Independent Investigation

into the

Care and Treatment Provided to Mr. X

by the

Lincolnshire Partnership NHS Foundation Trust

and the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by
South West Strategic Health Authority
and East Midlands Strategic Health Authority

Report Authored by Dr. Androulla Johnstone

Investigation Prepared by the Health and Social Care Advisory Service

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS East Midlands Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the deaths of Mr. and Mrs. X senior, the parents of Mr. X, who were found killed on the 11 July 2007.

Mr. X received care and treatment for his mental health condition from the Lincolnshire Partnership NHS Foundation Trust and the Avon and Wiltshire Mental Health Partnership NHS Trust (the Independent Investigation Team acknowledges the fact that Mr. X was not actually seen by Avon and Wiltshire services). It is the care and treatment that Mr. X received, or should have received, from these organisations that is the subject of this Investigation.

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

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

We would like to thank the family of Mr. and Mrs. X senior who offered their full support to this process and who worked with the Independent Investigation Team. We acknowledge their distress and we are grateful for the openness and honesty with which they engaged with

1. Health service Guidance (94) 27

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

2. Condolences to the Family and Friends of Mr. and Mrs. X Senior

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. and Mrs. X senior. In particular we would like to acknowledge the help and support that we received from the daughter and son-in-law of Mr. and Mrs. X senior. We know that this has been an extremely difficult and distressing time for them and appreciate deeply the dignified and thoughtful contributions that they have made to this Investigation.

It is the sincere hope of the Independent Investigation Team that this inquiry process has addressed all of the issues that Mr. and Mrs. X senior's family have sought to have examined and explained.

3. Executive Summary

3.1. Incident Description and Consequences

The following account has been taken from a variety of sources. The main source used is that of the transcription taken during the proceedings of the Crown Court in the case of Regina Versus Mr. X early in 2008. The events leading up to the incident and the incident description are set out below.

Mr. and Mrs. X senior lived in a bungalow in the Swindon area. Their son, Mr. X, also lived with them at this address[2]. Mr. X had been periodically engaged with mental health services between 2000 and 2003, at this time he had been living and working in Lincolnshire. At the time of the Court proceedings early in 2008 it was noted that Mr. X's last contact with Lincolnshire mental health services occurred on the 18 August 2003[3].

Between August 2003 and July 2007 Mr. X's mental health appeared to deteriorate. During this period the sister of Mr. X made many attempts to obtain help for him from a number of agencies to no avail. Mr. X's behaviour became increasingly erratic and frightening and his family became desperate to obtain help for him[4].

On Friday 6 July 2007 the sister of Mr. X spoke to her parents to discuss the arrangements that she had made for them to meet with the Swindon Mental Health Crisis Team regarding Mr. X's deteriorating mental health[5].

On Saturday the 7 July 2007 at 8.00 am Mr. and Mrs. X senior's car was seen being reversed off their drive way. Mr. and Mrs. X senior's neighbours reported to the Court that no further activity was seen at their bungalow that day and that there was no further sign of their car[6].

On the morning of Monday 9 July 2007 Mr. X was seen coming out of his parents' bungalow by a neighbour. Later that day the neighbour's husband found two bin bags behind the shed at

2. Crown Court Case Summary P.1
3. Crown Court Case Summary P. 4
4. Crown Court Case Summary PP. 4-5
5. Crown Court Case Summary P. 5
6. Crown Court Case Summary PP.5-6

the back of the garden that divided Mr. and Mrs. X senior's garden and his own. Inside one bag were freshly laundered wet clothes, bedding and a towel. These were duly seized by the Police on the 12 July 2008.

On Tuesday 10 July 2007 Mr. X telephoned his sister to inform her that their parents would not be around that night as they had gone to Lincoln to look into selling the house that he still retained there. The fact that Mr. X telephoned his sister was a unique event as he did not usually communicate with her. She drove to her parents' bungalow and spoke at length to her brother; she told the Court that this was the first proper conversation that she had had with him in years[7]. The sister of Mr. X was concerned that her parents had decided to stay overnight in Lincoln without informing her and so she telephoned her brother later that evening to enquire as to their whereabouts. She was told that they still had not returned home[8].

On the morning of Wednesday 11 July 2007 the sister of Mr. X telephoned Mr. X. Mr. X informed her that their parents had still not returned home. Later the same day she went to her parents' bungalow and took Mr. X to Wickes (a DIY store) so that he could buy some plumbing fixtures as he was refitting the bathroom. The sister of Mr. X noted that Mr. X became very agitated when she picked up some bin bags and he told her not to touch them. She left to go home[9].

When the sister of Mr. X returned to her home she was given a message to contact the Police as her parents had been reported missing. Apparently Mr. and Mrs. X senior had failed to arrive at the weekly dance they always attended. Their friends telephoned Mr. and Mrs. X senior to find out if anything was wrong only to be told by Mr. X, who answered the telephone, that his parents had gone to Lincoln. The friends of Mr. and Mrs. X senior were not satisfied with this explanation and believing something to be wrong contacted the Police[10].

On hearing that her parents had been reported missing the sister of Mr. X telephoned her brother and told him that she was coming back to the bungalow. Before she could leave her

7. Crown Court Case Summary PP. 6-7
8. Crown Court Case Summary P. 7
9. Crown Court Case Summary P. 7
10. Crown Court Case Summary P. 4

home Mr. X telephoned her back to say that the Police had arrived. The Police made some general enquiries. Mr. X was reported as remaining calm and co-operative. He gave the Police an account of his parents' absence, explaining that they had taken a trip to Lincoln. The sister of Mr. X took the opportunity to inform the Police that Mr. X's mental health had not been good and that this had recently led to a poor relationship with his parents. At this stage the Police left both Mr. X and his sister alone at their parents' bungalow[11].

Enquiries in Lincoln by the Police resulted in the discovery of Mr. and Mrs. X senior's car near the railway line at Newark. Witnesses were to report that the car had first been seen parked there on Sunday 8 July 2007[12].

At 18.30 the Lincolnshire Police went to Mr. X's Lincoln home and searched the garden. The bodies of Mr. and Mrs. X senior were found under some bins at the rear of the house[13]. Mr. and Mrs. X senior had died from multiple blunt trauma injuries and both Mr. and Mrs. X senior had also been strangled. The Wiltshire Police returned to Mr. and Mrs. X senior's bungalow at 20.14 and arrested Mr. X[14].

Forensic examination revealed that Mr. and Mrs. X senior had been killed in their bungalow in Wiltshire and then transported in their car to Mr. X's garden in Lincolnshire. Forensic evidence would suggest that Mr. and Mrs. X senior were already dead by the afternoon of the 8 July 2007. Closed Circuit Television footage for the 8 July 2007 showed Mr. X travelling from Newark railway station at 8.30 in the morning and then emerging at Kings Cross Station. After this he was seen to arrive at Paddington Station and then at Swindon Station by 14.49[15].

At the time of their deaths Mr. X senior was 83 years of age and his wife was 76 years of age.

Mr. X was charged with the murder of his parents. Although Mr. X was unfit to plead, a jury at the Crown Court found him responsible for killing his parents. The Judge sentenced Mr. X to an indefinite period of detention at a high security hospital. Mr. X remains at the time of

11. Crown Court Case Summary P. 8
12. Crown Court Case Summary P. 8
13. Crown Court Case Summary P. 8
14. Crown Court Case Summary P. 8
15. Crown Court Case Summary PP.9-10

writing this report in a high security facility. At the time of the incident Mr. X was 43 years of age.

3.2. Background to the Independent Investigation

The Health and Social Care Advisory Service was commissioned by NHS East Midlands (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 27.

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

3.3. Terms of Reference

NHS East Midlands set out the Independent Investigation Terms of Reference as follows:

Undertake a systematic review of the care and treatment provided to Mr. X by Lincolnshire Partnership NHS Foundation Trust (LPT), Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and other organisations to identify whether there was any aspect of care and management that could have altered or prevented the events of 7-8 July 2007.

The Investigation Team is asked to pay particular attention to the following:

- Review the quality of the health and social care provided by LPT and AWP and whether this adhered to Trust policy and procedure, including:

- Identify whether the Care Programme Approach (CPA) had been followed by the Trusts with respect to Mr X.

- Identify whether the risk assessments of Mr X were timely, appropriate and followed by appropriate action.

- Examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.

- Examine the transfer of care between LPT and AWP.

- Examine the Application of the Mental Health Act 1983 including the assessment process and Section 117.

- Examine the efforts made by Mr. X's family to access appropriate services whilst he was resident in AWP's catchment area.

- Examine the role of General Practice in the care of Mr. X, including:

- Prescribing and monitoring of medication supplied to Mr. X and subsequent discharge from the GP Practice in Lincoln.

- Actions taken by GPs in Swindon PCT area in response to concerns raised by Mr. X's family.

- Examine the application of procedures relating to vulnerable adults in relation to Mr. X's parents in June 2007.

- To establish whether the recommendations identified in the Internal Investigation reports produced by LPT and AWP were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.

- To identify any learning from this Investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.

- To report the findings of this investigation to East Midlands Strategic Health Authority and South West Strategic Health Authority.

Approach

The Investigation will not duplicate the earlier Internal Investigations; this work is being commissioned to build upon the Internal Investigations.

Should the reviewers identify a serious cause for concern, this should be notified to the Strategic Health Authorities and to the Trusts immediately.

The Investigation will be undertaken in two phases.

Phase One

This will be an information and fact-finding phase incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

Phase Two

This will include interviews with key staff and managers – either individually or in groups. Fieldwork will be carried out at a neutral venue within a reasonable distance from LPT and AWP.

It is expected that the final report will include recommendations to inform the appropriate commissioning of the service by NHS Lincolnshire and NHS Swindon as the lead commissioners of mental health services.

Publication

The outcome of the review will be made public. East Midlands Strategic Health Authority in collaboration with South West Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the Chair of the Investigation Panel, relatives and other interested parties.

Review Team

The Review Team will comprise appropriately skilled members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work

promptly and effectively, with the full process completed within six months following consent being obtained from all parties.

The review team will submit monthly progress reports to the commissioners and family as agreed.

