the world and feels like she's watching herself, repeatedly counting things such as steps, words in a newspaper etc and excessive hand washing and teeth brushing.

The doctor concluded that the SU was suffering from Emotionally Unstable Personality Disorder with Obsessive Compulsive Traits and Associated Phenomena and Alcohol and Drug Abuse Problems. The SU was prescribed Fluoxetine 20mgs daily and her Venlafaxine prescription was ceased.

1st August 2005: The SU was seen in the ward round and appeared to be interacting well and wanting to leave hospital.

Plan of care agreed:

- Referral to Drug and Alcohol Services
- Referral to Psychology Services
- Discharge Care Programme Approach (CPA) meeting to take place the following week
- Allocation of Community Care Co-ordinator from CMHT requested
- The SU to go on a short home leave

1st August 2005: Letter sent by ward doctor to the Psychology Service at the CMHT requesting input for the SU. The letter was faxed on the same day.

Comment

The need for the SU to be referred to the Clinical Psychologist within the CMHT was documented in the clinical notes in April 2005 by the assessing doctor and social worker and by the ward doctor in August 2005.

However, at interview, the CMHT Clinical Psychologist confirmed that she had not received a referral for the SU at any time.

When asked to describe the referral process to psychologists in the CMHT team the Clinical Psychologist told the Independent Investigation Team:

"Generally it is just a short note, a letter; most of my referrals come from the psychiatrist."

The Independent Investigation Team conclude that if the SU had had a Care Co-ordinator who was overseeing her care package in its entirety, the lack of response from the CMHT Clinical Psychologist following the referral from the ward is more likely to have been noted and acted upon.

2nd August 2005: The ward team's request for a Care Co-ordinator for the SU on discharge was considered within the CMHT and was refused due to a referral to the Assertive Outreach Team being considered more appropriate.

The response to the referral to the Assertive Outreach Team is unclear and is not documented in the clinical notes available to the Independent Investigation Team but the SU was not allocated a Care Co-ordinator by either the CMHT or Assertive Outreach Team.

Comment
There are no records of any team or allocation meetings held within the CMHT in 2005 so it is not known why the CMHT refused to provide a Care Co-ordinator for the SU on discharge, or their rationale for recommending her referral to Assertive Outreach Services.

The criteria for inclusion in Assertive Outreach Services are explicit in the national policy[15]**.** The agreed criteria for treatment within this service is outlined as follows:

"Adults with severe mental health problems, high use of hospital, difficulty maintaining contact with services and complex or multiple needs that might include:

- *a history of violence or offending*
- *risk of self-harm or self-neglect*
- *poor response to previous treatment*
- *dual diagnosis*
- *detention under the Mental Health Act 1983 in past 2years*
- *unstable accommodation or homelessness"*

The Independent Investigation Team found no evidence to suggest that a referral to the Assertive Outreach Team was made. However, the SU did not meet all of the criteria specified within the national guidance for such a referral and it is the view of the Independent Investigation Team that such a referral would have been inappropriate.

8th August 2005: The SU's Discharge Planning CPA and Risk Assessment meeting took place on the ward. The SU and her mother were present. The SU's diagnosis of Borderline Personality Disorder was discussed with her.

[15] Department of Health (2001) *Mental Health Policy Implementation Guide*

Plan of care:

- The SU would remain an inpatient for a further two weeks whilst housing and benefit issues were sorted out
- That a further request be made to the CMHT for a Care Co-ordinator for the SU in the community
- An outpatient appointment with a psychiatrist was made for 25th August 2005. This would occur whilst the SU was on leave from the ward

The SU went on home leave from the ward following the meeting.

18th August 2005: The SU and her mother attended a meeting with the Consultant Psychiatrist and a Specialist Registrar. A Health and Social Care Plan was completed for the SU. The SU's diagnosis was recorded as 'Emotionally Unstable Personality Disorder'.

Care plan:

- Outpatient appointment 25th August 2005
- Refer to Psychology Service
- Referred to Drug and Alcohol Service
- Fluoxetine 20mgs in the morning
- Risperidone, an atypical antipsychotic, 0.5mg as required
- To live with father and see Citizens Advice Bureau (CAB) re housing
- Work part time in a pub and contact CAB re benefits
- Says she won't go back to using drugs
- Relapse indicators:
  - Deliberate self harm/overdose
  - Substance misuse
  - Putting responsibility on others to sort her problems out
- The form was completed by Specialist Registrar who has written "not Care Coordinator' on it. No Care Co-ordinator was identified
- The SU was identified as on standard level CPA

Comment

Trust policy[16] states that all patients who are admitted to inpatient care are, by default, considered to be on Enhanced CPA and that they remain at this CPA level unless regarded to Standard CPA at the pre-discharge multi-disciplinary review. At this meeting and in accordance with this policy the SU was recorded as standard level CPA.

It is the view of the Independent Investigating Team that given that the SU had just had an inpatient stay which was preceded by suicidal intent, that allocation to a member of the CMHT as her Care Co-ordinator would have been appropriate, even if this was only for a short period of time until stability within the community could be established by the SU.

[16] Hertfordshire Partnership NHS Trust. *Integrated Care Programme Approach and Care Management Policy* – Issue 4, July 2007

It is noted that in the Health and Social Care Plan, completed prior to the SU's discharge from the inpatient service, that the name of the Care Co-ordinator is not specified. It is acknowledged that the reason for this may have been that they were awaiting allocation of a Care Co-ordinator from the CMHT. In these circumstances, however, whilst allocation is awaited, as the SU was to continue to be seen be her Consultant Psychiatrist as an outpatient, the Consultant Psychiatrist should have assumed the role of Care Co-ordinator and either maintained this role or assumed responsibility for ensuring that the allocation of a CMHT Care Co-ordinator took place.

The Trust Internal Investigation Report quotes the Acute Ward Operational Policy that was in place at the time:
"The final Enhanced CPA review, prior to discharge, should identify the date of the first community review, the level of CPA on discharge and the name of the Care Co-ordinator. The date for the 7 day follow-up contact will be agreed in accordance with the HPT Policy, Follow-up after Discharge from Mental Health In-patient Units"

Allocation of a Care Co-ordinator did not happen in this case.

24th August 2005: Ward staff reminded the SU by telephone of her outpatient appointment with the Consultant Psychiatrist, which was scheduled during her leave the following day.

25th August 2005: The SU failed to attend the outpatient appointment with her Consultant Psychiatrist.

30th August 2005: A ward round was held and the SU was discussed. She was not present as she had remained on home leave. She had not been seen on the ward or by a clinician since 8th August 2005 and was discharged from the ward in her absence.

Plan of care:

- Further outpatient appointment with Consultant Psychiatrist to be made for the SU to attend within the next two weeks
- Referral made to Clinical Psychologist within the CMHT
- Discharge prescription Fluoxetine 20mg and Risperidone 0.5mg as required
- The SU to contact Citizens Advice Bureau regarding her housing and benefits issues

Comment
There is no evidence to suggest that a referral to the Clinical Psychologist was made as a result of this meeting.

Additionally there is no evidence to suggest that the SU was contacted following her non-attendance at the outpatient appointment arranged for her for 25th August 2005 prior to her discharge from the ward, in her absence, six days later, on 30th August 2005.

The Independent Investigation Team is of the opinion that it is not good practice to discharge a service user, who has not been seen and assessed by a clinician for a three-week

period, from an inpatient service without first ensuring their well being and making an assessment of their mental state.

31st August 2005: Letter sent to the SU offering an outpatient appointment with the Consultant Psychiatrist for 29th September 2005.

Comment
When the SU was discharged from the ward, on 30th August 2005, it was agreed that she should attend an outpatient appointment within two weeks. However, the appointment that was made for her was four weeks after her discharge from the ward.

27th September 2005: The discharge summary detailing the SU's treatment and progress on the ward states that the SU engaged with care for the first two weeks of her stay but then went on leave for the remainder and disengaged, apart from when she had an argument with one of her sisters whilst on leave and had to return to the ward. It was reported that whilst on leave the SU's mood was improved, her alcohol consumption had decreased and that there was no evidence of psychotic features. The SU expressed concern about overcrowding in the family home and her reluctance to return to the YMCA as she had felt isolated when there previously. The report states that the SU 'has been psycho-educated that she does not have a severe or enduring mental illness but does suffer from impulsivity due to emotional instability which is worsened by the use of drugs or alcohol'.

Plan of care:

- Referral made to Clinical Psychologist within the CMHT
- The SU advised to seek help by self referral to Hertsmere Drug and Alcohol Services
- To continue on Fluoxetine 20mgs and Risperidone 0.5mgs as required
- The SU to continue living with father and seek assistance from Citizens Advice Bureau regarding obtaining accommodation for herself, and her benefits
- The SU to see her GP regarding swelling in her salivary gland

29th September 2005: The SU did not attend the appointment made for her for 25th September 2005.

2nd November 2005: Letter sent to the SU asking her to contact the CMHT team if she wanted a further appointment. This letter was copied to the SU's GP.

25th April 2006: GP records show that the SU reported feeling better for the previous five months. Plans to reduce her Fluoxetine in the medium term were agreed with her as this was her wish.

13th June 2006: The SU spoke to her GP and reported being happier and living with her boyfriend. She expressed a wish to stop her Fluoxetine. GP advised she stay on it for a further three months.

30th April 2007: The SU visited the GP surgery with her sister and reported having panic attacks for the previous days since splitting up with her boyfriend. She stated she was living with her sister at this time.

21st May 2007: The SU reported to her GP that she had lost a stone in weight without trying and continued to experience panic attacks.

22nd May 2007: Fluoxetine dosage increased by the SU's GP due to continuing panic attacks.

6th June 2007: The SU attended the GP surgery in a panic and was hyperventilating. She stated that she'd lost her job due to the panic attacks. The GP wrote a referral to the Counselling Service within the GP surgery.

