Niche
PATIENT SAFETY

Independent Investigation into the Care & Treatment of Mr C

FINAL
25th Jan 2013

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1.0 INTRODUCTION

1.1 Niche Health & Social Care Consulting was commissioned by NHS South West (now part of NHS South of England), the Strategic Health Authority (SHA) that covers the South West of England, to conduct an independent investigation to examine the care and treatment of Mr C. Under Department of Health guidance[1] SHA's are required to undertake an independent investigation:

1.2 "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.

1.3 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.

1.4 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

2.1 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 Mr C, but to put into context the care and treatment that he received up to the murder of his stepmother, to establish whether or not that could have been prevented, and to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF INCIDENT

3.1 Mr C, who has a history of serious mental health problems and drug and alcohol misuse, was arrested after killing his stepmother in the garden of the family home in July 2010. He pleaded guilty to manslaughter on the grounds of diminished responsibility.

3.2 Mr C had been in frequent contact with mental health services, particularly the Gloucestershire Recovery in Psychosis (GRIP) services provided by 2gether NHS Foundation Trust, since he was first referred to mental health services in 2009. During his span of care, Mr C received treatment in an inpatient unit which has since closed, in October 2010.

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

3.3 In July 2010 the Trust reported an internal investigation led by a Community Service Manager and Assistant Director of Clinical Governance. This subsequently led to the development of an internal action plan, which proposed a number of actions to address points raised within the report.

4.0 CONDOLENCES TO THE FAMILY OF D

4.1 The independent investigation team would like to offer their deepest sympathies to the family and friends of D. It is our sincere wish that this report provides no further pain and distress but rather addresses any outstanding issues and questions raised by relatives regarding the care and treatment of Mr C up to the time of offence.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

5.1 This investigation involved member of D and Mr C's family, staff from 2gether NHS Foundation Trust and Gloucestershire Primary Care Trust and we would like to acknowledge the helpful contributions of all.

5.2 In particular, we would especially like to thank the Assistant Director of Governance & Compliance and his administration staff at 2gether NHS Foundation Trust for their valuable and efficient assistance.

6.0 TERMS OF REFERENCE

6.1 NHS South West has commissioned this independent investigation with the full co-operation of 2gether NHS Foundation Trust ('the Trust') and Gloucestershire PCT.

6.2 It is commissioned in accordance with guidance published by the Department of Health in the circular ***'HSG (94) 27: The discharge of mentally disordered people and their continuing care in the community'*** *and the updated paragraphs 33 – 36 issued in June 2005.*

6.3 Background

6.4 Mr C was born in 1991 and lived with his parents until they separated when he was 4 years old. He then went to live with his mother, where he stayed until he was 17. In 2009 Mr C experienced problems in that he was using cannabis and alcohol and was exhibiting some paranoia which culminated in him stabbing a friend in the face with a pen. This incident was never subject to any criminal proceedings. Mr C went missing for several days sleeping rough following this incident and when found, he moved to live with his father and stepmother, D, in Gloucestershire.

6.5 Mr C's father and stepmother were concerned about his ongoing behaviour so they took him to see his General Practitioner (GP) in August of 2009. The GP referred Mr C to the Gloucestershire Recovery and Psychosis (GRIP) team who carried out an assessment. As a

result, Mr C was regularly seen by the team, was assessed and was prescribed medication. He had an inpatient episode with periods of home leave at an inpatient unit from November 2009 until February 2010 but was discharged after multiple incidents whilst an inpatient.

6.6 Following his discharge, Mr C lived with his father and stepmother under the care of the GRIP team until his arrest in July 2010 after the incident.

6.7 On 4th July 2010 Mr C stabbed his stepmother at their home following a family meal.

6.8 He left the home after the incident and was found the following morning in a foetal position in a telephone box by residents of the town. He told them he had been walking all night and gave them a false name. They later called the police out of concern for him. The police arrived at 08:00 on 5th July 2010. At the police station he was assessed by a psychiatrist and was deemed to be exhibiting psychosis. Mr C told the police that he was prescribed antipsychotic medication but that he had flushed it down the toilet.

6.9 Tragically, D died as a result of her injuries on the evening of 4th July 2010.

6.10 In court, Mr C pleaded guilty to manslaughter on the grounds of diminished responsibility and as a result is subject to a restriction order under Section 41 of the Mental Health Act.

6.11 Terms of Reference

6.12 Overall aims and objectives of an independent investigation of the case of Mr C:

- *To evaluate the mental health care and treatment of the individual including risk assessment and risk management*
- *To identify key issues, lessons learnt, recommendations and actions by all directly involved health services*
- *Assess progress made on delivery of action plans following internal investigation*
- *Identify lessons and recommendations that have wider implications so that they are disseminated to other agencies and services*
- *To review the quality of healthcare provided by the Trust, and to determine whether it complied with statutory guidance, statutory obligations, relevant Department of Health guidance and Trust polices*
- *Whether the Care Programme Approach had been followed*
- *Compliance with medication*
- *Communication with the family and to consider the issues arising when a service user refuses to authorise contact with them*
- *Adequacy of risk assessments*
- *Documentation recording care plans and risk assessments, actions taken and responses of patient*
- *Adequacy of communication and joint working between all those involved in providing care, to include the availability of information to all*
- *To consider whether a Mental Health Act assessment would have been appropriate.*
- *To review the internal investigation, its recommendations and action plans and remedial action taken*

- *To identify learning points for improving systems and services, with practical recommendations for implementation*
- *To report findings and recommendations to NHS South West.*

6.13 Approach

6.14 *The independent investigation team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.*

6.15 *The independent investigation team will conduct its work in private and will take as its starting point the Trust's internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.*

6.16 *As well as key staff, the independent investigation team is encouraged to engage actively with the relatives of the victim and Mr C 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.*

6.17 *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 to be able to comment of the factual accuracy of their transcript of evidence.*

6.18 *If the independent investigation team identify a serious cause for concern, they will notify NHS South West immediately.*

6.19 Publication

6.20 *The outcome of the investigation will be made public. NHS South West will determine the nature and form of publication. The decision on publication will take into account the views of the chair of the independent investigation team, those directly involved in the incident.*

6.21 Timescales

6.22 *Mr C's signed consent for release of his clinical records was obtained by NHS South West prior to the start of the investigation. The independent investigation team will complete its investigation within six months of commencing work. The six months will start once the independent investigation team has received records and sufficient documents are available to the team for the investigation to start. The chair of the independent investigation team and the investigation manager will discuss any delay to the timetable with NHS South West and will also identify and report any difficulties in meeting any of the terms of reference. A monthly progress report will be provided to NHS South West.*

7.0 THE INDEPENDENT INVESTIGATION TEAM

7.1 This investigation was undertaken by the following team of healthcare professionals who are independent of the healthcare services provided:

7.2 Nicola Cooper - Investigation Manager and Report Author, Senior Patient Safety Lead of Niche Health & Social Care Consulting Ltd.

7.3 Dr Ian Davidson - Consultant Psychiatrist.

8.0 INVESTIGATION METHODOLOGY

8.1 This investigation follows national guidance[2] and commenced in October 2011.

8.2 Communication with Family

8.3 Telephone, written and face to face contact was made with Mr C's father (partner of D), and D's sister and adult children. The Terms of Reference and the methodology for the investigation were discussed with them and they were given the opportunity to discuss issues that were pertinent to them. At the end of the investigation, feedback regarding the findings and recommendations were relayed to the family members in detail.

8.4 Mr C's father was also interviewed for the purposes of this investigation. D's sister was present during this interview as support for Mr C's father.

8.5 The independent investigation team met with Mr C's mother at her home at the commencement of the investigation.

8.6 Consent

8.7 Consent to access his medical records was provided by Mr C to NHS South West prior to the commencement of the process.

8.8 Communication with the Perpetrator

8.9 Mr C was seen by the independent investigation team and the Terms of Reference and process for investigation was discussed with him.

8.10 The independent investigation team were also able to meet Mr C's current consultant psychiatrist.

8.11 Witnesses called by the Independent Investigation Team

8.12 The independent investigation team interviewed the staff involved making reference to the National Patient Safety Agency *investigation interview guidance.*[3] The staff titles of those

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

interviewed are detailed in the appendices. Niche Health & Social Care Consulting adheres to the Salmon Principles[4] in all investigations.

8.13 12 Trust staff were invited for interview in this investigation. These were:

Psychologist and Care Co-ordinator
Psychiatrist One
Psychiatrist Two
Care Co-ordinator
Community Services Manager and investigator
Assistant Director of Governance & Compliance and report author
Early Intervention Team Manager
Inpatient Matron Manager
Medical Director and interviewer for internal investigation
Current Executive Lead for Quality and Performance
Chief Operating Officer and interviewer for internal investigation
Director of Quality and Performance at the time of incident and interviewer for internal investigation

8.14 Independent Investigation Team Communication

8.15 Throughout the investigation, the independent investigation team members were in regular communication with each other and worked on specific areas of the investigation relevant to their areas of expertise.

8.16 Root Cause Analysis

8.17 This report was written with reference to National Patient Safety Agency guidance[5]. The methodology used to analyse the information gathered was 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 17.

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

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[3] National Patient Safety Agency, National Reporting and Learning Service (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, 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 Investigation of Serious Patient Safety Incidents in Mental Health*

[6] id p38

[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

9.0 SOURCES OF INFORMATION

9.1 The independent investigation team considered a vast and diverse range of information during the course of the investigation. This included (but is not limited to): the clinical records for Mr C held by 2gether NHS Foundation Trust; the primary care records held by Mr C's GP practice, which is governed by Gloucestershire Primary Care Trust; the Trust's internal investigation report; interview notes, police records; current and past 2gether NHS Foundation Trust policies and procedures; and internal performance management information.

9.2 The independent investigation team consulted local and national policies, strategy documents and circulars. A complete bibliography is provided in the appendices.

10.0 EXECUTIVE SUMMARY

10.1 Mr C, who has a history of serious mental health problems and drug and alcohol misuse, was arrested after killing his stepmother in the garden of the family home in July 2010. He pleaded guilty to manslaughter on the grounds of diminished responsibility.

10.2 Mr C had been in frequent contact with mental health services, particularly the Gloucestershire Recovery in Psychosis (GRIP) services provided by 2gether NHS Foundation Trust, since he was first referred to mental health services in 2009.

10.3 In July 2010 the Trust reported an internal investigation led by a Community Service Manager and Assistant Director of Clinical Governance. This subsequently led to the development of an internal action plan, which proposed a number of actions to address points raised within the report.

10.4 Mr C had been involved with mental health services for eleven months, from August 2009 until the offence in July 2010 when he killed his stepmother at their home, following an uneventful family meal.

10.5 During this period he received care from the Gloucestershire Recovery in Psychosis (GRIP) community team and was admitted to a psychiatric inpatient facility on one occasion. The inpatient unit concerned has since closed, in October 2010.

10.6 Mr C reported psychotic symptoms and on an ongoing basis throughout the time he was receiving care.

10.7 Mr C was born in 1991 and lived with his parents until they separated when he was four years old. He then went to live with his mother in the South East, where he stayed until he was 17. In 2009 Mr C experienced problems in that he was using cannabis and alcohol and was exhibiting some paranoia, which culminated in him stabbing a friend in the face with a pen. This incident was never subject to any criminal proceedings. He went missing for

several days sleeping rough following this incident and when found, Mr C moved to live with his father and stepmother in Gloucestershire.

10.8 Whilst at their home, Mr C's father and stepmother were concerned about his ongoing behaviour so they took him to see his GP in the August of 2009. The GP referred Mr C to the GRIP team who carried out an assessment. As a result, Mr C was regularly seen by the team, he was assessed and prescribed medication. He had an inpatient episode with periods of home leave at an inpatient unit from November 2009 until February 2010 but was discharged after multiple incidents, alcohol use and suspected cannabis use whilst an inpatient.

10.9 Following his discharge, Mr C lived with his father and stepmother under the care of the GRIP team until his arrest in July, after the incident.

10.10 Following the attack on D on 4th July 2010, Mr C left the home and was found the following morning in a foetal position in a telephone box by residents of the town. He told them he had been walking all night and gave them a false name. They later called the police out of concern for him. The police arrived at 08:00 on 5th July 2010. At the police station he was assessed by a psychiatrist and was deemed to be exhibiting psychosis. Mr C told the police that he was prescribed antipsychotic medication but that he had flushed it down the toilet.

10.11 Tragically, D died as a result of her injuries on the evening of 4th July 2010, at the hospital.

10.12 In court Mr C pleaded guilty to manslaughter on the grounds of diminished responsibility and as a result is subject to a restriction order under Section 41 of the Mental Health Act.

10.13 At the commencement of his care with the GRIP team, as part of the initial assessment process, Mr C's was assessed as not presenting any current risk despite his recent assault of one of his friends which involved stabbing him in the face with a pen in response to psychotic and paranoid phenomena. It appears to have been the view of the team that the risks were reduced as they felt that this incident was related to his use of cannabis and they were of the view that his paranoia was specific to this group of friends, so it was concluded that the risks were diminished if he did not use cannabis and because he had moved away from his social group about whom he had felt paranoid. It was acknowledged in the clinical risk assessment that the risks would increase if Mr C commenced the use of cannabis again, or if psychotic features continued.

10.14 Mr C lived with his mother when he stabbed his friend with a pen. She was not contacted and asked to give corroborative historical risk information by the GRIP team. Clinical staff, when asked about this at interview, were of the view that this was because Mr C did not want her to be contacted about his mental health care, but it is evident from the clinical notes that Mr C signed a consent to share form in August 2009 consenting to both his parents being spoken to about his treatment.

10.15 The independent investigation team do not agree that it was reasonable, given the information that Mr C and his father had given them during the assessment meeting on 4th August 2009, for the assessors to conclude that there were no "current risks".

10.16 Mr C was diagnosed as potentially having drug induced psychosis at the end of his assessment period in September 2009 and was not put on Care Programme Approach (CPA).

10.17 Mr C had abnormal blood and liver function test results following the initial prescription of antipsychotic medication, and concerns that he may be suffering from Wilson's disease led to a cautious approach to subsequent anti psychotic medication prescribing. Mr C admits, and it is evident from the clinical records, that he regularly took part in the binge drinking of alcohol which with hindsight, may have contributed to the adverse test results that he encountered. The presence of Wilson's disease was eventually ruled out.

10.18 Mr C was admitted to the inpatient unit in November 2009, initially to provide respite care so that his father and stepmother could go on holiday. This was later extended. The purpose of the extension and the treatment plan and objectives were unclear and Mr C used alcohol and was suspected of using cannabis during the admission. There was also an incident of him using a female resident's bank card to obtain funds whilst he was there. Mr C was discharged prematurely due to this behaviour.

10.19 Mr C was put onto CPA due to his admission to the inpatient unit in December 2009. He was not on CPA in the preceding months when he was being cared for in the community by the GRIP team.

10.20 A CPA review planned prior to his discharge was cancelled due to the consultant psychiatrist not being available so Mr C was discharged without a review of his community care plan or risk assessment, despite the presence of factors that were identified in Mr C's original risk assessment that were deemed to be indicative of increased risk, and the ongoing presence of psychosis.

10.21 At the CPA review, which took place a few weeks later, Mr C's antipsychotic medication was changed and he was allocated a new care co-ordinator who was an unregistered member of staff, a Senior Support Worker (SSW).

10.22 The independent investigation team is of the view that at the point of discharge Mr C was presenting with psychosis and increased risk factors and that therefore, admission to a nearby acute psychiatric in patient unit if accepted, or an assessment under the Mental Health Act if not, would have been appropriate.

10.23 In June 2010 Mr C harmed himself with a knife. This information was relayed to the clinical team in a team meeting, but no action was taken or changes to the risk assessment made as a result, despite this being a new behaviour for Mr C. He did not have a history of self harm.

10.24 The SSW last saw Mr C on 30th June 2010. He said he believed he had many "issues" from his past that he needed to address but felt he was not yet ready to work on them. They discussed his self harm incident and he found it difficult to talk about and said he was "just being silly". They spoke to his father and stepmother and it was agreed that he would talk to them if he felt unsafe in that way again. The SSW recorded that there were evident improvements in his cognition and concentration.

10.25 A meeting was held in the Trust on 5th July 2010, the day after the attack on D, to discuss the incident and the internal serious incident investigation process. This was chaired by the Chief Operations Officer who identified the Community Service Manager to do a preliminary investigation. He was given a deadline of ten days to complete this.

10.26 The Community Service Manager completed a tabular timeline and an account of Mr C's care but did not do any staff interviews or conduct any qualitative or root cause analysis of the information presented. The independent investigation team found no evidence that this issue was identified or that the information in the timeline, or given by clinicians at the meeting on 5th July 2010, was in any way checked or corroborated. This resulted in some assumptions being made about the quality of risk assessment and the reasons for Mr C's mother not being contacted to input into the risk assessment process which were not correct.

10.27 Staff interviews for the Trust's internal investigation took place in autumn of 2010. These did not involve the preliminary investigator and were based on the information gleaned from the meeting that was held on 5th July 2010 and the Community Service Managers report, some of which was flawed.

10.28 The independent investigation team did not find evidence that robust root cause analysis had taken place and were told that the analysis took place at a meeting with clinicians that was held in November 2011.

10.29 The independent investigation team have concerns about the objectivity of the investigation and analysis process given that the Community Services Manager who conducted the preliminary investigation was the manager of the GRIP team at the time, and the meeting where the outcomes of the internal investigation were agreed consisted of the clinical team who cared for Mr C.

10.30 The independent investigation team is of the view that the lack of objectivity and robust process in the internal investigation process led to some of the salient issues not being identified or adequately addressed in the internal investigation report.

10.31 The independent investigation team is of the view that it could not have been predicted that Mr C would kill his stepmother at the time that he did. However, the independent investigation team believe that the nature and level of Mr C's psychosis, and his previous risk behaviour, did indicate there was a high risk of him committing a serious violent assault on someone at sometime. The risk assessments carried out whilst he was under the care of 2gether NHS Foundation Trust at no time adequately considered or addressed this and therefore insufficient preventative measures were put in place. However the independent investigation team acknowledge that, even if the service had had a more realistic awareness of the ongoing risks, there is no certainty that any different actions could have prevented the incident that occurred on 4th July 2010.

10.32 The independent investigation team is of the view that the internal serious incident investigation process was flawed and did not contain the appropriate level of objective

qualitative analysis, and this has resulted in the relevant lessons for improving practice not to have been learned and implemented in a timely manner. Additionally, the independent investigation team are not satisfied that the Trust board can be assured that all of the actions identified in the Trust's internal action plan, arising from their own internal investigation, have been fully implemented.

10.33 After careful consideration the Independent Investigation Team makes draft recommendations in seven key areas. These are relating to:

- Assessment and risk assessment
- Care programme approach
- Medication and treatment
- Communication
- Serious incident investigation procedures
- Joint working with the police
- Governance and management issues.

10.34 The details of which are below in the Recommendations table.

1a	**Assessment and Risk Assessment**
1)	The Trust should carry out an audit of the quality and relevance of clinical risk assessments and care and risk management plans that are in place for current service users within three months of publication of this report.
2)	The Trust should ensure that all care coordinators receive regular caseload supervision that include documented formal review of care and clinical risk management plans and clinical risk assessments.
3)	The Trust should ensure that clinical risk assessment training reiterates the importance of obtaining a comprehensive corroborative risk history from all relevant significant others, where the service user consents, to inform clinical risk assessment.
4)	The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.
5)	The Trust should ensure that core assessments include the requirement for comprehensive drug and alcohol histories to be taken.
6)	The Trust should ensure that the need for collaboration between the multi disciplinary team, when completing risk assessments for people with complex presentations, as outlined in the Department of Health guidance, is detailed within the Trust's policy for clinical risk management.
7)	The Trust should establish systems to ensure that when assessment tools such as Lunser, PANSS, and clinical risk assessments are completed this should be in line with care plan and findings used to inform the care plan unless a rationale for not doing so is recorded in the clinical notes.
8)	The Trust should ensure that where a risk assessment has identified circumstances in which risk is predicted to increase, and those circumstances occur, the care plan should clearly identify what actions are being undertaken to address those risks.

2b	**Care Programme Approach**
1)	The Trust should carry out a review of all service users on CPA to ensure that their Care Co-ordinator has the appropriate qualification, skills and experience to take responsibility for the management of their case.
2)	The Trust should carry out a review of all service users who are currently not subject to CPA to ensure that they do not meet the stipulated criteria for CPA.
3)	The Trust should carry out an audit of all discharges from inpatient settings to ascertain that a discharge planning meeting took place and that it covered all the required elements.
3c	**Medication and Treatment**
1)	The Trust should ensure that they have a method of assuring themselves that when new medications are prescribed to service users, their risks and benefits are clearly explained to service users and carers.
2)	The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to management service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.
3)	The Trust should ensure that psychological therapies are offered to all service users diagnosed with psychosis in line with the NICE Schizophrenia Guidance 2009.
4d	**Communication**
1)	The Trust should ensure there are processes in place so that the collaboration and communication between inpatient settings and community teams with regard to shared service users can be demonstrated and audited.
2)	The Trust should review the Consent to Share process and ensure that all care coordinators and lead professionals are competent in its use.
3)	The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which consent to share and confidentiality restrictions should be overridden.
4)	The Trust should ensure that all eligible carers are offered a carer's assessment in line with the Carers Act 2004, and that the outcomes of assessments are clearly explained to them
5e	**Incident Investigation procedures**
1)	The Trust should take steps to ensure that Incidents Policy & Procedure (Including the Management of Serious Incidents) is being consistently followed.
2)	The Trust should ensure that there are evidence based and auditable processes in place to quality check the outcome of Serious Untoward Incident Investigations.
3)	The Trust Board should ensure that they have processes in place to assure themselves that evidence of action plan implementation is in place before action plans are signed off as complete.
6f	**Joint Working with the Police**
1)	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; *Investigating patient safety incidents involving unexpected death*

	or serious untoward harm published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)
2)	The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding and these should be made explicit within Trust policy.
3)	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 and are enabled the opportunity to take part in the Trust's internal investigation.
7g	**Management and Governance processes**
1)	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
2)	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.

11.0 CHRONOLOGY

11.1 The following information has been gleaned from clinical notes, assessments and reports from Mr C's clinical records.

11.2 Mr C was born two weeks premature. It's reported that he did not experience any developmental delays.

11.3 When he was five, his parents divorced. His mother remarried and he went to live with his mother East Midlands and they later moved to the South East. Mr C saw his father regularly until Mr C became involved with a group of friends with whom he smoked cannabis. Mr C reported less regular face to face contact with his father in his teenage years. His father lived in Gloucestershire with his partner, D. There is a maternal family history of schizophrenia.

11.4 It appears that Mr C was a good student in junior school but was described as inattentive and disruptive in high school. His grades deteriorated. He had problems making friends, was bullied and was involved in a number of fights. He got through his GSCEs but his grades were lower than predicted.

11.5 Mr C started using cannabis at the age of 15 and continued to use it regularly. He reported misusing alcohol during his early teenage years and onwards until the offence.

11.6 Mr C described having difficulties at school several years ago. He stated he felt that the teachers were always talking about him. He described himself as overweight at that time and said that he felt 'big' and self-conscious of this. He said that he had been beaten up a number of times and the worst instance was when he was attacked by a group of 20 year olds who "battered him" and broke his nose.

11.7 Mr C's GP referred him to mental health services after his father attended the surgery with concerns about Mr C's mental health. He appeared to develop signs of paranoia, which culminated at the end of July 2009 when he attacked a friend with a pen. Mr C said he had intended to stab him in the eye but missed and hit him on the nose. He reported seeing a figure that told him to do it.

11.8 Immediately following this assault, Mr C went missing from home and it is believed that he was living in nearby woods for three nights before he was found.

11.9 Following this incident, Mr C went to live with his father in Gloucestershire where he continued to exhibit bizarre behaviour, paranoia and both auditory and visual hallucinations.[8] His first contact with adult mental health services was in August 2009 following a referral by his GP to the GRIP team. The GRIP assessment reported strong psychotic symptoms in the context of cannabis use with genetic and environmental risk factors. After further assessments Mr C was started on Aripiprazole (Abilify) but unfortunately his liver function, which was already "mildly deranged at baseline", worsened on the medication. Therefore, it was discontinued and replaced by a low dose of Sulpiride based on the recommendation of the pharmacist on the grounds that it has the least damaging effect on the liver.