3.4. The Investigation Team

Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Report Author

Investigation Team Members

Ms. Sue Simmons	National Development Consultant, Health and Social Care Advisory Service. Nurse Member of the Team
Dr. Tim Saunders	General Practitioner Member of the Team
Dr. Liz Gethins	Consultant Psychiatrist Member of the Team
Mr. Alan Watson	National Development Consultant, Health and Social Care Advisory Service. Social Work Member of the Team
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

3.5. Findings and Conclusions

This has been a complex case to analyse. It has involved conducting a comprehensive investigation into the care and treatment that Mr. X received from three statutory health service providers over a seven-year period. Two main issues provided a consistent challenge to the work of the Independent Investigation Team, the first being the passage of time which hindered the recollection of clinical witnesses, and the second being the poor standard of the information available within the clinical record of Mr. X. In combination these two issues have made the provision of a full analysis difficult.

It must be noted that it is not possible to make comprehensive and generalisable statements about the quality of the care and treatment a statutory health service provides for an entire population when seen through the lens of an individual case. Both the Avon and Wiltshire Mental Health Partnership NHS Trust and the Lincolnshire Partnership NHS Foundation Trust have been independently assessed by national regulatory bodies as having in place sound governance procedures. This Investigation does not wish to discredit the work of either organisation. However in the spirit of learning and in the public interest, the Independent Investigation has identified serious failings with regard to the care and treatment that Mr. X received from mental health services over a period of seven years. It is the view of the Independent Investigation Team that these failings were cumulative over time and that each separate failing impacted one upon the other in a 'snowball effect' over the years. It is also the view of the Independent Investigation Team that at any time during this sequence of events the assertive clinical management of Mr. X would have helped to prevent the steady deterioration of his mental health. The trial judge when sentencing Mr. X late in 2008 made a direct link between his untreated mental state and the subsequent deaths of both Mr. and Mrs. X senior. This is a link that the Independent Investigation Team also makes.

Findings

Mr. X had a severe and enduring mental illness. This had been diagnosed for a period of some seven years prior to the deaths of his parents. Mr. X was a guarded and socially withdrawn individual and had been so all of his life. In 2002 when he came to the attention of the Lincolnshire Partnership NHS Trust this personality trait became a significant barrier to the provision of the care and treatment that he required. Mr. X's refusal to engage was never

assertively managed and as a result, even though his clinical presentation did not merit it, he was allowed to lose contact with services. The Independent Investigation Team acknowledges that it is difficult to work with service users who reject the care and treatment offered to them. However it has long been recognised that this is often the hallmark of individuals such as Mr. X who suffer from psychosis and delusional disorder. National best practice since the 1999 Confidential Inquiry into homicides perpetrated by the users of mental health services has required mental health Trusts to have policies in place to manage actively this kind of situation. Policies were in place but were not activated. Mr. X's refusal to engage was compounded by the fact that other clinical systems and safety nets across both geographical location and time persistently failed to operate.

The Independent Investigation Team found a persistent failure on the part of both Mental Health Trusts to provide Mr. X with care and treatment in accordance with either local or national best practice guidance. Frustratingly both Mental Health Trusts had in place clear, concise, and fit for purpose, clinical policies and procedures during the period that Mr. X was known to them. No sound explanation could be offered to this inquiry to clarify why such an extensive series of policies and procedures failed so completely in relation to every significant aspect of Mr. X's care and treatment. In mitigation it is known that Mr. X was hostile, suspicious and litigious in the extreme. However this still does not serve to offer a full explanation as to why his care and treatment was so seriously compromised over time. The systems that failed to work were identified as follows:

Lincoln

The following findings were identified.

1. **Diagnosis.** The Independent Investigation Team found that the diagnosis of delusional disorder was appropriate based on the clinical evidence available at the time Mr. X received his treatment and care in Lincolnshire. However a disorder of this kind requires a long-term treatment strategy and this failed to occur. Mr. X was allowed to disengage from the service even though he had an enduring mental illness which had been characterised by non compliance, lack of insight and engagement, and associated high risk behaviours. The nature and presentation of Mr. X's condition were not taken into sufficient account and this contributed to the breakdown of his mental health care.

2. **Medication.** It is the view of the Independent Investigation Team that the prescription of antipsychotic medication was appropriate for Mr. X. However the decision to change from depot to oral mediation was regrettable and this contributed to the breakdown of Mr. X's engagement with mental health care services.

3. **Mental Health Act (1983).** The initial assessment process when Mr. X was first admitted in September 2002 to inpatient services was sound. The subsequent decision to treat Mr. X under Section 3 of the Mental Health Act (1983) was appropriate. Unfortunately on the sudden discharge from his Section 3 by a Mental Health Act Tribunal Mr. X discharged himself from hospital with immediate effect. No care plan was put in place and the duty to provide care under Section 117 of the Mental Health Act (1983) was not achieved. The duty to provide aftercare under Section 117 only ceases once the Primary Care Trust, Strategic Health Authority or Local Authority are satisfied that the person is no longer in need of services. Mr. X was allowed to completely disengage and therefore slip through the safety net of care without any decision formally having been made about his future care and treatment requirements.

4. **Care Programme Approach (CPA).** There was no robust CPA assessment or care planning process in place following Mr. X's discharge from Lincolnshire inpatient services. The extant documentation would suggest a weak approach was taken. The Care Coordinator that was finally allocated to Mr. X was inexperienced in community-based working and lacking in supervision, this exacerbated the difficulties that ensued regarding the lack of engagement with Mr. X and his gradual withdrawal from the service. The CPA policy in operation at the time was not adhered to with regard to service users who disengage from the service.

5. **Risk Assessment.** Several risk assessments were partially completed; they did not illustrate fully the history and known criminal activities of Mr. X. This had the effect of minimising his presentation and needs, both during his time as an inpatient and also upon his discharge back into the community. The risk assessments did not lead to a dynamic management plan of Mr. X's risk. Multidisciplinary team work was not evident in the risk assessment process, the Trust policy in operation at the time stated that this was expected. In the case of Mr. X this contributed to weak assessment and planning as there was no 'pooling' of ideas or understanding of his full risk profile.

Another important factor that led to poor risk assessment was the failure to appreciate the importance of Mr. X's lack of engagement.

6. **Referral and Discharge.** 1) The referral to MAPPA during 2002 was not documented properly. It is not possible to understand why Mr. X was referred, or whether this referral was rejected or not. 2) On discharge from inpatient services there was no adherence to Section 117 arrangements, no care plan was developed and no multidisciplinary follow up occurred. 3) The transfer to Swindon never actually occurred; instead an informal communication took place between the Care Coordinator and Swindon Community Mental Health Team Managers. The Trust policy was not adhered to and this policy stated that all responsibility remained with the originating service until the new one had formally accepted the case. The eventual decision to discharge Mr. X from Lincoln-based services took place in the full knowledge that this would sever all links to specialist care and treatment from secondary services.

7. **Carer and Service User Experience.** Mr. X's carers were communicated with sporadically. We understand that Mr. X did not give his permission for ward staff to talk to his parents and that this is a very difficult area for services to navigate. However Mr. X's parents were elderly and Mr. X did present a significant risk and this should have been considered. Also their needs as carers should have been considered with special regard made to the fact that they had to travel with their son on a regular basis between Swindon and Lincoln in order to obtain his medication.

8. **Clinical Supervision.** The Lincolnshire Partnership NHS Foundation Trust had a clinical supervision policy which made clear that all staff who were involved in direct patient care should have both management supervision and practice supervision. In 2003 in Lincolnshire Mr. X's second Care Coordinator, was a nurse newly appointed to the community who had until then worked in one of the local inpatient wards. It would appear that he received no clinical supervision until December 2003. It appears that the Community Mental Health Team in Lincoln was operating outside of the Trust's supervision policy in allowing a relatively junior member of the team to carry the responsibility for the care coordination of a service user on enhanced CPA who was disengaging from the service.

9. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This occurred persistently over a seven-year period regardless of which agency or service Mr. X was involved with.

Swindon

1. Management of the Case in Swindon

This area needs to be divided into two separate episodes.

- **2003.** The Care Coordinator in Lincolnshire spoke to a Swindon Community Mental Health Team (CMHT) Manager over the telephone and also wrote to him on two occasions to arrange for Mr. X's case to be transferred between the Lincolnshire Mental Health Services to those in Swindon. Mr. X was at this time eligible for Section 117. It was agreed over the telephone that Mr. X's records would be sent to the Community Mental Health Team Manager and that Swindon Services would discuss how best to manage the case. The Lincolnshire records noted the outcome that Swindon would not accept the referral but that it had been agreed that the notes would be kept on file at the Swindon CMHT base in case Mr. X required future interventions. This was clearly an inadequate response. During the Independent Investigation Swindon witnesses stated that no letters or clinical records were ever received. No records of this episode can be found within the Trust. It is the view of the Independent Investigation Team that Mr. X's care transition was poorly managed at this stage.

- **June 2007.** The sister of Mr. X tried to access help for her brother from the Swindon Crisis and Home Treatment Team. On the 19 June she spoke to a Crisis Team Worker over the telephone. This led to the Crisis Team Worker contacting Mr. X's Lincolnshire Consultant Psychiatrist's Medical Secretary. The Medical Secretary sent a fax directly which contained some letters and a medical report from a previous Mental Health Act (1983) Tribunal. A copy of Mr. X's entire clinical record followed on the 26 June 2007. The Independent Investigation Team was told that these records remained partially read. These records clearly contained Mr. X's past history and risk profile. It is the view of the Independent Investigation Team that had these records

been read in a timely manner Mr. X's case would have been managed differently and a Mental Health Act (1983) assessment conducted as a matter of urgency.

2. **Liaison with the Lincolnshire Trust and Transfer Processes.** Liaison with Lincolnshire Services was not managed in a proactive manner either in 2003 or in 2007. At no time did anyone from the Swindon Service contact the Lincolnshire Consultant Psychiatrist directly to ascertain more details about Mr. X. On two separate occasions the Trust received and held sufficient information of a nature that should have led to a direct communication. This did not occur. The Independent Investigation Team has found that Avon and Wiltshire Partnership Mental Health NHS Trust did not act appropriately in relation to a patient entitled to Section 117 aftercare and living in their area.

3. **Mental Health Act.** Swindon-based services did not initiate an assessment under the Mental Health Act (1983) in an appropriate or timely manner.

4. **Adherence to Operational Policy and Use of the Mental Health Act (1983).** It would appear that Mr. X's case was wrongly picked up by the Crisis Team; the case would have been more appropriately allocated to a Community Mental Health Team. The Crisis Team struggled with the idea of conducting a Mental Health Act (1983) assessment as it was not part of their operational policy to do so, however they retained the case as they *'did not want to drop the baton'*. This resulted in Mr. X's case remaining with the Crisis Team for a period of 22 days during which time no visit was made, no assessment was undertaken and no plan was actually formulated.