Comment
Unfortunately, despite referrals from the GP to the GP Practice Counsellor in January 2005 and June 2007, the SU was not seen. The GP Practice Counsellor contacted the Independent Investigation Team and stated that the SU was offered an appointment on 28th June 2006 which she did not attend. However the reasons why she was offered this appontment in June 2006, and the referrals in 2005 and 2007 were not responded to remains unclear.

23rd June 2007: The SU presented at the A&E Department and was assessed by the Barnet Accident and Emergency Liaison Service who referred her to the CMHT and Hertfordshire Substance Misuse Service (HSMS). A clinical risk assessment carried out during this visit concluded that the SU was at risk of suicide, substance misuse and abuse of others and had a historic suicide risk. The SU stated that she was unhappy about being referred to the CMHT and wanted admission to hospital. The SU stated that she'd been asked to leave her sister's home as she had been stealing from her to live and feed her drug habit. She was recorded as having recurrent depression. Factors increasing risk were recorded as expressing suicidal ideas with a plan for implementation, persistent low mood, unemployment and loneliness. The assessing worker referred the SU to the CMHT using a referral screening form.

Comment
Based on the information available, the Independent Investigation Team concur with the decision that inpatient admission for the SU at this time would have been unhelpful. However, given the outcome of the clinical risk assessment, the SU's chaotic social situation and recurring depressive features, the Independent Investigation Team are of the view that the SU may have benefited from a period of home treatment and monitoring from CATT until she could be engaged with the CMHT.

27th June 2007: Letter sent to the SU offering her an appointment with the CMHT on 23rd August 2007.

9th July 2007: The SU was seen and assessed by the CATT team after attending the A&E Department on 7th July 2007. The SU presented to the A&E Department with chest pains having taken cocaine the night before. She was medically cleared but asked to see a

psychiatrist as she stated she was feeling suicidal and depressed. The SU told the assessors that she saw her GP weekly and was waiting for counselling. She said she had taken numerous overdoses and self harmed although she had not done this in the preceding three months. The SU described that she usually lived with her boyfriend and his two children in a one bedroom flat but that she found this stressful and was staying temporarily with her sister. She put her recent issues down to arguments with her boyfriend and the recent loss of her job after several days of unexplained absence. The SU also described regular cocaine and alcohol use and expressed a wish to be seen by drug services. The SU stated that she hears voices and described this as being her own voice being heard out loud rather than an auditory hallucination. The assessors described their impression of the SU as *''21 year old female with symptoms of mild depression, personality disorder and possible suicidal ideation. Long history of alcohol and cocaine use with concurrent panic attacks, escalation of symptoms in the last 6 months due to loss of job and breakdown in relationship''*.

The SU asked for an admission to hospital to provide her with some respite from her current situation. This was not felt by the assessors to be an appropriate reason for admission to hospital and that a lot of her problems could ''potentially resolve themselves''. The SU recognised that her relationship was destructive but was not prepared to give this up. She expressed willingness to engage in counselling and help with her drug use. She said that she had a forthcoming outpatient appointment with the CMHT Psychiatrist and would refer herself for help with her drug problems through that. The assessors told the SU that there was no ongoing role for CATT in her care but that she might benefit from having a Key Worker provided by the CMHT.

Comment

On interview, the CATT Nurse who was involved in the assessment of the SU said that she could not recall the SU, or undertaking this assessment, but that most of the problems that the notes show the SU described at the time were social in nature and that the view at the time was that the SU seeking help for her drug misuse and engagement with the CMHT would be of most benefit to her.

The CATT assessors did, however, conclude that the SU would benefit from additional support from the CMHT and the CATT Nurse stated at interview that in these circumstances she would have written a referral to the CMHT and followed this up with a phone call to the Duty Worker in the CMHT to ensure that they were aware of the referral. She said that this process remains the same currently.

Due to the fact that some of the SU's clinical records were not available to the Independent Investigation Team as they are missing, and because the Independent Investigation Team were unable to find any evidence in the clinical records available to such a referral being made, the Independent Investigation Team are unable to say whether or not such a referral was in fact made. The need for CMHT involvement was documented in the referral but there was no evidence of a referral letter to the CMHT in the clinical records received by the Independent Investigation Team. It is acknowledged, however, that due to some of the clinical files being missing, this does not necessarily mean that the referral was not made.

When asked at interview if there are currently forums in which clinicians from CATT and the CMHT discuss service users the Independent Investigation Team were told that this is done on a case-by-case basis and that if somebody had a care co-ordinator they could be telephoned directly or contacted by letter or fax.

The CATT Operational Policy[17] states:

"Whilst any alternative plan for care is being arranged CATT will hold responsibility for the monitoring of the service user"

11th July 2007: A letter was sent to the SU by the CMHT stating a referral had been received and that she had an appointment with a doctor in the Consultant Psychiatrist's medical team on 23rd August 2007.

23rd August 2007 12.12pm: The SU telephoned the CATT team in a distressed state and asked to speak to the member of staff who she saw on the previous occasion for her assessment. As the SU was not a current patient of the CATT team the person who took the call passed the details to the Deputy Manager of the CMHT.

The CMHT Deputy Manager called the SU's mobile phone without success so spoke to a doctor. They were aware that the SU had recently been seen in the A&E Department, that she was facing eviction and were under the impression that she did not wish to attend the CMHT. As a result of this information the Deputy Manager asked the doctor to write to the SU's GP and suggest he refer the SU to another CMHT as she did not wish to attend the one in which she was a current patient.

Later that day the SU's mother telephoned the CMHT and spoke to the Duty Worker expressing concern about the SU's behaviour and drug and alcohol consumption. She said that the SU was currently not with her and that she was not aware of her whereabouts. The worker who took the call discussed the situation with the Deputy Manager of the CMHT and then spoke to the SU's sister. The SU's family were advised to take the SU to the A&E Department if they were concerned about her.

Comment

It is of significance that both the SU and her mother contacted CATT and the CMHT on the same day expressing that the SU was experiencing difficulties given her previous history of ongoing non engagement with mental health services. The Independent Investigation Team conclude that this could have been an opportunity to attempt to engage with the SU that was missed by the CMHT.

It is unfortunate that the Independent Investigation Team have not been able to interview the CMHT Deputy Manager and gain a better understanding of the rationale for the response to these calls. However, he did provide a written statement.

[17] Hertfordshire Partnership NHS Trust. *Operational Policy for Crisis Assessment and Treatment Teams* – Issue 2, February 2006

In the written statement he provided to the Independent Investigation Team the CMHT Deputy Team Manager states that he had spoken to the doctor who had been due to see the SU at the outpatient appointment that she failed to attend that morning prior to the telephone calls. He states that due to her non-attendance the doctor was planning to discharge the SU back to the care of her GP and that the SU did not wish to attend the CMHT for outpatient appointments. The CMHT Deputy Team Manager states that he was unhappy about this and planned to discuss it at the multi-disciplinary team meeting the following week. He states that he relayed to the doctor that if the SU did not come to the CMHT for treatment then she would not get any help from mental health services and suggested that the doctor write to the GP requesting that he consider referring the SU to an alternative CMHT.

He says he tried to call the SU on her mobile phone but was unsuccessful.

The CMHT Deputy Team Manager stated that he has no other recollection about the days' events with regard to the SU and cannot recall conversations with the Duty Worker.

The current CMHT Operational Policy in the Trust[18] states:

"CMHT staff will endeavour to manage all emergencies without recourse to A&E"

The Independent Investigation Team, with regard to the advice given to the SU's family about taking her to A&E if concerned, was told at interview:

"Nowadays, we are told never to tell them, never to say that, because policies have changed, procedures have changed, pressures have changed. At the time, however, that would have been reasonable."

The Trust's Internal Investigation Report states:

"The responses to contacts made by the Service User and her family with CATT and the CMHT on 23 August 2007 were prompt. It is evident from records that staff had checked previous Care notes entries to inform their decision making and advice given. There is also evidence of appropriate discussions with senior staff e.g. the Deputy Manager and Doctor.

The request by the Deputy Manager that the Doctor write to the GP and ask them to refer to another CMHT as the Service User did not want to attend the Cranbourne Centre was not appropriate. The responsibility lay with the Deputy Manager to check this information, discuss the accuracy and reasons with the Service User and then consider alternatives with relevant staff, the Service User and appropriate family members.

Based on the information that the Service User did not want to attend the Cranbourne Centre, the advice to attend the Accident and Emergency Department given to the family by the Duty Worker, was appropriate. However, it is not clear if this information was accurate.

[18] Hertfordshire Partnership NHS Foundation Trust. *Operational Policy for Community Mental Health Services* – Version 6, January 2011

Ideally, the Service User should have been seen urgently at the CMHT and this option explored with the family by the Duty worker and/or the Deputy Manager."

26th August 2007: The SU was arrested on suspicion of being involved in the murder of her ex-boyfriend.

13.0 REVIEW THE ASSESSMENT, TREATMENT AND CARE THAT THE SU RECEIVED FROM HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

13.1 Engagement with services

The SU's engagement with mental health services was poor. She had two episodes of care between her first referral to the CMHT in February 2005 and the offence in August 2007. Apart from her initial contacts with the CMHT Social Worker she was seen only following crises in her life, either in response to urgent GP referral or after attending the A&E Department following severe and acute distress. Five routine outpatient appointments and one appointement with drug and alcohol services were made for the SU in total. She did not attend any of these.

The Trust's Internal Investigation Report states:

"Following each failure to attend there is written evidence that the CMHT attempted contact with the Service User by letters and/or telephone."

The Trust did not have a specific policy outlining action that should be taken by clinicians in the event of service users not attending appointments at the time that the SU was receiving services and it does not appear that action was taken by the multi-disciplinary team following the SU's non attendance at appointments, to assess what action should be taken in response to this.