4 August 2009[9]

11.10 A clinical psychologist (CP) from the GRIP team met with Mr C with a colleague.

11 August 2009[10]

11.11 The GRIP CP wrote to Mr C's GP to report on her meeting with Mr C. She reported that although his father said that his mental health had improved since returning to Gloucestershire to live with him, and since he stopped smoking cannabis, her impression upon meeting him was that he was still quite unwell, certainly disordered in thinking and had difficulty following conversation with her. She said it was hard to explore the current symptoms that he might have been experiencing because he was preoccupied with telling her about his experiences of drug use. She told the GP that she would discuss the issue of medication with Mr C and his father and ,if they were willing to consider it, she would arrange a medical assessment with one of their psychiatrists to consider prescribing him an antipsychotic medication. She asked that the GP carry out some baseline physical tests so that they could commence any medications as soon as possible. She assured the GP that she would inform him of the full results of the assessment and would provide him with copies of all their assessments once they were completed.

11.12 Mr C's clinical file contained contact details for his father as his nearest relative but not for his mother.

11.13 Mr C completed and signed a 'Consent to Sharing Information' form, thereby agreeing to sharing his information with his parents without any restrictions. It is recorded on the form

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[8] Discharge Summary on SM

[9] Letter from Clinical Psychologist at Gloucestershire Recovery in Psychosis to, 11/8/2009

[10] Letter from Clinical Psychologist at Gloucestershire Recovery in Psychosis to, 11/8/2009

that Mr C asked for copies of all correspondence written about him by members of his healthcare team.

Comment

11.14 There is a further Consent to Sharing Information form in the clinical notes which is dated 11th February 2009. The date on this form cannot be correct as Mr C was not known to services at that time. This additional document restricts staff from sharing “anything that isn’t crucial i.e. anything that does not concern Mr C’s mental wellbeing”. The form is not signed or witnessed and is clearly incorrectly dated.

19 August 2009

11.15 The CP’s handwritten notes state that Mr C suffered from occasional paranoia when outside the house. Mr C talked to the CP about the incident where he had stabbed a friend with a pen and his anxieties about people from school talking about him. He also spoke of thoughts about mind control and about an incident the week before when a voice had shouted his name. The CP noted that Mr C’s speech was tangential and difficult to follow.

11.16 The clinical notes reflect that Mr C’s father had expressed concerns about Mr C’s poor attention span, low motivation and difficulty getting out of bed in the morning.

20 August 2009

11.17 A handwritten risk assessment was completed by the CP. It detailed risk factors but attributed these to cannabis use although the influence of psychosis and alcohol was also referred to. This assessment stated that Mr C’s change in geographical location was a protective factor along with Mr C’s statement that if he were to re-experience severe symptoms he would inform his father and possibly professionals.

25 August 2009[11]

11.18 The Specialist Registrar (SPR) from the GRIP team[12] met Mr C with the CP. The visit was arranged for a psychiatric assessment. Mr C’s father joined them during the second half of the assessment. He confirmed that Mr C was referred to the GRIP team due to concerns about his mental health. As he understood it, things came to a head when he attacked a friend with a pen due to paranoia following excessive cannabis use. He had intended to stab his friend in the eye but missed and landed on his nose instead.

11.19 At the meeting, Mr C said he used cannabis for the first time at 15 years of age and described his experience as “laughing his head off completely”, “becoming sick”, and “could not stop laughing and being hysterical”. He also said he felt that he could not control himself. He smoked cannabis with a group of friends and initially he was having a few ‘spliffs’ but over a two year period he gradually increased it until he stopped using cannabis (a couple months prior to this meeting), he said they were smoking up to £40 worth in a night (the group as a whole).

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[11] Letter 2/9/2009

[12] Specialist Registrar GRIP/Early Intervention Team

11.20 When asked about the incident involving the attack on his friend, Mr C said:

- His friend had a creative mind and he looked weird, was walking differently and described him as "jelly"
- They were all smoking cannabis before this happened and he got the feeling his friend was ready for something and he started to 'worry about himself'
- He thought his friend was using different words against him
- He described a fairy who told him to pinch his ribs and touch his head and told him to pick up a pen
- He got the image of his friend stabbing him so decided to stab him first
- He said he had not thought of harming anyone else since that episode.

11.21 Mr C said that he had started to feel a lot better over the last few weeks and had been thinking about his future. He said that he was not letting 'bad incidents' into his head and was only thinking of good aspects. He enjoyed watching TV, listening to music and doing carpentry. He said his concentration seemed to have improved and his motivation and energy levels were better. He was vague but hopeful about his plans for the future.

11.22 Mr C described hearing voices, in particular a woman's voice, which he had heard over the previous night, which lasted a few seconds. It came from outside his head and was talking to him directly but he could not remember the exact words. He did not recognise the voice. He said that about a week ago he had heard a voice but was not sure about it. When asked about ideas of reference he said, 'there might be'. He said that people knew what he was thinking and described thoughts being put into his head. Though he was very vague, he described some thought broadcasting and wondered if it was withdrawal, but told them that he had not had this experience recently. He also thought that people had been playing with his thoughts but not recently. He described paranoid thoughts which he thought were getting better and he had some persecutory ideas as well. He expressed some delusional beliefs that people were running the world and they were 'big people' but when asked specifically, he said it was God and not leaders.

11.23 Mr C said that he did not drink much alcohol or smoke cigarettes. He said that the last time he smoked cannabis was two months prior to the meeting.

11.24 The assessment had begun with Mr C telling them about his secondary school experiences. He said he could not really concentrate at school and could not become "broad minded" or "educated". He started describing something about hearing the television and his senses becoming increasingly sensitive. He said he did not understand how to interact with kids at school who were studying and felt "bigger than them". He also had nasal problems. The assessors recorded that they wondered whether those experiences could have been psychotic in nature, at a very young age.

11.25 The SPR concluded and recorded his impression of Mr C as follows:

- An 18 year old who was a heavy user of cannabis for about two years and ended up having an acute psychotic episode
- He clearly described first rank symptoms of schizophrenia when he was under the influence of cannabis and also in the few weeks after he stopped it

- He seemed to be improving, although at a very slow pace, and remained thought disordered though to a lesser intensity
- There was a family history of schizophrenia, on his mother's side which increased the risk of him developing a schizophrenic illness. There was also evidence of significant intellectual decline when he started secondary school. Although the episode that led to the assessment seemed to be a drug induced psychosis, the SPR felt it was important to monitor him for a period of time to see if he developed a schizophrenic illness due to the risk factors.

11.26 The management plan was as follows:

1. They would continue to monitor Mr C over the next few weeks without any medications to see if the gradual progress continued
2. Mr C would receive input from a Senior Support Worker (SSW) from GRIP team and the Clinical Psychologist (CP) and there were plans to try engaging him in activities, socialising and developing skills
3. The SPR would see Mr C in three to four weeks time and, if there was no improvement in his symptoms, he thought it would be worth considering a trial low dose of antipsychotic medication, possibly Ariprazole
4. If things continued to improve, they should aim to reintroduce Mr C into mainstream education
5. The SPR had a discussion with a GP from the surgery regarding Mr C's blood tests dated 20th August 2009.

2 September 2009[13]

11.27 The GRIP team wrote to Mr C to inform him that the SPR would be going to his house to see him on 15th September 2009 at 12:00.

3 September 2009

11.28 Mr C seen by the SSW. Handwritten notes made by the SSW state that Mr C was experiencing thought disorder, odd behaviours, inability to sequence tasks and sleep disturbance.

7 September 2009[14]

11.29 The CP wrote a Care Plan letter to Mr C to provide him with a brief overview of the input he was receiving from the GRIP team stating that at that point he was under a period of extended assessment. She said that they wanted to meet him to get a sense of the difficulties he was experiencing and to develop a plan of care with him that would be helpful. In her letter to Mr C, she confirmed that she was currently the lead professional responsible for arranging the input he was receiving. She gave him a number to contact her on. She confirmed that at the moment, the main concerns that Mr C and his father had raised were the mental health difficulties he had faced over the past few months. She said that Mr C had clearly linked the difficulties to his use of cannabis over the past two years and confirmed that Mr C had made the decision not to smoke the substance anymore. She

[13] Letter to Consultant Psychiatrist, GRIP Early Intervention Team
[14] Letter from Clinical Psychologist, GRIP to SM, 7/9/2009

confirmed that his mental health problems were seemingly gradually improving with not smoking. However he still did not seem to be his usual self and they were considering whether medication might help him improve his experiences. She confirmed that he was meeting with the SPR to discuss the matter but had not started any medication yet.

11.30 The CP stated that Mr C's father had raised concerns about Mr C going to live in a new area where he did not know anyone and did not have any interests outside the house. He was also concerned about Mr C's progress with his education. For that reason, the SSW began having meetings with him to see if there was any way in which he could be of assistance.

11.31 The CP confirmed in the letter to Mr C, that Mr C was receiving Job Seekers Allowance, did not have any financial concerns, was living with his father and that he planned to continue the living arrangement for the near future.

11.32 The CP said that when Mr C was unwell he became very paranoid about his friends to the extent that he tried to attack one of them. She confirmed that he had said the situation continued to bother him and that he had thought a lot about what happened and why his friends might have acted the way they did. She also confirmed that he said he no longer felt paranoid since he stopped smoking cannabis and that if the experiences returned (e.g. voices, paranoid thoughts, seeing things that others did not), he thought he would be able to tell his father.

11.33 The CP stressed in the letter that should the experiences recur, it was important that Mr C contact the team or (if outside working hours), the GP's out of hours service or attend the local Accident and Emergency Department.

11.34 The CP confirmed that they would review the plan in a couple of months once they had a chance to get to know him and thoroughly assess his mental difficulties when they arrange a Care Programme Approach (CPA) review to discuss what would be helpful in the future.

9 September 2009

11.35 Mr C stayed with his mother for the weekend.

Comment

11.36 There is no evidence in the clinical records that suggest that any communication took place between Mr C's mother and professionals, either before or after any of his periods staying at her home.

15 September 2009[15]

11.37 The SPR wrote to the GP confirming that he had reviewed Mr C on a home visit and that the CP and SSW from the GRIP team had been in touch with him. He informed the GP that the SSW had been taking Mr C out for coffee and to the library and was concerned about his behaviour in a social environment.

[15] Letter, 22/9/2009

11.38 Mr C had said that his concentration was much better and it was more enjoyable watching TV. He said he had been exercising a lot and doing a lot of housework, his appetite had come back and he seemed to have put on some weight. He said sleep was not a problem and he no longer felt like he was in an "enclosed bubble" like he did before. He said that his mood was improving and he was keen to start college in September. He said he was 80 % clear in his thoughts and told the SPR that the cannabis was still in his "fat and had coated his brain". He said he learnt that from an internet site. He said he had had a weird experience four days ago, he felt "spaced out" after drinking six beers and four glasses of wine and he experienced a mixture of voices and images at around 04:00. He also said he had "drifted completely" while watching a film and felt "guided".

11.39 The SPR reported that Mr C's eye contact was much better and that his speech was coherent but reduced in volume and rate. Though there was a degree of preoccupation and distraction there was no evidence of any acute psychosis. Subjectively, he described his mood as fine, objectively flat. There were no thoughts of self harm, suicide or harm to others. At a certain point during the meeting, the SPR thought he was responding to voices. There was no evidence of formal thought disorder, his concentration was improved and his insight good. They discussed medication and Mr C was willing to try it.

11.40 The SPR had a chat with Mr C's father and he was agreeable to the following plan:

1. Mr C to start Aripiprazole (Abilify) 10 mgs in the morning. The SPR gave him a four week prescription
2. He would continue to receive input from the CP and SSW from GRIP. They would continue to monitor his mental state to see if there was any improvement on this medication
3. The SPR would see him in four weeks.

11.41 The SPR noted that Mr C had an appointment with the GP for a fasting blood sugar test on 21st September 2009.

20 September 2009[16]

11.42 A core assessment was completed by the CP, Mr C's Lead Professional. It was dated 20th September 2009.

Comment

The CP has since informed the independent investigation team that she thinks the date on the core assessment was written in error and that it should have been dated 20th August 2009.

11.43 The assessment outlined that a referral was made by Mr C's GP after his father attended the surgery with concerns about Mr C's mental health. Mr C had been living with his mother in the South East Following reported extensive cannabis use, Mr C developed paranoia which came to a head at the end of July when he attacked a friend with a pen. Mr C stated he had not experienced any other mental health difficulties. He reported that he had been smoking

[16] 2gether NHS Foundation Trust, Core Assessment, 20/9/2009

cannabis for approximately two years and tried many forms of the drug including 'skunk'. He reported a number of psychotic features including having visions of people who interacted with him, hearing voices, experiencing distorting in his visual perception and also having paranoid thoughts. He also experienced ideas of reference whilst under the influence.

11.44 Mr C's father reported that he had struggled with concentration for the past couple of years. He took the GSCEs twice with limited success. Mr C reported having periods during the past two to three years when he started having spells where he "did not feel like himself". He interpreted these difficulties as a result of his cannabis use and from smoking.

11.45 Mr C said that he used to base his life around smoking and that he used to smoke, at the most, a quarter of an ounce per night, approximately 2 to 7 days a week. He believed the cannabis was affecting him and made him act in an "immature way". He reported experiencing racing thoughts going through his head and that people were changing around him while under the influence of cannabis. He felt big in comparison to them. He described feeling like he needed to laugh or smile at people to impress them. He said that before his problems with cannabis he was someone who thought a lot about things, but had now become "extremely boring" and that this affected his interactions with people.

11.46 Mr C presented at the surgery as well kempt. He had poor eye contact but did not appear anxious and there were no objective signs of low mood. His speech was normal in rate and volume but he appeared to have difficulties in following conversations and would go off at a tangent. Mr C said that he was not low in mood but his father expressed concerns that Mr C was depressed.

11.47 Mr C had good family support from his father and step mother and had chosen to leave the South East to stay away from the temptation to use more cannabis. However by moving, he lost much of his social network and lived in a village in Gloucestershire. He was open and honest in discussion and was reported to be a clearly a thoughtful young man who was trying to make sense of the difficulties.

11.48 His father reported that Mr C's mental state was gradually improving and that he was returning to his former self. He wondered if he was depressed and noted that his attention, concentration and motivation were all poor.

11.49 Although Mr C had described experiencing suicidal thoughts in the past, he denied experiencing anything at present.

11.50 His clinical risk assessment was as follows:
Suicide: Low. The rationale for this was that although Mr C had described experiencing suicidal thoughts in the past, at the time of assessment he denied experiencing any current suicidal feelings. It would appear that these thoughts were related to a period of low mood and Mr C subsequently reported that his mood had improved.

11.51 Violence: Medium, Low. The rationale for this was that Mr C had attacked a friend whilst paranoid and under the influence of cannabis but subsequently recognised that it was wrong although he continued to feel that his friend "had it in for him". He was no longer

mixing with those peers and his father had made it clear that he would no longer mix with them due to their ongoing drug use. However, it was noted that should Mr C become paranoid in the future and start to re-experience auditory, visual or command hallucinations which were present when he attacked his friend, then the risk would significantly increase.

11.52 Deliberate self harm: Low

11.53 Neglect: Low

11.54 Wandering: Low. The rationale for this was that whilst acutely psychotic, Mr C disappeared for three nights and it was believed that he was living in the woods at the time. Should he become psychotic again in the future this would cause the risk of wandering to significantly increase. However, it appeared that the symptoms of psychosis at the time of that incident was related to cannabis use which he was currently abstaining from at the time of assessment.

11.55 Falls: Low

11.56 Vulnerability: Low

11.57 Child protection issues: Low

22 September 2009

11.58 Mr C reported to the SSW that he had drunk eight cans of beer the previous night.

11.59 Mr C took his first dose of Aripiprazole. He remained on this for three days but it was stopped on 25th September 2009 due to abnormal blood results.

23 September 2009[17]

11.60 The GRIP team wrote to Mr C to inform him that the SPR wanted an appointment to see him on 13th - October 2009 at 14:00.

12 October 2009

11.61 It states in the CP's handwritten notes that Mr C expressed anger towards some friends and a girlfriend, was thought disordered and had heard a voice. The CP also recorded that Mr C stated he did not feel he needed any further medication.

13 October 2009[18]

11.62 The SPR made a home visit to Mr C.

15 October 2009[19]

11.63 The SPR wrote to the GP to report on his meeting with Mr C on 13th October 2009. He said Mr C reported feeling annoyed and frustrated as he was not able to move on. He told the SPR that his ex- girlfriend had made him into a "monster" and that his friends were looking

[17] Letter to SM, 23/9/2009
[18] Letter, 15/10/2011
[19] Letter, 15/10/2011

at him strangely and then at one another. He said “I don’t know how to be”. He reported hearing voices. He said his sleep had been better but had been disturbed before this because of thoughts about his friends. His appetite was fine. He said that his friends interfered with his thoughts and they knew what he was thinking. He felt that they could control his emotions. He said he was in an “awkward horrible position” and likened it to being caught in a spider’s web. He admitted feeling increasingly paranoid but found it difficult to describe. He denied taking any illicit drugs but confirmed occasional alcohol usage. The SPR confirmed that Mr C had been seeing the SSW regularly. Mr C admitted Aripiorazole made him more relaxed though he said that it was his body that became less depressed not his mind.

11.64 Mr C’s father reported that the Aripiorazole made Mr C lively and that he was more communicative when on his medicine and was willing to help around the house. He said he had been very frustrated and angry with his friends lately and had been pacing up and down in his bedroom making funny noises when on his own. He also reported that Mr C was getting conflicting messages from his mother who, he felt, was opposed to medication.

11.65 The SPR stated that from his current presentation, it was clear that Mr C needed antipsychotic medication to prevent further deterioration in his mental state. He cautioned that they needed to be careful of what antipsychotic was prescribed because of the reaction he had had to Aripiorazole. He said he would have a discussion with pharmacists and that they might give him another trial with antipsychotic medication but with careful monitoring of his liver function. The SPR said he would get back to the GP in a week or so to make a decision about the medication. The SPR noted that he had spoken to Mr C’s father and step mother about the risks of commencing Mr C on an antipsychotic and that they were keen for him to start medication with monitoring of the liver.

16 October 2009

11.66 The Physiotherapist commenced a physical health assessment but this was not completed due to time constraints and Mr C’s fatigue.

4 November 2009[20]

11.67 The SSW emailed the SPR saying that when he had seen Mr C the previous week, his father had spoken to him about going on holiday with his partner and that Mr C was not going. His father expressed concerns about Mr C being at home alone and the SSW concurred that Mr C would not cope with this. Mr C’s father is reported to have stated that the option of Mr C going to his mother's might not be a good one as recently Mr C became upset when he stayed with her due to her belief that he had no illness and did not require treatment. He also talked about anger towards his mother's partner. The SSW suggested supported lodgings or staying at an inpatient facility, as respite.

5 November 2009[21]

11.68 The SPR emailed the SSW and CP saying that he felt that an admission to an inpatient unit would be a good option for respite or, if necessary, a longer admission. The SPR said that he

[20] E-mail, 4/11/2009
[21] E-mail, 5/11/2009

would not be happy for Mr C to go to his mother's house. He stated that when he had met him that week Mr C seemed happy but mentioned some odd beliefs that he had about his stepfather.

11.69 Handwritten notes state that Mr C was "expressing odd ideas regarding stepfather and mother and that he felt they were opposed to the GRIP service and didn't feel that Mr C was ill." Potential concordance risks and possible risk to stepfather due to Mr C's anger towards him was noted.

Comment

11.70 Despite the SPR's concerns about Mr C staying with his mother while his father and stepmother were away due to the odd and potentially risky ideas he had expressed about his stepfather, the independent investigation team found there to be no evidence that the prospect of Mr C going to stay at his mother's home for weekends on a regular basis was considered an issue or cause for concern, or a potential concern that should be risk assessed and be brought to the attention of Mr C's mother.

10 November 2009

11.71 A Carers Needs and Assessment Support Plan was completed for Mr C's father.

Comment

11.72 Mr C's father does not recall taking part in a Carer's Assessment or being informed of the outcome. Additionally, there is no evidence available to suggest the Mr C's mother was ever offered a carer's assessment despite her having Mr C to stay at her home on a regular basis.

16 November 2009

11.73 Notes made by the SSW suggest that Mr C remained thought disordered and angry at friends and his stepfather who he felt had contributed to his condition. He reported to have consumed four to five cans of alcohol the night before.

17 November 2009[22]

11.74 The SPR visited Mr C at his home. He noted that there was no change in his presentation. He continued to be preoccupied with thoughts about his "mates" and things that had happened at school. He told the SPR that he felt angry with his stepfather and lots of things could have been prevented. He did not explain what these were. He spoke of a cousin who was a heroin addict. There was evidence of paranoid thinking but Mr C denied hearing voices over the last couple of weeks. Mr C said that he had been going out running with the physiotherapist and had been enjoying this input. SSW from the GRIP team had also been seeing Mr C regularly and taking him out. The SPR had a detailed discussion with Mr C and his father about starting Mr C on antipsychotic medication, explaining the risks and benefits. They appeared to take it on board and were happy for Mr C to start Sulpiride which has a low risk of causing liver problems. He also explained the possibility of Mr C experiencing extra pyramidal side effects such as tremors, stiffness, agitation and restlessness. He advised them to get in touch with the GRIP team or the GP surgery if they had any concerns

[22] Letter, 17/11/2009

about the side effects of the medication. They decided to start with Sulpiride 200 mgs (low dose) daily and Mr C was given a two week prescription.

17 November 2009[23]

11.75 In a letter to the GP, the SPR discussed restarting Mr C on antipsychotic medication. He confirmed Mr C's blood results from 29th October 2009. The SPR stated that after discussions with the pharmacist they decided that Sulpiride was the antipsychotic of choice for Mr C as it was reported to be virtually un-metabolised with little or no biliary excretion.

11.76 The SPR confirmed that he had met with Mr C that day and there had been no change in his presentation. He had a detailed discussion with Mr C and his father about the risks and benefits of starting antipsychotics and they both seemed happy for him to commence Sulphide which had a low risk of causing liver problems.

11.77 The SPR detailed the following Management Plan following discussion of Mr C's father:

1. Mr C to start Sulpiride 200 mg daily
2. Mr C to have blood tests, arranged by the GP, to check his liver functions, a week after starting medication
3. Mr C and his father to look out for side effects and report any immediately
4. The SPR would ask the team to continue their input and monitor if Mr C developed any problems from the medication or whether there was deterioration in the mental state
5. The SPR would arrange a home visit in two or three weeks and would be in touch with Mr C over the phone
6. The SPR requested that the GP inform him of results of the other blood tests once he gets them.

20 November 2009

11.78 The CP recorded that Mr C reported feeling angry towards his friends and that he should do something to them for doing this to him. He said that he did not think he would act on these thoughts but the CP recorded that it was difficult to distract Mr C or to get him to think about alternative reasons for his current experiences.

24 November 2009[24]

11.79 The SPR emailed the consultant psychiatrist, staff grade psychiatrist, staff from the inpatient unit, CP, SSW, and the physiotherapist confirming that admission had been arranged for Mr C for assessments/respite for a period of three to four weeks. He stated that Mr C and his father were happy with the plan and were coming in on 27th November 2009**.** He said that Mr C had responded well to Sulpiride 200 mg and his liver function was getting back to normal. He said that the admission should be relatively short and that the risks were low with Mr C. He said he would visit Mr C at the inpatient unit and continue to follow up with him after his discharge.

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[23] Letter, 17/11/09

[24] Email from Specialist Registrar GRIP team

24 November 2009[25]

11.80 The SPR made a home visit to Mr C. Mr C reported feeling much better and was thinking about the future. He had not been suffering from any side effects. He said he had not heard any voices since starting the medication. His father reported "little bits of improvement". The management plan was as follows:

1. After a discussion with the staff grade psychiatrist at GRIP and the nursing staff at The inpatient unit, it was decided that he would be admitted on 27th November 2009
2. They were aiming for Mr C to develop his social skills during the admission and for the admission to give them an opportunity to assess his mental state and review medication with careful monitoring of his physical health especially liver function tests
3. The SPR said he would visit Mr C and continue to follow up with him after his discharge.

11.81 The physiotherapist made handwritten notes stating that Mr C was ambivalent about going to the inpatient unit but accepted a one week admission and that he spoke about killing old friends but said that it was unlikely that he would.

26 November 2009[26]

11.82 A secretary emailed the SPR to inform him that she received a call from the GP who said that Mr C may have Wilson's disease which could mean his problems were medical and not psychiatric. She asked that he ring the GP.