5. **Assessment of Risk and Forensic History.** It would appear that the Crisis Team did not take the sister of Mr. X's concerns about her brother seriously. This is because there was not enough information available to the Team in the first instance. However, even when this information did become available, no one took responsibility for arranging the appropriate assessment that this information would have indicated. It is a fact that Mr. X's clinical records were with the Crisis Team for a period of 16 days without being taken into full account.

6. **Liaison with the Family of Mr. X and Vulnerable Adult Safeguarding Measures.** The accounts made available to the Independent Investigation Team from both the sister of Mr. X and the Crisis Team vary, however the Independent Investigation

Team find that the family were not consulted with appropriately and that the Crisis Team appeared to advocate for Mr. X as a default position without ever having met him or read his clinical records. Safeguarding Vulnerable Adult issues were identified by the Crisis Team but not acted upon in a timely manner. This omission ensured that Mr. and Mrs. X senior remained in a situation that presented a significant risk to them.

7. **Documentation and use of Clinical Records.** The Independent Investigation Team identified serious concerns regarding the maintenance, storage and clinical use of clinical records in that:

    - the Trust would appear to have lost Mr. X's records sent to them in 2003;
    - communications with the Trust between 2003 and 2007 regarding Mr. X do not appear to have been archived;
    - the Trust did not make the appropriate use of clinical records they acquired in June 2007 when there was a pressing need for them to do so;
    - the records in Mr. X's file were not entered contemporaneously thus giving rise to serious doubts about what actually occurred between the 19 June and the 10 July 2007.

8. **Supervision and Staff Competency.** Although this case was 'held' by the Crisis Team the case was in reality allocated to one Crisis Team Worker. The Independent Investigation Team heard that this Crisis Worker was unqualified but was supervised within the Team. Each case was discussed fully by the Multi Disciplinary Team on a regular basis, however it would appear that the Crisis Worker was allowed to attempt to formulate a plan for this case on her own. She was inexperienced and not qualified to do so. The Independent Investigation Team are of the view that significant delays occurred because the Crisis Worker was uncertain how to proceed and that a more experienced person would have acted more decisively.

9. **Performance of Community Services.** The Independent Investigation Team have found that many of the issues identified by NHS Swindon in June 2009 regarding the performance of Avon and Wiltshire Mental Health Partnership NHS Trust services in Swindon are pertinent to the Mr. X investigation, namely:

    a. unanswered telephones;

b. difficulty making referrals or getting people admitted into the services;

c. difficulties in accessing services if a person has no GP;

d. poor case allocation and skill mix;

e. difficulty in referrers being signposted to appropriate services.

10. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This persistently occurred over a seven year period regardless of which agency or service that Mr. X was involved with.

Conclusions

Local and national policy and procedure guidance is in place to provide a safety net under both the care of service users and the practise of health and social care professionals. Whilst on occasion there may be the requirement to deviate from formal guidelines this should only be done in a considered manner were the rationale has been discussed and recorded as a multidisciplinary team. In the case of Mr. X, policy and procedure was systematically ignored to the detriment of safe and effective patient care.

Mr. X had a well-documented risk profile developed by Lincolnshire Police Services. This risk profile was minimised by both Lincoln-based and Swindon-based Mental Health Services. It is the view of the Independent Investigation Team that whilst the deaths of Mr. and Mrs. X senior could *not* have been predicted, it *was* possible to predict that Mr. X was capable of acts of violence on the occasions when his mental health broke down. It was evident that Mr. X's mental health had indeed broken down in 2007 and that the risk to those around him was significant as a result.

Whilst the deaths of Mr. and Mrs. X senior may not have been predictable, the deterioration in Mr. X's mental health which contributed directly to their deaths was almost certainly preventable had it been managed in a professional and robust manner. It is the finding of this Independent Investigation that there was a direct causal link between the inadequate management of Mr. X's care and treatment over a seven-year period and the deaths of Mr. and Mrs. X senior. Both the Avon and Wiltshire Mental Health Partnership NHS Trust and the Lincolnshire Partnership NHS Foundation Trust failed to deliver the required standard of

care and treatment to Mr. X. This is particularly so in relation to the Avon and Wiltshire Trust whose failure to respond to information received fell far short of any acceptable standard.

3.6. Recommendations

Lincolnshire Partnership NHS Foundation Trust

Due to the long interval that has occurred between the time Mr. X received care and treatment from the Trust and the completion of this report, the following section has set out the progress that the Lincolnshire Partnership Foundation NHS Trust has made over the past seven years. The recommendations focus on the assurance of this progress.

Recommendation Number One. All key junctures of the 'Multi Disciplinary Integrated Care Pathway Acute Care' should be subject to a comprehensive audit on the publication of this report. This audit to be Lincoln-based and to ensure compliance with:

- the appropriate completion of all pathway documentation within the preset timescales;
- variance tracking, cause of variance and action taken;
- the views of carers having been sought and recorded.

Recommendation Number Two. All key junctures of the 'Integrated Care Pathway Assertive Outreach' should be subject to a comprehensive audit on the publication of this report. This audit to be Trust-wide and to ensure compliance with:

- the appropriate completion of all pathway documentation within the preset timescales;
- variance tracking, cause of variance and action taken;
- the views of service users having been sought and recorded.

Recommendation Number Three. The Operational Policies of the Community Mental Health and Assertive Outreach Teams must be revised in accordance with any service issues raised from the audit of the Integrated Care Pathways. For example these revisions may need to consider:

- establishment;

- skill mix;
- clinical supervision;
- record keeping;
- joint working with other services;
- referral and discharge processes.

Recommendation Number Four. On the publication of this report a Lincoln-based service user and carer satisfaction survey should be conducted to ascertain the perceived effectiveness of the Integrated Care Pathway Approach. This survey to establish whether:

- good quality, relevant information was provided in a timely manner;
- the wishes and preferences of service users were taken into consideration;
- the service user was introduced to a named nurse;
- conversations on recovery occurred and were recorded;
- the service user, and where appropriate the carer, were involved in all aspects of assessment and care planning;
- carer assessments were offered;
- copies of relevant information were shared appropriately.

Recommendation Number Five. The clinical risk assessment and management policy should be revised in accordance with national best practice guidance. The revised policy should integrate fully with the Trust Integrated Care Pathway Approach and Care Programme Approach procedures. The new policy should make explicit the requirements for:

- a professional standard of documentation;
- interagency/service liaison;
- safeguarding;
- carer communication and safety alerts (if indicated);
- dynamic care, contingency and crisis planning;
- plans for timed and specific intervention, should relapse indicators be evident;
- the responsibilities of all Trust personnel at all levels in ensuring that policy is appropriately implemented.

Recommendation Number Six. The new clinical risk assessment and management policy should be supported by a mandatory comprehensive training programme for *all* health and

social care staff within the Trust. This training should make explicit the roles and responsibilities of:

- each health and social care professional;
- each clinical team;
- the corporate body.

Recommendation Number Seven. On the publication of this report the Trust should conduct an audit against its 2009 Discharge and Transfer Policies and Procedures to ascertain their effectiveness. These arrangements are relatively new and good practice would require that they are appraised and any appropriate revisions made as necessary.

Recommendation Number Eight. The Trust, in conjunction with NHS Lincolnshire and NHS East Midlands, should develop a formal memorandum of understanding with the Lincolnshire Police Force to establish information sharing protocols.

Recommendation Number Nine. The Trust should undertake a full and comprehensive audit against its current clinical and caseload supervision practice. This audit should review:

- the rate of compliance of clinicians undertaking clinical supervision;
- whether the grade of clinician affects the uptake of supervision;
- sessions *per annum* undertaken by supervisees;
- how many supervisors have been appropriately trained;
- how clinical supervision is recorded;
- how supervision impacts positively on clinical outcomes.

Recommendation Number Ten. The Trust should revise its existing clinical supervision policy in the light of the audit findings. Appropriate training should then be provided for individuals acting in a supervisory role. This policy should also make provision for:

- Clinical Supervision
- Caseload Supervision
- Management Supervision
- Trust internal Professional Regulatory Management systems

Recommendation Number Eleven. All Trust policies and procedures should make explicit the responsibility of the individual professional, the team and the statutory corporate body in the implementation of all local and national best practice guidance. These responsibilities should be restated at all annual staff development reviews and appraisals. These responsibilities should also be presented to all new staff as part of a formal induction process.

Recommendation Number Twelve. New Policies should be disseminated in a formal and systematic manner. The following actions should be undertaken:

- formal training events should be conducted for both new policies providing guidance for significant clinical frameworks and major policy revisions (mandatory training should be considered for CPA and risk);
- policies and procedures should be provided in both electronic and hard copy formats for access by all clinical staff;
- team briefings and team meetings should highlight new policies and procedures;
- team briefings and team meetings should highlight issues arising from internal Trust investigations that have occurred directly due to non-adherence to policy and procedure guidance;
- team leaders should notify either the Director of Nursing or the Medical Director if they have reason to believe that extant Trust policy and procedure cannot be implemented effectively.
- new staff should have sufficient time made available to them to read and understand Trust policy and procedure requirements.

Avon and Wiltshire Mental Health Partnership NHS Trust

The Trust has recently undertaken a whole systems review of its services in Swindon. The recommendations below have been framed in the knowledge of the progress that has been made to-date. This progress has been independently verified by the Trust's statutory performance managers.

Recommendation Number One. The Trust should undertake a comprehensive audit six months after the publication of this report/one year on from the implementation of the new revised Priority Pathways (whichever is first). This audit should be developed in conjunction

with local stakeholders. As well as auditing adherence to policy and procedure it should review:

- sources of referral;
- reasons for not accepting referrals;
- service user and carer satisfaction with ease of referral to a service;
- stakeholder (e.g. General Practice, Police Service, third sector) satisfaction with ease of referral to a service.

Recommendation Number Two. The Trust needs to use the flexibilities contained in the Mental Health Act (2007) to further extend the opportunities to make provisions under The Act. This will assist in ensuring a greater availability of Approved Mental Health Act Practitioners and will ensure a timely implementation of The Act in situations of crisis.