Initiation of this process would usually be the responsibility of the CPA Care Co-ordinator and given that during the SU's second episode of care in particular, she was not allocated a Care Co-ordinator, a robust response to her non-engagement did not occur.

Current Trust policy[19] details actions that should be taken following a service users' non-attendance at an arranged appointment. This includes the assessment of clinical risk and a process of decision making to ensure an appropriate action is taken to engage the service user or facilitate their discharge back to the care of their GP or other appropriate service.

It is apparent throughout the SU's care that she regularly moved between various family and other addresses. As the Independent Investigation Team have not had access to all of the clinical records it has been impossible to review all appointment letters sent to the SU and the addresses to which they were all sent. However, it is reasonable to assume that

[19] Hertfordshire Partnership NHS Foundation Trust. *Responding to Service Users who Did Not Attend (DNA) Appointments with Trust Services – Guidance and Procedures* – Version 1, February 2011

services were not always aware of the SU's movements and temporary changes of residence at this time and therefore that all of the appointment letters may not have been received by her in a timely fashion, or at all.

Recommendations

The Trust should review the processes in place for ensuring that details of service users' addresses on Trust information systems are up to date.

Where alternative communication mechanisms and technologies are used to communicate with, and inform, service users of appointments, the efficacy of these should be evaluated.

13.2 CPA

The Trust's Internal Investigation Report states:

"Liaison & continuity of care would have been improved by the allocation of a Care Co-ordinator during admission. Ideally, the previous Care Co-ordinator should have been re-allocated."

The Independent Investigation Team concur with this view.

There is no evidence that CPA was followed during the SU's second episode of care as there appear to be no plans of care or evidence that reviews have taken place. The Independent Investigation Team note that this would have been impossible given the SU's non-attendance at her prearranged outpatient appointments and non-engagement with services. The Independent Investigation Team cannot know whether the allocation of an identified Care Co-ordinator by the CMHT would have increased the SU's level of engagement with services but it should have increased the clarity of decision making about the appropriate course of action to take regarding her lack of engagement.

Trust policy[20] states that all patients who are admitted to inpatient care are, by default, considered to be on Enhanced CPA and that they remain at this CPA level unless regarded to Standard CPA at the pre discharge multi-disciplinary review. This appears to have occurred in this case as it is noted that the SU was on standard level CPA on discharge from the ward.

Managers of local teams and services must ensure that all service users accepted for services are in receipt of the full CPA requirements. In circumstances where there may be a potential delay in the preferred professional picking up a case, an interim arrangement must be agreed. This could be by way of the case being temporarily held by a manager or duty worker who takes on Care Co-ordinator responsibilities.

The responsibility for ensuring the effective and timely entry of service users into the CPA process rests with the respective Team Manager.

[20] Hertfordshire Partnership NHS Trust. *Integrated Care Programme Approach and Care Management Policy* – Issue 4, July 2007

If a service user is on Standard CPA and has only contact with one professional, the role of the Care Co-ordinator will automatically fall to that professional.

It is the view of the Independent Investigation Team that given that the SU had just had an inpatient stay which was preceded by suicidal intent, that allocation to a member of the CMHT as her Care Co-ordinator would have been appropriate, even if this was only for a short period of time until stability within the community could be established by the SU.

In the Health and Social Care Plan, completed prior to the SU's discharge from the inpatient service, the name of the Care Co-ordinator is not specified. In the absence of being able to establish why, the Independent Investigation Team have considered the possibility that this may have been due to the Consultant Psychiatrist and the inpatient clinical team awaiting allocation of a Care Co-ordinator from the CMHT. If this was the case, as the SU was to continue to see her Consultant Psychiatrist as an outpatient, the Independent Investigation Team are of the view that the Consultant Psychiatrist should have assumed the role of Care Co-ordinator and either maintained this role or assumed responsibility for ensuring that the allocation of a CMHT Care Co-ordinator took place.

The Trust Internal Investigation Report quotes the Acute Ward Operational Policy that was in place at the time:

"The final Enhanced CPA review, prior to discharge, should identify the date of the first community review, the level of CPA on discharge and the name of the Care Co-ordinator. The date for the 7 day follow-up contact will be agreed in accordance with the HPT Policy, Follow-up after Discharge from Mental Health In-patient Units"

Allocation of a Care Co-ordinator did not happen in this case.

An audit completed in August 2011[21] states that on discharge from inpatient services to the community, 85% of service users audited had a care plan and 48% had a discharge plan. Less than 60% of discharge meetings were attended by representatives from the community teams.

Recommendations

The Trust should ensure that wards and CMHT's work together and formally agree CPA and aftercare arrangements for service users prior to their discharge from hospital.

The Trust should ensure that the requirements of CPA are fulfilled for service users who are only seen as outpatients by Consultant Psychiatrists and their medical teams.

[21] Hertfordshire Partnership NHS Trust (August 2011*) Report on discharge and transfer*

13.3 Access to drug and alcohol services

The SU was appropriately referred to drug and alcohol services. She did not, however, engage with this or attend for her appointment. The SU's non-engagement with the possibility of receiving assistance and support with her drug use was not explored following her failure to attend at the initial appointment arranged for her.

Given her apparent regular use of recreational drugs, chaotic life style and psychological state, the Independent Investigation Team conclude that there was an over reliance on the SU's statements that she would cease using drugs or refer herself to available services on an ongoing basis.

However the Independent Investigation Team agree that even if clinicians had taken a more assertive approach in attempting to assist the SU to acknowledge the reasons for, and the destructive nature of, her drug use, is no reason to believe that she would have reduced her drug use as she showed very little consistent motivation to do so.

13.4 Assessment, treatment and care

The SU was initially diagnosed with Depression by her GP in November 2004 and was prescribed antidepressant medication and referred for counselling with the GP Practice Counsellor.

This treatment plan was consistent with national clinical guidance[22] which advocates a combination of antidepressant prescribing, psychologial therapy and ongoing monitoring.

The referrals to the GP Practice Counsellor in 2005 and 2007 were not responded to although the SU was offered an appointment in 2006 which she did not attend. The reasons for this are unclear as the the Independent Investigation Team have been unable to ascertain this information from the GP Practice Counsellor's records. There is no explanation for this in the GP clinical records reviewed by the Independent Investigation Team.

The Improving Access to Psychological Therapies (IAPT) programme was set up nationally in May 2006. It aims to improve public access to a range of National Institute for Health and Clinical Excellence (NICE) approved psychological therapies for depression and anxiety disorders through:

- Provision of an appropriately trained workforce,
- Delivering therapies to specific quality standards,
- Routine monitoring of patient reported outcome measures,
- Defined care pathways (characterised by a stepped care model) and
- Flexible referrals routes (including self-referral by potential patients).

[22] NICE (2004) *Depression: Management of depression in primary and secondary care* [CG23] this has been replaced by NICE (2009) *Depression: The treatment and management of depression in adults (update)* [CG90]

NHS Hertfordshire currently have an Enhanced Primary Mental Health Service (EPMHS) in place which delivers psychological therapies to service users referred by Hertfordshire GP's.

Recommendation
Commissioners should undertake a review of the provison of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

In April 2005 a further provisional diagnosis for the SU was made of Depressive Symptoms with Long Standing Personality Traits by the CMHT.

The SU was discharged from the service on 9th June 2005 following her moving to the YMCA which was outside of the CMHT catchment area.

Comment
From the information available, the Independent Investigation Team are of the opinion that in view of the SU's ongoing psychological and social difficulties at the time, and the fact that her new housing arrangements were temporary, discharge from the mental health services at this time was inappropriate and the decision to discharge without robust transfer arrangements in place was based on service boundaries rather than the SU's clinical needs.

The Independent Investigation Team have been provided with evidence by the Trust that annual CPA audits now take place to ensure that that the standards outlined in current CPA policy are being met within the organisation.

Later, in August 2005, when discharged from the ward, the SU was diagnosed with 'Emotionally Unstable Personality Disorder'. This is recorded on the discharge summary as Unstable Personality Disorder – Borderline, with Alcohol and Drug Abuse.

Emotionally Unstable Personality Disorder is defined by the World Health Organisation[23] as:

"A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

Borderline type

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be

[23] World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*

associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)."

National guidance for Borderline Personality Disorder, Treatment and Management [24] was issued in January 2009. It should be noted that this was not available at the time that the SU was receiving care from the Trust. The guidance advocates comprehensive assessment and care planning for people suffering from the disorder, and involvement of the individual and their carers in the development and implementation of care and crisis management strategies. Psychological therapies are also advised for some people who suffer from the disorder.

Referrals to the CMHT Clinical Psychologist were not received and therefore not responded to so she did not receive a specialised psychological assessment at any point although it is acknowledged that given the SU's presentation, assessment, if completed, may well have concluded that her ambivalence about ongoing engagement with mental health services and her recreational drug use may have presented a barrier to successful therapy.

On the occasions that clinical assessments were completed by the CMHT, ward and CATT for the SU, they were reasonably comprehensive and reached conclusions that the Independent Investigation Team deem reasonable given the clinical and social circumstances that the SU was exhibiting. However there were occasions when allocation to a Care Co-ordinator was recommended by both the ward and the CATT assessors but the Independent Investigation Team found no evidence that this happened. Additionally, on one occasion the CMHT advised that referral to the Assertive Outreach Team would be appropriate but there is no evidence that this was completed.

The National Personality Disorder (PD) Development Programme was introduced and ran from 2002 to 2011, and extended the government's interest to mainstream mental health (community PD) and preventative work for young people (emerging PD). It was launched with the publication of *No Longer a Diagnosis of Exclusion*[25] to support service development and *Breaking the Cycle of Rejection*[26] to set a framework for training and workforce development. According to the programme, this is a population that tests boundaries, breaks rules, challenges authority, has failed in other interventions and persistently re-offends in harmful ways.