26 November 2009[27]

11.83 The SPR emailed the consultant psychiatrist and the staff grade psychiatrist to inform them that he had had a discussion with the GP about the possibility of Mr C suffering from Wilson's disease and that he had requested further investigations. The SPR noted that if he did have Wilson's disease it could explain the psychiatric symptoms. The SPR commented that he felt it was important that the consultant and the staff grade psychiatrist were aware of this as he was coming to the inpatient unit.

28 November 2009[28]

11.84 Mr C was admitted informally to the inpatient unit for a three week respite admission to assess his mental state and functioning with a view to treatment and intervention while his family went on holiday due to him being unsuitable to be left alone at that time. He had a history of cannabis use which resulted in paranoia, hallucinations, low mood and suicidal thoughts. At that point he was on regular low dose antipsychotic medication and his mental health had improved but he still had some symptoms and required respite and monitoring.

Comment

11.85 Admission to an inpatient unit is a major step and is done because the risks from not admitting to hospital are greater than the risks from admitting to hospital. The independent

[25] Letter, 26/11/09
[26] Email, 25/11/09
[27] Email, 25/11/09
[28] Nursing Admission Assessment, 28/11/2009

investigation team were unable to identify any clear rationale or formal clinical risk assessment documenting what the concerns were about why Mr C could not be treated at home with increased inputs, especially if the team considered him to be “low risk”. It might be that the team did not consider the risks of home treatment to be low, but if so the plan should indicate whether treatment at home had been considered. The independent investigation team note that there was no involvement by the crisis resolution/home treatment service as admission gate keepers as this was Trust policy at the time.

11.86 At this point Mr C had no previous psychiatric admissions. On admission, he presented with paranoid delusions about his friends interfering with his thoughts and a mild to moderate degree of thought disorder. He also described ideas that people were looking at him and talking to him. The physical examination was unremarkable. He was maintained on his Sulpiride 200 mgs a day and his mental state began to improve. His thinking became clearer and his speech less confused and tangential. He engaged well in activities and interacted well with staff. Clinical records show that the inpatient staff felt that as time went on his behaviour deteriorated; he began to display antisocial and disruptive behaviour. He was confrontational to staff and would go out to drink alcohol and eventually smoked cannabis.[29]

11.87 His Care Plan was as follows:[30]

11.88 Goal: For Mr C to be settled into the inpatient environment and to have a period of assessment of mental state and functioning with a view to treatment and intervention. Interventions/plan:

1. Mr C to be introduced to the environment
2. Staff to build the therapeutic relationship with Mr C by offering him one-to-one time each shift to discuss any thoughts and feelings, being open, honest and offering support and reassurance and providing a friendly and therapeutic atmosphere and explanations as to the nature and progress of any treatment or intervention
3. Mr C to be encouraged to participate in the programme
4. Mr C to plan a weekly activity programme with his named nurse and to continue with his college work on Mondays and Fridays
5. Staff to monitor Mr C's mental state by completing weekly mental state examinations
6. Mr C to receive his prescribed medication
7. Staff to explain the policy regarding client’s misuse of alcohol and illicit substances.

11.89 As doctors were investigating the possibility of Wilson’s disease, a 24 hour urine collection was requested. The results were normal and were passed on to Mr C’s gastroenterologist.

11.90 Medical reviews were to be organised by the care coordinator in due course. Mr C continued to live primarily with his father but also spent time with his mother.

[29] Discharge Summary
[30] Inpatient Care Plan, 28/11/2009

2 December 2009

11.91 The CP emailed staff at the inpatient unit to suggest that it would be a good time to do a PANSS[31] assessment with Mr C.

3 December 2009

11.92 A weekly review took place. It was reported by staff that Mr C had been heard to be making animal noises whilst alone in the kitchen but no other concerns reported.

4 December 2009

11.93 Liverpool University Neuroleptic Rating Scale (LUNSERS) completed. Mr C was on Sulpiride 200mg.

Comment

11.94 The purpose of completing the LUNSERS assessment as a single measure is unclear to the independent investigation team given that Mr C's Sulpiride was increased shortly thereafter. It would have been useful to have repeated the assessment to see whether scores became worse which would have suggested the presence of side effects.

4 December 2009

11.95 The nursing report shows that Mr C was seen laughing inappropriately and grimacing to a fellow client in the morning. He denied perceptual disturbances but was seen doing the same during lunchtime. Some of the notes are not very legible but it appears that Mr C may have missed one dose of Sulpiride.

11.96 Mr C was seen muttering to himself and grimacing in the evening.

5 December 2009

11.97 Medication concordance issues were noted. Mr C handed over an unused Sulpiride tablet that he had not taken as prescribed. During the evening Mr C went out at 22:15 with another resident despite staff trying to discourage this. He was "cautioned to return promptly" but came back at 23:55 smelling of alcohol. Mr C denied drinking alcohol but this was confirmed by the other service user who was present.

7 December 2009

11.98 Mr C's stepmother told staff that Mr C had disclosed to them that he had missed two days of Sulpiride on 4th and 5th December 2009 whilst at the inpatient unit. Mr C's father stated he noticed differences in Mr C's presentation after he missed his medication.

9 December 2009

11.99 A handwritten note by the GRIP team stated that Mr C was still preoccupied with symptoms and the past and was upset when he was out shopping, he had seen people who reminded him of his old friends.

[31] Positive and Negative Syndrome Scale

10 December 2009

11.100 Handwritten multi disciplinary team (MDT) meeting notes state nursing staff reported Mr C missed some doses of medication whilst on home leave, although the independent investigation team note that evidence in records suggests he missed them at whilst at the inpatient unit.

11.101 A mental state examination showed Mr C to be exhibiting paranoid and psychotic phenomena. He said he believed two of his friends had "done this to him". Mr C's thoughts of killing friends were noted but that he said he would not do it. Mr C expressed anger about being on medication and blamed his friends for it. He stated he did not want an increase in medication but agreed to "think about it". Mr C stated he was hearing "a lot of rubbish".

11.102 The resulting plan was recorded as:

- Mr C to stay at the unit to mid January. Mr C's father was agreeable to a longer stay if it will help Mr C
- CPA review to take place in the new year.

13 December 2009

11.103 Nursing notes state Mr C said he did not care if he were dead and reported feeling that his brain was split with hundreds of thoughts per day splitting into millions. He reported feeling "angry, mad, crazy and depressed" and said he felt like someone could control his mind and wondered if other patients could "see what's in my head and are taking my place".

14 December 2009

11.104 Mr C was caught by nursing staff drinking multiple bottles of cider in his room. A medical review took place on the same date stating Mr C's illness was unlikely to be Wilson's disease due to normal urine results. He presented as very thought disordered. Mr C was given more time to consider increasing his medication.

16 December 2009[32]

11.105 Mr C's blood test results received.

17 December 2009

11.106 A multi disciplinary team meeting took place. Nursing staff stated they were divided about whether Mr C's presentation was due to psychosis or was behavioural. Mr C reluctantly agreed to an increase in his Sulpiride to 200mgs twice a day.

19 December 2009[33]

11.107 Jobcentre Plus wrote to the SPR confirming that Mr C met the criteria for Employment and Support Allowance.

20 December 2009

[32] Letter to Consultant Gastroenterologist, 16/12/2009
[33] Letter from Jobcentre Plus

11.108 Alcohol was found by nursing staff in Mr C's room.

21 December 2009

11.109 It was noted in a multi disciplinary team review that alcohol had been found in Mr C's room. Mr C complained of feeling "spaced out" on the increased medication. It was noted that it would be discussed with GRIP staff whether Mr C could return to the inpatient unit following his planned weekend leave due to him "breaking the rules".

29[t] December 2009

11.110 A multi disciplinary review meeting took place. Mr C is reported in the clinical notes to have appeared vague and preoccupied with trains of thoughts that were difficult to follow. A discussion took place regarding his alcohol use. It was suggested he spend more time at the inpatient unit as a "treatment option". Mr C and his father agreed to this.

11.111 The resulting plan was recorded as:

- Mr C to spend next five days with mother
- Mr C to return to the unit on 5th January 2010 for Tuesday-Friday each week and to spend the rest of time at father's home
- Review after 2 months.

12 January 2010[34]

11.112 The physiotherapist[35] wrote to Mr C inviting him to participate in the new GRIP team healthy living group on 3rd February 2010.

14 January 2010

11.113 Mr C's father informed the team that there had been problems with Mr C getting up in mornings due to not sleeping at night.

15 January 2010

11.114 A medical review took place. Mr C expressed some paranoid thoughts about his friends; "they continue to interfere" and some evidence of thought alienation. Mr C blamed cannabis for the problems and stated he did not understand why friends were still out to get him. He said he would not touch drink or drugs. The plan was to continue and consider further increase in Sulpiride.

19 January 2010

11.115 Mr C was reviewed by the consultant psychiatrist on his return from leave. He presented as drowsy and sluggish and spoke of feeling paranoid. The consultant recorded that Mr C was vague when he tried to explore this but that he spoke of having taunting thoughts in his head and hearing his thoughts spoken out loud.

[34] Letter to SM, 12/1/2010
[35] Physiotherapist, GRIP

11.116 That night Mr C returned two hours late from leave. He said he had been with a friend from the East Midlands. He denied taking cannabis but refused a drugs test stating he would have one the following day.

21 January 2010

11.117 A female fellow resident reported Mr C was in the lounge with his hand down his trousers masturbating. When approached by staff, he became verbally aggressive to staff and the female resident. Mr C denied masturbating but said he was scratching his genitals. The staff said it was still inappropriate in a public area and Mr C walked out shouting at staff. He later apologised. Mr C did not attend college that day and later went out with another resident. It is unclear where they went but staff felt he may have gone to the pub.

21 January 2010[36]

11.118 A multi disciplinary review took place. The notes say that Mr C was engaging with all the activities at the inpatient unit but needed firm boundaries to be enforced. One night he did not return until two hours past the agreed time. He was reluctant to provide a urine specimen saying that he had not used cannabis in six months but that it would still be in his system. Notes state that he had at times behaved in a ''tormenting and inappropriate manner'' towards a female patient.

21 January 2010[37]

11.119 A physician[38] wrote to the GP. He confirmed that Mr C's cardiovascular and respiratory examinations were normal and there was no sign of chronic liver disease. The blood tests returned negative results for hepatitis serology, auto antibodies, immunoglobins and TTG and iron studies. The physician said that he would like to take the investigation further and had requested another check of his liver function and a 24 hour urine collection. He said he would also like to refer him to the ophthalmologist for a review of his eyes under the slit lamp and if the results turned out positive the next step would be a liver biopsy. He said they would review Mr C and had asked for a follow up appointment in four weeks.

11.120 Also invited were the consultant psychiatrist, the physiotherapist, the SSW and staff from the unit.

26 January 2010

11.121 Nursing notes show that Mr C returned from leave with his father. Mr C's father expressed concerns that Mr C had lied to him about going to the pub and that an empty vodka bottle had been found in his bag.

11.122 Later, back on the ward, Mr C said he had seen someone in the mirror in his room although he had denied hearing voices.

11.123 That evening, Mr C returned from the shop with another bottle of vodka. He later admitted that he had been drinking heavily for two to three weeks.

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[36] MDT Weekly Review Sheet, 21/1/2010

[37] Letter, 21/1/2010

[38] SpR to Consultant Gastroenterologist

11.124 Mr C produced urine for a drug test although production of the sample was not observed. This was negative.

11.125 Staff advised Mr C that he could withhold his consent for them to share information with his father if he wished.

28 January 2010

11.126 A multi disciplinary meeting took place. Mr C was noted to be less thought disordered.

11.127 That night Mr C approached staff smelling of alcohol and said he had consumed half a bottle of vodka. Staff offered him information and leaflets about alcohol support.

3 February 2010

11.128 Mr C is recorded in nursing notes as being rude and demanding. He was demanding money and cigarettes from other residents and had a female resident in his room. He later went out to the shop with her bank card and PIN. Staff confronted Mr C about this on his return from the shops and he said that he had bought scratch cards and cola.

Comment

11.129 The independent investigation team were unable to establish that these various incidents were reported and investigated as incidents or to establish that any adult safeguarding referral was made.

4 February 2010[39]

11.130 Mr C's Inpatient Care Plan was as follows:

11.131 Identified need/problem: Mr C was informally admitted to the ward for a period of respite, following this it was thought that he would need continuing support for further assessment with regard to mental and behavioural state and further exploration of positive symptomatology. Due to the timescale of investigations surrounding Wilson's disease a medication review has not been appropriate until now. Also need the psychopharmacological education.

11.132 Goals: To provide a safe environment for Mr C to explore his thoughts and feelings and emotions, and to further understand Mr C's behaviours, for Mr C to communicate and participate in activities.

11.133 Interventions and plan;

1. *One-to-one therapeutic time each shift*
2. *To spend the weekend of 6th of February at Dad's and then to remain as a full-time client until 9th March 2010 for further assessment. Mr C has agreed to have no overnight leave for 2 weeks*

[39] Inpatient Care Plan, 4/2/2010

3. *Due to erratic concordance with medication Mr C to be continually educated regarding his medication, the possible benefits and side effects*
4. *To conduct a weekly mental state examination*
5. *Continue to help Mr C structure his days to aid self worth and confidence and reduce maladaptive behaviours*
6. *Mr C to participate in core activities*
7. *Mr C to be given consistent boundaries as on a number of occasions he has not complied with rules and regulations. Mr C has been made aware that this type of behaviour will not be of benefit to his recovery or other clients and may jeopardise his placement at the unit*
8. *Mr C to continue college and to explore further his life goals and aspirations*
9. *Staff to liaise with Mr C's father in relation to Mr C's presentation and behaviour at home*
10. *Mr C to remain free from illicit drugs and alcohol. Random test whilst at the unit with Mr C's consent*
11. *Await the outcome of Hepatology appointment before full medication review*
12. *Mr C to attend MDT regularly to discuss progress*
13. *Staff to discuss possible assessments or interventions that may be of benefit to Mr C and help further understand what Mr C is experiencing at present. Consider psychology referral*
14. *Review at MDT/ward round and review placement if behaviour escalates.*

11 February 2010[40]

11.134 An EEG appointment was made for Mr C for 8th March 2010 at 10:00. The reasons for the investigation were listed as follows: psychotic symptoms, auditory hallucinations, thought disorders, paranoid ideas, episodes of distraction and preoccupation, temporal lobe epilepsy.

[40] EEG Request Form, Department of Neurophysiology, Clinical Investigation Department, Gloucestershire Royal Hospital, 11/2/2010

14 February 2010[41]

11.135 Mr C scored the following on the PANNS rating scale:

- Delusions-minimal
- Conceptual disorganisation-mild
- Hallucinatory behaviour-mild
- Excitement-mild
- Grandiosity-mild
- Suspiciousness /persecution-mild
- Hostility-mild
- Blunted affect-moderate
- Emotional withdrawal-mild
- Poor rapport-minimal
- Passive/apathetic social withdrawal-absent
- Difficulty in abstract thinking-mild
- Lack of spontaneity and flow of conversation-absent
- Stereotyped thinking –minimal
- Somatic concern-absent
- Anxiety –minimal
- Guilt feelings-minimal
- Tension-absent
- Mannerisms and posturing-absent
- Depression-moderate
- Motor retardation-absent
- Uncooperativeness-mild
- Unusual thought content-mild
- Disorientation –mild
- Poor attention-mild
- Lack of judgement and insight-mild
- Disturbance of volition-minimal
- Poor impulse control-mild
- Preoccupation-minimal
- Active social avoidance-absent

Comment

11.136 The PANNS assessment is a mixture of some items which are rated on self report and observation in interview and some which take into account corroborative information. It requires the rater to score holistically and for each item to score at highest level identified. The independent investigation team found no evidence that the results of this assessment were incorporated into Mr C's care and treatment plan. For example it states Mr C not ready for discharge but he was subsequently sent home and then discharged in his absence only a week later.

15 February 2010

11.137 Mr C's father received a call from Mr C's college informing him that Mr C had not been attending. Mr C's father was upset about this. He contacted staff at the unit about this and

[41] PANNS rating form

was told that they could not discuss it due to patient confidentiality as Mr C had not consented to share any information that did not concern his mental health.

Comment

11.138 There is a Consent to Sharing Information form in the clinical notes which is dated 11th February 2009. The date on this form cannot be correct as Mr C was not known to the service at the time. This document names Mr C's father as someone with whom information could be shared but restricts his access by refusing him information on "anything that is not crucial i.e. anything that does not concern Mr C's mental wellbeing". The form is not signed or witnessed.

11.139 The independent investigation team can only assume that this form may have been completed in 2010 and wrongly dated but this cannot be verified as it is unclear which member of staff was involved in the completion of this form.

22 February 2010[42]

11.140 Mr C was discharged home. A discharge summary was completed on 5th March 2010. It noted that Mr C's provisional ICD 10[43] diagnosis was: schizophrenia and possible Wilson's disease, which was still under investigation.

11.141 It stated that on admission Mr C presented with paranoid delusions about his friends interfering with his thoughts and mild-to-moderate degree of thought disorder. He also described ideas of reference that people were looking at him and talking about him. His physical examination was unremarkable. He was maintained on Sulpiride 200 mg daily and his mental state started to improve. His thinking became clearer and his speech less confused and tangential. He engaged well in activities and interacted well with staff and other residents. As his mental state improved however, his behaviour began to deteriorate and he started displaying a lot of disruptive and antisocial behaviour, such as being confrontational towards staff, going out to drink alcohol and eventually smoking cannabis.

11.142 As part of the ongoing investigation into possible Wilson's disease, a 24 hour urine collection was requested and the results were normal. These results were passed on to the gastroenterologist who is seeing Mr C.

11.143 Due to his challenging behaviour, it was decided at a CPA review in January 2010 that Mr C would become a part-time patient, splitting his time between his father's home and the unit. Initially this appeared to be going well. However this eventually resulted in 'mission drift' and the loss of clear goals and focus. It was therefore decided that he should be made a full-time patient again with clear boundaries from the beginning of February 2010 after which the admission would be reviewed.

11.144 Regarding medication, Mr C was maintained on Sulpiride 200 mg daily whilst awaiting guidance from the outcome of the gastroenterologist's appointment. However when this

[42] Discharge Summary

[43] The International Classification of Disease tenth revised edition (ICD-10) is a system of coding created by the World Health Organization that notes various medical records including diseases, symptoms, abnormal findings and external causes of injury

was not forthcoming it was decided that further delay was not in Mr C's best interest and therefore the dose was gradually increased to 600 mg daily in divided doses with Mr C's consent. He also had a routine EEG and was awaiting the results. A repeat 24-hour urine sample was also requested by the gastroenterologist but Mr C refused to comply with this.

11.145 Mr C continued to display disruptive behaviour and was suspected of abusing cannabis on the unit but refused to have a urine drug screen. On 16th December 2009 it other residents alleged that Mr C had supplied them with cannabis, which Mr C denied. He was interviewed by the police and given a warning. Due to his behaviour which was putting other vulnerable patients at risk, and the fact that he did not seem to be getting any therapeutic benefit from staying in the hospital, it was decided that he should be sent home on extended leave. A discharge CPA was arranged for the 23rd of February 2010. However this CPA meeting was cancelled and he was formally discharged in his absence on 22nd February 2010.

11.146 Discharge plan:

1. To continue to have Sulpiride 600 mg per day
2. To await the outcome of the gastroenterology investigation and the EEG result
3. Follow-up to be provided by the GRIP team care coordinator, the CP and SSW who will arrange medical reviews in due course
4. To continue to live with his father and spend time with his mother in The East Midlands.

Comment

11.147 The independent investigation team found no mention of the incidents of 16th December 2009, which are referred to on the discharge summary, in the chronological nursing notes. The independent investigation team conclude that this date may have been wrongly recorded in the discharge summary and refer to a more recent date in January or February 2010. The discharge summary states Mr C was seen by the police and cautioned regarding his use of cannabis. The independent investigation team is of the view that it was correct to involve the police in this matter and that the police input appears to have been proportionate. It is not clear to the independent investigation team what, if any, action was taken in relation to the other patients using cannabis including the patient who allegedly introduced Mr C to the drug.

11.148 It is not clear to the independent investigation team as to why the decision to discharge Mr C was reached, or by whom, or why the various issues and incidents were not linked to his illness. It is also unclear what other options were considered, other than discharge in his absence. Sending him home at a few hours' notice without a pre discharge meeting, community care plan review, updated risk assessment or informing his Care Co-ordinator, is in contravention to Trust policy and constitutes poor practice.

24 February 2010

11.149 The CP[44] wrote to Mr C and his father to rearrange the CPA meeting for 30th March 2010.

[44] Clinical Psychologist, GRIP

Comment

11.150 The CPA meeting that was planned for 23rd February 2010 did not take place. The CP stated at interview that this meeting was cancelled due to non-availability of the consultant psychiatrist due to leave.

30 March 2010

11.151 A CPA meeting was held and the Care Co-ordinator role was transferred to the SSW. The clinical notes show that it was agreed that:

- *The consultant psychiatrist would chase up the results of the physical investigations (possible liver problems)*
- *The physiotherapist would meet up with Mr C to discuss possible involvement to provide support regarding an exercise regimen*
- *A medical review with the consultant psychiatrist in a month to discuss effectiveness of current medication and review his mood*
- *Mr C and family would discuss and decide whether they would like to have some family meetings to look at problem solving around difficulties that they might be having with him and to let the SSW know so that he could arrange some meetings*
- *Professionals to consider whether a referral to a specialist drug and alcohol service would be helpful once other treatment had been investigated*
- *The SSW would arrange another medical certificate as his benefits were due for review*
- *The SSW would help him with his lack of motivation*
- *The CP was to refer Mr C's father and stepmother to Carers Gloucestershire for a carer's assessment and notify them of any carers groups that were planned for the future.*

11.152 At that time it was agreed by clinicians that the risks were low although it was recognised that there was a risk of him smoking cannabis if he had access to it. It was agreed that the care plan would be reviewed in approximately six months.

31 March 2010[45]

11.153 The CP wrote to Mr C outlining his review of care, detailing the plans and actions in place and contingency and crisis arrangements. She also stated the inpatient staff had explained that he had been discharged due to his unacceptable behaviour.

11.154 This letter clearly indicates that despite some improvement, Mr C's paranoia was continuing.

11.155 Mr C self reported that he was finding it difficult to think, experiencing paranoia and strange thoughts in his head and feeling uncomfortable. He also reported concern about the amount of weight he had gained in the previous few months. Mr C's father and his partner also reported that Mr C had dropped in mood, found it difficult to make decisions and had quite poor concentration.

[45] Letter to SM, 31/3/2010

11.156 Wilson's disease was still being considered as a possible diagnosis for Mr C but neither Mr C nor his father were of the opinion that the 600mg of Sulpiride was helping Mr C's cognitive abilities or mood. They were informed that no change could be made to medication until a definite decision on Wilson's disease had been made and that this should be subject to review in one month.

11.157 Issues in family relationships at home were noted, and an argument with Mr C's stepmother the previous Friday was highlighted. Family work was suggested but not pursued as Mr C was not keen on this.

11.158 Mr C's family requested a referral to a dual diagnosis specialist as they felt Mr C had problems in other areas than psychosis. This was refused. The rationale for the refusal was that they should wait until there was a definite diagnosis on Wilson's disease.

11.159 It was agreed by the team that risks were low although it was stated in the letter to Mr C that "there is a risk of you smoking cannabis if you have access to it which in the past has adversely affected your mental state".

11.160 A CPA review was planned for six months later or sooner if the situation were to change.

31 March 2010

11.161 A clinical risk assessment form on Mr C was completed by the CP.

11.162 This form mentions the stabbing incident with the pen but minimises risk on basis of geographical move. The risk assessment mentioned Mr C supplying cannabis and alludes to the issue of cannabis use adversely affecting his mental state, and that in the past he had acted on paranoid ideation after using it. The risk assessment concluded that "whilst Mr C continues to live with his father and away from his friends, engages in services and avoids cannabis use the risks that he presents are low. He appears to show some improvement with medication and currently is not smoking cannabis. His father is aware of potential risks and monitors these and would seek professional input if he were concerned".

Comment

11.163 The conclusion within the risk assessment relies on Mr C's father seeking professional input if he were concerned. However, the independent investigation team found this to be incongruent given that Mr C's father had raised issues about Mr C's substance misuse and had requested involvement from a dual diagnosis specialist and that this had been turned down.