Recommendation Number Three. In conjunction with NHS Swindon the Trust must review the newly revised Single Point of Entry system including the changes to Standard Operating Procedures within a twelve-month period of its inception.

Recommendation Number Four. The Trust must audit the use of the Risk Assessment Template currently being used by the Crisis and Home Treatment Teams. This audit will review:

- adherence to the Trust policy ensuring that *every* person referred to Crisis and Home Treatment Teams has been assessed appropriately;
- the interval of time taken between initial referral and the Risk Assessment Template being completed;
- evidence that the Risk Assessment Template has been discussed by the multi disciplinary team;
- evidence that either appropriate triage/referral occurred within an acceptable timeframe, or a comprehensive and dynamic plan of care and treatment was developed.

Recommendation Number Five. The Trust should continue to provide training across the Trust with regard to the new MAPPA guidance arrangements, changes to information sharing and safeguarding arrangements. This training should be monitored and its effectiveness

audited and reviewed on a regular basis. Opportunities to review the effectiveness and uptake of training should be taken:

- following any referral from the Police Service, Probation Service or Social Services;
- following any safeguarding process;
- following any related serious untoward incident;
- following any related near miss.

Recommendation Number Six. All Trust health and social care personnel should receive training with regard to their duty of care to both the Trust Safeguarding Adults' Policy and the Safeguarding Vulnerable Adults in Swindon and Wiltshire Policy that operates on behalf of all statutory agencies in the County. This training should make explicit:

- what constitutes a vulnerable adult;
- situations that constitute potential risk to vulnerable adults and that require action;
- every individual health and social care workers' duty of care as an employee of the Trust;
- each separate Agencies' duty of care;
- systems and alerts for initiating formal assessment and action.

Recommendation Number Seven. The Trust and the Swindon-based Police Service should formalise a Safeguarding Vulnerable Adults protocol to ensure a rapid response process is formulated. This protocol should be made available to all clinical teams in the Swindon area.

Recommendation Number Eight. The new Records Management System will require audit in order to ensure compliance with pre-existing Trust policy and procedure.

Recommendation Number Nine. The Trust must disseminate the findings of this Independent Investigation across the organisation as a case study to explore the implications of not producing contemporaneous records. These implications need to underline:

- the risks to the service user and their carers;
- the risks to the individual professional/worker;
- the risks to the corporate body.

Recommendation Number Ten. A quantitative and qualitative audit should take place to examine the supervision status of non-qualified staff. The findings of this audit should be used to revise the Clinical Supervision Policy. This audit should review:

- the percentage of non-qualified staff receiving clinical supervision;
- the number of sessions made available *per annum* to individuals;
- the grade of the person acting as supervisor;
- the links to training and development opportunities arising from the needs identified during supervision;
- the recording process utilised for any discussions and decisions made that are service user focused.

Recommendation Number Eleven. New Policies should be disseminated in a formal and systematic manner. The following actions should be undertaken:

- formal training events should be conducted for both new policies providing guidance for significant clinical frameworks and major policy revisions (mandatory training should be considered for CPA and risk);
- policies and procedures should be provided in both electronic and hard copy formats for access by all clinical staff;
- team briefings and team meetings should highlight new policies and procedures;
- team briefings and team meetings should highlight issues arising from internal Trust investigations that have occurred directly due to the non-adherence to policy and procedure guidance;
- team leaders should notify either the Director of Nursing or the Medical Director if they have reason to believe that extant Trust policy and procedure cannot be implemented effectively.
- new staff should have sufficient time made available to them to read and understand Trust policy and procedure requirements.

4. Incident Description and Consequences

The following account has been taken from a variety of sources. The main source used is that of the transcription taken during the proceedings of the Crown Court in the case of Regina Versus Mr. X early in 2008. The events leading up to the incident and the incident description are set out below.

Mr. and Mrs. X senior lived in a bungalow in the Swindon area. Their son, Mr. X, also lived with them at this address[16]. Mr. X had been periodically engaged with mental health services between 2000 and 2003, at this time he had been living and working in Lincolnshire. At the time of the Court proceedings early in 2008 it was noted that Mr. X's last contact with Lincolnshire mental health services occurred on the 18 August 2003[17].

Between August 2003 and July 2007 Mr. X's mental health appeared to deteriorate. During this period the sister of Mr. X made many attempts to obtain help for him from a number of agencies to no avail. Mr. X's behaviour became increasingly erratic and frightening and his family became desperate to obtain help for him[18].

On Friday 6 July 2007 the sister of Mr. X spoke to her parents to discuss the arrangements that she had made for them to meet with the Swindon Mental Health Crisis Team regarding Mr. X's deteriorating mental health[19].

On Saturday the 7 July 2007 at 8.00 am Mr. and Mrs. X senior's car was seen being reversed off their drive way. Mr. and Mrs. X senior's neighbours reported to the Court that no further activity was seen at their bungalow that day and that there was no further sign of their car[20].

On the morning of Monday 9 July 2007 Mr. X was seen coming out of his parents' bungalow by a neighbour. Later that day the neighbour's husband found two bin bags behind the shed at the back of the garden that divided Mr. and Mrs. X senior's garden and his own. Inside one

16. Crown Court Case Summary P.1
17. Crown Court Case Summary P. 4
18. Crown Court Case Summary PP. 4-5
19. Crown Court Case Summary P. 5
20. Crown Court Case Summary PP.5-6

bag were freshly laundered wet clothes, bedding and a towel. These were duly seized by the Police on the 12 July 2008.

On Tuesday 10 July 2007 Mr. X telephoned his sister to inform her that their parents would not be around that night as they had gone to Lincoln to look into selling the house that he still retained there. The fact that Mr. X telephoned his sister was a unique event as he did not usually communicate with her. She drove to her parents' bungalow and spoke at length to her brother; she told the Court that this was the first proper conversation that she had had with him in years[21]. The sister of Mr. X was concerned that her parents had decided to stay overnight in Lincoln without informing her and so she telephoned her brother later that evening to enquire as to their whereabouts. She was told that they still had not returned home[22].

On the morning of Wednesday 11 July 2007 the sister of Mr. X telephoned him. Mr. X informed her that their parents had still not returned home. Later the same day she went to her parents' bungalow and took Mr. X to Wickes (a DIY store) so that he could buy some plumbing fixtures as he was refitting the bathroom. The sister of Mr. X noted that Mr. X became very agitated when she picked up some bin bags and he told her not to touch them. She left to go home[23].

When the sister of Mr. X returned to her home she was given a message to contact the Police as her parents had been reported missing. Apparently Mr. and Mrs. X senior had failed to arrive at the weekly dance they always attended. Their friends telephoned Mr. and Mrs. X senior to find out if anything was wrong only to be told by Mr. X, who answered the telephone that his parents had gone to Lincoln. The friends of Mr. and Mrs. X senior were not satisfied with this explanation and believing something to be wrong contacted the Police[24].

On hearing that her parents had been reported missing the sister of Mr. X telephoned him and told him that she was coming back to the bungalow. Before she could leave her home Mr. X telephoned her back to say that the Police had arrived. The Police made some general enquiries. Mr. X was reported as remaining calm and co-operative. He gave the Police an

21. Crown Court Case Summary PP. 6-7
22. Crown Court Case Summary P. 7
23. Crown Court Case Summary P. 7
24. Crown Court Case Summary P. 4

account of his parents' absence, explaining that they had taken a trip to Lincoln. The sister of Mr. X took the opportunity to inform the Police that Mr. X's mental health had not been good and that this had recently led to poor relations with his parents. At this stage the Police left both Mr. X and his sister alone at their parents' bungalow[25].

Enquiries in Lincoln by the Police resulted in the discovery of Mr. and Mrs. X senior's car near the railway line at Newark. Witnesses were to report that the car had first been seen parked there on Sunday 8 July 2007[26].

At 18.30 the Lincolnshire Police went to Mr. X's Lincoln home and searched the garden. Under some bins at the rear of the house the bodies of Mr. and Mrs. X senior were found[27]. Mr. and Mrs. X senior had died from multiple blunt trauma injuries and both Mr. and Mrs. X senior had also been strangled. The Wiltshire Police returned to Mr. and Mrs. X senior's bungalow at 20.14 and arrested Mr. X[28].

Forensic examination revealed that Mr. and Mrs. X senior had been killed in their bungalow in Wiltshire and then transported in their car to Mr. X's garden in Lincolnshire. Forensic evidence would suggest that Mr. and Mrs. X senior were already dead by the afternoon of the 8 July 2007. Closed Circuit Television footage for the 8 July 2007 showed Mr. X travelling from Newark railway station at 8.30 in the morning and then emerging at Kings Cross Station. After this he was seen to arrive at Paddington Station and then at Swindon Station by 14.49[29].

At the time of their deaths Mr. X senior was 83 years of age and his wife was 76 years of age.

Mr. X was charged with the murder of his parents. Although Mr. X was unfit to plead a jury at the Crown Court found him responsible for killing his parents. The Judge sentenced Mr. X to an indefinite period of detention at a high security hospital. Mr. X remains at the time of writing this report in a high security facility. At the time of the incident Mr. X was 43 years of age.

25. Crown Court Case Summary P. 8
26. Crown Court Case Summary P. 8
27. Crown Court Case Summary P. 8
28. Crown Court Case Summary P. 8
29. Crown Court Case Summary PP.9-10

5. Background and Context to the Investigation (Purpose of Report)

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

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

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

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

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

iii) Where the 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.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

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

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

6. Terms of Reference

NHS East Midlands set out the Independent Investigation Terms of Reference as follows:

Undertake a systematic review of the care and treatment provided to Mr. X by Lincolnshire Partnership NHS Foundation Trust (LPT), Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and other organisations to identify whether there was any aspect of care and management that could have altered or prevented the events of 11 July 2007.

The investigation team is asked to pay particular attention to the following:

- Review the quality of the health and social care provided by LPT and AWP and whether this adhered to Trust policy and procedure, including:

- Identify whether the Care Programme Approach (CPA) had been followed by the Trusts with respect to Mr. X.

- Identify whether the risk assessments of Mr. X were timely, appropriate and followed by appropriate action.

- Examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.

- Examine the transfer of care between LPT and AWP.

- Application of the Mental Health Act 1983 including the assessment process and Section 117.

- Examine the efforts made by Mr. X's family to access appropriate services whilst he was resident in AWP's catchment area.

- Examine the role of General Practice in the care of Mr. X, including:

- Prescribing and monitoring of medication supplied to and subsequent discharge from the GP Practice in Lincoln.