No Longer a Diagnosis of Exclusion sets out policy implementation guidance for services for people diagnosed with personality disorders. It details the difficulties experienced by people diagnosed with personality disorders in accessing mainstream secondary care mental health services and the lack of specialist dedicated services nationally. The document details that people suffering from personality disorders are likely to experience co-morbid conditions such as depression, drug use and homelessness. With regard to CPA nationally the guidance states that service users' experience was:

[24] NICE (2009) *Borderline Personality Disorder: Treatment and management* [CG78]
[25] National Institute for Mental Health in England (2003) *Personality Disorder: No longer a diagnosis of exclusion*
[26] National Institute for Mental Health in England (2003) *Breaking the Cycle of Rejection: The personality disorder capabilities framework*

"That (CPA) procedures were often not followed or not helpful"

It has been difficult for the Independent Investigation Team to ascertain whether the procedural issues that resulted in the SU's lack of access to co-ordinated care stemmed from attitudinal issues with regard to people with personality disorders but the Independent Investigation Team note that in recent years the Trust has developed a specialist team for people who are experiencing personality disorders who provide direct care and support to those with very complex clinical presentations and training, supervision and support to clinicians who are providing care to those in mainstream mental health services.

Recommendation
The Trust should ensure that all clinicians working in mainstream mental health services receive awareness training on the management of people with personality disorders and the thresholds for involvement of the specialist team.

There is no evidence to suggest that the SU was contacted following her non attendance at the outpatient appointment arranged for her for 25th August 2005 prior to her discharge from the ward, in her absence, six days later, on 30th August 2005.

The Independent Investigation Team believes that it is not good practice to discharge a service user, who has not been seen and assessed by a clinician for a three-week period, from an inpatient service without first ensuring their well being and making an assessment of their mental state.

An audit completed in August 2011[27] states that *''It was evident from the audit that the policy for discharge and transfer is not being followed''.* An action plan was devised following this audit, which contained details of improvement actions.

Recommendation
The Trust should ensure there is guidance available to clinicians outlining criteria and standards that should apply for service users who are discharged from inpatient units in their absence, and ensure that compliance with this is audited within three months of receipt of this report.

13.5 Referrals to the CMHT Clinical Psychologist

The need for the SU to be referred to the Clinical Psychologist within the CMHT was documented in the clinical notes in April 2005 by the assessing doctor and Social Worker and by the ward doctor in August 2005.

Current national guidance *Borderline Personality Disorder: Treatment and management* [28] states:

[27] Hertfordshire Partnership NHS Trust (August 2011*) Report on discharge and transfer*

"For women with borderline personality disorder for whom reducing recurrent self- harm is a priority, consider a comprehensive dialectical behaviour therapy programme."

However, at interview, the CMHT Clinical Psychologist confirmed that she never received a referral for the SU at any time.

When asked to describe the referral process to psychologists in the CMHT team the Clinical Psychologist told the Independent Investigation Team:

"Generally it is just a short note, a letter; most of my referrals come from the psychiatrist."

The Trust Internal Investigation Report states:

"As recommended, the Service User was referred for psychological assessment during her period of care but there is no evidence that she was offered any appointments. It was decided that the referral from in-patient services would be actioned after the Service User had attended an Out-patient appointment. It would have been good practice to offer appointments with psychology despite the Service User's non-attendance at Out-patients appointments to assess and attempt engagement."

The Independent Investigation Team, conclude that if the SU had had a Care Co-ordinator who was overseeing her care package in its entirety, the lack of response from the CMHT Clinical Psychologist following the referral from the ward, or the fact that it had not been received by the Clinical Psychologist, is more likely to have been noted and acted upon.

It should be noted that the Clinical Psychologist stated that if the SU's referral had been received it is unlikely that she would have been seen for psychological treatment until she had reduced her use of recreational drugs as this use may have lessened her capacity to engage in and deal with the effects of the therapeutic process.

Recommendations

When a service user does not have a Care Co-ordinator identified, the Trust should ensure that there is a clinician identified at each CPA review or discharge planning meeting who will take responsibility for ensuring that all actions and referrals deemed necessary are acted upon and completed in full.

An audit of CPA reviews and discharge planning meetings, for service users currently receiving care under CPA, should take place within the next three months to ascertain that all actions and referrals deemed necessary have been acted upon and completed in full.

[28] NICE (2009) *Borderline Personality Disorder: Treatment and management* [CG78]

14.0 REVIEW THE CARE PLANNING AND RISK ASSESSMENT POLICY AND PROCEDURES

14.1 Care Planning

As the complete set of the SU's clinical records were not available for review by the Independent Investigation Team, it has not been possible for the Independent Investigation Team to be satisfied that they have had sight of all care plans and risk assessments undertaken in respect of the SU.

The Trust's Internal Investigation Report [29] states the following with regard to care planning in this case:

"There is evidence that care plans were negotiated with the Service User and she was encouraged to take personal responsibility with support. This is in keeping with the guidelines in avoiding unhelpful dependency."

It was evident from the clinical records that were available to the Independent Investigation Team that care plans were developed for the SU during her first episode of care and following her discharge from the ward in 2005. There is no evidence in the clinical records available for review that further care plans developed, and the care plan devised prior to the discharge was not carried out in full as there was not a Care Co-ordinator identified to ensure this.

14.2 Risk Assessment

Trust policy[30] states:

"The nature of the risk assessment will be dependent upon how well known the service user is to the professionals completing the assessment. A risk assessment that takes place within an initial interview in Accident and Emergency or when someone is admitted as an emergency in the middle of the night will be different from a risk assessment that is part of the ongoing management of a long term case.

In a similar manner a service user who is only seen in outpatient clinic and is assessed as low risk and maintained on Standard CPA, will not need a complex care plan or risk assessment."

Risk assessments were completed for the SU when she was initially seen by the CMHT in 2005 and subsequently on the ward and by CATT on occasions. Each of these was completed after seeing the SU for a single contact whilst she was experiencing a crisis situation and the depth of the risk assessment reflects that. Each assessment was based largely on the SU's self report and the immediacy for the need for the completion of the assessments and the lack of in depth and enduring knowledge of the SU meant that the

[29] Hertfordshire Partnership NHS Foundation Trust (2008) *Confidential Internal Investigation Report. Serious Incidents. THE SU.*

[30] Hertfordshire Partnership NHS Trust. *Clinical Risk Assessment and Management for Individual Service Users* – Issue 4, October 2005

professionals completing these individual assessments were unable to examine additional sources of information and historical data to inform their assessments in any meaningful way.

It is the conclusion of the Independent Investigation Team that when risk assessments were completed for the SU, the risks of potential accidental or purposeful harm to herself were appropriately identified.

The SU did not appear to have a history of violence to others, with the exception of an incident that she reported to assessors where she claimed to that she smashed a glass into a girls face after the girl poured a drink over her following a disagreement. She says she was arrested by police following this and was reprimanded but not charged. She also talked of homicidal dreams.

There is no evidence in the clinical notes examined by the Independent Investigation Team that clinicians completing risk assessments recorded details of any exploration of this matter or attempted to gain any supporting information about what preceded this incident in terms of psychological or circumstantial triggers for the SU. There is also no evidence that any attempts were made to explore the severity of this incident or whether there had been other issues relating to the SU's anger management by attempting to explore this further with her or gain collateral information from other sources such as the police or members of the SU's family.

The Trust's Internal Investigation Report states:

"Attention must be paid not only to actual past harm committed by the person but also to the potential of likely harm and acts of harm which were intended but prevented. These must be given proper consideration and weight so as to avoid the tendency to minimise the potential of harm."

There is no reason to believe that if this had been done, it would have affected the subsequent care that the SU was offered. However, it is the view of the Independent Investigation Team that because the SU stated she had not been charged by the police for this offence, clinicians may have dismissed this event as not being of significance. The opportunity to explore how the SU dealt with situations in which she became angry and felt aggressive, and could pose a danger to others, was missed.

Recommendation
The Trust should ensure that future risk assessment training for all clinicians must also include the exploration of 'near misses' or serious and violent incidents that could have led to severe harm as an outcome, but didn't.

15.0 REVIEW THE COMMUNICATION BETWEEN AGENCIES, SERVICES, FRIENDS AND FAMILY, INCLUDING THE TRANSFER OF RELEVANT INFORMATION TO INFORM RISK ASSESSMENT

15.1 Risk Assessment

There is evidence that ward staff communicated well in general terms with the SU's mother and that she was invited to, and involved in, meetings and care planning relating to the SU. It is not apparent from the clinical notes, however, that the SU's mother was involved specifically in formulating the risk assessment or contributing information to this.

The SU's contact with the CMHT and CATT was sporadic and contacts were usually precipitated by her being in crisis. Assessments and care plans made during those contacts were based on the information presented by the SU at the time. It does not appear that collateral and historical information was gathered from previous clinical records or other sources to inform clinical assessments, risk assessments and care plans completed on those occasions.

However, it is acknowledged by the independent invetigation team that when emergency clinical assessments are undertaken it is difficult for clinicians completing these assessments to explore all external sources of information due to the urgent and short term nature of their intervention.

The Independent Investigation Team conclude, having reviewed all the documentation before them, that if the SU had been allocated a Care Co-ordinator it would have been their responsibility to have explored alternative sources of information and built up a more comprehensive picture of risks for the SU over time. This did not happen as there was not a specific individual identified to complete this and the other responsibilites of a Care Co-ordinator.

15.2 Communication between teams and services in the Trust

It is the view of the Independent Investigation Team that communication between the CMHT, CATT, the ward and individual professionals was on occasions ineffective.

Both the ward and CATT made attempts to communicate the SU's need for consideration to be given to the allocation of a CMHT Care Co-ordinator and these requests were not responded to on either occasion. Additionally, a referral from the ward to the CMHT Clinical Psychologist was not received despite a copy of a letter written by a ward doctor to the CMHT Clinical Psychologist being evident on the clinical file.