11.164 The risk assessment did not deem self neglect to be a risk for Mr C despite reports of him living for three days in the woods following the stabbing incident, nor that it was considered he could not be safely managed at home if his father was away on holiday.

11.165 The risk assessment stated no risks caused by medication despite Mr C's abnormal blood results following him being prescribed Aripiprazole plus significant weight gain (which may or may not be linked to medication but is a risk issue in itself regardless of causation). Violence/aggression/abuse to staff or other clients was not deemed a risk despite reports

suggesting that Mr C used the cash card of another patient, was sexually inappropriate and was rude and demanding, plus shouting on occasion. Mr C was discharged from the unit due to "unacceptable behaviour''.

11.166 Use of weapons was not deemed a risk with regard to Mr C despite him stabbing a friend with a pen.

11.167 Use of cannabis was listed as a clinical risk for Mr C but his continuing use of alcohol was not referred to.

11.168 Acceptance of medication and services was not listed as a risk on the risk assessment despite Mr C not accepting family therapy and reluctance on occasions to take medication, nor is there reference to evidence of Mr C missing doses of medication leading to rapid deterioration in his mental state.

1 April 2010[46]

11.169 The consultant psychiatrist wrote to the GP updating him on Mr C's Care Plan on 2nd March 2010. He reported that Mr C continued to struggle to motivate himself to any activity, that the odd behaviour continued and that he was hearing voices. He had appeared apathetic and disinterested at the interview. With Mr C's agreement, his father had agreed to keep tabs on his compliance with the Sulpiride medication and to manage his benefits with a view to limiting Mr C's access to drugs and alcohol.

11.170 The consultant psychiatrist confirmed that support from GRIP would continue with a Care Plan in place to support his needs and that he was to meet with him as an outpatient in four weeks to review psychotropic treatment. He asked that the GP inform him of the results of the investigations with the Hepatologist as they would have a bearing on the psychotropic options.

12 April 2010[47]

11.171 The SSW met Mr C as planned and they went into town for a drink. The SSW noted that he was quieter than the previous time. Mr C had been involved in an altercation with a group of youths after a heavy drinking session two nights previously. He was unable to stop pondering over the incident even though it had been reframed in the context of him drinking heavily. The SSW had a conversation with Mr C's father and his partner. Mr C's father was keen to motivate Mr C and hoped to enrol them both at the local gym. Mr C's father reported that Mr C's symptoms had not changed much and that he had observed him pacing a lot, often throughout the night. Mr C had an appointment pending with a gastroenterologist and it was planned that a medical review with the consultant psychiatrist would be arranged after the appointment. The SSW noted that he planned to see Mr C the following Friday.

[46] Letter, 1/4/2010

[47] Progress notes, 12/4/2010

13 April 2010[48]

11.172 The physiotherapist carried out a home visit to Mr C, as previously arranged, to go through an exercise plan. Mr C appeared distracted and was unable to maintain concentration for any period of time. He reported that he had not been doing much, occasionally played in the garden and had a brief run to the end of the road and back, he had stopped smoking and appeared to be pleased about it and reported feeling better as a result. He said he had reduced his food intake and this was confirmed by his stepmother. Mr C agreed to go for a run/walk session. He did not talk much but made some hand gestures and appeared distracted throughout. He grew very short of breath on exertion but recovered during periods of walking and, when urged, managed to sprint during the last run.

11.173 Mr C had just bought a bike and planned to use it regularly to increase his fitness. A running plan was given to him and he agreed to try this three times a week. His stepmother suggested that she or his father could go running with him. Back at home, he was constantly pacing and appeared very distracted.

11.174 The physiotherapist had a conversation with Mr C's stepmother and she said that she felt he had deteriorated recently and was concerned that he was going to spend time at his mothers the following week. She was happy to help motivate Mr C in the thrice weekly running plan that was established.

11.175 The physiotherapist noted that she was going to see Mr C on 19th April 2010 to go running with him again and would continue to encourage physical activity routine.

16 April 2010[49]

11.176 The SSW met with Mr C. He did not want to go out into the town but was happy to stay at home and talk. He was frustrated that he felt that he could not move forwards and had been having trouble sleeping recently. He had begun the programme that the physiotherapist had introduced him to and believed that it would be beneficial. He said he also wanted to start going to the local gym and hoped that his father would support him with this. He was in good spirits at times and joked about previous good times with friends. He was to stay with his mother the following week and would be attending a wedding when he was there. As he would be away, the SSW planned to contact him the week beginning 26th April 2010.

19 April 2010[50]

11.177 The physiotherapist paid a home visit to Mr C for his running appointment. He appeared distracted and reported feeling tired. He ran over the weekend and also smoked cigarettes which he felt was the main contributing factor to his feeling tired. He reported having some thoughts but was unable to elaborate on them. Mr C had been going out running and was apparently enjoying the program. He also used his new bike once that week. They went out for a run. Mr C struggled and needed a lot of encouragement. He said he was feeling lethargic. She encouraged him to take his trainers with him when he visited his mother so that he could continue with the running program.

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[48] Progress notes, 13/10/2010
[49] Progress notes, 19/4/2010
[50] Progress notes, 20/4/2010

11.178 His next appointment was scheduled for 10th May 2010 due to the bank holiday and Mr C's holiday.

30 April 2010[51]

11.179 The SSW was supposed to see Mr C but his father informed the SSW that Mr C would be staying with his mother until Sunday. Mr C's father reported he had spoken to Mr C over the phone and he sounded well but was concerned that he may not have enough medication to last until Sunday. The SSW made a note to contact Mr C the following week and arrange a visit.

6 May 2010[52]

11.180 The SSW spoke to Mr C's father who reported that Mr C had been to his gastroenterology appointment and that the results had been fine. The doctor suggested that Mr C would now be able to commence new medication if required. The SSW made a note to speak to the consultant psychiatrist to confirm these results with Mr C's consultant at Cheltenham General Hospital. This would enable a medical review for Mr C.

11.181 The SSW met with Mr C who had returned at the weekend from staying with his mum in the East Midlands. Mr C had little to say about his visits but did report that he did not have enough Sulpiride medication to last the duration. Mr C presented as low in mood and reported little motivation. He had not adhered to his programme formulated by the physiotherapist. There was evidence of poverty of thought and poor concentration. He found it difficult to focus on conversation or direct questions. There was no real evidence of psychotic thoughts but this was difficult to assess due to lack of communication.

10 May2010[53]

11.182 The physiotherapist went running with Mr C. Mr C appeared distracted and was not initiating any conversation. He reported that he had done no exercise at his mothers' and that he felt he would have to start the program from scratch. They completed a short run but Mr C needed encouragement. He occasionally smiled and laughed. At home, he was unable to concentrate on the conversation and was pacing back and forth in the kitchen. He agreed to try to increase his activity over the coming week and to use the running programme.

14 May 2010[54]

11.183 The SSW paid Mr C a visit at home. His father and his partner were both away. Mr C reported feeling low in mood and lacked motivation in the previous weeks. He was also finding it hard to concentrate and there was evidence of thought blocking in conversation. He was encouraged to continue with his programme of exercise and to get out of the house whenever possible as he reported spending large amounts of time in bed.

[51] Progress notes, 30/4/2010
[52] Progress notes, 7/5/2010
[53] Progress notes, 10/5/2010
[54] Progress notes, 17/10/2010

20 May 2010[55]

11.184 The CP received a telephone call from Mr C's stepmother. She said that Mr C had drunk three and three quarter bottles of wine and had become violently sick on Tuesday night. They were concerned that he had a drinking problem as he seemed unable to control his alcohol intake. They felt that something had to be done about it and said that he had not had a drink since the last episode. Mr C's stepmother said Mr C was unable to remember anything of the incident and had apologised begrudgingly to them.

11.185 Mr C's stepmother believed Mr C had a medical review that day and wanted to let the SSW know about the incident prior to the review. She was happy for the SSW to discuss it with the consultant psychiatrist and to discuss it further herself. Mr C was supposed to go to his mother's house on Friday but Mr C's father did not think that it was a good idea.

20 May 2010[56]

11.186 The consultant psychiatrist saw Mr C with the SSW. Mr C reported he was spending much of his time doing nothing. He had trouble thinking straight and was hearing voices in his head. He had transient thoughts of self harm but no specific plans. There was an episodic pattern of binge drinking. He was recently discharged by the gastroenterologists with a clean bill of health with regards to his liver. At the interview the consultant recorded that Mr C presented as having restricted effect, mumbling and appeared bored and disinterested.

11.187 The plan was as follows:

1. *Change of antipsychotic: start Risperidone 2mg then 4mg at night*
2. *Mr C was advised on the usual side effects. He was to continue present dose of Sulpiride for one week, to take half the dose for the following week then stop*
3. *Mr C was encouraged to discuss any concerns with the SSW and contacting GRIP if thoughts of deliberate self harm became any worse*
4. *Medical review in six weeks or sooner if necessary.*

11.188 The consultant psychiatrist wrote to the GP informing him of the above and that he had ruled out an organic cause for Mr C's psychotic presentation, he was of the opinion that he was suffering from a hebephrenic type of schizophrenia rather than any affective condition. He confirmed that now that Mr C's liver function was uncompromised, he could be changed from Sulpiride to an atypical antipsychotic.

21 May 2010[57]

11.189 The CP received a telephone call from Mr C's mother. She had found out through Mr C's father that Mr C was in contact with the GRIP team and that he was taking antipsychotic medication. She was very shocked and felt guilty that she had not noticed the changes in him. She had a number of questions but the CP explained that she did not have permission to share specific information. Mr C's mother accepted this. She had concerns about his medication, particularly the weight gain, and wished to know about the long term effects of medication. The CP explained that she did not know this information but explained the

[55] Progress notes, 20/5/2010
[56] Progress notes, 20/5/2010
[57] Progress notes, 21/5/2010

theory that untreated psychosis has a toxic effect on the brain and that prescribing medication is always a cost benefit balance. Mr C's mother said she wanted to talk to one of their medical staff about medication. She also confirmed that a close relative was diagnosed with schizophrenia and that Mr C was badly beaten up at 17 and she wondered if that could be related.

11.190 She said that Mr C always had good friends and she noticed a change in his personality at the age of 15 ½ when his motivation reduced following a breakup with his girlfriend. She put this down to normal teenage behaviour. She said she had not known that Mr C was taking drugs while he lived with her and wondered if his current problems could be attributed to drugs. The CP explained that they were pretty certain that he had no access to cannabis where they were living and it therefore seemed unlikely. Mr C's mother said she would like contact from the SSW as he worked closely with Mr C. They agreed that the SSW would contact her the following week once he had requested consent from Mr C.

21 May 2010[58]

11.191 Following the contact from Mr C's mother, the SSW contacted Mr C's father to arrange a meeting with Mr C to discuss consent. Mr C's father was aware of his medication change and said he would support Mr C with it. Mr C's father also stated that Mr C would be visiting his mother the following Friday for a family function.

27 May 2010[59]

11.192 The SSW met with Mr C as planned. He presented as low in mood although there was evidence of improved concentration; he appeared more focussed on the conversation with less evidence of thought blocking or distraction. He had started Risperidone as prescribed by the consultant psychiatrist. Mr C was to see his mother on Friday and was to stay there for a week. He gave consent for GRIP to discuss his care with his mother at her request. The SSW made note to contact his mother on Friday. Mr C was still spending large amounts of time in his bed and had not begun any exercise as discussed at the last meeting. Mr C had contact details for GRIP for when he was away and the SSW made a note to arrange to meet with him when he returned.

28 May 2010[60]

11.193 The SSW spoke to Mr C's mother, as arranged. She requested details of GRIP contact with Mr C and details of the medications prescribed. She was clearly upset that she had been unaware until recently of her son's mental state and subsequent treatment from the mental health team. She said she would try to support him and encourage concordance with medication when he was staying with her. She spoke of her sister's schizophrenia and expressed concerns about the side effects of medication. She was offered telephone contact with the SPR to discuss her concerns in detail. She had GRIP contact details and said she would make contact the following week to discuss Mr C's time with her and to arrange a telephone conversation with the SPR.

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[58] Progress notes, 21/5/2010
[59] Progress notes, 27/5/2010
[60] Progress notes, 28/5/2010

15 June 2010[61]

11.194 The SSW picked up Mr C from home and took him to Gloucester Job Centre. Mr C presented as low in mood and had limited interaction throughout the journey. He said that he enjoyed his time at his mother's but did not elaborate any further. Mr C gave very limited answers to questions at the medical and the SSW was required to elaborate on his behalf. Mr C was very quiet on the way home and reported that he had taken all the medication prescribed while he was away at his mother's. He was unable to give any feedback regarding his mental state but he appeared distracted and preoccupied. He had a medication review with the staff grade psychiatrist planned for August 3rd. The SSW made a note to continue to visit and monitor him.

22 June 2010[62]

11.195 The physiotherapist made a visit to Mr C to go running. He was up and appeared keen to go. He reported that he had been running a few times in the past week, sometimes on his own and sometimes with his father. He had also used his bike recently. He reported feeling reasonably bright and generally better since changing medications. He managed the run well. He became increasingly tired but did not stop during the runs. At one point he said he was going to pick up his prescription but was happy to wait and do this later. The physiotherapist congratulated him on his obvious improvement and encouraged him to follow the programme to increase his fitness. His father and stepmother reported a general improvement in his mood and motivation since changing the medication. They said he was more likely and willing to do things with people. The physiotherapist explained that he was not on a therapeutic dose of medication yet and that things would hopefully progress as the dose increased. She reminded Mr C that the SSW was on annual leave that week and that she would be available if there were any problems. An appointment was scheduled for 5th July 2010.

28 June 2010[63]

11.196 The SSW received a call from Mr C's father who informed him that Mr C had self harmed with a kitchen knife whilst at home. The clinical notes state that according to his father, the scratches were "no worse than cat scratches". The SSW has recorded that Mr C's father said he felt Mr C was doing it for attention. The SSW spoke on the telephone to Mr C who reported being low in mood. He agreed to visit him at home the following day at 15:30.

30 June 2010[64]

11.197 The SSW met with Mr C. The SSW reported that Mr C seemed warm and welcoming and had clearly lost weight. He reported exercising daily and feeling the benefit thereof. They went for a walk during which Mr C was talkative. He believed he had many "issues" from his past that he needed to address but felt he was not yet ready to work on them. They discussed his self harm incident and he found it difficult to talk about and said he was "just being silly". They spoke to his father and stepmother and it was agreed that he would talk to them if he felt unsafe in that way again. The SSW recorded that there were evident improvements in his cognition and concentration.

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[61] Progress notes, 15/6/2010
[62] Progress notes, 22/06/2010
[63] Progress notes, 28/6/2010
[64] Progress notes, 30/6/2010

5 July 2010[65]

11.198 The police visited the inpatient unit looking for Mr C in connection with the death of his stepmother. He had gone missing after stabbing her in the garden at their home. Police advised staff to call 999 if he showed up and not to let him in. Staff informed the on call manager who advised them to complete the online incident report.

11.199 Later police told inpatient staff that they were "in the process of securing the person". She took that to mean that they knew where Mr C was and were arresting him. A member of staff at:

- Contacted Mr C's consultant psychiatrist and informed her of the information available
- Left a message for the CP to ring her back
- Had a telephone conversation with the CP relaying information. The CP said she would endeavour to speak to the SSW as soon as possible.[66]

6 July 2010[67]

11.200 Mr C was reviewed by Consultant Psychiatrist Two at Cheltenham Police Station. He was reported to be cooperative during the assignment and appeared to have very retarded psychomotricity and be flat in affect. He reported that his mood had been "up and down" in the last few weeks and that for a long time he had thoughts that "the world could kill me". He stated that a year ago a young man of his age had sexually abused him and recently he was feeling nervous when thinking about it. He was having thoughts of beating him and acted on these thoughts by punching his pillow. He said he had heard his father and stepmother having an argument in the garden and that he then heard his father's voice telling him to attack her and clearly heard "Do it, do it now". He also heard his father telling him "weird jokes". He felt that if he didn't act on this voice he would end up dead and as he was worried about the consequences, he stabbed his stepmother and ran off. When asked if there was any tension between him and his stepmother he said he could not understand why he did what he did because he liked his stepmother and was now feeling sad. When asked if he understood the consequences of his action, he said he did but did not want to elaborate further.

11.201 He said that he had stopped his Risperidone medication four days ago. When his father gave it to him, he was flushing it away or washing it down the sink. He was not able to say whether he had noticed any difference in his mental health since he stopped the medication. He said he had used cannabis a few days ago and none since then.

11.202 Consultant Psychiatrist Two reported that Mr C's insight into his mental illness seemed limited. He said he had experienced voices on the day of the assessment as well and that they were negative things. He was contradictory when asked if he had thoughts of self harming. He denied any plans of harming himself. He said he sometimes felt sad when he thought about the split from his girlfriend and his attack on his friend. He said that he had

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[65] Progress notes, 5/7/2010
[66] Progress notes, 5/7/2010
[67] Assessment of SM, Cheltenham Police Station by Consultant Psychiatrist and Clinical Psychologist, 6/7/2010

had other thoughts of stabbing people but had always been able to control himself but that yesterday he felt he “couldn’t control himself”.

11.203 He reported a good relationship with his GRIP care coordinator, the SSW. Mr C did not feel he wanted to let him know that he had stopped his medication because he wanted to see how long he could go without it. At the end of the interview Consultant Psychiatrist Two recorded it was clear that Mr C was mentally unwell.

12.0 EVALUATION OF THE MENTAL HEALTH CARE AND TREATMENT OF MR C

12.1 Assessment and clinical risk assessment

12.2 Mr C's assessment with the GRIP team began on 4th August 2009 when he was seen in response to a GP referral. Mr C was seen with his father. Mr C had only recently moved in with his father after living with his mother for many years. He moved in with his father after an incident in the South East where Mr C had stabbed a friend in the face with a pen and then went missing and lived in the woods for three days. Mr C clearly described that the attack on his friend was in response to command hallucinations and other psychotic experiences. An alcohol history was not taken. Mr C and his father informed the assessors of a psychiatric history in the family, namely schizophrenia on his mother's side. Mr C described that he had recently been back to spend the weekend with his mother.

12.3 This assessment resulted in the conclusion that there were "no current risks identified".

12.4 The Trust's Clinical Risk Assessment and Management Policy[68] states with regard to principles for assessing risk states:

12.5 ''The assessor should seek information from others who are professionally and personally involved with the individual, as well as from the individual themselves. These consultations should be documented.''

and

12.6 "Of importance in reaching a conclusion around the level of risk is the opinion of the service user and carer in the discussion. The use of narrative can inform and provide valuable detail around the service user's perception of the safety/risk issue. Medium to long term risk issues should always be supported by a view from the service user and an attempt should be made to use narrative in order to formulate the basis of the risk behaviour".

12.7 Department of Health guidance on Best Practice in Managing Risk[69] states:
''Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible''.

Comment

12.8 Mr C had recently moved in with his father and had had limited contact with him in the preceding years.

12.9 Liaison with the family generally, and specifically Mr C's mother, will be covered in more detail later in this report. However, it is the view of the independent investigation team that there were risk indicators apparent when Mr C was assessed in August 2009,

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[68] Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy - Version 1*

[69] Department of Health (2007) *Best Practice In Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

specifically the assault on his friend by stabbing him in the face with a pen, that should have warranted further exploration, particularly as it was described as being in response to psychotic phenomena.

12.10 It is the view of the independent investigation team that this incident, when Mr C stabbed his friend in the face with a pen, and events leading up to it, should have been more fully explored, both with Mr C and his mother, as she would have been able to provide an objective view on Mr C's mental health presentation prior to the incident which could have informed the clinical risk assessment. Mr C's father was not in a position to do this first hand.

12.11 Mr C's mother was not involved or consulted at any time during the initial assessment and clinical risk assessment process despite Mr C giving clinicians consent to share information with both her and his father on 11th August 2009.

12.12 The independent investigation team do not agree that it was reasonable, given the information that Mr C and his father had given them during the assessment meeting on 4th August 2009, for the assessors to conclude that there were no "current risks".

12.13 On 9th August 2009 Mr C continued to talk about being paranoid and suspicious and spoke of anxieties about friends from school, he spoke of being able to control minds and thoughts of his mind being controlled.

12.14 A handwritten risk assessment, written the following day by the CP, recognised alcohol and psychosis as issues that increased risk in Mr C's case but put the main emphasis on his cannabis usage prior to the incident where he stabbed his friend with a pen. The fact that Mr C had since changed geographical location since the incident was noted to be deemed by the assessor to be a protective factor.

Comment

12.15 It is clear from the clinical chronology that Mr C used alcohol both prior to being involved with the GRIP team and whilst they were caring for him, and reported using it heavily on occasion. Mr C also told the independent investigation team that he drank heavily on occasions from his early teenage years. Despite this the clinical risk assessment focused primarily on cannabis use as a risk trigger and less on the use of alcohol as this appears to have been used by Mr C on a long term basis.

12.16 A core assessment regarding Mr C was recorded as being completed on 20th September 2009, although the CP has later stated that she thinks this was actually written on 20th August 2009.

12.17 The outcome of this in terms of clinical risks was as follows:

Suicide: Low The rationale for this was that Mr C had described experiencing suicidal thoughts in the past but at the time of assessment he was denying experiencing anything at that time and that his mood had improved.

12.18 **Violence: Medium, Low** The rationale for this was that Mr C had attacked a friend whilst paranoid and under the influence of cannabis but that at the time of assessment he recognised that this was wrong although he continued to feel that his friend "had it in for him". It was noted that he was no longer mixing with the same peers and his father had made it clear that he would no longer mix with them due to their ongoing drug use. As a caveat the clinical risk assessment stated that should Mr C become paranoid in the future and start to re experience auditory, visual or command hallucinations which were present when he attacked his friend, then the risk would significantly increase.

12.19 **Deliberate Self Harm: Low**

12.20 **Neglect: Low**

12.21 **Wandering: Low** The text in the clinical risk assessment acknowledged that whilst acutely psychotic Mr C disappeared for three nights and it was believed that he was living in the woods at this time. It stated that should he become psychotic again, this would cause this risk to significantly increase. However, at this time it appeared that his symptoms of psychosis were related to cannabis use in the clinical risk assessment, but it was noted that at the time of assessment that he was abstaining from it.

12.22 **Falls: Low**

12.23 **Vulnerability: Low**

12.24 **Child protection issues: Low**

12.25 On 31st March 2010 a further clinical risk assessment form was completed by the CP relating to Mr C.

12.26 This form mentions the stabbing incident with the pen but minimises risk on basis of geographical move. Mr C smoking cannabis is mentioned in the risk assessment and it alludes to cannabis adversely affecting Mr C's mental state and that in the past he has acted on paranoid ideation after using it. The risk assessment concludes that "whilst Mr C continues to live with his father and away from his friends, engages in services and avoids cannabis use the risks that he presents are low. He appears to show some improvement with medication and currently is not smoking cannabis. His father is aware of potential risks and monitors these and would seek professional input if he were concerned".

Comment

12.27 The conclusion within the risk assessment relied on Mr C's father seeking professional input if he were concerned. However the independent investigation team found this to be incongruent given that Mr C's father had raised issues about Mr C's substance misuse and had requested involvement from a dual diagnosis specialist and that this had been turned down. Additionally, on another occasion Mr C's father raised legitimate concern and was told by inpatient staff that they wouldn't discuss his concerns regarding Mr C's lack of attendance at college when not attending college was relevant to Mr C's care plan and his mental state.

12.28 The risk assessment does not deem self neglect to be a risk for Mr C despite reports of him living for three days living in the woods following the stabbing incident. The CP told the independent investigation team that this was because it was considered a historical risk factor, rather than a current one, as at the time he was at home and well supported by his family.

12.29 The risk assessment states no risks caused by medication despite Mr C's abnormal blood results after he was prescribed Aripiprazole.

12.30 Violence/aggression/abuse to staff or other clients was not deemed a risk despite inpatient staff reports suggesting that Mr C used the cash card of another patient, was sexually inappropriate and was rude and demanding on occasion. Mr C was discharged home due to "unacceptable behaviour''.

12.31 Use of weapons was not deemed a risk with regard for Mr C despite him stabbing a friend with a pen.

12.32 Use of cannabis is listed as a clinical risk for Mr C but his continuing use of alcohol is not referred to.

12.33 Acceptance of medication and services is not listed as a risk on the risk assessment despite Mr C not accepting family therapy and reluctance on occasions to take medication.

12.34 Department of Health guidance on Best Practice in Managing Risk[70] states:

12.35 ''Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement''.