- Actions taken by GPs in Swindon PCT area in response to concerns raised by Mr. X's family.

- Examine the application of procedures relating to vulnerable adults in relation to Mr. X's parents in June 2007.

- To establish whether the recommendations identified in the internal investigation reports produced by LPT and AWP were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response these recommendations.

- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.

- To report the findings of this investigation to East Midlands Strategic Health Authority and South West Strategic Health Authority.

Approach

The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations.

Should the reviewers identify a serious cause for concern, this should be notified to the Strategic Health Authorities and the Trusts immediately.

The investigation will be undertaken in two phases.

Phase One

This will be an information and fact-finding phase incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

Phase Two

This will include interviews with key staff and managers – either individually or in groups. Fieldwork will be carried out at a neutral venue within a reasonable distance from LPT and AWP.

It is expected the final report will include recommendations to inform the appropriate commissioning of the service by NHS Lincolnshire and NHS Swindon as the lead commissioners of mental health services.

Publication

The outcome of the review will be made public. East Midlands Strategic Health Authority in collaboration with South West Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the Chair of the Investigation Panel, relatives and other interested parties.

Review Team

The review team will comprise appropriately skilled members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work promptly and effectively, with the full process completed within six months following consent being obtained from all parties.

The review team will submit monthly progress reports to the commissioners and family as agreed.

7. The Investigation Team

This Investigation was undertaken by the following panel of healthcare professionals who are independent of the healthcare services provided by the Mental Health Services under investigation.

Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Report Author

Investigation Team Members

Ms. Sue Simmons	National Development Consultant, Health and Social Care Advisory Service. Nurse Member of the Team.
Dr. Tim Saunders	General Practitioner Member of the Team
Dr. Liz Gethins	Consultant Psychiatrist Member of the Team
Mr. Alan Watson	National Development Consultant, Health and Social Care Advisory Service. Social Work Member of the Team
Mrs. Tina Coldham	National Development Consultant, Health and Social Care Advisory Service. Service User Member of the Team

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

8. Investigation Methodology

On the 5 February 2009 NHS East Midlands commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in Section Six of this report. The Investigation Methodology is set out below.

Consent and Communication with Mr. X

At the inception of this Investigation Mr. X was approached by NHS East Midlands in order to obtain his consent for the Independent Investigation Team to access his clinical records. Following discussion between the Responsible Medical Officer (RMO) for Mr. X and the Strategic Health Authority, a meeting was held with Mr. X and a Senior Officer of NHS East Midlands. At this meeting the Independent Investigation process and purpose was explained to Mr. X and on the 4 March 2009 he signed the consent form. Once the signed consent form was received preparations were made to release Mr. X's clinical records to the Independent Investigation Team. On this occasion the future sharing of the published with Mr. X was also discussed.

It was agreed by NHS East Midlands and the Independent Investigation Team Chair that all further communication regarding the report publication and release would be conducted via the Strategic Health Authority. At the time of writing this report the Independent Investigation Team had not met with Mr. X. The Independent Investigation Team Chair has discussed how best to engage with Mr. X with his Responsible Medical Officer regarding his current mental state and ability to contribute to the process.

Communication with the Victims' Family

In February 2009 at the inception of this Investigation a letter was sent to the sister of Mr. X, the daughter of Mr. and Mrs. X senior. This letter introduced the Investigation process and purpose.

3 March 2009. The Independent Investigation Chair visited the sister of Mr. X at her home. The purpose of this meeting was to provide an initial introduction and to explain how the Investigation would be managed. During this meeting the Investigation Terms of Reference

were discussed and the sister of Mr. X was invited to consider them at her leisure and suggest amendments. It was agreed that the Independent Investigation Team Chair would maintain regular communication in order to keep her informed of progress.

17 June 2009. The Independent Investigation Chair and Nurse Team Member visited the sister of Mr. X at her home. The purpose of this visit was to undertake a documentary analysis of certain clinical records relating to Mr. X that were in her possession. On this occasion the sister of Mr. X and her husband were invited to a formal interview with the Independent Investigation Team as part of the inquiry process.

9 September 2009. The sister of Mr. X and her husband attended a formal interview with the full Independent Investigation Team. At this interview they were both able to describe the events as they experienced them between the summer of 2003 and the summer of 2007. The evidence that was provided on this day contributed directly to the formulation of the Investigation chronology.

14 December 2009. A Senior Officer from NHS East Midlands and the Independent Investigation Team Chair met with the sister of Mr. X and her husband at their home. The purpose of this meeting was to provide feedback regarding the findings of the Investigation prior to the report undergoing its final factual accuracy checking stages in readiness for publication. On this occasion the publication process and possible timescales were also discussed with them.

During the Investigation process the Independent Investigation Team Chair maintained communication with the sister of Mr. X via telephone and email in order to provide support, and where appropriate, information, during what has been a very distressing time for the family.

Communication with the Lincolnshire Partnership NHS Foundation Trust

An initial courtesy call was made to the Chief Executive of the Lincolnshire Partnership NHS Foundation Trust. A meeting was arranged.

3 April 2009. A meeting was held between the Independent Investigation Team Chair, the Trust Chief Executive, Director of Nursing, and Deputy Director of Nursing and Clinical

Governance. During this meeting the Investigation process was explained. Initial plans were made regarding staff support and interview dates.

26 June 2009. A workshop was held at the Lincolnshire Partnership NHS Foundation Trust headquarters. All potential witnesses for the Investigation were invited. The Investigation Team Chair was present and accompanied by a Solicitor from Capsticks and the Investigation GP Team Member. The purpose of the workshop was to ensure that the Investigation process was as fair and transparent as possible. All potential witnesses were given a verbal briefing, briefing packs and a question and answer session was also held. Witnesses who could not attend this meeting were offered the opportunity of being briefed over the telephone.

26 November 2009. The Investigation Team Chair and the Social Work Team Member met with the Lincolnshire Partnership NHS Foundation Trust Executive Board Members. The purpose of this meeting was to provide feedback regarding the findings of the Independent Investigation. On this occasion The Trust was invited to work with the Investigation Team to develop recommendations.

Communication with NHS Lincolnshire

An initial courtesy call was made to the Designated Senior Officer of NHS Lincoln. A meeting was arranged.

3 April 2009. A meeting was held between the Independent Investigation Team Chair and the Head of Practitioner Performance and Development and the Professional Executive Committee Chair from NHS Lincolnshire. The process and purpose of the Investigation was explained. Initial plans were made regarding staff support and interview dates.

26 June 2009. Potential witnesses and stakeholders from NHS Lincolnshire attended the same workshop as the Lincolnshire Partnership NHS Foundation Trust personnel as described above.

Communication with the Avon and Wiltshire Mental Health Partnership NHS Trust

Contact with the Avon and Wiltshire Mental Health Partnership NHS Trust was initially made with the Medical Director. This was followed up with written communication that explained the process and purpose of the Investigation.

8 July 2009. A meeting was held between the Independent Investigation Chair and the Trust Chief Executive, Executive Medical Director and Director of Strategy, Director of Nursing, Compliance, Assurance and Standards, and Head of Risk and Compliance. At this meeting the process and purpose of the Investigation was confirmed and initial plans were made regarding staff support and interview dates.

4 August 2009. A workshop was held at the Avon and Wiltshire Mental Health Partnership NHS Trust headquarters. All potential witnesses for the Investigation were invited. The Investigation Team Chair was present and accompanied by a Solicitor from Capsticks and the Investigation Nurse and Service User Team Members. The purpose of the workshop was to ensure that the Investigation process was as fair and transparent as possible. All potential witnesses were given a verbal briefing, briefing packs and a question and answer session was also held. Witnesses who could not attend this meeting were offered the opportunity of being briefed over the telephone.

17 November 2009. The Investigation Team Chair and the Nurse Team Member met with the Avon and Wiltshire Mental Health Partnership NHS Trust Executive Board Members. The purpose of this meeting was to provide feedback regarding the findings of the Independent Investigation. On this occasion The Trust was invited to work with the Investigation Team to develop recommendations.

Communication with NHS Swindon

Initial communications were made with NHS Swindon via the Senior Officer designated to the Investigation.

8 July 2009. A meeting was held between the Independent Investigation Chair and the Assistant Director of Mental Health Commissioning. At this meeting the process and purpose of the Investigation was explained and discussed.

Witnesses Called by the Independent Investigation Team

The Independent Investigation Team was not able to interview all of the individuals involved in the care and treatment of Mr. X. Due to the passage of time some of the witnesses that the Team wanted to call were either living abroad or were no longer contactable. Every effort was made to contact everyone who comprised Mr. X's clinical care team between 2000 and

July 2007. A total of 39 formal Witnesses were interviewed by the Independent Investigation Team. Assistance was also given to the Independent Investigation Team by members of the Wiltshire Police Force, NHS Lincolnshire and Rampton High Security Hospital.

All witnesses were sent letters that outlined the process and purpose of the Investigation. All witnesses were invited to attend a workshop that set out the expectations and functions of an Independent Investigation commissioned under *HSG (94)27*. All witnesses were given briefing packs to assist them in the writing of their witness statements, and to advise them regarding a formal interview situation.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	**Witnesses**	**Interviewers**
14 July 2009	Lincolnshire-based witnesses • Trust Director of Nursing • Trust Medical Director • Trust Assistant Director of Nursing and Clinical Governance • Risk Control Manager (Internal Investigation Member) • Assessment and Care Planning Coordinator (Internal Investigation Member) • Untoward Incident Manager (Internal Investigation Member) • Deputy General Manager of Child and Family Services (Deputy Director of Nursing at the time of the Internal Investigation) • Ward Manager	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer and Investigation Manager
15 July 2009	Lincolnshire-based witnesses • Care Coordinator 2 • General Manager for the Adult Division	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse

	• Director of Operations • Ward Nurse 1 • Service Manager • Consultant Psychiatrist (RMO) • Psychologist (Internal Investigation Member)	Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer and Investigation Manager
16 July 2009	Lincolnshire-based witnesses • Social Worker 1 • Social Worker 2 • Forensic Consultant Psychiatrist • Mental Health Act Manager	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer and Investigation Manager
1 September 2009	Wiltshire-based witnesses • Trust Medical Director • Clinical Director of Service Redesign • Crisis Team Worker (KO) • Social Work Lead for Mental Health in Swindon • Director of Operations • Community Services Manager • Director of Operations • Area Manager for Adults of Working Age in Wiltshire (Internal Investigation Member)	Investigation Team Chair Investigation Team Nurse Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer
2 September 2009	Wiltshire-based witnesses • Mental Capacity and Programme Manager for Swindon Borough Council • Social Worker 3 • Assistant Director of Mental Health Commissioning	Investigation Team Chair Investigation Team Nurse Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer
3 September 2009	Lincolnshire-based witnesses • Trust CEO • Medical Secretary	Investigation Team Chair Investigation Team GP

	• Ward Nurse 2 • GP • Director of Strategic Development and Social Care	In attendance: Stenographer
9 September 2009	• The sister and brother-law of Mr. X	Investigation Team Chair Investigation Team Psychiatrist Investigation Team GP Investigation Team Nurse Investigation Team Social Worker Investigation Service User Member In attendance: Stenographer, and Investigation Manager
17 November 2009	Wiltshire-based witness • Crisis Team Worker	Investigation Team Chair Investigation Team Nurse In attendance: Stenographer
19 January 2010	Wiltshire-based witness • Community Mental Health Team Leader	Investigation Team Chair Investigation Team Nurse In attendance: Stenographer

Salmon Compliant Procedures

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

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

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

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

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

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

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

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

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

(h) that they will be given the opportunity to review clinical records prior to and during the interview.