As the clinical notes for the SU which the Independent Investigation Team have reviewed are potentially incomplete, and as records of meetings held within the CMHT to discuss service user care and allocations are not available, the Independent Investigation Team have not been able to conclusively define the reasons for these issues.

Recommendations

The Trust should ensure that communication and referral pathways between CATT's, CMHT's and inpatient services are clear and auditable and are understood by all relevant clinical staff.

The Trust should put processes in place to ensure that inter team and service referrals are acknowledged on receipt, and that any referrals not acknowledged are followed up by the referrer.

Recommendations

The Trust should ensure that there are standards and a formal process in place to ensure the completion and retention of minutes of all meetings that take place in community teams when current, past, or potential service users are discussed and agreements or clinical decisions made.

The Trust should ensure that there is a formal, auditable process in place that ensures referrals from CATT to CMHT's are forwarded, acknowledged and responded to on an urgent basis.

Clinicians working within CATT should be made aware of their responsibility to monitor service users, where a need has been identified for an alternative plan of care from a CMHT, until the CMHT have acknowledged receipt of the referral.

15.3 Carer involvement and support

The CMHT response to the calls received from the SU and her family on 23rd August was inadequate.

It is acknowledged by the Independent Investigation Team that there was little that the CMHT could do immediately in response to the calls from the SU and her mother given that the SU had been using alcohol and drugs and was uncontactable. However, the Independent Investigation Team conclude that further action should have been taken to attempt to communicate with the SU and her mother and offer her an urgent appointment the following day, prior to the bank holiday weekend. However, it is possible that if these arrangements had been put in place, given the SU's history of poor attendance at clinical appointments, the SU may not have attended for a further appointment.

The Independent Investigation Team is of the opinion that the advice given to the doctor to ask the SU's GP to refer her into another CMHT was inappropriate. If it was indeed the SU's wish to be seen by another CMHT, this should have been arranged after consultation with her and explorations into the reasons for her non engagement. If this had been her wish then inter-team transfers should be arranged within the mental health trust and not require a further referral from primary care.

Recommendations
The Trust should review the processes in place for responding to service users and carers reporting crisis situations to the CMHT and develop guidance and policy for clinicians detailing the appropriate care pathways that should be used to ensure risk is assessed and an appropriate response is made.

The Trust should ensure that clinicians and managers are aware of the appropriate pathway and referral routes for inter team referrals and develop interface agreements between services which will then clarify the movement of service users between teams.

The Trust's internal investigation team identified within their report that at no time were the SU's family offered an assessment of their support needs as carers, and that work should be done within the Trust to ensure that carers assessments are offered routinely. The Independent Investigation Team concurr with this recommendation.

An audit completed in August 2011[31] states that out of those cases audited, 41% had been offered carers assessments.

Recommendation
The Trust should ensure that all eligible carers receive a carers assessment.

16.0 REVIEW DOCUMENTATION AND RECORDING OF KEY INFORMATION

As the Independent Investigation Team were not able to review all of the SU's clinical records as these were unavailable, it has not been possible for the Independent Investigation Team to reach a view whether notes of meetings held in the CMHT to discuss clinical issues and allocations were not made or were made and have not been retained.

Notes of meetings held within the CMHT to discuss clinical issues and allocations were not made, or were made and have not been retained, so these were not available to the Independent Investigation Team .

Clinical records that have been reviewed by the Independent Investigation Team appear to have been clearly and accurately completed and represent the clinical information that clinicians who were interviewed could recollect.

The Trust's current policy for the management of care records[32] states:

"Care records must be stored in such a way that whether the record is currently in use or has been transferred to an archive/storage facility, there is a robust tracking system that:

- *Identifies the person responsible for the care record if it is removed.*

[31] Hertfordshire Partnership NHS Trust (November 2010*) Report on Care Co-ordination*
[32] Hertfordshire Partnership NHS Foundation Trust. *Care Records Management Policy* – Version 6, February 2011

- *Provides details of the expected date of return (where appropriate)*
- *Has an alert mechanism if the expected date of return is not met.*
- *Has the capacity to enquire if the care record is not returned by the due date."*

The NHS Code of Practice for Records Management[33] states:

"All staff, whether clinical or administrative, must be appropriately trained so that they are fully aware of their personal responsibilities in respect of record keeping and records management, and that they are competent to carry out their designated duties. This should include training for staff in the use of electronic records systems. It should be done through both generic and specific training programmes, complemented by organisational policies and procedures and guidance documentation. For example, health records managers who have lead responsibility for hospital patient case-notes and who manage the 'records library' and other storage areas where records are kept, must have an up-to-date knowledge of, or access to expert advice on, the laws and guidelines concerning confidentiality, data protection (including subject access requests), and freedom of information."

Recommendations

The Trust should ensure that there is a robust process in place to ensure the appropriate retention and storage of records and ensure there is a tracking procedure in place so that the whereabouts of original paper clinical records and any copies taken is known. This process should be tested by a process of regular audit.

The Trust should ensure that all clinical and administrative staff have received training in their responsibilities regarding the administration of clinical records and that the content of such training contains all aspects contained within the NHS Code of Practice and Information Governance Toolkit.

[33] Department of Health (2006) *Records Management: NHS code of practice*

17.0 REVIEW TRUST INTERNAL INVESTIGATION OF THE INCIDENT TO INCLUDE TIMELINESS AND METHODOLOGY TO IDENTIY WHETHER ALL KEY ISSUES AND LESSONS LEARNT HAVE BEEN IDENTIFIED AND RECOMMENDATIONS ARE APPROPRIATE AND COMPREHENSIVE AND FLOW FROM THE LESSONS LEARNT

17.1 Process and timescales

The incident was reported to the Risk Management Depertment within the Trust and senior managers in line with the Trust's Learning from Adverse Events Policy[34] on 28th August 2007. It was reported on to the Primary Care Trust (PCT) and the SHA the same day. The Trust graded the incident as level 4.

A level 4 incident is defined by the Trust as:

"Level 4 incidents/accidents are extremely serious adverse events that automatically require an inquiry led by agencies external to the Trust, as specified by the Regional Office of the NHSE. This would include:

- *Area Child Protection Committee Procedures*
- *Homicide*
- *Suspected and attempted homicide*
- *Series of suicides in inpatient service*
- *Very serious criminal activity by staff*
- *Exceptional public interest"*

An initial management report was sent to the PCT and SHA on 7th September 2007.

On 17th September 2007 the initial report was considered by a Trust Scrutiny Panel, which comprised Trust directors and senior managers. This Trust Scrutiny Panel concluded that some of the services received by the SU were the responsibility of a neighbouring trust and that a joint investigation should be considered. The panel also concluded that there was no reference to lost referrals in the report.

[34] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

The Trust policy[35] says:

> *"When a serious adverse event occurs the circumstances and 7 Day follow-up report will be submitted to a Scrutiny Panel for consideration, review of grading and to recommend what further action should be taken under the Learning From Adverse Event Procedure. This will apply to Level 3 and Level 4 incidents and will be co-ordinated by the Incidents and Claims Manager.*
>
> *The Scrutiny Panel will be made up of a small group of senior staff, in conjunction with at least two Directors, as appropriate to each incident and Directorate.*
>
> *When the 7 Day Report is received by the Incidents & Claims Manager, it will be forwarded to the group, who will consider the seriousness and complexity of the incident, making further recommendations for investigation and by whom, to ensure that lessons are learned by the Trust and any necessary changes to practice are made.*
>
> *The Scrutiny Panel will have 7 days from the receipt of all reports to comment and return to the Incidents and Claims Manager the decisions that have taken."*

Comment
An appropriately qualified Trust Scrutiny Panel was convened to review the initial management report that was completed in response to this incident. However the directive from the Trust Scrutiny Panel that a joint investigation with a neighbouring trust, who at the time provided some of the services received by the SU, was not communicated to the Trust's internal investigators who were later appointed or included in the Terms of Reference for the investigation.

The Trust policy[36] states that the Incidents and Incident and Claims Manager will receive the comments from the Trust Scrutiny Panel and it is the responsibility of the Incident and Claims Manager to appoint a suitable investigation Panel.

The policy also states:

> *"For level 3 incidents the Senior Manager, must open a confidential file on the Incident. Having considered the information available from the Incident Form, the 7-Day Report and the recommendations of the Scrutiny Panel, and discussed this with the relevant service manager/appropriate others, including the Incidents and Incident and Claims Manager, the Senior Manager should formulate written Terms of Reference. These should be made available to the relevant staff and to the service user and their family (if applicable)."*

[35] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007
[36] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

The Independent Investigation Team questioned managers in the Trust at interview about how the Terms of Reference were formulated in this case. The Independent Investigation Team was told:

> *"That comes back to the Joint Heads. That goes to the next level, so in cases such as this (the Incident and Claims Manager) would let the Joint Head of Service know that the Scrutiny Panel wants this to go to full Root Cause Analysis, and then somebody like me would pull up the Terms of Reference, having looked at the seven-day report, and then liaise with (The Incident and Claims Manager), making sure that we are covering what we want to in terms of the learning we need to come out of this, and making sure that we cover in the Terms of Reference that we are clear that this learning is going to come out of that. So somebody like me would draft the Terms of Reference, liaise with (The Incident and Claims Manager) about whether it is peer support in terms of making sure they are robust enough, and then go back to (The Incident and Claims Manager) for allocation by the individual person who is root cause analysis trained."*

And

> *"The responsibility would sit with them (the Heads of Service). The Scrutiny Panel responses would go back. They would consider what was in there, and make a decision about how the investigation should be progressed, and that progression is usually, as you know, written within the Terms of Reference."*

As this case was some years ago, staff in place at the time cannot recall the particulars of this case but it appears that the findings of the Trust Scrutiny Panel, namely that a joint investigation should be considered with the neighbouring trust, were not included in the Terms of Reference for the internal investigation. It is not clear from the Trust's investigation policy[37] that was in place at the time, how this process should be executed and the roles and responsibilities of individuals for each stage of the process.