12.36 It goes on to outline the main factors that have been found to be associated with violence and suicide in the research literature as follows:

12.37 Risk factors for violence

12.38 Demographic factors

- *Male*
- *Young age*
- *Socially disadvantaged neighbourhoods*
- *Lack of social support*
- *Employment problems*
- *Criminal peer group*
- *Background history*
- *Childhood maltreatment*

[70] Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

- *History of violence*
- *First violent at young age*
- *History of childhood conduct disorder*
- *History of non-violent criminality*
- *Clinical history*
- *Psychopathy*
- *Substance abuse*
- *Personality disorder*
- *Schizophrenia*
- *Executive dysfunction*
- *Non-compliance with treatment*

12.39 Psychological and psychosocial factors

- *Anger*
- *Impulsivity*
- *Suspiciousness*
- *Morbid jealousy*
- *Criminal/violent attitudes*
- *Command hallucinations*
- *Lack of insight*
- *Current 'context'*
- *Threats of violence*
- *Interpersonal discord/instability*
- *Availability of weapons''*

12.40 Department of Health guidance on Best Practice in Managing Risk[71] also states:

12.41 ''Risk formulation is a process in which the practitioner decides how the risk might become acute or triggered. It identifies and describes predisposing, precipitating, perpetuating and protective factors, and also how these interact to produce risk. This formulation should be agreed with the service user and others involved in their care in advance, and should lead to an individualised risk management plan. Every risk formulation should have attached to it a plan for what to do when the warning signs become apparent. The plan should also include more general aspects of management, such as monitoring arrangements, therapeutic interventions, appropriate placements and employment needs.

12.42 Best practice point 9: The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis''.

Comment

[71] Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

12.43 It is the view of the independent investigation team that the risk factors for violence identified in research were not taken into account when assessing risk with regards to Mr C, and that significant risk factors described by Mr C and his father, and his ongoing psychotic symptoms, were missed out in the clinical risk assessment. Additionally, some of the risk factors identified were assumed or deemed to be person or geographically specific, or due to cannabis use, where there was no evidence base to support this.

The CP told the independent investigation team that these were thought to be person specific as Mr C spoke of his previous delusional thoughts being specific to certain friends. However it is the view of the independent investigation team that the potential of these ideas and risks transferring to other persons in the future, when Mr C was psychotic, should have been considered a possibility.

12.44 It is the view of the independent investigation team that the incident in which Mr C stabbed his friend in the face with a pen was minimised as it did not have a catastrophic outcome. However, Mr C clearly told clinicians that at the time of the incident he had intended to kill his friend. The independent investigation team strongly believe that the risk assessment should have been formulated on the basis that Mr C intended to cause his friend very serious harm at the point that he committed the act.

The independent investigation team have found no evidence that this incident was reported by the police at the time.

12.45 It is the view of the independent investigation team that, between the two formal documentations of risk assessments, Mr C had multiple on-going psychotic symptoms, was admitted to and discharged from an inpatient unit, had shown seriously risky behaviour and was discharged from inpatient care due to the risks he was posing. But there is no evidence of the team changing their view that he was low risk despite all the documented evidence to the contrary, even when making decisions as major as admission to or discharge from hospital or safeguarding Mr C or other residents in hospital.

12.46 The Trust's Clinical Risk Assessment and Management Policy[72] do not specify how the quality and appropriateness of individual clinical risk assessments will be monitored but it does state:

12.47 ''Formal risk assessments must be carried out by competent members of staff who have received the Trust's risk training and have access to regular supervision. Appraisal and the Knowledge and Skills Framework are the mechanism to provide assurance that a member of staff is competent to carry out a formal risk assessment and any other associated activities''.

Comment

12.48 The Trust's policy does not make clear how appraisal and the Knowledge and Skills Framework[73] provides assurance competence for clinical risk assessors and how the Trust monitor the quality and appropriateness of clinical risk assessments on an ongoing basis.

[72] Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy* - Version 1

12.49 Interviewees told the independent investigation team that, at the time, risk assessments were not taken to the team meeting for discussion and that ideally they should have been done by the clinical team caring for an individual, as a group, and then be discussed in clinical supervision sessions. In this case, the independent investigation team did not find evidence of any robust scrutiny of the clinical risk assessment, either by the rest of the clinical team caring for Mr C, or in clinical supervision with the Team Manager.

12.50 The independent investigation team were, however, told that since this incident, clinical risk assessments are now reviewed at team meetings as a matter of course.

12.51 The Department of Health guidance for assessing risk[74] clearly states that clinical risk assessments should be made within the context of a multi disciplinary team as follows:

12.52 ''The practitioner may sometimes be working alone, but in most situations the best risk assessments and the most effective decisions are made by a team of experienced practitioners in consultation with the service user and carer. Decisions and assessments should also be based on collaboration between health and social care agencies in hospitals and in the community. In some cases they should be based on collaboration between general and specialist services. The judgements made in a risk assessment should be made in collaboration with others in the multidisciplinary team and with the service user and carer. In instances where the risk seems high, the involvement of senior colleagues to advise and support may be helpful.

12.53 Care teams should think about the way that they operate and communicate: effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared. Teams should consider the best way for them to resolve disagreements about a decision, to ensure that the best decisions are made and that team cohesion is preserved. Teams should also be alert to group processes such as the pressure to conform and the potential for groups to recommend more risky courses of action than an individual would. When working across agencies, a common understanding and language should be established for the issues that will be addressed.

12.54 If a positive and open relationship exists between the user and their key worker, risk management can be a positive process and a vital step towards recovery.

12.55 Best practice point 14: Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.''

12.56 The Trust policy for the Trust's Clinical Risk Assessment and Management Policy[75] states the following with regard to whose responsibility it is to complete risk assessments,:

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[73] Department of Health Agenda for Change Team (2004) *The Knowledge and Skills Framework (NHS KSF) and the Development Review Process*

[74] Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

12.57 *''It will be normal practice for the Care Coordinator to undertake an assessment of risk and any subsequent management plan. The task may be delegated to another practitioner with significant involvement. The consultant will need to be involved where they are discharging the role of the Responsible Clinician under the Mental Health Act and in other complex cases. Where other team members are involved they should be consulted*

12.58 *Wherever possible the risk assessment should be carried out in collaboration with the service user and carers.*

12.59 *Clinical staff should actively carry out risk assessments with peer support and input. This is in order to reduce bias and error and to provide support to individual practitioners.''*

Comment

12.60 It is the view of the independent investigation team that the need for collaboration between the multi disciplinary team, when completing risk assessments for people with complex presentations, as outlined in the Department of Health guidance[76] is not clearly reflected in the Trust's policy.

Recommendations

12.61 The Trust should carry out an audit of the quality and relevance of clinical risk assessments and care and risk management plans that are in place for current service users within three months of publication of this report.

12.62 The Trust should ensure that all care coordinators receive regular caseload supervision that include documented formal review of care and clinical risk management plans and clinical risk assessments.

12.63 The Trust should ensure that clinical risk assessment training reiterates the importance of obtaining a comprehensive corroborative risk history from all relevant significant others, where the service user consents, to inform clinical risk assessment.

12.64 The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.

12.65 The Trust should ensure that core assessments include the requirement for comprehensive drug and alcohol histories to be taken.

12.66 The Trust should ensure that the need for collaboration between the multi disciplinary team, when completing risk assessments for people with complex presentations, as outlined

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[75] Gloucestershire Partnership NHS Foundation Trust (2007) *Clinical Risk Assessment and Management Policy - Version 1*

[76] Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

in the Department of Health guidance,[77] is detailed within the Trust's policy for clinical risk management.

12.67 Care Programme Approach

12.68 In the Core Assessment document, dated 20th September 2009, the CPA Screening box is not completed and there is no indication if, as a result of the assessment, Mr C was deemed to be subject to CPA. However, in the same assessment document it states that Mr C was not deemed to have a severe mental disorder. The rationale for this decision was given that Mr C was still subject to ongoing assessment to determine what impact his drug use had had on his mental health.

12.69 Mr C was not put onto CPA until his admission at the end of November 2009, four months after his referral to the GRIP team.

12.70 The Trust's Care Management/Care Programme Approach Policy[78] outlines the criteria in the Trust for CPA as follows:

12.71 *Within the Trust we operate 4 levels of care coordination. These are –*

(a) *Primary Care – Person seen by and managed in primary care by a member of the Primary Care Assessment and Treatment service.*

(b) *Not on CPA – service user accepted into 'specialist' secondary services, but who does not need full CPA*

(c) *On CPA – the service user has a severe mental disorder and a range of complex needs that require management under CPA.*

(d) *Complex Care – for service users with a learning disability who have complex care needs that require care coordination but who do not have a mental health problem.*

12.72 And it quotes the national criteria for CPA as follows:

12.73 For a person to be subject to CPA they must have a severe mental disorder (including personality disorder) with high degree of clinical complexity as described below –

- *Current or potential risk(s), including:*
  - *Suicide, self harm, harm to others (including history of offending)*
  - *Relapse history requiring urgent response*
  - *Self neglect/non concordance with treatment plan*
- *Vulnerable adult; adult/child protection e.g. –*

[77] Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

[78] 2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* - Version 4.2

  - *exploitation e.g. financial/sexual –*
  - *financial difficulties related to mental illness*
  - *disinhibition*
  - *physical/emotional abuse*
  - *cognitive impairment*
  - *child protection issues*
- *Current or significant history of severe distress/instability or disengagement*
- *Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs - misuse, learning disability*
- *Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies*
- *Currently/recently detained under Mental Health Act or referred to crisis/home treatment team*
- *Significant reliance on carer(s) or has own significant caring responsibilities*
- *Experiencing disadvantage or difficulty as a result of:*
- *Parenting responsibilities*
  - *Physical health problems/disability*
  - *Unsettled accommodation/housing issues*
  - *Employment issues when mentally ill*
  - *Significant impairment of function due to mental illness*
  - *Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices);*
  - *sexuality or gender issues*

- *Disadvantage or Difficulty as a result of -*
  - *Parenting Problems*
  - *Physical health problems/ disability*
  - *Unsettled Accommodation*
  - *Employment issues*
  - *Significant impairment of function*
  - *Ethnicity, sexuality, or gender issues*

12.74 The Trust's Care Management/Care Programme Approach Policy[79] outlines minimum care standards for those subject to, and not subject to, CPA, as follows:

12.75 Standard 7 Minimum requirements for on CPA

1. *A CPA Care Co-ordinator (trained, part of job description, significant part of caseload) will be identified*
2. *The CPA Care Co-ordinator will maintain contact when the service user is in hospital or prison*
3. *Comprehensive multi-disciplinary multi-agency assessment*
4. *Formal multi-disciplinary, multi-agency review at least once a year, but likely to be needed more regularly, which includes consideration of on-going need for (new) CPA support*

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[79] 2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* - Version 4.2

5. *Carers must be identified and informed of rights to own assessment*
6. *A thorough risk assessment including the service user/s and carer/s must be made before a decision is made that (new) CPA is no longer required*
7. *A current overarching care plan should be maintained throughout the person's journey though the services*
8. *Details of who is responsible for addressing elements of care and support*
9. *Copies of the plans should be offered to the service user and given to his or her GP and any other significant care provider, including carers if appropriate. This is recorded on the Rio (*electronic care record system*) care plan distribution list*
10. *HoNOS ratings will be completed at significant points as per HoNOS policy*.

12.76 Standard 8 Minimum Standards for service users 'Not on CPA'

1 *They will have a named 'Care Coordinator' (Lead Professional) who will manage their care*
2 *Their care will need to be planned and recorded on the appropriate letter and distribution recorded*
3 *Regular assessment of need for clinical care and treatment, including risk assessment*
4 *An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)*
5 *When the care is reviewed there should be a reassessment of the need to assess whether they may need to go on to CPA*
6 *Self-directed care, with some support if necessary*
7 *Carers' assessments will still be offered as a standard item.*

Comment

12.77 Mr C was not put onto CPA until his admission in November 2009. It is the view of the independent investigation team that Mr C met the national and local criteria for CPA from his first contact with the GRIP team in August 2009, and that this should have been applied at the earliest opportunity. The rationale for not caring for Mr C under CPA was that he was still subject to ongoing assessment to determine what impact his drug use had had on his mental health. However his core assessment had been completed and he was displaying ongoing psychotic symptoms and complex needs. Having said that, it is the view of the independent investigation team that even if Mr C had been put on CPA after the completion of the Core Assessment it may not have made any difference to the care provided. However, under this framework Mr C's care would have been formalised and subject to more rigorous standards and audit.

12.78 Mr C was put on CPA when admitted for a respite admission to the inpatient unit in November 2009 and had his first CPA review in January 2010 whilst still an inpatient.

12.79 A discharge CPA meeting was arranged for the 23rd of February 2010. Mr C was to be discharged prematurely due to challenging behaviour. However this CPA meeting was cancelled due to the consultant psychiatrist's non availability and Mr C was formally discharged in his absence on 22nd February 2010.

12.80 The inpatient unit Operational Policy[80] states with regard to CPA:

12.81 Users will be subject to the enhanced level care plan and this will be circulated with permission of the service user to all those involved in their care.

*12.82 CPA reviews will be held at each critical point on the user care pathway, within a month of admission midway through their stay at the unit and again on discharg*e.

12.83 The Operational Policy[81] also states, with regard to the GRIP team's involvement with services users whilst inpatients at the unit:

12.84 ''Consultant responsibility remains with the GRIP Consultant.

12.85 Care coordination will be active during admission and provide in reach and attend reviews to promote consistency in care for the user''

12.86 The CP from the GRIP team had Care Coordinator responsibility for Mr C whilst he was an inpatient. Her role had changed from Lead Professional to Care Coordinator due to Mr C being subject to CPA following his admission to hospital. However she had no knowledge that he was going to be discharged early due to his challenging behaviour and did not become aware of this until after he left.

The unit Operational Policy[84] made it the responsibility for responding to increased clinical risk, and clinical risk assessment, clear for inpatient service users:

'The care co-ordinator is responsible for risk assessment. Service users residing at the unit are low to medium risk patients. If risk levels rise then it is the responsibility of the care co – coordinator and named nurse to organise a meeting with the appropriate professionals within a twenty four hour period maximum'.

Mr C's clinical risk assessment was not updated prior to his discharge from the inpatient unit. It was the responsibility of his Care Co-ordinator, the CP, to do this. However, as she was not made aware of Mr C's expedited discharge prior to the event, she was not able to fulfil this responsibility.

Comment

12.87 It is not recorded within the clinical records why the CPA review scheduled for the 23rd February 2010 was cancelled but the independent investigation team were told that this was due to the consultant psychiatrist not being able to attend. However the lack of a discharge CPA meeting prior to, or very shortly after Mr C's discharge from the unit, constituted a breach of the unit's operational policy.

12.88 It is the view of the independent investigation team that the need for a CPA review was further increased in this case due to Mr C being discharged earlier than planned, for

[80] Operational Policy (Undated)
[81] Operational Policy (Undated)
[84]

exhibiting challenging behaviours, some of which indicated behaviours that could increase clinical risk in his case e.g. cannabis usage, alcohol usage, poor compliance with care plan, ongoing active symptoms. He was being discharged home to the care of his father and stepmother and prematurely, without the knowledge of his care coordinator. Additionally, no changes had been made to his clinical risk assessment, care package or level of support provided to Mr C's father and stepmother, to reflect the potential increase in risk presented by Mr C.

12.89 On 30th March 2010, the post discharge CPA meeting was held, six weeks after Mr C's premature discharge from the unit. At this meeting, the care coordinator role was transferred from the CP to the SSW. The independent investigation team were told during the interviews that this was because the SSW had a much better relationship with Mr C than the CP did and that the CP had become progressively less involved in Mr C's care for that reason and also throughout the duration of the admission to the inpatient unit.

12.90 The independent investigation team were told during the interviews that the care coordinator role had been handed over to the SSW in its entirety and that the responsibility for clinical risk assessment, care planning and mental state and medication monitoring were handed over to him despite the SSW not being a registered mental health practitioner. The SSW was employed in the Trust at Band 4 of the Agenda for Change grading scale for healthcare staff.

12.91 The Trust's Care Management/Care Programme Approach Policy[82] states with regard to what care coordination responsibilities can be taken on by which grade of staff:

12.92 ''Band 4 Clinical Workers for those in specialist services but who are 'NOT on CPA' with Complex Care Needs providing they have;

- *An NVQ in health and social care at level 3;* ***<u>or</u>***
- *Undertaken a Associate Nurse Practitioner course;* ***<u>or</u>***
- *Equivalent experience in social/health care* ***<u>and</u>***
- *Completed the Foundations for Practice training delivered by the Trust;*
- *Have defined line management support and case management to undertake the care coordination role.''*

Comment

12.93 Mr C was on CPA at this time so the care coordination role being delegated to the SSW, an unregistered member of staff, was inappropriate and in breach of the Trust's own policy.

12.94 The independent investigation team have no doubt that the SSW is a competent professional and he clearly had a good relationship with Mr C. However it is the view of the independent investigation team that the decision to make the SSW care coordinator, left Mr C without regular monitoring from a qualified professional at a time when medication changes were being made and he was exhibiting identified risk behaviours. It also left the

[82] 2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* - Version 4.2

SSW in a vulnerable position professionally, as he was being expected to work outside of his scope of expertise and in breach of Trust policy.

Recommendations

12.95 The Trust should carry out a review of all service users on CPA to ensure that their Care Co-ordinator has the appropriate qualification, skills and experience to take responsibility for the management of their case.

12.96 The Trust should carry out a review of all service users who are currently not subject to CPA to ensure that they do not meet the stipulated criteria for CPA.

12.97 The Trust should carry out an audit of all discharges from inpatient settings to ascertain that discharge planning meetings took place and that they covered all the required elements.

12.98 The Trust should establish systems to ensure that when assessment tools such as Lunser, PANSS, and clinical risk assessments are completed this should be in line with care plan and findings used to inform the care plan unless a rational for not doing so is recorded in the clinical notes.

12.99 Clinical care, diagnosis and medication

12.100 In the Core Assessment document, dated 20th September 2009 it states that Mr C was not deemed to have a severe mental disorder. The rationale for this decision was given that Mr C was still subject to ongoing assessment to determine what impact his drug use had had on his mental health.

12.101 Yet, on 25th August 2009 a provisional diagnosis of drug induced psychosis had been made.

Comment

12.102 The CP told the independent investigation team that it is her belief that the core assessment was completed on 20th August 2009, not 20th September 2009 as stated on the document, which may go some way to explain why a further provisional diagnosis of drug induced psychosis was made on 25th August 2009. She states that the box in the assessment that had been marked saying that Mr C did not have a severe mental disorder had been crossed incorrectly. Nonetheless it is the view of the independent investigation team that Mr C's diagnosis of drug-induced psychosis, made on 25th August 2009, appears to have been made purely based on Mr C's self report with regard to his symptoms and experiences. However, in the same assessment records it is noted that Mr C stated on assessment that he had not had cannabis for the two months prior to his assessment. The independent investigation team conclude that if Mr C's statement is true and correct it means that he was not taking cannabis at time of the incident in which he stabbed a friend in the face with a pen. Even if he was taking it, as other reports suggest, this does not prove that the cannabis caused the psychotic symptoms leading up to the incident especially as he was reporting ongoing

psychotic symptoms since moving to his father's home in Gloucestershire, after which all agreed he was taking no cannabis. The assumption that the incident was caused by cannabis use forms the basis of Mr C's risk assessment and diagnosis so, if not correct, all actions and treatment arising from it may not have been appropriate.

12.103 It is the view of the independent investigation team that Mr C showed clear unequivocal evidence of ongoing serious psychotic symptoms and multiple risk factors at the point that his provisional diagnosis was made in August 2009, and, given Mr C's statement that he had not taken cannabis for the previous two months, the assumption that his psychotic symptoms were potentially purely drug induced or drug related, particularly without premorbid information being gained from Mr C's mother, is not reasonable.

12.104 Mr C commenced taking Aripiprazole on 22nd September 2009. He had an abnormal blood test regarding his liver function the following day on 23rd September 2009. It was stopped for this reason on 25th September 2009.

12.105 On 18th January 2010 a letter from SPR in Gastroenterology reports that Mr C "states that all his problems started after he had been binge drinking for quite some time of approximately 20 beers and spirits at weekends" as well as noting history of frequent cannabis use. The clinical notes report improvement in Mr C's liver function whilst taking Sulpiride.

Comment

12.106 Mr C had an abnormal result regarding his liver function in August 2009 but this had become worse when tested on 22nd September 2009. Mr C reported on 22nd September 2009 that he had consumed eight pints of beer the night before.

12.107 It is not possible for the independent investigation team to know the reason for Mr C's impaired liver function. However the independent investigation team is of the view that it is possible that Mr C's ongoing alcohol use may have been the cause, or a contributing factor and that this should have been considered and explored further.

12.108 It is clear and documented that Mr C continued to show and describe multiple active psychotic symptoms including paranoid thoughts about "friends" both whilst waiting to go to the unit and whilst there. The concerns that he might have Wilson's disease led to a very slow increase in usage of Sulpiride so that even by the time he left the unit he was only on 25% of the maximum daily dose.

Comment

12.109 The independent investigation team accept that caution in increasing use of psychotropic medication was appropriate in this case, but are of the view that the test results should have been accessed sooner given Mr C's ongoing symptoms.

12.110 On 4th February 2010 Mr C's Sulpiride was increased to 600 mgs per day.

12.111 On 14th February 2010, the inpatient care plan states that the plan for Mr C was to continue his hospital admission for one month and that the goal was for Mr C to self medicate safely

and gradually starting 17th February 2010 However Mr C was discharged from the unit on 22nd February 2010.

12.112 On 20th May 2010, Mr C's stepmother contacted the CP to raise concerns regarding Mr C's alcohol misuse and said that he was due to go to his mother's home in a few days but they did not want him to. She said that on one occasion, Mr C had consumed nearly four bottles of wine and had then been violently sick in middle of the night. Later the same day, following this conversation, Mr C was seen by the consultant psychiatrist. Mr C said that he was spending much time doing nothing, had trouble thinking straight, was hearing voices in his head, experiencing transient thoughts of self harm, and had had an episodic pattern of binge drinking. The clinical records show Mr C had a restricted affect during the interview and was mumbling and appeared bored and distracted. As a result of this consultation, Mr C's antipsychotic medication was changed to Risperidone 2 mg increasing to 4mg and his Sulpiride 600mg to continue for one week, then halved for a week, then stopped.

Comment

12.113 The independent investigation team found no evidence to suggest that a discussion regarding the risks and benefit of this change and the changeover issues took place between the care team or with Mr C or his family at this time.

12.114 Given Mr C's apparent loss of confidence in his treatment, the independent investigation team is of the view that a change to a different type of antipsychotic medication at this time was reasonable. However the documentation regarding the change, particularly the risk information given to Mr C and his family, was inadequate. Given evidence of previous poor compliance with medication, previous problems with Aripiprazole, and rapid deterioration if doses were missed, a changeover was a period of increased risk. However there does not appear to have been any extra support put in place to manage this increased risk.

12.115 At interview the independent investigation team were told that depot antipsychotic medication was considered at this time for Mr C, due to known non-concordance risks, and Risperidone was chosen to facilitate this as it is available in depot form if needed.

Comment

12.116 The independent investigation team is of the view that this decision was reasonable but it is not recorded in the records. The independent investigation team is of the view that the changeover plan from Sulpiride to Risperidone for Mr C was not unreasonable for someone with good concordance with their medication. However this had not always been the case with Mr C and he was about to spend time at his mother's home, where he had previously not taken medication as prescribed, and the team had not engaged her in any way to seek her support with this change.

12.117 It is apparent from the notes that the GRIP team did have contact with Mr C's mother after she approached them by telephone. On 28th May 2010 a telephone discussion took place with Mr C's mother. The clinical notes show that she stated she was keen to help give Mr C support, including support with his medication.

Comment

12.118 The independent investigation team found no evidence to suggest that the opportunity was taken to gain a proper history from his mother regarding Mr C's symptoms prior to moving to Gloucestershire or whether any risks associated with the medication or the change in medication were discussed with her.

12.119 On 15th June 2010 the clinical records show that Mr C was back from his mother's home. He said he had enjoyed his time there but did not elaborate. He said that he took his medication as prescribed. The records show that Mr C appeared low in mood, distracted and preoccupied, but would provide no feedback on his mental state.

12.120 On 22nd June 2010 Mr C reported to the physiotherapist that he was feeling reasonably bright and generally better since changing medication. His father and stepmother reported an improvement in his mood and motivation since changing medication but said that he was not interacting well with people.