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

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

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

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

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

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

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

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

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

Other Meetings and Communications

During the course of this Investigation the following meetings were also held.

17 June 2009. The Independent Investigation Chair and the Nurse Team Member met with a member of the Wiltshire Police Force who was able to assist by providing background information. This contribution was received gratefully as it ensured essential signposting was available to the Investigation at an early stage of the inquiry proceedings.

19 August 2009. The Independent Investigation Chair and the Medical Team Member visited Rampton High Security Hospital. During this visit Mr. X's Rampton-held clinical records were accessed and appropriate copies taken for the use of the Investigation Team.

Independent Investigation Team Meetings

In addition to the meetings set out above, the Independent Investigation Team held three full Team Days.

29 May 2009. The first Team day was held on this occasion. Prior to this date each Team Member had already been in receipt of a copy of Mr. X's clinical records. This day consisted of a full briefing regarding the case and the Investigation process; it also consisted of an analysis of the draft Timeline and emerging issues.

Prior to the second Team day each Team Member contributed to the development of the Timeline and the composition of witness questions.

9 September 2009. The second Team day was held on this occasion. Root Cause Analysis was deployed on this day and findings were determined.

26 October 2009. The third Team day was held on this occasion. During this meeting a full care pathway was constructed based on the findings and evidence that had been presented to the Investigation. From this conclusions and recommendations were formulated.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

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

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

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

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

9. Information and Evidence Gathered (Documents)

During the course of this investigation some 5,000 pages of documentary evidence were gathered and considered. The following documents were actively used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. X's NHS Lincoln-based Trust records
2. Mr. X's Lincoln-based GP records
3. Mr. X's Wiltshire-based Trust records
4. Mr. X's Rampton-based clinical records
5. The transcription of the Crown Court proceedings
6. The Lincolnshire Partnership NHS Foundation Trust Internal Investigation Report and action plan
7. The Lincolnshire Partnership NHS Foundation Trust Internal Investigation Archive
8. The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation Report and action plan
9. The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation Archive
10. The NHS Lincolnshire Internal Investigation Report and action plan
11. Secondary literature of review of the media reporting the deaths of Mr. and Mrs. X senior
12. Independent Investigation Witness Transcriptions.
13. Lincolnshire Care Programme Approach Policies, past and present
14. Lincolnshire Clinical Risk Assessment and Management Policies, past and present
15. Lincolnshire Crisis Resolution Home Treatment Policy
16. Lincolnshire Assertive Outreach Operational Policy
17. Lincolnshire Incident Reporting Policies
18. Lincolnshire Policy for the Safe and Supportive Observation of Patients
19. Lincolnshire Clinical Supervision Policy
20. Avon and Wiltshire Being Open Policy
21. Avon and Wiltshire Clinical Supervision Policy and Procedure
22. Avon and Wiltshire Serious Untoward Incident Policy
23. Avon and Wiltshire Policy to Manage Care Pathways and Risk

24. Avon and Wiltshire Integrated Care Programme Approach and the Assessment and Management of Risk Policy

25. Swindon Crisis service Operational Policy

26. Avon and Wiltshire Community Mental Health Service Review (2009)

27. Swindon Action Plan (Community Mental Health Service Review)

28. Avon and Wiltshire Partnership NHS Trust performance management action plans

29. Swindon Borough Council Safeguarding Vulnerable Adults Annual Report 2007/2008

30. Policy and Procedure for Safeguarding Vulnerable Adults in Wilshire and Swindon 2006-2007

31. Healthcare Commission/Care Quality Commission Reports for Lincolnshire services

32. Health Commission/Care Quality Commission reports for Wiltshire services

33. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006

34. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

10. Profile of the Lincolnshire Partnership NHS Foundation Trust Services (Past, Present and Transition)

The county of Lincolnshire is geographically large with a relatively small and dispersed population which is largely rural. The population has grown significantly over the past four years and, this is largely due to immigrant migration. Much of this new population is comprised of young families.

The Lincolnshire Partnership NHS Trust was formed in 2001 from two predecessor Trusts in the north and south of the county. In 2001 the Trust provided, then as now, specialist mental health services to the people of the county of Lincolnshire. Between 2002 and 2006 the Trust provided mental health services to a population of 650,000, currently in 2010 the population stands at approximately 750,000. In 2006 the three Lincolnshire Primary Care Trusts were merged into one organisation and this means that the Trust only has to interface with one Local Authority and one single commissioning body.

During the time that Mr. X was receiving his care and treatment from the Trust, services were aligned to the three Primary Care Trusts. This equated to three divisions that were led by separate General Managers. Following the Primary Care Trust merger all Trust services are now delivered as a countywide provision.

In October 2007 the Trust became a Foundation NHS Trust. The Trust's current annual income is *circa.* £90 million. Services are primarily community based, supported by inpatient units across the county.

11. Profile of the Avon and Wiltshire Mental Health Partnership NHS Trust Services (Past, Present and Transition)

Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health and social care services and specialist services for people with needs relating to drug or alcohol misuse. The Trust promotes health and wellbeing through the recovery model, aiming to support people to reach their potential.

The Trust is a significant provider of mental health services, operating across a geographical span of 2,200 square miles, encompassing a population of 1.6m people and covering six primary care trusts. Services are centred upon 11 main in-patient sites, 97 community bases and four community mental health team bases. The Trust has an operating budget of just over £200m per year and employs approximately 4,200 people.

The Trust's strategic objectives during the next five years are to:

- deliver patient-centred services that focus on recovery;
- develop its core business;
- achieve Foundation Trust status.

The Trust achieved a rating of 'good' for its quality of financial management and 'fair' for quality of services in the Care Quality Commission Annual Health Check for 2008/09.

Swindon is an expanding new town with high morbidity, with a population that is set to increase by 23% over the next ten years.

The Trust provides a full range of mental health services in Swindon for adults of working age and older people, including Community Mental Health Teams, a Crisis Resolution and Home Treatment Team and inpatient services.

Services in Swindon

At the time Mr. X was in contact with the Trust, services for adults of working age were split into three community mental health teams, five specialist teams, an acute inpatient ward and

a rehabilitation unit. The philosophy of the Swindon services provided to adults of working age was to provide as much care and treatment as possible in community settings.

The Community Mental Health Teams (CMHTs) in Swindon provided assessment and care for people living in the community who experienced mental health problems or difficulties. The CMHTs also offered support for carers, assessing their needs and providing any required assistance and support. The CMHTs were comprised of a multidisciplinary profile and included psychiatrists, community psychiatric nurses, occupational therapists, social workers and other specialist staff.

The Swindon Adult Crisis and Home Treatment Team was dedicated to dealing with anyone over the age of 18 years in an acute crisis. This service operated 24 hours a day, seven days a week and would respond to, and assess, individuals wherever they happened to be. This team acted a gatekeeper to acute inpatient services and also provided advice and support to relatives.

12. Chronology of Events

This Forms Part of the RCA First Stage

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

Background Information

Mr. X was born in 1964 and at the time the incident occurred he was 43 years of age. He has one full elder sibling[30]. As a child Mr. X was described as being quiet and socially withdrawn, he never made friends or had any relationships outside of his home. He was however close to his parents. He left school at 16 and undertook an electrical apprenticeship[31].

In 1989 Mr. X took up a civilian post with the Royal Air Force, initially close to Swindon where he still lived with his parents. Between 1994 and 1998 he moved to RAF Waddington and at this stage he bought a house in Lincoln where he lived during the week, returning to his parent's home each weekend. Once a month his parents would drive up and stay with Mr. X in Lincoln[32].

In 1999 Mr. X was suspended from his job following accusations regarding the sustained harassment of a female work colleague which had persisted over a 12 month period. As the result of a subsequent disciplinary hearing in December 1999 Mr. X was dismissed from his job[33].

At this time Mr. X's family were unaware of the exact details of the situation believing that he was in the process of taking his employers to an Employment Tribunal due to an unfair dismissal process. Mr. X visited his parents in Swindon where it would appear that he blamed them for the negative outcome of his case. During this visit Mr. X attacked his father bruising

30. File 3 P. 26
31. File 3 P. 26
32. File 3 P. 26

33. File 1A P. 20

him badly, and also hurt his mother. Mr. and Mrs. X senior were both so frightened that they barricaded themselves into their bedroom. After this event Mr. X left Swindon to live in Lincoln and became estranged from his family. Mr. and Mrs. X senior were too afraid to travel to Lincoln to see him and lost contact with Mr. X at this stage[34].

In January 2000 the female work colleague that Mr. X had been accused of harassing became aware of a series of letters that he had written to many people, including the Prime Minister, alleging that she was endangering others by spreading AIDS and using illicit drugs. At this stage she contacted the Police and Mr. X was subsequently charged with harassment[35].

Clinical History in Lincolnshire

17 October 2000. Mr. X was interviewed by a Forensic Consultant Psychiatrist on behalf of the Lincoln Court Assessment Scheme. At this time Mr. X was awaiting sentencing. This report described Mr. X's perspective on the events that had led up to his prosecution. The Consultant noted that Mr. X had no previous psychiatric history. He was of the opinion that Mr. X suffered from distorted thinking and a discrete delusional disorder. He recommended a Probation Order and voluntary referral to mental health services[36].