Managers were asked by the Independent Investigation Team about how governance processes at the time differed from those in place currently. The Independent Investigation Team was told;

> "*The other key difference is I don't think that the practice governance structures via the leads were as established. They were in place, but they were not as thoroughly established as they are now. I think I am right in saying that.*
>
> *In addition, at that time, we didn't have a specific Board Director who had a very clear remit for quality and safety at Board level."*

Current Trust policy for incident management issued in 2010 is much clearer with regard to the governance processes in place for the management of the investigation of incidents. The Trust Scrutiny Panel process is now changed and the responsibility for decision making is with Directors and Heads of Service. There is now an Executive Director with lead

[37] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

responsibility for quality and patient safety and a committee structure which is steered by an overarching Integrated Governance Committee which reports to the Trust board.

The Independent Investigation Team is satisfied that the required governance structures for the scrutiny and management of serious incidents are now in place.

On 15th November 2007 a discussion was held between a Trust manager and a senior police officer from the local police force that was investigating the offence. He said that the SU had made a bail application the previous week, which was granted and was due to appear in court on 20th November 2007 for a case management hearing and to enter a plea.

On 17th December 2007 the Patient Safety Manager wrote to colleagues in the Trust asking them to conduct the investigation. She stated that the investigation was to be concise and should largely be a review of records.

A letter was received from the police on 7th January 2008 stating they agreed the Terms of Reference for the internal investigation into the SU's care and treatment and were happy for the inquiry to be conducted but that no members of staff or members of the public should be interviewed as they may be witnesses in future court proceedings.

Comment
It is unclear why the police specified that members of the staff and members of the public should not be interviewed for the purposes of a Trust internal investigation. Although it is acknowledged that at times in homicide cases this may be necessary it is unclear why this was considered to be so in this case.

In 2006 a Memorandum of Understanding[38] was agreed by the Association of Chief Police Officers, Health and Safety Executive and Department of Health laying out multi-agency procedures to be followed in the event of patient safety incidents that cause death or serious harm.

The protocol specifies that in the event of a serious incident that will require police, health service and potentially Health and Safety Executive investigation, an Incident Co-ordination Group should be set up that incorporates the appropriate bodies to provide strategic oversight and investigation co-ordination. The protocol specifies that the group should be attended by senior representatives from each organisation and each meeting be formally be minuted.

A multi-agency policy is in place in Hertfordshire[39] that mirrors the content of the national Memorandum of Understanding[40]. This document states that the responsibility for initiation of the Incident Co-ordination Group rests with the health services.

[38] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*
[39] Memorandum of Understanding for Investigating Patient Safety Incidents involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

The need for the establishment of an Incident Co-ordination Group was not made clear in the Trusts Incident Investigation Policy[41] in 2007 but is specified in the current policy. The responsibility for health service managers to initiate this within five days of the incident is not, however, made clear.

The Trust provided evidence that the Trust has recently reviewed the local Memorandum of Understanding with the local police in meetings that took place in late 2011 and early 2012. This document is undated. It does not, however, refer to the requirement for an Incident Co-ordination Group.

Recommendations

A high level discussion between the Trust and local police needs to take place to agree to implement the components outlined within the Memorandum of Understanding.

The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding[42] and these should be made explicit within Trust policy.

The clinical notes were received by the Trust's internal investigators on 14th February 2008. Their completed report was forwarded to senior managers on 24th April 2008.

17.2 Quality of investigation and report

The Trust's Internal Investigation Report was benchmarked using the National Patient Safety Agency's *"Investigation credibility and thoroughness criteria"*[43]. The Trust Internal Report scored 24%. This is a low score. The main reason for this was that the investigation was limited in its scope. It was a documentary review. There was no executive summary and the report did not contain information relating to the care and support of the victim's family or the perpetrators family. It did not refer to support and engagement of staff in the internal review.

The care and service delivery problems, contributory factors, root causes, lessons learnt, a summary of the recommendations and the arrangements for shared learning are not specifically identified and there is no evidence that a systematic Root Cause Analysis or other equitable method of analysis was used. The main body of the report did not have the usual subheadings that one would expect. The chronology, although limited, was clear and was of a good standard. The recommendations were limited and it was not clear how they linked to the issues identified within the report. The investigation outcome was poor. There

[40] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*

[41] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

[42] Memorandum of Understanding for Investigating Patient Safety Incidents involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

[43] National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log*

was no identifiable action plan attached to the report. There was no comment on the implementation, monitoring and evaluation arrangements in the report.

Comment
The Trust conducted their internal investigation prior to the publication of the National Patient Safety Agency *Independent Investigations of Serious Patient Safety Incidents in Mental Health,* which was published in 2008. It is therefore acknowledged by the independent investigation team that they cannot have been expected, at that time, to meet all the standards set out within the document. However, for the purposes of learning lessons for future care and service delivery, the independent investigation team have nonetheless used the standards within the guidance as a benchmark.

The report was completed by three members of Trust staff, two who had been trained in Root Cause Analysis[44] in line with the requirements of the Trust policy.
The Trust set Terms of Reference for the Trust's internal investigation as follows;

1. *Carry out a review of the mental healthcare provided to the Service User in relation to HPFT policies and good practice guidelines and identify any shortfalls in service delivery.*
2. *Review decisions/actions taken by the Mental Health Team after the patient failed to keep appointments during the period of Mental Health Care.*
3. *Review whether the approach used with the client was in line with good practice guidelines in treating patients with Borderline Personality Disorder.*
4. *Review whether any further action should have been taken by the Mental Health Team when family phoned requesting help on 23rd August 2007.*

Comment
Root Cause Analysis was not used to analyse the data obtained for the purposes of the internal investigation and this was very much a paper-based desk-top review. The investigation was limited in scope as the Trust's internal investigators had been told not to conduct interviews as part of the process.

Recommendations
The Trust should ensure that there are evidence based and auditable processes in place to quality check the outcome of Serious Untoward Incident Investigations.

The Trust Serious Untoward Incident Investigation should be robust and thorough with identified learning points, a robust action plan that is carefully monitored by the Trust Board.

The Trust Board should confirm and challenge the outputs from the reports and the actions arising.

[44] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

17.3 Internal investigation findings (Quotations form the Trusts Internal investigation Report are in italics)

The Trust's Internal Investigation Report says;

Carry out a review of the mental healthcare provided to the Service User in relation to HPFT policies and good practice guidelines and identify any shortfalls in service delivery.

And

Review decisions/actions taken by the Mental Health Team after the patient failed to keep appointments during the period of Mental Health Care.

Although family members were consulted and involved in plans of care, there is no record that a Carers Assessment was offered during either episode of care.

Following each failure to attend there is written evidence that the CMHT attempted contact with the Service User by letters and/or telephone.

Contact made by the CMHT was timely and appropriate, followed good practice guidelines and was in keeping with the CMHT Operational Policy.

Liaison & continuity of care would have been improved by the allocation of a Care Co-ordinator during admission. Ideally, the previous Care Co-ordinator should have been re-allocated.

Electronic records were in use only from August 2007. The remainder were paper records and although not large in quantity, were at times difficult to read or follow, particularly when tracking referrals to other teams or disciplines.

Consultation or supervision with psychologists has not been recorded as having taken place.

During the 1st episode of care whilst at the YMCA (2005), the Service User should not have been discharged until she had registered with a new GP and/or handover to local services had taken place.

Review whether the approach used with the client was in line with good practice guidelines in treating patients with Borderline Personality Disorder

The guidelines recommend minimising emergency admission and keeping any periods of admission brief.

The Service User presented on several occasions in crisis but, in keeping with the guidelines, was admitted on only one occasion.

During this admission the Service User was on leave for an extended period. Ideally, an earlier discharge should have been planned.

Care Planning
There is evidence that care plans were negotiated with the Service User and she was encouraged to take personal responsibility with support. This is in keeping with the guidelines in avoiding unhelpful dependency.

Therapeutic Alliance
There is evidence that a relationship was developed with the allocated Social Worker despite poor engagement/non attendance of appointments by the Service User. It would have been good practice for the allocated Social Worker to have continued contact whilst the Service User was living at the YMCA, and to resume the role of Care Co-ordinator during the period of in-patient care.

Team Approach
Whilst individual staff and teams completed good pieces of work and generally communicated well, a planned team approach is not evident. Notes from MDT and/or professionals meetings, multi-disciplinary care plans and recorded outcomes from referrals would have been helpful in providing a clear, team approach, including contingency plans.

Treatment 'should be broadly psychotherapeutic or psychological'
As recommended, the Service User was referred for psychological assessment during her period of care but there is no evidence that she was offered any appointments. It was decided that the referral from in-patient services would be actioned after the Service User had attended an Out-patient appointment. It would have been good practice to offer appointments with psychology despite the Service User's non-attendance at out-patients appointments to assess and attempt engagement.

Review whether any further action should have been taken by the Mental Health Team when family phoned requesting help on 23rd August 2007.

The responses to contacts made by the Service User and her family with CATT and the CMHT on 23 August 2007 were prompt. It is evident from records that staff had checked previous Carenotes entries to inform their decision making and advice given. There is also evidence of appropriate discussions with senior staff e.g. the Deputy Manager and Doctor.

The request by the Deputy Manager that the Doctor write to the GP and ask them to refer to another CMHT as the Service User did not want to attend the Cranbourne Centre was not appropriate. The responsibility lay with the Deputy Manager to check this information, discuss the accuracy and reasons with the Service User and then consider alternatives with relevant staff, the Service User and appropriate family members.

Based on the information that the Service User did not want to attend the Cranbourne Centre, the advice to attend the Accident and Emergency Department given to the family by the Duty Worker, was appropriate. However, it is not clear if this information was accurate. Ideally, the Service User should have been seen urgently at the CMHT and this option explored with the family by the Duty worker and/or the Deputy Manager.