12.121 On 28th June 2010 Mr C's stepmother contacted the GRIP team to report that Mr C self-harmed using a kitchen knife three days previously. She stated that Mr C told his father it was due to being low in mood. Mr C was visited at home by the SSW, on 29th June 2010, following the contact with Mr C's stepmother. The clinical notes state that the SSW found Mr C to be warm, welcoming and talkative about his past, stating he felt he had many issues to address but that he was not ready to do so yet. The SSW described Mr C's self harm wounds in the clinical notes as being on the left arm and ''*superficial*". It is recorded that Mr C found it hard to talk about it and felt that he was *"just being stupid*''. Mr C reported he would tell his father or stepmother should he feel unsafe again in any way.

12.122 At interview, the independent investigation team were told that Mr C's father and stepmother told the SSW that they had guests on the day that Mr C cut himself. They were in the garden and they felt him cutting himself was in an attempt to gain attention.

12.123 The independent investigation team were told at interview that the SSW discussed this incident with the team and an earlier visit was arranged to Mr C, but no changes were made to the care plan or risk assessment as a result.

Comment

12.124 The independent investigation team have found no evidence to suggest that Mr C had ever actively harmed himself prior to this incident and that therefore this action was potentially indicative of a deterioration of mental state and/or increased clinical risk. It is the view of the independent investigation team that this incident should have been taken more seriously, despite the fact that the scratches Mr C administered to himself were described as being like "cat scratches" and that he should have been assessed by a qualified practitioner and his clinical risk assessment updated accordingly.

12.125 Additionally, the independent investigation team is of the view that the SSW should not have been expected to monitor Mr C whilst undertaking a change of medication and make judgements about the severity of the self-harm incident and its potential meaning in terms of Mr C's mental health and clinical risk.

Recommendation

12.126 The Trust should ensure they have a method of assuring themselves that when new medications are prescribed to service users, their risks and benefits are clearly explained to service users and carers.

12.127 Clinical care at the inpatient unit

12.128 In November 2009 there were email exchanges within the GRIP team as Mr C's father and stepmother were going on holiday for a week in December and it was their view, and the view of the GRIP team, that Mr C could not stay at his father's home on his own for a week. It was agreed that he would stay at the unit for a period of respite care whilst his father and stepmother were on holiday.

12.129 On 28th November 2009, Mr C was admitted informally for a three weeks respite admission and to assess his mental state and functioning with a view to treatment and intervention. Mr C actually remained an inpatient, apart from periods of home leave, until he was discharged prematurely for exhibiting "challenging behaviour" on 22nd February 2010.

Comment

12.130 The possibility of supporting Mr C at home during the period that his family were away on holiday was not explored by the care team.

12.131 It is the view of the independent investigation team that modern treatment emphasis is on treating people as close to home as possible and in Mr C's case, by this stage, this meant his father's home.

12.132 Removing someone from such an environment and admitting them elsewhere carries risks. It may also deliver benefits. The decision to admit should be underpinned by a good risk assessment and be clear about how the benefits will outweigh the risks.

12.133 Mr C was admitted to an inpatient facility used by the GRIP team based in a house in the community, rather than to the local acute psychiatric inpatient facility, as it was seen as "less stigmatising".

Comment

12.134 The independent investigation team is of the view that the clinical records and discharge summary make it clear that despite the initial plan for Mr C to remain in the unit for three weeks whilst his family were on holiday, over time no one was clear of the purpose or expected duration of the admission, e.g. Mr C was documented as only agreeing to a one week stay. The independent investigation team were told during the interviews that this may have been to do with risks of self neglect but this was not clear. The independent investigation team were also told during the interviews that Mr C was going to an inpatient facility as it provided respite for the family and would enable assessment and a ''technical overview of his case because he was a bit chaotic and difficult to get a grip on''.

12.135 The discharge letter written when Mr C was discharged from the unit referred to the fact that there had been 'mission drift' during Mr C's stay.

Comment

12.136 The independent investigation team received no clear rationale as to why home treatment could not have been tried for Mr C and formed the general opinion from the information given by interviewees and the clinical notes, that Mr C was admitted was available. The GRIP team's risk assessment for Mr C deemed him to be 'low risk' and if this was indeed the case, the independent investigation team is of the view that the fact that they felt the need to admit Mr C to an inpatient facility as he could not be left at home during his family's absence seems incongruent with this assessment.

12.137 There were issues of Mr C's heavy alcohol use and non-concordance with medication from the very early days of Mr C's admission.

12.138 On 21st January 2010, the MDT review form notes that Mr C needed firm boundaries as "at times behaved in a tormenting and inappropriate manner towards female patient".

12.139 Later, in February 2010, Mr C admitted to cannabis use and the independent investigation team were told at interview that there were concerns that he was obtaining it for other patients.

12.140 Mr C's clinical risk assessment, completed in September 2009, states:

12.141 "should he become psychotic again in the future, this would cause this risk to significantly increase. However at this time it appears that his symptoms of psychosis were related to cannabis use and he's currently abstaining from this.[83]

Comment

12.142 The independent investigation team is in no doubt that Mr C's behaviour and clinical presentation whilst at the inpatient unit was challenging. However, it is the view of the independent investigation team that the behaviour that Mr C was exhibiting, cannabis and alcohol use and his ongoing psychosis, indicated increasing clinical risk. The independent investigation team found no evidence to suggest that at any point between referral to GRIP team, and the attack on his stepmother did Mr C make a significant sustained recovery from his illness. There is repeated clear documented evidence of ongoing and recurrent psychotic symptoms, including during time periods when all agree that he was not using cannabis, so the criteria set in the above statement for there being significantly increased risk were met.

[83] Risk Assessment, September 2009

Recommendation

12.143 The Trust should ensure that where a risk assessment has identified circumstances in which risk is predicted to increase, and those circumstances occur, the care plan should clearly identify what actions are being undertaken to address those risks.

12.144 It is understandable to the independent investigation team that this behaviour may have been difficult for staff at the inpatient unit to manage, given the environment and conditions in which they were providing care.

12.145 The clinical records indicate that staff reported Mr C's mental state as having deteriorated in the few weeks prior to discharge, which they attributed to cannabis use, and that the reason for his exclusion from the unit was concern over him supplying cannabis to other vulnerable people, and that his admission had not worked.

Comment

12.146 It is the view of the independent investigation team that this combination of concerns and risk factors should have prompted an escalation of the plan and consideration of admission to an acute psychiatric unit rather than his exclusion from inpatient services without a pre-discharge CPA review or communication with the GRIP team or Mr C's gather or step mother. This may have necessitated an assessment of Mr C under the Mental Health Act[84] if he had refused admission to an acute psychiatric hospital on a voluntary basis. The independent investigation team cannot speculate as to what the outcome of an assessment would have been but Mr C clearly met the criteria for the instigation of such an assessment had the need arisen.

12.147 Even if, following this, it was decided that the best option was for Mr C to go home, a robust aftercare plan should have been put in place with the agreement of Mr C, his family and the GRIP team.

Recommendation

12.148 The Trust should ensure there are processes in place so that the collaboration and communication between inpatient settings and community teams with regard to shared service users can be demonstrated and audited.

12.149 Medication Concordance

12.150 Mr C's compliance with prescribed medication was a key issue as his concordance with antipsychotic medication was erratic throughout his care. The independent investigation team found no evidence that Mr C's actual lack of concordance was explored with him in any meaningful manner. Concordance with any form of psychotropic medication is often poor and the GRIP team relied heavily, in Mr C's case, on his family ensuring that he took his medication. They attempted to do this but were unaware that a few days prior to the homicide, he had been disposing of his Risperidone.

[84] Mental Health Act 1983

Comment

12.151 It is the view of the independent investigation team that where there is evidence of erratic concordance with medication, it is unacceptable to rely on family members to ensure that medication is taken as prescribed if this is used as a sole strategy to address this issue. The independent investigation team believe that this approach can be helpful in the short term to assist in this process, as an additional protective measure whilst other strategies are being implemented, but that in Mr C's case, additional measures should have been implemented by the GRIP team to attempt to educate Mr C in the longer term to become more self sufficient and self medicating.

12.152 In the Journal of Psychopharmacology[85] it states:

12.153 "Factors that may impact negatively on adherence to antipsychotics are illness-related factors such as delusions, disorganisation and depression, having a poor relationship with the prescriber, denial of illness, negative attitudes towards medication from family members or peers, having co morbid substance misuse problems and being young and male (Bebbington, 1995; Mutsatsa et al., 2003; Perkins et al., 2008; Valenstein et al., 2006)"

12.154 Barnes et al recommend the following to improve medication adherence by service users:

- *Where possible offer a choice of medication, based on the known relative liability for adverse effects. Take into account the known adverse effect profiles of individual antipsychotics, a patient's past experience of adverse effects, and the risk of drug interactions and past medical history.*

- *Wherever possible, the prescriber should agree jointly with the patient on the choice of, and desired outcomes from pharmacological treatment and how these can be achieved.*

- *The medication regimen should be kept as simple as possible with respect to both the number of tablets to be taken and the number of times each day.*

- *The efficacy of medication should be monitored and any identified side effects should be actively managed as appropriate.*

- *The patient should be asked at regular intervals how much of their medication they have taken in the last week, and their view sought regarding the efficacy of this medication.*

- *Consideration should be given to using one of the validated rating scales or checklists to assess a patient's attitudes towards medication.*

[85] Thomas RE Barnes and the Schizophrenia Consensus Group of the British Association of Pharmacology (2011) Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association of Pharmacology. *Journal of Psychopharmacology,* May 2011, 25(5), pp.567-620

- *In patients with a history of non-adherence leading to relapse, consideration should be given to using more objective methods to monitor adherence to oral medication regimens such as pill counts, and for some antipsychotics, plasma drug levels.*

- *A depot/long-acting injection formulation should be considered when this is preferred by the patient, previous non-adherence has led to frequent relapse or the avoidance of non-adherence is a clinical priority.*

- *Interventions to improve adherence should be patient specific, in that they should target the barriers to achieving adherence as perceived or noted by the clinical team to be present in that patient.*

Recommendation

12.155 The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to management of service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.

12.156 Psychological therapies

12.157 National guidance on the treatment of psychosis[86] states that mental health services should:

- *Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase 2 or later, including in inpatient settings.*
- *Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including inpatient settings.*

12.158 It is noted in the inpatient care plan dated 4th February 2010 that a referral to a psychologist may be appropriate but that Mr C was still thought disordered.

12.159 Other than the reference in the inpatient care plan dated 4th February 2010, the independent investigation team found no evidence of any attempt to discuss engaging Mr C in psychological therapy at any time.

Comment

12.160 Psychological input as part of guidance is essential but guidance does not say when it should occur. Given difficulties in getting Mr C onto an adequate dose of medication and the various problems identified, it is the view of the independent investigation team that this is a case where one would have expected psychological therapy to be actively considered from September 2009. This is particularly relevant in this case as without some form of effective treatment, the duration of untreated psychosis was simply being extended. The external investigation team found no written rationale as to why psychological therapy was not actively pursued with Mr C other than the offer of family therapy at the CPA meeting in

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[86] National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.* (CG82)

March 2010, which he declined. The CP told the independent investigation team that psychological input was implicit in her work with him as a CP but that it was her view that Mr C was not ready for formal psychological therapy. The independent investigation team accept that this may well have been the case and also recognise that acceptance of psychological therapy is subject to the same consent requirements as for any other form of intervention but if offered and refused, or if service users are not mentally well enough for formal psychological therapy, this should be documented and taken into account in risk assessment and care planning.

Recommendation

12.161 The Trust should ensure that psychological therapies are offered to all service users diagnosed with psychosis in line with the NICE Schizophrenia Guidance 2009.

12.162 Communication with the family and consent to the sharing of information issues

12.163 A Consent to Sharing Information form was completed and signed by Mr C in August 2009, agreeing to information sharing with his parents with no restrictions. The form also details that Mr C asked for copies of all correspondence written about him by members of his healthcare team.

12.164 There is another Consent to Sharing Information form in the clinical notes, which is dated 11th February 2009. The date on this form cannot be correct as Mr C was not known to the service at that time. This document names Mr C's father as someone with whom information could be shared but restricts sharing "anything that isn't crucial i.e. anything that doesn't concern Mr Cs mental wellbeing". The form is not signed or witnessed.

12.165 At no time did clinicians have any contact with Mr C's mother until she contacted the CP in the GRIP team on 21st May 2010 after being told by Mr C's father that Mr C was in receipt of mental health services.

12.166 Handwritten notes made in November 2009 by the SSW state that Mr C was "expressing odd ideas" regarding his stepfather and mother and that he felt they were opposed to the GRIP service and did not feel that Mr C was ill. Potential concordance risks and possible risk to stepfather due to Mr C's anger towards him was noted.

12.167 Inpatient notes written in February 2010 show that Mr C's father called the inpatient unit to say he had had a call from the college, which Mr C had a place at two days each week, stating that Mr C had not been attending. Mr C's father was upset about this. When Mr C's father contacted the unit about this he was told that they could not discuss it due to patient confidentiality as Mr C had not consented to share any information that did not concern his mental health.

12.168 The Trust's Care Management/Care Programme Approach Policy[87] states in Standard 21, Consent to Share Information:

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[87] 2gether NHS Foundation Trust (2008) *Care Management/Care Programme Approach (CPA) Policy* - Version 4.2

12.169 At the point of entering secondary specialist services the service user will –

- *Have the need for consent to share information explained to them*
- *Asked to complete the Trust approved consent to share information form*

12.170 The consent to share information form will be checked on a regular basis, but at least-

- *Annually*
- *On admission to hospital*
- *On transfer to a new team or service*

And

12.171 Where a service user states that information should not be shared with a close family member, agency or other person who has a legitimate need to be kept informed of some aspect of his/her health, mental health workers are responsible to:

- *Ensure that the service user has considered the pros and cons of the decision without seeking to influence;*
- *Regularly confirm the service user's wishes;*
- *Document these discussions in the health record;*
- *To continue working with a carer and family even when there are Consent to Sharing concerns.*

Comment

12.172 Mr C's father and stepmother were very supportive and involved in Mr C's care but were not in a position to provide the detailed historical information regarding Mr C's past presentation generally, and more specifically prior to the incident where Mr C stabbed his friend in the face with a pen and then went missing for three days.

12.173 The clinical team were aware that Mr C had lived with his mother for the majority of his life and that he went to stay with her, often for a few days at a time, on a very regular basis. Concerns about Mr C "expressing odd ideas" regarding his stepfather and mother, potential medication concordance risks and possible risk to his stepfather due to Mr C's anger towards him, was noted in November 2009 but was never communicated to Mr C's mother, or explored with her, despite him going on leave to her home on a regular basis.

12.174 Staff involved in the care of Mr C were asked about the rationale for not contacting Mr C's mother during interviews and the team was told that they felt that Mr C had not consented to sharing information with his mother. This, however, is not the case. Mr C very clearly completed a Consent to Sharing Information form in August 2009 giving staff consent to talk to both of his parents about his care.

12.175 There is another Consent to Sharing Information form in the clinical notes, which is dated 11th February 2009. The date on this form cannot be correct as Mr C was not known to the service at that time. This additional document names Mr C's father as someone with whom information could be shared but restricts this by not allowing sharing "anything that isn't

crucial i.e. anything that doesn't concern Mr Cs mental wellbeing". The form is not signed or witnessed.

Recommendations

12.176 The Trust should review the Consent to Share process and ensure that all care coordinators and lead professionals are competent in its use.

12.177 The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which consent to share and confidentiality restrictions should be overridden.

12.178 National guidance regarding Schizophrenia[88] states with regard to carers:

12.179 "*When working with carers of people with schizophrenia:*

- *provide written and verbal information on schizophrenia and its management, including how families and carers can help through all phases of treatment*
- *offer them a carer's assessment*
- *provide information about local carer and family support groups and voluntary organisations, and help carers to access these*
- *negotiate confidentiality and information sharing between the service user and their carers, if appropriate*
- *assess the needs of any children in the family, including young carers".*

12.180 Mr C's father told the independent investigation team that he was never informed of a clear diagnosis for Mr C and was not at any time told about Schizophrenia or involved in any clinical risk assessment process.

Comment

12.181 It is the view of the independent investigation team that the inpatient unit team and GRIP team should have discussed Mr C's diagnosis and treatment plan with Mr C's family and involved them in the clinical risk assessment process on the basis that Mr C had consented to the sharing of information and that his father and stepmother were actively involved with his care planning and support.

12.182 The Trust should ensure that clinical staff are aware of their obligations to involve and inform carers and should develop a structured framework to ensure that this occurs and that performance can be measured.

[88] National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.* (CG82)

12.183 Mr C's father does not recall taking part in a Carer's Assessment or being informed of the outcome. Additionally, there is no evidence available to suggest the Mr C's mother was ever offered a carer's assessment despite her having Mr C to stay at her home on a regular basis.

Recommendation

The Trust should ensure that all eligible carers are offered a carer's assessment in line with the Carers Act 2004, and that the outcomes of assessments are clearly explained to them

13.0 THE INPATIENT UNIT

13.1 The inpatient unit where Mr C received care was a six bedded unit, called The Vron, that provided care for service users of the GRIP team in a large converted house in a residential area. It closed down in October 2010.

13.2 The unit Operational Policy[89] stated;

13.3 ''The unit is a Community in Patient early intervention recovery unit for users with early episodes of psychosis between the ages of 16 to 35. The unit offers separate Trust wide access to age appropriate in patient facility for young people. The location in the community offers opportunity to engage with the local community served. The aim is to provide a user centred seamless service integrating with adult services, CAMHS, Youth education, and other services. There are close links to the County wide Early Intervention GRIP Team (Gloucester Recovery in Psychosis). The unit aims to reduce DUP (Duration of Untreated Psychosis), reduce stigma, social disability, unemployment and suicide through increasing meaningful engagement. Best practice treatment and recovery in early stages of psychosis is offered to create or restore increase stability in the lives of users, their families and carers''.

And

13.4 ''The unit will be used as an alternative to the main hospital and will offer admission and respite care for individuals expressing psychotic episodes low to medium risk of self and others and high risk of self neglect. It is acknowledged that it is not always possible for the user to stay at home. The team will collaborate and involve service users at all times during the referral and admission process. Length of stay will be discussed on referral with the user, length of stay will not usually exceed six months. The key aspect of the unit is to increase social functioning and symptom awareness within an environment which users of the service feel is easier to engage in. The focus is upon working in collaboration with the user to work towards heath improvement or getting the user better and home.''

13.5 The unit statement of purpose was listed as;

- *To provide a user centred, seamless service for GRIP users between 16 – 35 years with first episode psychosis*

[89] Operational Policy (Undated)

- *Best practice principles will be adhered to in admitting young people between the ages of 16 to 18. Consideration will be given to link with CAMHS / GRIP*
- *To offer an age appropriate alternative to hospital within a community setting Head Space tool kit information leaflet is given to the young person if transferred under section. Notification would be given to the commissioners, PCT*
- *To provide a non stigma and socially inclusive environment*
- *To reduce the length of time young people remain undiagnosed and untreated within an in – patient facility*
- *To develop meaningful engagement providing evidence based interventions and to promote recovery during the early phases of illness within a community setting*
- *To increase self esteem, self worth and self efficacy*
- *To provide respite facility*
- *To ensure the referral process is user friendly and referrer*
- *friendly to ensure that there is not unnecessary waits*
- *To offer consultancy, support and advice to others teams in contact with users*
- *To develop programmes based on need*
- *To offer placement to users who will be able to benefit from a placement*
- *To actively engage users who wish not to be admitted but are willing to engage and attend during the day.*

13.6 The independent investigation team were told during the interviews that the senior management arrangements were altered in the Trust in January 2010 as part of a reorganisation process. This resulted in the unit coming under the same management as the acute psychiatric inpatient setting and the Crisis Resolution Service.

13.7 The independent investigation team were told that the senior manager who acquired the unit as part of their new portfolio in January 2010 stated that as she sought to understand the role, function and efficacy of the unit as she was unclear as to its purpose and had concerns about the efficacy of the stand alone isolated unit and their ability to adequately assess and manage clinical risk in these circumstances. The unit was dependent on emergency police or ambulance assistance in the event of a health emergency or an incident of violence. Additionally, as the building was a converted house in the community, levels of observation and the ability to minimise ligatures were compromised.

13.8 The new manager also had concerns that this was not a suitable environment to nurse service users of both sexes. Staffing numbers and the physical environment made the management of this difficult.

13.9 The independent investigation team were told at interview that in view of these concerns, the newly responsible senior manager for the unit felt that the risks posed by nursing this specific client group within the unit were potentially too high for the Trust, or indeed herself as a manager, to endorse the continuation of its use for that purpose. These concerns were reported to the Trust and the unit was closed in October 2010 as a result.

13.10 The manager concerned reported to the independent investigation team that prior to the closure, the unit was functioning with an average of 80% occupancy and that there were often service users on leave or engaging in community activities which meant that the

numbers of service users in the unit at any one time was generally low. She told us that the service users that previously would have been cared for at the unit who present low clinical risk would now be managed with intensive support within the community or at one of the other rehabilitation type facilities that are available in the area. Those who are more unwell and potentially represent higher levels of clinical risk are cared for within the acute mental health inpatient service at the local acute psychiatric inpatient unit.

Comment

13.11 The independent investigation team were unable to ascertain details of how the unit originated and what the original commissioning arrangements were, including how the environmental and functional clinical risk and mixed sex issues were adequately addressed in the business plan. There is no doubt that the unit was intended to provide pleasant, normalised surroundings in a community setting. The independent investigation team acknowledge that the original intention of the unit was to provide care in an environment that was less intimidating and stigmatising than an acute care setting for the young people it was designed to care for. The independent investigation team agree that the unit was not fit for purpose to provide care for young people with acute psychosis and with associated clinical risks. The independent investigation team commended the senior manager who, after becoming responsible for the unit, was quickly able to ascertain this and take swift action in escalating her concerns and the Trust for acting on these without delay.

It is not possible for the independent investigation team to make an accurate judgement about how relevant the incidents that occurred at the unit were, and whether these, and Mr C's premature discharge, from the unit contributed to the eventual outcome. It is the view of the independent investigation team that Mr C's discharge from the unit, in itself, may have been appropriate given the detrimental effect that being in the unit seemed to be having on his mental health. However, this discharge should have been carried out within the framework of appropriate CPA procedures, communication between the inpatient unit staff and GRIP staff, communication wit the family, and a review of the clinical risk assessment and community care package.

14.0 REVIEW OF THE INTERNAL INVESTIGATION

14.1 The Trust's internal investigation report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria*"[90]. The Trust's internal report did not score well against the criteria. The main reason for this was that the investigation was limited in its scope. The report did not contain information relating to the care and support of the victim's family or the perpetrators family, liaison with police or use Root Cause Analysis methodology.

14.2 The National Patient Safety Agency (NPSA) issued guidance in 2008[91]outlining the investigation process that should take place following a serious patient safety incident.

[90] National Patient Safety Agency (2008) *RCA Investigation Evaluation Checklist, Tracking and Learning Log*
[91] National Patient Safety Agency (2008) *Independent Investigation of Serious Patient Safety Incidents in Mental Health*

14.3 The three stages of the independent investigation process are described in detail:

1. *Initial service management review: an internal trust review within 72 hours of the incident being known about in order to identify any necessary urgent action.*
2. ***Internal NHS mental health trust investigation:** using root cause analysis (RCA) or similar process to establish a chronology and identify underlying causes and any further action that needs to be taken. This would usually be completed within 90 days.*
3. ***SHA independent investigation:** commissioned and conducted independently of the providers of care.*

14.4 The NPSA state that when carrying out an internal investigation trusts should take into consideration the following issues, which should be addressed in local policies:

- *Management of patient safety incidents;*
- *Consent;*
- *Confidentiality;*
- *Data protection;*
- *Freedom of information.*

14.5 Depending on the nature of the incident, there may be other relevant policies such as vulnerable adult and safeguarding children policies and procedures that need to be taken into account.