2 November 2000. Mr. X was convicted of harassment and placed on probation for 12 months. Mr. X also had to pay costs and compensation and was placed under a restraining order. The Probation Order was made with the specific purpose of monitoring Mr. X and encouraging him to access mental health services[37].

In the latter part of 2000 it is thought that Mr. X moved to Bolton where he intended to study for a Masters Degree. The Forensic Consultant Psychiatrist sent a letter to the Lincoln Probation Service. This letter is undated but was probably written in either November or December 2000. The Consultant wrote in this letter that he needed to know whether or not he should arrange further follow up for Mr. X either himself or through psychiatric services in Bolton. In this letter he stated that Mr. X's father had contacted him recently. The Consultant had advised Mr. X senior to contact the supervising Probation Officer and in the letter

34. The sister of Mr. X's transcription
35. File 1A P.20
36. File 1A PP. 20-22
37. File 1A P. 3

provided the family's telephone number in case Probation Services wished to be proactive in communicating with the family[38].

19 December 2000. Mr. X's Probation Officer in Bolton wrote to the Forensic Consultant Psychiatrist. She had become concerned about Mr. X's mental health and was not certain how to proceed. In her letter the Probation Officer asked for advice on how best to persuade Mr. X to engage with mental health services[39].

26 March 2001. The Forensic Consultant Psychiatrist responded to the Bolton-based Probation Officer and suggested that Mr. X should be referred to the Mentally Disordered Offender Panel, and said that he would be happy for a copy of his report to be forwarded as part of the referral process[40].

There is no further documentation about this episode on file.

2000-2001. It would appear that between 2000 and 2002 Mr. X continued to live in Lincoln and that the period of time that he was domiciled in Bolton was of a limited duration. It would also appear from the evidence supplied to the Investigation by witnesses, that Mr. X was subject to his Probation Order and that he received regular advice from a Lincoln-based Probation Officer to engage with mental health services. This he declined to do[41].

2001-2002. During this period Mr. X began to write letters of complaint to the Chief Constables of the Greater Manchester and Cambridgeshire Police Forces. These letters cited incidents of harassment and assault perpetrated against him[42].

5 July 2002. Mr. X wrote to the Chief Constable of the Lincolnshire Police Force. In this letter he complained that he had been assaulted, bullied and harassed continuously by Lincolnshire-based Police officers. Mr. X also stated that these Police Officers were spreading lies about him and were trespassing on his property, one incident had included

38. File 1A P.65
39. Witness statement appended letters
40.Witness statement appended letters
41. Witness statement
42.Witness statement

posting dog excrement through his letter box. The letter stated that he was going to purchase a legal weapon to carry '*to protect myself*'[43].

28 July 2002. Mr. X went to the home of a Police Officer, a Sergeant, who lived in a house in the same road as himself. Mr. X demanded to know whether or not the Sergeant was a Police Officer and became abusive and threatening. As a result Mr. X was escorted off the premises and told not to return. On this occasion the Police Officer who had had no previous contact with Mr. X felt that he was behaving in an irrational and bizarre manner. The Police Officer formally reported the incident[44].

31 July 2002. On this day Mr. X subjected a second Police Officer, who also lived in the same road as himself, to abusive gestures whilst he stood in the street[45].

1 August 2002. Following these incidents a check was undertaken and it was discovered that Mr. X had been involved with the Cambridgeshire Police and that he had been issued with a restraining order. The Cambridgeshire Police confirmed that Mr. X was well known to them and that he had the habit of bombarding them with '*bizarre communications'* and that he had been assessed as being mentally unstable. His behaviour was such that they had refused to communicate with him any further and that he was dealt with by two specially designated officers. Cambridgeshire Police also described Mr. X as '*dangerous*'. As a result of this information it was agreed that a risk assessment would be conducted the following day and an action plan would be developed[46].

2 August 2002. Mr. X was arrested in the rear garden of his home for the offence of suspicion of causing a public nuisance. He was taken to the Police station and kept in custody. He was reported as being violent on arrest; he was also reported as having secateurs in his hand which he refused to put down. There was a struggle and Mr. X was handcuffed[47].

Later this same day Mr. X was seen by a Police Surgeon for a psychiatric assessment. The Police Surgeon reported that Mr. X was not cooperative and recommended that he be

43. File 1A P.65
44. File 1A P.7
45. File 1A P.7
46. File 1A P.8
47. File 1A P. 36 & P. 38

assessed formally by a Consultant Psychiatrist. He was deemed fit to be detained and fit to be interviewed[48].

3 August 2002. Mr. X was seen by a Duty Psychiatrist, an Approved Social Worker and the Police Surgeon for a Mental Health Act (1983) assessment. Mr. X refused to answer any questions. The Duty Psychiatrist recorded '*I am of the opinion that Mr. X suffers from a long-standing paranoid delusional disorder. He in the long term poses a risk to others and would benefit and needs further psychiatrist assessment and treatment. I would recommend that Mr. X be charged for the alleged offences and a request for four weeks remand in a secure ward for further assessment be obtained at the Magistrates Court, or be remanded in custody in a prison where he could be assessed by a forensic psychiatrist with a view to recommendation for section 37*'[49].

Later this same day Mr. X was charged with three counts under the Public Order Act. Mr. X's detention in custody was reviewed and the reviewing officer reported that he felt grave concern and that Mr. X was a '*bomb waiting to go off*'. It was agreed that Mr. X's detention should continue[50].

5 August 2002. Mr. X was due to be placed before the Court on this day. NB. There are no further records that were made available to this Investigation regarding Mr. X's Court appearance or any decision that was made regarding his offences. It would appear however that he was released to his own home some time after the 5 August 2002.

August and September 2002. During this period Mr. X sent numerous letters to the Police Complaints Authority and the Lincolnshire Chief Constable complaining that he had been arrested with excessive force, illegally searched, and assaulted in his back garden by Police Officers. In these letters Mr. X also made reference to his earlier dismissal from the RAF and that United States Rangers were trespassing on his property[51].

17 September 2002. Mr. X was referred to the Lincolnshire Multi-Agency Public Protection Panel because of his '*rapidly deteriorating mental health combined with his move towards*

48. File 1A P.50
49. File 1A PP. 41-42
50. File 1A PP. 43-44
51. File 1A PP. 25-26

arming himself with knives and other edged weapons'. The referral followed a risk assessment that had been conducted by the Lincolnshire Police and this assessment had concluded that Mr. X posed a significant threat and that he was highly dangerous to Police Officers[52]. NB. There was no further documentation made available to this Investigation regarding this referral. The outcome is not recorded in the clinical record.

On the same day the Police-held records were faxed over to the Lincolnshire Mental Health Trust.

19 September 2002. A Mental Health Act (1983) assessment of Mr. X was conducted in his own home. An initial attempt was made to carry out the assessment without forcible entry, but with no success. The Approved Social Worker had to obtain a Section 135 warrant. The Police forcibly entered Mr. X's home with a Consultant Psychiatrist (who was to become Mr. X's RMO), a General Practitioner and the Approved Social Worker. Mr. X refused the option of informal admission and was finally admitted under a Section 2 of the Mental Health Act (1983)[53].

Following Mr. X's admission the Approved Social Worker noted that she was unable to make contact with his next of kin. During the evening of the 19 August an initial risk assessment was completed by a ward staff nurse. Mr. X was described as paranoid and deluded. Evaluation of the risk that he posed was recorded as:

'Risk of suicide – low
Risk of violence or aggression according to this risk assessment – low to moderate
Risk of self neglect – low'

Under a section headed 'personal impressions' there was an entry which stated '*I believe he has the potential to commit greater acts of violence etc.'*

A psychiatric assessment was also conducted and a history taken by the Duty Psychiatric Senior House Officer. The differential diagnosis was paranoid schizophrenia. The plan was to

52. File 1A P. 5
53. File 1A P. 85 & File 1B P.181

treat Mr. X with PRN Zopiclone and Lorazepam. Mr. X was to be placed on close observations for the first 24-48 hours of his admission[54].

20 September 2002. Trifluoperazine was added to Mr. X's medication[55]. A Section 17 form was completed allowing Mr. X escorted leave in the hospital grounds for a period of five days[56].

23 September 2002. The Ward Manager sent a fax to the Lincoln Magistrates Court attaching a letter from Mr. X asking for an emergency adjournment of the hearing that had been set for the 26 September 2002 due to his being in hospital under Section 2 of the Mental Health Act (1983)[57].

26 September 2002. Mr. X's Section 2 was regraded to a Section 3 of the Mental Health Act (1983). The reasons for this regrading were that he was becoming increasingly hostile and aggressive and he was refusing all treatment[58].

Mr. X had previously made an application for an appeal against his Section 2 detention. On this date Mr. X was sent a letter from the Trust Mental Health Act Administrative Assistant to inform him that a date had been set for a Mental Health Review Tribunal on the 30 September 2002[59].

27 September 2002. On this day Mr. X was sent a letter from the Trust Mental Health Act Administrative Assistant to inform him that he had been regraded from a Section 2 to a Section 3 of the Mental Health Act (1983)[60].

30 September 2002. The Mental Health Review Tribunal met on this date. The Consultant Psychiatrist's (RMO) written report stated that Mr. X had a diagnosis of Delusional Disorder '*this group of disorders is characterised by the development either of a single delusion or a set of related delusions that are usually persistent and sometimes lifelong'.* The RMO also indicated that Mr. X was a danger to the safety of others. The tribunal decided to maintain

54. File 1B PP. 322-323
55. File 1B P. 342
56. File 1B P. 395
57. File 1B PP. 387-391
58. File 1B PP. 240-254
59. File 1B P. 258
60. File 1B P. 257

Mr. X's section '*to prevent the deterioration of an already chronic and potentially unpredictable disorder*'[61].

2 October 2002. Clopixol 100mg (test dose) was administered to Mr. X on the ward. Mr. X had to be restrained by staff as he continued to refuse medication[62]. During this period Mr. X refused to talk to doctors and continued in his belief that he was not ill and that there was a conspiracy between the Police and the hospital to detain him[63].