The Carenotes entries made by the CATT staff member and the Deputy Manager on 23rd August 2007 could have been improved by accurate spelling and clarity of expression.

17.4 Investigation report conclusions

The Trust's Internal Investigation Report concludes;

The shortfalls identified and the recommendations that follow are areas where service delivery could have been improved and could enable staff to work more effectively with people with a diagnosis of Personality Disorder.

It is acknowledged that for much of the period of the service users involvement with Mental Health Services, the CMHT catchment area had not been repatriated to HPFT. Staff were therefore working to different guidelines, services and procedures.

The care provided and the findings identified are not felt to have been related to the arrest of the Service User.

17.5 Recommendations following internal investigation

The following recommendations are made within the Trust's Internal Investigation Report;

1. ***Improve systems to ensure timely allocation of Care Co-ordinators, with particular emphasis on referrals from in-patient services.***

   This could include:
   - *Review of CMHT tracking systems for Care Co-ordinator allocation*
   - *Regular liaison meetings involving key staff e.g. CMHT Team Leaders and Ward Managers, to improve communication and adherence to Operational Policies.*

2. ***Review systems to ensure Carer's needs assessed***

   This could include:
   - *Monthly reports of assessments to Carer's leads*
   - *Review tracking systems*
   - *Reviews at ward/CMHT liaison meetings (see above)*
   - *Identify training needs*

3. ***Develop use of electronic records (Carenotes) particularly in Hertsmere CMHT***

   This could include:
   - *Allocation of additional admin time to ensure significant reports and information are transferred from paper records to Carenotes*
   - *Ongoing training of Carenotes for all staff*
   - *Clear guidelines for recording and tracking referrals including within services e.g. to psychology*

- *Guidelines/training for quality of entries, including spelling, use of first names, reasons for decisions, etc.*

4. ***Develop staff knowledge and skills of management of people with Personality Disorders.***

   This could include:
   - *Development of Specialist Service*
   - *Training to raise awareness/understanding of guidelines*
   - *Access to Specialist advice, consultation and supervision for staff*
   - *Outlining pathways between existing and specialist teams*
   - *Develop in house training programme*

5. ***Raise awareness of good practice in relation to discharge including need for contingency plans.***

   This could include:
   - *Training*
   - *Review of relevant policies*

18.0 REVIEW PROGRESS AGAINST THE ACTION PLAN

The actions outlined within the Trust action plan[45] that was devised as a result of the recommendations in the Internal Investigation Report[46] are examined in turn below. An action plan that details progress against each action has been provided by the Trust. It is undated so it is not clear at what point the progress update was current.

Establish systems within the CMHT to allocate Community Care Co-ordinators when inpatient admission occurs

In the Trust progress update it states that a system is now in place to address this recommendation and that at the point of update there were currently no unallocated inpatient cases.

This action is unspecific and does not specify how the required outcome was achieved or will be sustained. It is also specific to the CMHT involved in this incident and it is unclear whether this learning was shared across the organisation as this issue will potentially affect service users receiving care in other geographical areas from other wards and CMHT's.

Explore better systems of communication with inpatient services

The Trust report that CMHT team members now regularly attend ward rounds and that workers have been identified and allocated to specific wards to ensure proactive liaison.

[45] Hertfordshire Partnership NHS Foundation Trust. *Action Plan for Adverse Events – THE SU*. 7th July 2008
[46] *Confidential Internal Investigation Report. Serious Incidents. THE SU.* Hertfordshire Partnership NHS Foundation Trust

Establish better systems in the CMHT to ensure proper transfers when people move out of the area or need an alternative service

The Trust report that a system is now in place to handover all cases.

Continue work on getting improved standards of recording on Carenotes[47]

The CMHT team have taken part in a Carenotes data improvement project and refresher training has been completed for managers.

Work with teams on improving their use of contingency plans

The Trust report that working on contingency plans has been impoved and that contingency planning is now routinely included in the clinical risk assessment process.

Establish systems in CMHT to ensure assessments are routinely offered to those providing substantial and regular care

It appears that at the time of the incident the Carers Co-ordinator was on training. The Trust report that, since the return of the Carers Co-ordinator, Carers assessements are now routinely offered.

Some training in Personality Disorder to be arranged

The Trust report that a Consultant from the Personality Disorder Team attends the CMHT monthly meeting. The Trust has provided evidence to show that they now have a training programme in place and a forum where staff can discuss specific cases and share good practice.

Advertise vacant Psychologist post

At the time of the Trust progress update it was reported that there had been delays to the recruitment process due to a review of Psychology Services and financial pressures but that these had been resolved and a recruitment process was in place.

Review allocation of local Community Psychiatric Nurse (CPN) resources when Assertive Outreach Service merged with team in Watford

An extra nurse had been recruited to the team at the point of Trust update.

Feedback findings of this investigation and contents of the action plan to the team

The Trust report that this had been completed immediately and reviewed six months later.

[47] Hertfordshire Partnership NHS Foundation trust electronic clinical record system

Comment
Evidence of completion of the actions, with regard to some of the action points, at the point of finalisation of the report, has not been provided.

The action plan was devised by the Service Manager who had responsibility for the CMHT at the time. The actions are non specific and do not clearly outline the actions required, timescale for completion and evidence needed to demonstrate completion.

Actions identified are focused on the team concerned and there is no evidence within the action plan of Trust wide ownership of the actions and attempts to incorporate learning into similar teams within the Trust.

The progress update provided by the Trust, outlining progress of implementation against each action, is insufficient to demonstrate that each action has been completed sufficiently.

19.0 REVIEW PROCESSES IN PLACE TO EMBED ANY LESSONS LEARNT

There is little evidence that the lessons identified within the the SU internal investigation were systematically shared across the organisation.

However the Independent Investigation Team are satisfied that processes have been developed within the Trust since this incident to facilitate a more robust learning culture.

The current Trust policy for Learning from Adverse Events states:

"The Joint Head of Service must appoint an appropriate Service Manager to be responsible for the development and monitoring of an Action Plan to implement the Review Team recommendations."

Robust reporting arrangements for reporting progress on action plan implementation through the line management and committee structure are also detailed within the policy.

There are currently a variety of mechanisms in place within the Trust to communicate learning of lessons across the organisation.

Lessons learned are communicated across the Trust through a variety of channels such as staff e-bulletins, a 'Lessons in Practice' publication, screensavers, presentations and seminars for staff, meetings with service users and families, staff intranet, minutes of Risk Management Committee and the Practice Governance Leads who have specific responsibilities for the learning and sharing of lessons.

Reports and action plans are shared with Joint Heads of Service and Practice Governance Leads across the Trust. These are shared with the Practice Governance Groups and colleagues as appropriate for further dissemination and discussion with team/units involved.

"*Lessons in Practice*" is a publication which contains a selection of case studies with a brief synopsis of the incident and summary of the main recommendations arising from the investigation and improvements/changes made as a result. This is an internal newsletter dedicated to learning which is published periodically throughout the year. The aim of this newsletter is to inform staff of learning points and the wider trend analysis picture around incidents.

All reports and subsequent action plans are considered by Practice Governance Groups with a view to taking actions on behalf of the Trust or business stream i.e. Review policies, develop training programmes, and change practice.

The Risk Management & Patient Safety Group reports to the Integrated Governance Committees and plays a key role in the internal assurance processes by analysis of themes and trends in incident data.

The Trust has provided evidence detailing that there is now a 'Clinical Risk and Learning Lessons Group' now in place. This includes standing agenda items including the summary of recent patient safety incidents and review of quarterly patient safety reports.

Recommendation
The Trust should review the efficacy of the processes in place for the learning and sharing of lessons learned.

20.0 REVIEW ANY COMMUNICATION AND WORK WITH FAMILIES OF VICTIM AND PERPETRATOR

Despite the requirement for appropriate liaison to take place with families and victims and perpetrators of homicides being well documented in Trust policy and national guidance such as the Being Open framework[48] the families involved in this case were not contacted by the Trust.

It is acknowledged that this was due in part to the instruction given by the police for the Trust not to interview any staff or members of the public. The appropriateness of this instruction is unclear in this case but when such an agreement is in place this should not prevent identified persons within the Trust contacting families to offer support and inform them of the processes in place and the agreements that have been made by the Trust or multi-agency Incident Co-ordination Group.

Recommendation
The Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

[48] National Patient Safety Agency (2004) *Being Open Guidance* (Updated November 2009)

21.0 ROOT CAUSE ANALYSIS

Whilst it has been established that the Trust has a number of policies and procedures in place, at the time of the incident there was a lack of clarity on some points.

The care and service delivery problems with contributory factors are represented diagrammatically in the adapted fishbone diagram below.

This analysis follows NPSA guidance. In essence, an attempt is made to identify root causes in organisational process, how those directly resulted in specific care and service delivery problems and how those led to the documented actual or potential effect on the outcome.

The issues raised within this investigation identify sub optimal processes. These issues are not causative but are highlighted for organisational learning.

ROOT CAUSE ANALYSIS DIAGRAM

Task/Guidelines

Lack of allocation of a Care Co-ordinator and adherence to the CPA process.
Referrals to practice Counsellor not acted upon.
Clinical notes not stored and archived effectively.
Communication systems between the ward, the Crisis Team and CMHT not in place or effectively utilised.
Poor management of the SU's non compliance with treatment or attendance at appointments.
Lack of adherence to DNA Policy.
Discharge of the SU back to primary care at a time of social instability with no follow up arrangements.
Actions agreed at ward rounds not always completed.
Referrals to psychology service not received.
System for maintaining records of contact details for patients with unstable housing arrangements not robust.