14.6 An internal investigation oversight group should be established in the most serious incidents. This group should:

- *Identify senior individuals to carry out the trust's internal investigation and decide whether any other agencies or organisations need to be included;*
- *Agree a communications plan, which will include drawing up a briefing paper for the trust board;*
- *Agree who will be the contact person for the victims, perpetrators and families;*
- *Oversee the internal investigation;*
- *Liaise with the SHA so that discussions about the potential need for an independent investigation occur early;*
- *Include the commissioning PCT in discussions;*
- *Liaise with the police, and through the police the Crown Prosecution Service (CPS), to determine how the investigation will take place without compromising any legal process.*

14.7 Reference should also be made to the DH/ACPO/HSE Memorandum of Understanding at this stage. If the Memorandum is invoked then an incident co-ordination group comprising senior stakeholders should meet to ensure co-ordination of investigations and communications. The membership of the internal investigation oversight group and the incident co-ordination group will have some overlap, although their functions differ.

14.8 The internal investigation should be completed as soon as possible after the event, usually within 90 days. It is important that this process takes place promptly so that any changes

needed to policy or practice to enhance patient safety can be made and the independent investigation, if there is to be one, is not delayed. This process is a necessary precursor to the independent investigation. It will ensure that early action can be taken where needed, within a timescale in which it would not be feasible to have commissioned and completed an independent investigation. It is also a means of informing the scope and terms of reference for the independent investigation.

14.9 A systematic approach to investigation, such as RCA, should be used (see appendix 3 and the NPSA website for further details on RCA). The staff conducting the investigation should be of appropriate seniority and fully trained in the techniques used.

14.10 The internal investigation should follow the process described below:

1. *Scope the incident, and decide how far back to investigate.*
2. *Decide on the terms of reference.*
3. *Gather information and map events, including developing a detailed chronology.*
4. *Analyse the available information to determine any underlying causes.*
5. *Recommend solutions, for example, potential changes to the environment, practice, policies, procedures or staff.*
6. *Produce a final report outlining clear and sustainable recommendations.*

14.11 Investigation process

14.12 After being informed of Mr C's arrest, a meeting was held in the Trust on 5th July 2010[92] chaired by the Chief Operating Officer, to review the initial information that had been assimilated and to determine the next steps. The meeting was attended by the senior clinicians involved in Mr C's care prior to the incident.

14.13 Consultant Psychiatrist Two told the meeting that she had seen Mr C since he had been in police custody and that he had a flat affect, was floridly psychotic and that he had stopped taking his medication four days before the incident. Mr C had told her that his father had been giving his medication to him but that he had been disposing of it. He said he had not used cannabis for a few weeks. Mr C told Consultant Psychiatrist Two that he liked his stepmother. He also said he heard his friend's voice telling him mainly good things, that he has had urges to stab in the past but could control this, but that the previous day he heard his father's voice telling him to stab and he acted on it.

14.14 Consultant Psychiatrist Two said she and the CP had seen Mr C and initially felt that he was unfit to be interviewed due to his mental health. This opinion was changed following consultation with another Consultant Psychiatrist in the Trust.

14.15 Arrangements for supporting staff were made and it was agreed that the CP would contact Mr C's father.

14.16 It was agreed that the Community Service Manager would do a preliminary report within ten days of the meeting.

[92] Meeting minutes, 5/7/2010

14.17 The Trust policy for the Management of Serious and Untoward Incidents[93] states;

14.18 An initial executive management team meeting is called to coordinate a response and develop a communication plan

And

14.19 The Service Director/Associate Medical Director will be responsible for commissioning a preliminary report, including a tabular timeline (staff trained in root cause analysis techniques can advise on this process) and submitting this to the Medical Director, Director of Quality and Performance (Nursing, Social Care & Therapies) and Chief Operating Officer within 5 working days.

[93] 2gether NHS Foundation Trust (2009) *Policy and Procedure for Reporting Incidents including Policy for the Management of Serious and Untoward Incidents*

Comment

14.20 On receipt of the information that Mr C was in police custody, the Chief Operating Officer at the Trust convened this meeting quickly and identified an initial investigator to complete the preliminary report within the timescales specified in the Trust policy.

14.21 The Community Services Manager completed a report and a tabular timeline detailing the care received by Mr C after review of Mr C's clinical notes. This was then submitted to the Medical Director within the agreed two week timescale.

14.22 The Trust policy for the Management of Serious and Untoward Incidents[94] states that the preliminary report will include the following components;

- Background
- Purpose
- Introduction
- Review process
- Contributory factors
- Outcome
- Involvement and support of service users/family
- Support provided to staff
- Tabular timeline
- Initial recommendations

14.23 The National Framework for reporting and Learning from Serious incident requiring Investigation Guidance[95] states;

14.24 The identified team must have no conflicts of interest in the incident concerned and must be available, possibly at short notice, to undertake serious incident investigations

Comment

14.25 The preliminary report provided by the Community Services Manager did not contain the required components outlined within Trust policy and comprised only of a report stating what care Mr C had received and a tabular timeline. The independent investigation team were told at interview that it was the view of the Community Services Manager that the production of a timeline was what he had been required to produce and there is no evidence known to the independent investigation team to suggest that he was at any time informed that this was insufficient.

14.26 The independent investigation team note that the Community Services Manager was the manager of the GRIP team at the time of the incident and in the days following the incident he was dealing with the incident and the staff involved from a managerial perspective and communicating with Mr C's family.

[94] 2gether NHS Foundation Trust (2009) *Policy and Procedure for Reporting Incidents including Policy for the Management of Serious and Untoward Incidents*

[95] National Patient Safety Agency (2010) *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation*

14.27 It is the view of the independent investigation team that the preliminary report completed by the Community Services Manager was insufficient and did not contain the required information or any analysis. However it is also the view of the independent investigation team that the Community Services Manager should not have been asked to complete the preliminary investigation report in relation to this case as he did not have the necessary objectivity or capacity to be able to complete this task adequately.

14.28 During the interviews the independent investigation team were informed by senior staff within the Trust that it is not normal practice to ask the manager of a service to be involved in investigating the quality of that service but as in this case the manager in question had not been in the Trust long, and was about to move to another role, that it was felt that his involvement would be appropriate. The independent investigation team does not concur with this view.

14.29 This preliminary report was not completed within five days as specified in the Trust policy. However, it is the view of the independent investigation team that this timescale is unrealistic and unachievable if all the components required within the preliminary report are to be included and to be accurate and the investigation of good quality.

14.30 The Trust policy for the Management of Serious and Untoward Incidents[96] states;

14.31 Medical Director and Director of Quality and Performance (Nursing, Social Care & Therapies) will then decide if a full internal review is required and will inform the Service Director/ Associate Medical Director of the decision. If a review is not required then the incident is closed.

14.32 In October 2010 members of the executive team in the Trust conducted interviews with the members of staff involved in the clinical care of Mr C and questioned them on the care and treatment of Mr C based on the information provided in the report and tabular timeline compiled by the Community Services Manager. All the subsequent investigation actions and staff interviews were based on the content of the tabular timeline.

Comment

14.33 The independent investigation team have identified a lack of qualitative analysis in the report and tabular timeline that was produced by the Community Service Manager. On balance the independent investigation team accept the views of those who stated that it was only ever intended to be a quick and simplistic table of key dates/events and that this would be further explored in depth, including in depth review of the records using root cause analysis and focussed interviews. It was made clear to the independent investigation team in the interviews that in this case no adequate internal investigation was undertaken and the independent investigation team accept that this explains the inadequacies of the final report which was therefore based on information that had not been subject to any analysis. The details of this will be covered later in this report.

[96] 2gether NHS Foundation Trust (2009) *Policy and Procedure for Reporting Incidents including Policy for the Management of Serious and Untoward Incidents*

14.34 On interview the independent investigation team found that staff had differing views on how the information provided in preliminary investigation reports that have been compiled by one person with a tight deadline is verified. Most interviewees felt that a review of the clinical notes and a checking of factual accuracy are completed, as a matter of course, by the Medical Director or one of his colleagues. The Medical Director verified, however, that this is not the case.

14.35 On 5th November 2010[97] a meeting was held with the clinicians involved in Mr C's care to discuss and analyse the care that he received. This meeting was chaired by the Medical Director. The observations, recommendations and identified root causes arising from the meeting are as follows;

14.36 Observations

1. *We would wish to express our condolences to the family.*

2. *There is good evidence of effective note keeping, documentation of risk assessments and appropriate inputs from team members in providing this package of care consistent with the early intervention approach.*

Comment

14.37 The independent investigation team do not concur with the view that the clinical risk assessments conducted in relation to Mr C were of good quality as the conclusions drawn were based on incomplete historical information and some assumption about the context of Mr C's risk behaviour.

3. *There is good evidence in the notes of engagement with the family and effective two way communication within the limitations of the consent to share and Mr C's and the family's expressed wishes.*

Comment

14.38 The independent investigation team concur that there was good engagement with Mr C's father and stepmother in that there was communication on an ongoing basis. Mr C's father, however, has informed the independent investigation team that he was not involved in the clinical risk assessment process or aware of the outcomes of it. He also states that he was not informed of Mr C's diagnosis or provided with education about the implications of this. Additionally, Mr C's father did not have the opportunity to be involved in pre discharge planning when Mr C was prematurely discharged from the inpatient unit due to the cancellation of the CPA review, despite the evidence that identified clinical risk factors were evident.

4. *There is good evidence of support for clinicians.*

5. *There is good evidence of continued support and input to the family and patient.*

[97] Meeting minutes, 5/11/2010

6. *There is evidence of a flexible use of both community and inpatient resource to support the patient and family however this flexibility was complicated by limitations in communication and seasonal weather led to some challenges in coordinating the care package when the admission to (the unit) was curtailed following a series of drug and alcohol related incidents.*

7. *The CPA meeting prior to discharge from the unit was cancelled due to the non-availability of the consultant as a result it appears no multidisciplinary discharge meeting was held and there was a period of 3 -4 weeks when the patient was on leave with his family during which the care plan had not been formally amended.*

8. *Supporting the patient in receiving medication and being concordant with this was complicated by the limitations of the consent to share document and supervision and supply arrangements for medication particularly during the periods of leave immediately following discharge.*

Comment

14.39 Mr C's mother was at no time contacted by the GRIP team to discuss Mr C's care, leaves to her home, medication management or to gain historical information. The internal investigation team's assumption that this was based on Mr C not consenting to share this information was flawed and was based on unvalidated information in the initial tabular timeline. Mr C did in fact provide written consent for the contacting of his mother in August 2009.

9. *The prescription of medication was complicated by the need to clarify diagnosis in respect of Wilson's disease in the interest of the patient's safety and it is possible this affected the patient's concordance with medication. Establishing a diagnosis for his physical health was a lengthy process and complicated by difficulties in accessing the result of investigations including haematology and biochemistry.*

10. *Guidance regarding the application of CPA policy allowed for interpretation of the CPA status. Although this did not alter the quality of the care provided or influence the outcome.*

Comment

14.40 The independent investigation team found evidence that the Trust's CPA policy was not followed consistently in Mr C's case. This issue has not been adequately addressed by the internal investigation.

11. *Whilst there is evidence of both professional and caseload management supervision and multidisciplinary supervision in the clinical team minutes, there was at that time limited planned and structured clinical supervision available for Band 4 workers.*

Comment

14.41 The independent investigation team note that the internal investigation does not address the issue of Mr C having a Band 4 Care Co-ordinator despite this being in contravention to

the Trust CPA Policy and being mentioned as a concern in the preliminary internal investigation report and the minutes of the investigation meeting on 5th November 2010.

12. *The consent to share document can provide inappropriate assurance to clinicians if it is not reviewed at each contact in order that the patient's wishes can be assessed against the risks posed by not sharing information.*

13. *Review of the clinical care does not provide any evidence that this alleged homicide could have been predicted or that any alternative reasonable justified and indicated interventions would have prevented this outcome.*

Comment

14.42 The independent investigation team is of the view that it was inappropriate for the internal investigation team to form such a view based on an investigation that was carried out by members of the team providing care and based on an unvalidated chronological timeline.

14. *There was no evidence from general assessment of risk of an increase in risk and no evidence of specific risk to the victim.*

Comment

14.43 The independent investigation team does not concur with the statement that 'there was no evidence from general assessment of risk of an increase in risk'. Mr C was discharged prematurely from the inpatient unit due to cannabis use. This was one of the indicators of increased risk identified in Mr C's risk assessment. He was also obviously psychotic on occasions, drinking heavily and self harmed for the first time in the lead up to the offence.

15. *Following notification of the incident, the interested parties contacted was rather more limited than best practice would dictate and specifically there should have been involvement of the duty consultant, who may have been required to assess the patient had he been arrested, and the on-call Executive Director.*

16. *Process around appropriate assessment of mental state and the duties of an appropriate adult could have conflicted with established clinical roles and responsibilities.*

14.44 *Recommendations* as identified in the Trusts internal serious incident investigation report

1. *There should be an agreed plan with regard to admission and outcomes between community and inpatient teams at the start of the admission and progress against this should be reviewed prior to discharge. This will necessarily include clarity regarding the purpose of an admission and its likely duration.*
2. *Operational difficulties must not prevent a CPA meeting prior to discharge and appropriate review of risk assessment and management plans.*
3. *There should be clear guidance in the CPA policy consistent with national policy regarding CPA status.*
4. *Supervision arrangements should be clarified in order to ensure that there is planned and structured supervision available for registered and unregistered staff alike*

consistent with national and trust standards and that records are kept of this supervision.

5. *There should be guidance regarding the necessity of assessing and documenting consent and capacity following any change in therapeutic intervention including the sharing of information. This should be documented in the clinical record regardless of the use of a consent to share form.*
6. *There should be guidance regarding procedures for escalating and alerting clinicians and managers immediately following a serious clinical adverse incident.*
7. *There should be guidance regarding the importance of avoiding clinicians with ongoing responsibility for a patient being required to undertake assessments in relation to criminal justice matters, which might create a conflict of interest.*

14.45 Root causes
The presence of psychosis and associated psychopathology led to an unpredicted, unpredictable and unprovoked alleged episode of violence.

Comment

14.46 The independent investigation team agrees that an attack of the severity of the attack on Mr C's step mother that took place on 4th July 2010 was not predictable on that day but are of the view that Mr C committing a violent incident, to someone, at some time, could have been predicted.

14.47 The Trust policy for the Management of Serious and Untoward Incidents[98] states;

14.48 The Internal review meeting to be organised by the relevant Service Director; to include Medical Director (Chair), Director of Quality and Performance (Nursing, Social Care & Therapies) (or nominated deputy), a Non-Executive Director and Assistant Director of Clinical Governance as well as all staff involved in the incident or treatment of the patient concerned. The patient and relatives (with the consent of patient where possible) will be invited to take part in the process with appropriate support. This must occur within 50 working days of the incidents.

14.49 The review will follow root cause analysis processes. Documentation required for the meeting includes the preliminary report, tabular timeline and coroners report (when appropriate) and patient notes.

14.50 The Independent Investigation of Serious Patient Safety Incidents in Mental Health Services guidance[99] states the following regarding the use of root cause analysis in trust internal and independent investigations;

14.51 A number of tools are available and the following have been shown to work well across a number of different healthcare settings:

[98] 2gether NHS Foundation Trust (2009) *Policy and Procedure for Reporting Incidents including Policy for the Management of Serious and Untoward Incidents*
[99] National Patient Safety Agency (2008) *Independent Investigation of Serious Patient Safety Incidents in Mental Health*

- *brainstorming;*
- *change analysis;*
- *nominal group techniques; five whys techniques;*
- *fishbone diagrams, based on the NPSA list of contributory factors: - patient factors;*
  - individual factors;
  - task factors;
- *communication factors;*
  - team and social factors;
  - education and training factors;
  - equipment and resources factors;
  - working conditions and environmental factors; - organisation and strategic factors.

Comment

14.52 The Trust policy[100] states that root cause analysis should be followed at the internal review meeting. The independent investigation team did not find evidence that this occurred and no evidence of root cause analysis tools being utilised to analyse the information available in the clinical notes and in the tabular timeline.

14.53 The Trust internal serious incident investigation report was compiled following the meeting on 5th November 2010. This is dated 11th January 2011 and identifies the author as the Assistant Director of Clinical Governance and the investigator as the Community Services Manager. The independent investigation team is of the view that this is not an accurate reflection as the Community Services Manager did not conduct the investigation and merely produced an initial tabular timeline and account of events.

Additionally it is of concern to the independent investigation team that the author of the report was not involved in the investigation, the staff interviews or present at the meeting on 5th November 2010 and was required to produce the report based on meeting notes and a tabular timeline.

14.54 The independent investigation team has been provided with the Trust's current policy[101] which outlines governance and incident investigation processes and the independent investigation team is satisfied that the contents of the policy are in line with good practice.

[100] 2gether NHS Foundation Trust (2009) *Policy and Procedure for Reporting Incidents including Policy for the Management of Serious and Untoward Incidents*
[101] 2gether NHS Foundation Trust (2011) *Incidents Policy and Procedure (Including the Management of Serious Incidents)* – Version 10

Recommendations

14.55 The Trust should take steps to ensure that Incidents Policy & Procedure (Including the Management of Serious Incidents) is being consistently followed.

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

14.57 The Trust Board should ensure that they have processes in place to assure themselves that evidence of action plan implementation is in place before action plans are signed off as complete.

14.58 Liaison with the police after the incident

The independent investigation team found no evidence to suggest that there was liaison between the police and the Trust throughout the investigation process.

14.59 In 2006 a Memorandum of Understanding[102] 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.

14.60 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.

14.61 The need for the establishment of an incident co-ordination group and the responsibility for health service managers to initiate this within five days of the incident are not specified in the Trust's current incident investigation policy[103]

[102] 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*

[103] 2gether NHS Foundation Trust (2011) *Incidents Policy and Procedure (Including the Management of Serious Incidents)* – Version 10

Recommendations

14.62 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; *Investigating patient safety incidents involving unexpected death or serious untoward harm* published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)[104]

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

15.0 ASSESSMENT OF PROGRESS MADE ON DELIVERY OF ACTION PLANS FOLLOWING INTERNAL INVESTIGATION

15.1 Findings identified within the trusts internal investigation (quotations in italics)

1. *With minor exceptions, there is good evidence of effective note keeping, documentation of risk assessments and appropriate inputs from team members in providing this package of care consistent with the early intervention approach.*

2. *There is good evidence in the notes of engagement with the family and effective two way communication within the limitations of the consent to share set by the patient's and the family's expressed wishes.*

3. *There is good evidence of support for clinicians, although it is recognised there were difficulties supporting the care coordinator due to sickness absence.*

4. *There is good evidence of continued support and input to the family and patient.*

5. *There is evidence of a flexible use of both community and inpatient resource to support the patient and family, however this flexibility complicated by limitations in communication and seasonal weather led to some challenges in coordinating the care package when the admission to the unit was curtailed following a series of drug and alcohol related incidents.*
   Subsequent to clarification of changes, there is little evidence documented regarding information given for the patient's understanding of the importance of his treatment.

6. *The CPA meeting prior to discharge from the unit was cancelled due to the non-availability of the consultant as a result it appears no multidisciplinary discharge meeting was held and there was a period of 3-4 weeks when the patient was on leave with his family during which the care plan had not been formally amended.*

[104] 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*

7. *Supporting the patient in receiving medication and being concordant with this was complicated by the limitations of the consent to share document and supervision and supply arrangements for medication particularly during the periods of leave immediately following discharge.*

8. *The prescription of medication was complicated by the need to clarify diagnosis in respect of Wilson's disease in the interest of patient's safety and it is possible this affected the patient's concordance with medication. Establishing a diagnosis for his physical health was a lengthy process and complicated by difficulties in accessing the results of investigations including haematology and biochemistry.*

9. *Guidance regarding the application of CPA policy allowed for interpretation of the CPA status, although this did not alter the quality of the care provided or influence the outcome.*

10. *Whilst there is evidence of both professional and caseload management supervision and multidisciplinary supervision in the clinical team minutes, there was at that time limited planned and structured clinical supervision available for Band 4 workers.*

11. *The consent to share document can provide inappropriate assurance to clinicians if it is not reviewed at each contact in order that the patient's wishes can be assessed against the risks posed by not sharing information.*

12. *Review of the clinical care does not provide any evidence that this alleged homicide could have been predicted or that any alternative reasonable justified and indicated interventions would have prevented this outcome*

13. *The panel felt that a greater weight should have been given to his history and his clinical presentation.*

14. *Following notification of the incident, the list of interested parties contacted was rather more limited than best practice would dictate and specifically there should have been involvement of the duty consultant, who may have been required to assess the patient had he been arrested, and the on-call Executive Director in line with the policy.*

15. *Process around appropriate assessment of mental state and the duties of an appropriate adult could have conflicted with established clinical roles and responsibilities.*

15.2 Recommendations and actions outlined within the Trust's action plan following the internal investigation[105]

Recommendation 1

15.3 There should always be an agreed plan with regard to admission and outcomes between community and inpatient teams at the start of the admission and progress against this should be reviewed prior to discharge. This will necessarily include clarity regarding the purpose of an admission and its likely duration.

15.4 Identified Action- *Clear admission & discharge plans for all inpatient episodes must be documented, to include purpose of admission and estimated length of stay.*

Comment

15.5 The Trust has redefined its Acute Care Pathway since this recommendation was made and is working through an action plan for implementation. The work plan was supplied to the independent investigation panel and this work remains ongoing. The work plan demonstrates the intention to ensure goal orientated admissions to hospital. This work was due to be audited to measure compliance in December 2011. The Trust informed the independent investigation team that due to staff sickness this audit was not completed within the specified timescale and was scheduled for September 2012.

Recommendation2

15.6 Operational difficulties must not prevent a CPA meeting prior to discharge and appropriate review of risk assessment and management plans.

15.7 Identified action- *CPA meetings must occur prior to discharge, and include risk review and management plan. Monitoring will be via CPA Audit*

15.8 This action is documented in the trust's action plan dated September 2011 to have been completed.

Comment

15.9 The independent investigation team have examined the Trust CPA audit report dated March 2011. The audit does provide data regarding how many service users have had a CPA review in the previous 12 months but does not specifically measure pre discharge CPA reviews or provide data on the level of compliance with this requirement or the quality of the content.

15.10 The independent investigation panel are not satisfied that this action has been completed nor that the Trust Board can be assured that all service users leaving hospital to be discharged have had a pre discharge CPA review.

Recommendation 3

15.11 Guidance in the CPA policy consistent with national policy must be clear, concise and precise to avoid misinterpretation regarding the application of CPA status and enable consistent

[105] Trust Action Plan, September 2011

application. Strategic Service Unit (SSU) boards should ensure that clinicians adhere to the guidance in the CPA policy.

15.12 Identified action- *The CPA Policy will be reviewed. All clinicians must adhere to the CPA policy, the monitoring of which will via ongoing CPA audit.*

15.13 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Comment

15.14 The independent investigation team found evidence that the Trust CPA Policy was updated and that CPA audit on some of the key requirements takes place annually. However this audit is quantitative and does not seek to review or measure quality of intervention. It is the view of the independent investigation team that there is an over reliance on quantitative clinical audit to ensure quality of application and compliance with the CPA process.

15.15 The independent investigation panel are not satisfied that this action has been completed nor that the Trust Board can be assured that CPA is being adequately implemented across the board.

Recommendation 4

15.16 Supervision arrangements should be clarified in order to ensure that there is planned and structured supervision available for registered and unregistered staff alike consistent with national and Trust standards and that records are kept of this supervision.

15.17 Identified action - *The supervision policy will be reviewed and expectation regarding its application made explicit.*

15.18 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Comment

15.19 The independent investigation team have seen evidence that the Trust updated its Supervision Policy in August 2011. However the independent investigation team have not been furnished with information about the policy implementation process, or results of any audit or outcome monitoring. The Trust has informed the independent investigation panel that profession specific supervision audits are commencing this year.

15.20 The independent investigation panel are not assured that all clinical staff are receiving adequate supervision.

Recommendation 5

15.21 There should be a review of guidance regarding the necessity of assessing and documenting consent and capacity following any change in therapeutic intervention including the sharing of information. This should be documented in the clinical record regardless of the use of a consent to share form.

15.22 Identified action - *The Clinical Governance Committee will agree the process for review of this guidance.*

Comment

15.23 The Trust provided evidence to the independent investigation team that Part 11 of the Trust Policy on Assessment, Care co-ordination and Care Planning[106], which covers the recording of consent to sharing personal information has been reviewed and updated. A report to the Trust Information Governance Committee in July 2012 details the changes to the policy as follows;

15.24 As part of the review of CPA and Risk carried out in 2011, there has been a significant change in the Trust understanding and administration of consent to share information. In particular, the review concluded that consent was situational and dynamic and not fixed point.

- *Consent needed to be considered <u>when</u> information might need to be shared.*
- *Day to day consent should be recorded in the progress notes, but that a proper form should be retained, particularly when sharing with a third party outside of the care network.*
- *A revised format would be needed as service users found the existing form difficult to understand.*

15.25 The new procedure also contains updates Consent to Share forms which are designed to be more easily understandable for service users.

15.26 The new process was discussed at the Information Governance Committee in July 2012 but it was agreed that there were issues to be addressed prior to implementation. Therefore at the time of completion of this report the new system is not yet in place.

Recommendation 6

15.27 Reinforce procedures for escalating and alerting clinicians and managers immediately following a serious clinical adverse incident should be followed.

15.28 Identified action - *Following approval of the revised Serious Incident Policy, staff will be alerted to this via "News in Brief" and cascade through operational line management structures.*

15.29 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Recommendation 7

15.30 Responsible Clinicians should not undertake assessments in relation to criminal justice matters which might create a conflict of interest.

15.31 Identified action - *The Medical Director will issue a Practice Notice.*

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[106] 2gether NHS Foundation Trust (2011) *Trust Policy on Assessment, Care Coordination & Care Planning* – Version 7.2

15.32 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Recommendation 8

15.33 Where there is evidence of poor compliance with medication management there should be concordance plans with appropriate professional input and supervision must be in place as a component of a holistic care plan.

15.34 Identified action - *Clear medicines concordance plans will be established and documented on RiO.*

Comment

15.35 The Trust provided evidence that learning about the need for medicine concordance plans was distributed to Team Managers and clinicians in February and May 2012.

Recommendation 9

15.36 Multi disciplinary working, particularly in relation to oversight of Band 4 workers, should be further evaluated alongside analysis of service users profile of need, case mix and workload of the team with oversight from an external expert.

15.37 Identified action - *There will be a review of Multi-disciplinary working.*

Comment

15.38 This action is documented in the Trust's action plan dated September 2011 to have been completed. The Trust provided evidence to the independent investigation team of a qualitative audit that took place in April 2012. The audit report demonstrates a qualitative review of the care pathway of two randomly selected service users where their care was supported by band 4 workers in the GRIP teams. Data was reviewed in accordance with the current Assessment, Care Coordination and Care Planning Policy[107] . The two service users were randomly selected from a total population of 6, who were cared for by the GRIP teams and on CPA. The audit concludes that whilst the delivery of care is appropriate and in accordance with policy; the recording of CPA levels is not consistent for one service user, which may have caused an issue with validating updated core assessments. This could be due to a reporting error.

Comment

15.39 The Trust's 2011 CPA Policy states that Band 4 (unregistered) staff in specialist teams can fulfil the role of Lead Professional for service users who are not on CPA. However this does not represent a change as this was also stated in the 2008 policy. It was not adhered to in Mr C's case.

15.40 The independent investigation team have not seen any evidence of the level of compliance with this aspect of the CPA.

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[107] 2gether NHS Foundation Trust (2011) *Trust Policy on Assessment, Care Coordination & Care Planning* – Version 7.2

Recommendation 10

15.41 The GRIP operational policy to be reviewed and amended within 3 months.

15.42 Identified action - *The GRIP operational policy to be reviewed and amended within 3 months.*

15.43 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Recommendation 11

15.44 The chronology of risk section in RiO with relapse plan will assist in the systematic formulation of risk and gathering of a full family history. This needs to be reviewed formally and updated at every CPA review as a minimum when there is a change in clinical presentation.

15.45 Identified action - *All agreed risk fields within RiO must be completed in accordance with the recommendation, and a review of clinical risk procedures will be undertaken.*

15.46 This action is documented in the Trust's action plan dated September 2011 to have been completed.

Recommendation 12

15.47 Following assessment a working diagnosis should be detailed and where appropriate differential diagnoses. The management plan should reflect both the working diagnosis and risk assessment. (Diagnosis should be a forced response in completing the core assessment and CPA documentation).

15.48 Identified action - *Diagnosis must always be documented following assessment.*

Comment

15.49 The Trust supplied evidence that showed that the issue of nurses diagnosing service users and documenting diagnosis was discussed at the Nurses Professional Group on three occasions in the summer of 2011. However no further evidence has been supplied.

15.50 The independent investigation panel are not assured that this action has been completed.

15.51 Trust Governance

15.52 The current Incidents Policy and Procedure[108] outlines its procedure for the governance of serious incidents as follows;

1. *This policy requires approval by the Governance Committee and will be reviewed at least annually and sooner if required.*

[108] 2gether NHS Foundation Trust (2011) *Incidents Policy and Procedure (Including the Management of Serious Incidents)* – Version 10

2. *The Governance Committee is responsible for ensuring that compliance against the standards defined by the NPSA within the National Framework for Reporting & Learning From Serious Incidents Requiring Investigations is followed by receiving a quarterly report from the Assistant Director of Clinical Governance*

3. *An audit of the implementation of the policy will be undertaken every two years, commissioned by the Director of Quality & Performance. The audit criteria will include assessing compliance against the following standards.*

   - *Duties of individuals and committees*
   - *Process for reporting all incidents/near misses, involving staff, service users and others*
   - *The process for reporting to external agencies*
   - *The processes for staff to raise concerns e.g. whistle blowing/open disclosure*

4. *It is expected that implementation of all these elements will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.*

15.53 The independent investigation team found evidence that this incident, and the subsequent action plan, was monitored by the Governance Committee within the Trust but the process for verifying evidence to ensure all actions have been completed is not clear. There is evidence that the actions and outputs of the Trust Governance Committee are regularly reviewed by the Trust Board and that the internal investigation findings and the action plan were reviewed by the Working Age Management Board in February and May 2011.

15.54 During the interviews the independent investigation team were told that action plans, which are developed in the Serious Incident Review meeting, are signed off (documented and checked prior to distribution) by the Medical Director or delegate. However, checking the progress against plans of completion is not within the remit of the Medical Director. The independent investigation team is of the view that a more formal process is required.

15.55 The independent investigation team found, from the evidence provided, that the internal investigation report was scrutinised at a high level within the Trust, and that progress against the action plan was monitored by the Governance Committee periodically. There is no clear evidence, however, that there was a robust action plan sign off process in place to enable the Trust Board to assure themselves that the evidence was in place demonstrating that all actions had been completed to a satisfactory standard.

Recommendation

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

15.57 Sharing of lessons

15.58 The Trust have publicised and shared the learning of lessons from this incident through their governance forums and by use of a bulletin newsletter. There is also evidence that good practice notices in relation to some of the learning from this incident was circulated to Team Managers and clinicians in February and May 2012.

15.59 The Governance Committee monitors implementation of action plans and there is evidence of proactive work to improve investigation processes and the dissemination of learning.

15.60 The Trust's procedure for Learning from Incidents, Complaints and Claims[109] outlines that aggregated reports detailing themes and trends of learning are reviewed by the Governance Committee on a quarterly basis.

15.61 The procedure[110] details that learning detailed in the quarterly report influences changes in organisational culture and practice as follows;

15.62 Each quarter, following publication of the reports, the Assistant Director of Governance & Compliance will meet with the Head of Quality Care Management/ other parties where appropriate to review clusters/trends/lessons identified through the analysis of incidents, complaints and claims. This may promote possible areas of work for future care pathway development. Implementation of care pathways and compliance with these is supported through the clinical audit cycle.

15.63 When lessons learned indicate a training requirement, the Assistant Director of Governance & Compliance will liaise with the Head of Training to establish how this may best be implemented. All changes to the delivery of training, additions to the Training Prospectus and the monitoring of attendance at training sessions will be via the Delivery Committee.

15.64 All actions arising from serious untoward incidents will be incorporated into the Trust's audit work plan to establish compliance with changes in culture and practice. NHS Gloucestershire & NHS Herefordshire also monitor the implementation of these action plans and are the responsible agencies for "signing off" completed actions by closing the incidents logged on STEIS

15.65 The independent investigation team is satisfied that the Trust has put processes in place to ensure the ongoing learning of lessons and use information gained from investigations to attempt to change culture and influence practice. However the efficacy of these processes is as yet unknown and has not yet been measured.

Recommendation

15.66 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.

[109] 2gether NHS Foundation Trust (2011) *Learning from Incident's Complaints and Claims*
[110] 2gether NHS Foundation Trust (2011) *Learning from Incident's Complaints and Claims*

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

16.1 Mr C's father and aunt have told the independent investigation team that they were contacted following the death of D and invited to a meeting at the Trust. This meeting occurred ten days following the offence. They told the independent investigation team that they were offered support at this meeting, they also state that they were told that a preliminary internal investigation had taken place and it was indicated to them that at that stage in the process no problems in Mr C's care had not been identified and that an independent investigation would be commissioned following completion of the criminal proceedings.

16.2 The criminal proceedings in relation to Mr C finished on 24th April 2011. Mr C's aunt told the independent investigation team that following this she contacted the Trust to ascertain what the next steps were. A subsequent meeting took place between the Trust and Mr C's father and aunt in July 2011 in which they were informed that the Strategic Health Authority had been contacted and had informed the Trust that an independent investigation was being commissioned. The Trust stated they contacted the family again in September 2011 offering to meet with them to share the findings and recommendations from the internal investigation. This offer was not taken up by Mr C's family at this time. In February 2012 the Trust wrote to Mr C's family again, updating them on progress of the independent investigation.

Comment

16.3 The independent investigation team note that Mr C's father and aunt were contacted following the offence and offered the opportunity to attend a meeting with the clinical team. This is good practice. However, despite the requirement for appropriate liaison to take place with families, victims and perpetrators of homicides being well documented in national guidance such as the Being Open framework[111], the family involved in this case were not involved the Trust's internal investigation or offered the opportunity to discuss this until after it was completed. They were supplied with a copy in March 2012.

Recommendation

16.4 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 and are enabled the opportunity to take part in the Trust's internal investigation.

[111] National Patient Safety Agency (2009) *Being Open*

17.0 ROOT CAUSE ANALYSIS

17.1 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 on the following page identify sub-optimal processes as identified by using this technique. These issues are not necessarily causative but are highlighted for organisational learning.

Organisational factors

Inpatient unit's fitness for purpose

Inadequate serious incident investigation and sign off processes

Task/Guidelines

Risk assessment did not take into account evident risk factors

Risk assessment not updated when risk profile changed

Risk and clinical history not taken from mother

Lack of clarity about diagnosis and treatment plan

Clinical signs of deterioration not responded to

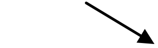
Pre discharge review and discharge care planning did not take place in a timely manner

Team and social factors

Over reliance on family to monitor medication and report concerns

Over emphasis on cannabis use and under emphasis on alcohol use

Unregistered SSW being expected to monitor mental health during medication change without appropriate supervision/ support



Serious Incident: Harm to another Offence: Death of D

Patient factors

Ongoing psychosis

Cannabis and alcohol use

Lack of insight

Variable concordance with medication

Paranoid feelings when unwell

Violent incident

Self harm incident

Lack of peer group in the area

Mr C known to not always be able to articulate his psychotic thoughts and feelings

Communication

Lack of communication with mother

Over reliance on family to monitor medication and report concerns / lack of response to their concerns

Lack of communication between unit and GRIP staff

Working conditions

Inadequate supervision for SSW

18.0 CONCLUSIONS

18.1 Mr C had been involved with mental health services for eleven months, from August 2009 until the offence in July 2010 when he killed his stepmother, at their home, following an uneventful family meal.

18.2 During this period he received care from the Gloucestershire Recovery in Psychosis (GRIP) community team and was admitted to a psychiatric inpatient facility on one occasion.

18.3 Mr C reported psychotic symptoms and on an ongoing basis throughout the time he was receiving care.

18.4 Mr C was born in 1991 and lived with his parents until they separated when he was four years old. He then went to live with his mother in the South East, where he stayed until he was 17. In 2009 Mr C experienced problems in that he was using cannabis and alcohol and was exhibiting some paranoia, which culminated in him stabbing a friend in the face with a pen. This incident was never subject to any criminal proceedings. He went missing for several days sleeping rough following this incident and when found, Mr C moved to live with his father and stepmother in Gloucestershire.

18.5 Mr C's father and stepmother were concerned about his ongoing behaviour so they took him to see his GP in the August of 2009. The GP referred Mr C to the GRIP team who carried out an assessment. As a result, Mr C was regularly seen by the team, he was assessed and prescribed medication. He had an inpatient episode with periods of home leave at an inpatient unit from November 2009 until February 2010 but was discharged after multiple incidents, alcohol use and suspected cannabis use whilst an inpatient.

18.6 Following his discharge, Mr C lived with his father and stepmother under the care of the GRIP team until his arrest in July after the incident.

18.7 Following the attack on D on 4th July 2010, Mr C left the home and was found the following morning in a foetal position in a telephone box by residents of the town. He told them he had been walking all night and gave them a false name. They later called the police out of concern for him. The police arrived at 08:00 on 5th July 2010. At the police station he was assessed by a psychiatrist and was deemed to be exhibiting psychosis. Mr C told the police that he was prescribed antipsychotic medication but that he had flushed it down the toilet.

18.8 Tragically, D died as a result of her injuries on the evening of 4th July 2010, at the hospital.

18.9 In court Mr C pleaded guilty to manslaughter on the grounds of diminished responsibility and as a result is subject to a restriction order under Section 41 of the Mental Health Act .

18.10 At the commencement of his care with the GRIP team, as part of the initial assessment process, Mr C's was assessed as not presenting any current risk despite his recent assault of one of his friends which involved stabbing him in the face with a pen in response to reported psychotic and paranoid phenomena. It appears to have been the view of the team that the risks were reduced as they felt that this incident was related to his use of cannabis

and they were of the view that his paranoia was specific to this group of friends, so it was concluded that the risks were diminished if he did not use cannabis and because he had moved away from his social group about whom he had felt paranoid. It was acknowledged in the clinical risk assessment that the risks would increase if Mr C commenced the use of cannabis again or if psychotic features continued.

18.11 Mr C lived with his mother when he stabbed his friend with a pen. She was not contacted and asked to give corroborative historical risk information. Clinical staff, when asked about this at interview, were of the view that this was because Mr C did not want her to be contacted about his mental health care, but it is evident from the clinical notes that Mr C signed a consent to share form in August 2009 consenting to both his parents being spoken to about his treatment.

18.12 The independent investigation team do not agree that it was reasonable, given the information that Mr C and his father had given them during the assessment meeting on 4th August 2009, for the assessors to conclude that there were no "current risks".

18.13 Mr C was diagnosed as potentially having drug induced psychosis at the end of his assessment period in September 2009 and was not put on CPA.

18.14 Mr C had abnormal blood and liver function test results following the initial prescription of antipsychotic medication, and concerns that he may be suffering from Wilson's disease led to a cautious approach to subsequent anti psychotic prescribing. Mr C admits, and it is evident from the clinical records, that he regularly took part in the binge drinking of alcohol which with hindsight, may have contributed to the adverse test results that he encountered. The presence of Wilson's disease was eventually ruled out.

18.15 Mr C was admitted to an inpatient unit in November 2009, initially to provide respite care so that his father and stepmother could go on holiday. This was later extended. The purpose of the extension and the treatment plan and objectives were unclear and Mr C used alcohol and was suspected of using cannabis during the admission. There was also an incident of him using a female resident's bank card to obtain funds whilst he was there. Mr C was discharged prematurely due to this behaviour.

18.16 Mr C was put onto CPA due to his admission to a unit at the end of November 2009.

18.17 A CPA review planned prior to his discharge was cancelled due to the consultant psychiatrist not being available so Mr C was discharged without a review of his community care plan or risk assessment, despite the presence of factors that were identified in Mr C's original risk assessment that were deemed to be indicative of increased risk, and the ongoing presence of psychosis. The decision to discharge Mr C prematurely was made independently by the unit staff. Mr C's Care Co-ordinator was not aware until afterwards.

18.18 At the CPA review, which took place a few weeks later, he was allocated a new care co-ordinator who was an unregistered member of staff, a SSW. A few weeks later, his medication was changed.

18.19 The independent investigation team is of the view that at the point of discharge Mr C was presenting with psychosis and increased risk factors and that therefore, admission to an acute psychiatric unit if accepted, or an assessment under the Mental Health Act if not, would have been appropriate.

18.20 In April 2010 Mr C got into an altercation with a group of youths after a heavy drinking session two nights previously. He was unable to stop pondering over the incident even though it had been reframed in the context of him drinking heavily. In June 2010 Mr C harmed himself with a knife. This information was relayed to the clinical team in a team meeting, but no action was taken or changes to the risk assessment made as a result, despite this being a new behaviour for Mr C. He did not have a history of self harm. Both these incidents were potential indications of Mr C's deteriorating mental health and increasing risk factors.

18.21 The SSW last saw Mr C on 29th June 2010. He said he believed he had many "issues" from his past that he needed to address but felt he was not yet ready to work on them. They discussed his self harm incident and he found it difficult to talk about and said he was "just being silly". They spoke to his father and stepmother and it was agreed that he would talk to them if he felt unsafe in that way again. The SSW recorded that there were evident improvements in his cognition and concentration.

18.22 The homicide occurred on 4th July 2010.

18.23 A meeting was held in the Trust on 5th July 2010 to discuss the incident and the internal serious incident investigation process. This was chaired by the Chief Operation Officer who identified the Community Service Manager to do a preliminary investigation. He was given a deadline of ten days to complete this.

18.24 The Community Service Manager completed a tabular timeline and an account of Mr C's care but did not do any staff interviews or conduct any qualitative or root cause analysis of the information presented. The independent investigation team found no evidence that this issue was identified or that the information in the timeline, or given by clinicians at the meeting on 5th July 2010, was in any way checked or corroborated. This resulted in some assumptions being made about the quality of risk assessment and the reasons for Mr C's mother not being contacted to contribute to the risk assessment process.

18.25 Staff interviews took place in autumn of 2010. These did not involve the preliminary investigator and were based in the information gleaned from the meeting that was held on 5th July 2010 and the Community Service Managers report, some of which was flawed.

18.26 The independent investigation team did not find evidence that robust root cause analysis had taken place and were told that the analysis took place at a meeting with clinicians that was held in November 2011.

18.27 The independent investigation team have concerns about the objectivity of the investigation and analysis process given that the Community Services Manager who conducted the preliminary investigation was the manager of the GRIP team at the time, and the meeting

where the outcomes of the internal investigation were agreed consisted of the clinical team who cared for Mr C.

18.28 The independent investigation team is of the view that the lack of objectivity in the internal investigation process led to some of the salient issues not being identified or adequately addressed in the internal investigation report.

18.29 The independent investigation team is of the view that it could not have been predicted that Mr C would kill his stepmother at the time that he did. However, the independent investigation team believe that the nature and level of Mr C's psychosis and his previous risk behaviour did indicate there was a high risk of him committing a serious violent assault on someone at sometime. The risk assessments carried out whilst he was under the care of 2gether NHS Foundation Trust at no time adequately considered or addressed this and therefore insufficient preventative measures were put in place. However the independent investigation team acknowledge that, even if the service had had a more realistic awareness of the ongoing risks, there is no certainty that any different actions could have prevented the incident that occurred on 4th July 2010.

18.30 The independent investigation team is of the view that the internal serious incident investigation process was flawed and did not contain the appropriate level of objective qualitative analysis, and this has resulting in the relevant lessons for improving practice not to have been learned and implemented in a timely manner.

18.31 Additionally, the independent investigation team are not satisfied that the Trust board can be assured that all of the actions identified in the Trust's internal action plan, arising from their own internal investigation, have been fully implemented.

APPENDIX A:
TABLE OF RECOMMENDATIONS

1a	Assessment and Risk Assessment
1)	The Trust should carry out an audit of the quality and relevance of clinical risk assessments and care and risk management plans that are in place for current service users within three months of publication of this report.
2)	The Trust should ensure that all care coordinators receive regular caseload supervision that include documented formal review of care and clinical risk management plans and clinical risk assessments.
3)	The Trust should ensure that clinical risk assessment training reiterates the importance of obtaining a comprehensive corroborative risk history from all relevant significant others, where the service user consents, to inform clinical risk assessment.
4)	The Trust should carry out qualitative audit to establish the quality, comprehensiveness and relevance of the content of core assessments with specific reference to personal and family histories.
5)	The Trust should ensure that core assessments include the requirement for comprehensive drug and alcohol histories to be taken.
6)	The Trust should ensure that the need for collaboration between the multi disciplinary team, when completing risk assessments for people with complex presentations, as outlined in the Department of Health guidance, is detailed within the Trust's policy for clinical risk management.
7)	The Trust should establish systems to ensure that when assessment tools such as Lunser, PANSS, and clinical risk assessments are completed this should be in line with care plan and findings used to inform the care plan unless a rationale for not doing so is recorded in the clinical notes.
8)	The Trust should ensure that where a risk assessment has identified circumstances in which risk is predicted to increase, and those circumstances occur, the care plan should clearly identify what actions are being undertaken to address those risks.
2b	**Care Programme Approach**
1)	The Trust should carry out a review of all service users on CPA to ensure that their Care Co-ordinator has the appropriate qualification, skills and experience to take responsibility for the management of their case.
2)	The Trust should carry out a review of all service users who are currently not subject to CPA to ensure that they do not meet the stipulated criteria for CPA.
3)	The Trust should carry out an audit of all discharges from inpatient settings to ascertain that a discharge planning meeting took place and that it covered all the required elements.
3c	**Medication and Treatment**
1)	The Trust should ensure that they have a method of assuring themselves that when new medications are prescribed to service users, their risks and benefits are clearly explained to service users and carers.
2)	The Trust should ensure that there is guidance and training available to staff detailing a consistent approach to management service users who are not concordant with their prescribed medication and monitor the efficacy of its use by a process of clinical audit.
3)	The Trust should ensure that psychological therapies are offered to all service users diagnosed with psychosis in line with the NICE Schizophrenia Guidance 2009.
4d	**Communication**
1)	The Trust should ensure there are processes in place so that the collaboration and communication between inpatient settings and community teams with regard to shared service users can be demonstrated and audited.

2)	The Trust should review the Consent to Share process and ensure that all care coordinators and lead professionals are competent in its use.
3)	The Trust should ensure that staff are aware of their responsibility to communicate potential risk information and the conditions in which consent to share and confidentiality restrictions should be overridden.
4)	The Trust should ensure that all eligible carers are offered a carer's assessment in line with the Carers Act 2004, and that the outcomes of assessments are clearly explained to them
5e	**Incident Investigation procedures**
1)	The Trust should take steps to ensure that Incidents Policy & Procedure (Including the Management of Serious Incidents) is being consistently followed.
2)	The Trust should ensure that there are evidence based and auditable processes in place to quality check the outcome of Serious Untoward Incident Investigations.
3)	The Trust Board should ensure that they have processes in place to assure themselves that evidence of action plan implementation is in place before action plans are signed off as complete.
6f	**Joint Working with the Police**
1)	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; *Investigating patient safety incidents involving unexpected death or serious untoward harm* published by Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006)
2)	The Trust should ensure that senior managers and Trust directors are aware of their responsibilities outlined within the Memorandum of Understanding and these should be made explicit within Trust policy.
3)	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 and are enabled the opportunity to take part in the Trust's internal investigation.
7g	**Management and Governance processes**
1)	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
2)	The Trust should undertake a review to examine the efficacy of the processes in place for th learning and sharing of lessons learned to establish their efficacy.

APPENDIX B:
TABLE OF STAFF TITLES - INTERVIEWS

Table of Staff Titles - Interviews

Psychologist and Care Co-ordinator
Psychiatrist One
Psychiatrist Two
Care Co-ordinator
Community Services Manager and investigator
Assistant Director of Governance & Compliance and report author
Early Intervention Team Manager
Inpatient Matron Manager
Medical Director and interviewer for internal investigation
Current Executive Lead for Quality and Performance
Chief Operating Officer and interviewer for internal investigation
Director of Quality and Performance at the time of incident and interviewer for internal investigation

GLOSSARY

A & E	Accident and Emergency	
HMP	Her Majesty's Prison	
HSG	Health Service Guidelines	
MHA	Mental Health Act	
NPSA	National Patient Safety Agency	
RCA	Root Cause Analysis	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
GRIP	Gloucestershire Recovery in Psychosis	
CP	Clinical Psychologist	
SSW	Senior Support Worker	
CPA	Care Programme Approach	The approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics
GP	General Practitioner	
	Aripiprazole (Abilify)	An anti psychotic drug for treating psychosis
	Sulpiride	An anti psychotic drug for treating psychosis
	Risperidone	An anti psychotic drug for treating psychosis
SPR	Specialist Registrar	

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