Organisational factors

Lack of clinician input in relation to the management of Serious Incidents.
Over reliance on instruction from the police not to investigate meant that full investigation and RCA never took place.
Lack of processes for the storage and retrieval of clinical notes.
Complex reorganisation of services and commissioning arrangements prior to the incident, confusion and chaos with regard to service provision.

Team and social factors

Poor CPA / allocation of Care co-ordinator processes in the CMHT.
Lack of clarity about decision making.
Lack of clarity re eligibility criteria for access to services for people with Personality Disorder.

Serious Incident: Harm to another Offence: Death of JR

Patient factors

Personality Disorder.
History of low mood and self harm.
Difficulties with accessibility due to regular address changes.
Ambivalence about treatment.
History of non engagement with mental health services.
New to service, service had no prior knowledge of how to manage the SU.
Recreational drug use and no motivation to address this.
Complex family dynamics.
Chaotic lifestyle.

Education and training

Lack of training and awareness regarding the care of those diagnosed with or exhibiting the symptoms of Personality Disorder.

Working conditions

Complex reorganisation of services and commissioning arrangements prior to the incident, confusion and chaos with regard to service provision.

Individual

Attitudes to the management of people with Personality Disorder.
High expectation on the SU to take responsibility for herself and her care.

Communication

Opportunities to engage with the SU and her family missed.
Lack of knowledge about the SU's addresses at times due to her moving frequently.
Poor communication between the ward, Crisis Team and CMHT.
Fragmented services due to reorganisation.

22.0 CONCLUSIONS

The SU had been involved with mental health services for two and a half years, prior to the offence, in two discrete episodes of care.

She specifies that she experienced emotional difficulties when her mother left the family home to live with another man and began to adopt some self harming behaviours at this time. The SU describes a long history of low mood and self harm since she was a teenager. She said she was burning her hands, walking into things and hitting herself. She also described homicidal nightmares and hearing voices which sounded like her own voice and said these were worse when she 'did bad things'.

The SU said that she had smashed a glass in a girls face during an argument at some point in her history, and had been cautioned by police. This incident was never explored as part of the risk assessment process.

Prior to the referral being made to mental health services the SU was treated with antidepressants by her GP. She was also referred to the GP Practice Counsellor at this time, and again in 2007 but was never seen by them. The reason for this is unclear as the GP Practice has not supplied contextual information regarding this issue to the Independent Investigation Team.

She was first referred to the CMHT by her GP in February 2005 and was seen by the CMHT until she moved to a YMCA out of the CMHT's catchment area in June 2005. She would have benefited from being transferred to the appropriate CMHT for her new location rather than being discharged from the service at this point.

On 25th July 2005 the SU was admitted to an inpatient psychiatric service after contemplating jumping in front of a train. She told clinicians at the time that she regretted her actions a few days later and went on leave from the ward on 8th August 2005.

An outpatient appointment was made for the SU to attend whilst on leave from hospital for 25th August 2005. She did not attend this.

The SU did not attend the ward again and was discharged in her absence on 30th August 2005.

The SU was referred, to the CMHT for allocation of a Care Co-ordinator on discharge from the ward. She was not allocated a Care Co-ordinator.

The SU did not attend any of the outpatient appointments made for her during her first episode of care. She was only seen by clinicians when she presented for urgent assessment following life crisis.

In June and July 2007 the SU came to the attention of services again when she was seen at the local A&E Department presenting as a suicide risk. She was asking for admission to hospital, which was refused by the CATT clinicians who assessed her as they felt her problems could resolve themselves.

They noted that the SU had a forthcoming outpatient appointment with a Consultant Psychiatrist on 23rd August 2007 and advised her to attend and referred her to the CMHT for allocation to a Care Co-ordinator.

Whilst the decision not to admit the SU to hospital at that point is felt to have been appropriate, the SU would have benefited from continuing contact by CATT until a Care Co-ordinator from the CMHT was arranged.

The SU did not attend the outpatient appointment on 23rd August 2007 but both her and her mother contacted the CMHT later that day stating that the SU was experiencing difficulties and was taking drugs and drinking alcohol to excess. Her mother was advised by the Duty Worker within the CMHT to take the SU to the A&E Department if necessary. It is acknowledged by the investigating team that there was little that the CMHT could do immediately in response to the calls from the SU and her mother given that the SU had been using alcohol and drugs and was uncontactable. However, the Independent Investigation Team conclude that further action should have been taken to attempt to communicate with the SU and her mother and offer her an urgent appointment the following day, prior to the bank holiday weekend. It is acknowledged, however, that if these arrangements had been put in place, it is possible that the SU would not have attended for a further appointment.

It is the conclusion of the Independent Investigation Team that the tragic murder of JR was not predictable or preventable by services although with the benefit of hindsight, allocation of a Care Co-ordinator from the CMHT on an ongoing basis may have helped the SU to better engage with services and accept help and support. However, there is no reason to believe that even if the SU had been better engaged with services, this incident would not have occurred.

APPENDIX A: TABLE OF RECOMMENDATIONS

1.	**COMMUNICATION WITH SERVICE USERS AND CARERS**
A.	The Trust should review the processes in place for ensuring that details of service users' addresses on Trust information systems are up to date.
B.	Where alternative communication mechanisms and technologies are used to communicate with, and inform, service users of appointments, the efficacy of these should be evaluated.
C.	The Trust should ensure that all eligible carers receive a carers assessment.
2.	**CARE PROGRAMME APPROACH**
A.	The Trust should ensure that there are standards and a formal process in place to ensure the completion and retention of minutes of all meetings that take place in community teams, when current, past, or potential service users are discussed and agreements or clinical decisions made.
B.	When a service user does not have a Care Co-ordinator identified, the Trust should ensure that there is a clinician identified at each CPA review or discharge planning meeting who will take responsibility for ensuring that all actions and referrals deemed necessary are acted upon and completed in full.
C.	An audit of CPA reviews and discharge planning meetings, for service users currently receiving care under CPA, should take place to ascertain that all actions and referrals deemed necessary have been acted upon and completed in full.
3.	**DISCHARGE PROCEDURES**
A.	The Trust should ensure there is guidance available to clinicians outlining criteria and standards that should apply for service users who are discharged from inpatient units in their absence, and ensure that compliance with this is audited within three months of receipt of this report.
4.	**INTER TEAM AND SERVICE COMMUNICATION AND WORKING PROCEDURES**
A.	The Trust should ensure that there is a formal, auditable process in place that ensures referrals from CATT to CMHT's are forwarded, acknowledged and responded to on an urgent basis.
B.	Clinicians working within CATT should be made aware of their responsibility to monitor service users, where a need has been identified for an alternative plan of care from a CMHT, until the CMHT have acknowledged receipt of the referral.
C.	The Trust should review the processes in place for responding to service users and carers reporting crisis situations to the CMHT and develop guidance and policy for clinicians detailing the appropriate care pathways that should be used to ensure risk is assessed and an appropriate response is made.
D.	The Trust should ensure that communication and referral pathways between CATT's, CMHT's and inpatient services are clear and auditable and are understood by all relevant clinical staff.
E.	The Trust should ensure that clinicians and managers are aware of the appropriate pathway and referral routes for inter team referrals and develop interface agreements between services which will then clarify the movement of service users between teams.
F.	The Trust should put processes in place to ensure that inter team and service referrals are acknowledged on receipt and that any referrals not acknowledged are followed up by the referrer.
5.	**PERSONALITY DISORDER AWARENESS**
A.	The Trust should ensure that all clinicians working in mainstream mental health services receive awareness training on the management of people with personality disorders and the thresholds for involvement of the specialist team.
6.	**RISK ASSESSMENT**
A.	The Trust should ensure that future risk assessment training for all clinicians must also include the exploration of 'near misses' or serious and violent incidents that could have led to severe harm as an outcome but didn't.

7.	**RECORDS MANAGEMENT**
A.	The Trust should ensure that there is a robust process in place to ensure the appropriate retention and storage of records and ensure there is a tracking procedure in place so that the whereabouts of original paper clinical records and any copies taken is known. This process should be tested by a process of regular audit.
B.	The Trust should should ensure that all clinical and admisistrative staff have received training in their responsibilities regarding the administration of clinical records and that the content of such training contains all aspects contained within the NHS Code of Practice and Information Governance Toolkit.
8.	**LIAISON WITH THE POLICE**
A.	A high level discussion between the Trust and local police needs to take place to agree to implement the components outlined within the Memorandum of Understanding.
B.	The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding[49] and these should be made explicit within Trust policy.
9.	**INVESTIGATIONS AND LEARNING THE LESSONS**
A.	The Trust should ensure that there are evidence based and auditable processes in place to quality check the outcome of Serious Untoward Incident Investigation.
B.	The Trust Serious Untoward Incident investigation should be robust and thorough with identified learning points and a robust action plan that is carefully monitored by the Trust Board.
C.	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
D.	The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy.
E.	The Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.
10.	**PSYCHOLOGICAL THERAPIES IN PRIMARY CARE**
A.	Commissioners should undertake a review of the provison of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

[49] Memorandum of Understanding for Investigating Patient Safety Incidents involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

APPENDIX B: TABLE OF STAFF TITLES - INTERVIEWS

TITLE
GP Representative of The SU's GP Practice
CPN
Service Manager Watford, Three Rivers
Joint Head of Community Services
Internal Investigator
Consultant Psychiatrist
Clinical Psychologist
Team Manager
Social Worker
Internal Investigator
Patient Safety Manager
Duty Worker

APPENDIX C: GLOSSARY

A&E	Accident and Emergency
HSG	Health Service Guidelines
NPSA	National Patient Safety Agency
RCA	Root Cause Analysis
SHA	Strategic Health Authority
CMHT	Community Mental Health Team
CATT	Community Assessment and Treatment Team
YMCA	
GP	General Practitioner
CAB	Citizens Advice Bureau
CPA	Care Programme Approach

The Root Cause is the prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future

APPENDIX D: BIBLIOGRAPHY

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