9 October 2002. Clopixol 200mg was administered to Mr. X on the ward[64].

10 October 2002. The Trust Mental Health Act Administrator wrote to Mr. X advising him (in response to an earlier communication from Mr. X) that if he wished for a Hospital Managers Hearing to appeal against his section 3 one would be arranged[65]. On a patient summary sheet Mr. X was recorded as being on Enhanced CPA.

21 October 2002. The Mental Health Act Administrator wrote to Mr. X's Primary Nurse requesting a Nursing Report for the pending Hospital Managers Hearing which was due to be held on the 6 November 2002[66]. The nurse supplied this report and concluded that Mr. X needed to remain on his Section as a further period of treatment was necessary to his well being[67].

23 October 2002. Clopixol 200mg was administered to Mr. X on the ward[68]. During this period Mr. X continued to have escorted leave around the hospital grounds.

25 October 2002. The Consultant Psychiatrist received a letter from Mr. X's solicitor. This letter stated that they understood that Mr. X had been receiving medication without his consent[69]. During this period the ward staff recorded that Mr. X was constantly asking them for papers and envelopes and that he wrote numerous letters.

61. File 1B PP. 233-235
62. File 1B P. 343
63. File 1B PP. 323-330
64. File 1B P. 343
65. File 1B P. 236
66. File 1B P. 231
67. File 1B P. 343
68. File 1B P. 343
69. File 1B P. 228

29 October 2002. The Consultant Psychiatrist confirmed to Mr. X's solicitors that he had been given medication against his will, but that it had been administered under Section 3 of the Mental Health Act (1983)[70].

31 October 2002. At the ward round it was recorded that there may have been some improvement, that Mr X appeared to be more communicative to staff and that he had attended a group that morning[71].

6 November 2002. A Hospital Managers' Hearing was held. At this meeting it was decided that Mr. X was not to be discharged from his Section 3[72]. Mr. X had full Solicitor involvement and support during the Managers' meeting. During the hearing Mr. X presented well and a compromise was agreed between him and his Consultant Psychiatrist. The compromise was that Mr. X would remain on a Section 3 but that he could have extended leave to stay in his own home. Mr. X was expected to return to the ward every two weeks so that his Clopixol injection could be administered. Mr. X was not happy about having to continue with his medication as he still maintained that he was not mentally ill and did not need it. It was decided that the Police would be informed of this outcome, and plans were made to fix Mr. X's front door which had been broken down when he had been originally detained[73].

7 November 2002. Mr. X was given Section 17 leave for one week and returned to his home[74].

13 November 2002. The nursing notes recorded a conversation between the ward staff and the Mental Health Act Administrator. Mr. X was refusing to take his depot. Mr. X's solicitor had been contacted and the ward was advised that Mr. X could not be given his injection against his will whilst on Section 17 leave[75].

70. File 1B P. 343
71. File 1B P.331
72. File 1B P.227
73. File 1B P.419
74. File 1B P.370
75. File 1B P.418

14 November 2002. Mr. X attended the ward round. He said that he was not harassing the Police and that they were not harassing him. He agreed to a home visit by a Community Psychiatric Nurse, and Section 17 leave was granted until the 21 November 2002[76].

18 November 2002. A Care Coordinator was allocated to Mr. X and a home visit took place. The Care Coordinator described Mr. X as being reasonably friendly and willing to have his depot injection administered[77].

19 November 2002. The Care Coordinator made another visit to Mr. X's home and took forms with him so that Mr. X could register with a GP. Mr. X was concerned that he was running out of money as he had spent most of his savings. Mr. X talked about taking his case to the European Court of Human Rights[78].

21 November 2002. Mr. X attended the ward round. He received his Clopixol injection[79].

25 November 2002. Mr. X registered with a General Practice and also had a consultation with a GP. The Care Coordinator accompanied Mr. X to the Benefits office[80].

27 November 2002. Mr. X appealed against his Section 3 at a Mental Health Act Tribunal. The Tribunal discharged him from his Section 3. The Tribunal felt that whilst they had no doubt that the original detention was justified by his psychotic state at the time of his admission Mr. X was now responding to treatment and was no longer expressing persecutory ideas. The Tribunal noted that Mr. X had been living at his own home for a three-week period '*without untoward incident*' and that there could be no justification for further detention[81]. Mr. X immediately discharged himself from the ward.

12 December 2002. Following a contact with Mr. X's parents, Mr. X's father (Mr. X senior) telephoned a Social Worker to express his concern about Mr. X's financial situation. Mr. X senior mentioned that he had not had any contact with Mr. X for three years. He told the

76. File 1B PP.369-370 & PP. 331-332
77. File 1A P.140
78. File 1B P.141
79. File 1B P.332
80. File 1A P.142 & File 2 P.3
81. File 1B P. 225

Social Worker that he had posted a mobile telephone to Mr. X so that he could keep in touch[82].

18 December 2002. A member of the Community Mental Health Team contacted Mr. X senior and was told that the family had arranged for Mr. X to visit them over the Christmas period[83].

23-24 December 2002. The Care Coordinator made a total of four visits to Mr. X's home. He was not in[84].

24 December 2002 - 1 January 2003. Mr. X stayed with his parents in Swindon[85].

2 January 2003. The Care Coordinator visited Mr. X at his home in Lincoln. Mr. X's parents were also present. Mr. X accepted his Clopixol injection and appeared to be settled[86].

7-8 January 2003. A Lincolnshire Police Officer contacted the Care Coordinator about returning Mr. X's property. He referred to four photographs that Mr. X had taken of Police Officers that they wished to destroy. Mr. X said that he been advised to take the Photographs by his solicitor as the Police Officers were trespassing on his property. It was agreed that the Care Coordinator would collect Mr. X's property. The Police retained the photographs and Mr. X's camera. Mr. X told the Care Coordinator that he felt the Police were in a conspiracy with American Rangers, although he accepted that the 'harassment' had ceased at the time of his hospital admission[87]. The Police Officer offered to show the Care Coordinator the letters of complaint that Mr. X had once again commenced writing about the conduct of the Police.

9 January 2003. The Consultant Psychiatrist wrote to the Care Coordinator seeking news of Mr. X as he had not attended his Care Programme Approach meeting[88].

10 January 2003. The Care Coordinator wrote to the Consultant Psychiatrist informing him that Mr. X was accepting his fortnightly Clopixol, although reluctantly. The Care Coordinator

82. File 1A PP. 160-161
83. File 1A PP. 143-144
84. File 1A P. 144
85. File 3 P.27
86. File 1A P.145
87. File 1A PP. 145-146
88. File 1A P.169

reported that Mr. X continued to be suspicious and still maintained that there was a conspiracy against him. This letter was copied into Mr. X's GP[89].

On this day a telephone discussion occurred between Mr. X senior and the Care Coordinator. Mr. X senior said that Mr. X would be welcome to move back home to Swindon if he decided to sell his house in Lincoln. The Care Coordinator visited Mr. X at his home to provide advice on sickness certification and benefits[90].

16 January 2003. The Care Coordinator made a home visit and administered Mr. X's Clopixol injection. Mr. X was noted to remain '*distant, maybe suspicious, though not obviously mentally disturbed*." Mr. X said that he would be willing to comply with oral medication. The Care Coordinator agreed to discuss this with the Consultant Psychiatrist[91].

21 January 2003. A Care Programme Approach (CPA) review was held. The Consultant Psychiatrist, the Care Coordinator and Mr. X were present. Mr. X remained distant and said that he was not ill. He continued to appear guarded and was monosyllabic. His medication was reviewed and it was agreed that his Clopixol would be stopped and that he should commence oral medication (Olanzapine) that would be prescribed by his GP[92].

The CPA documentation from this review was partially completed, on it he was recorded as being on Standard CPA. There is no mention of his being on a Section 117[93]. Risk assessment documentation was partially completed by the Care Coordinator. The assessment noted that Mr. X had a long history of grievances against the Police, that he was suspicious, mildly hostile and difficult to engage. However, the Care Coordinator stated that Mr. X did not give the impression of being a violent person '*although his illness may have affected this'*. Mr. X received a severity rating of '0'. This meant that Mr. X was considered to have no problems relating to risk either to himself or to others[94].

22 January 2003. A Police Officer who had been working on the Mr. X case telephoned the Care Coordinator. Apparently Mr. X's solicitor had advised Mr. X to surrender the

89. File 1B P.89 & File 11. P.7
90. File 1A P.147
91. File 1A P.147
92. File 1B P.333
93. File 1A PP.78-82
94. File 1A PP. 124-131

photographs he had taken of Police Officers. Based on this, if Mr. X complied, the Police were willing to drop the harassment charges against him[95].

23 January 2003. The Consultant Psychiatrist wrote to Mr. X's GP. The letter said that in view of Mr. X's compliance a change to oral medication, Olanzapine 10mg at night, was suggested and that the Clopixol should be stopped. The Consultant Psychiatrist raised no issues regarding Mr. X's mental state and said that he would be reviewed in two months time.

29 January 2003. The Care Coordinator visited the Police Officer involved with Mr. X's case in order to look at the letters that Mr. X had been writing to the Chief Constable and the Police Complaints Authority. It was the view of the Care Coordinator that the letters indicated disordered thinking. The letters, some of them dating back to July 2002, raised concerns in the mind of the Care Coordinator and he recorded that the Police Officer leading Mr. X's case would be available to attend the next review meeting that had been arranged for February 2003. The Care Coordinator was to find out if the Consultant Psychiatrist would be happy with this[96].

30 January 2003. The Care Coordinator visited Mr. X at his home. On this occasion the subject of the photographs was raised. Mr. X became irritable and angry and voiced the opinion that the Care Coordinator was siding with the Police. The Care Coordinator discussed this matter with the Consultant Psychiatrist and also informed the Police Officer of Mr. X's continuing views and possible continuing risk to the Police officers whose photographs he had taken. The Care Coordinator felt so concerned about Mr. X's presentation that he recorded his intention to be accompanied on his next planned visit on 12 February[97].

12 February 2003. On this day the Care Coordinator recorded '*continues to stay with parents – spoke on phone.*' During this period Mr. X senior, Mr. X's father, was very concerned about his son's lack of money. He had written to his MP who had written to the Mental Health Services Trust complaining that no one appeared to be supporting his son in this matter. Mr. X however did not appear to have been very cooperative. The situation was that Mr. X had to present his share certificates and bank statements to the Department of Health and Social Security prior to his being able to claim income support. On this day the

95. File 1A P.147
96. File 1A P.148
97. File 1A P.149

Care Coordinator reminded Mr. X that this needed to be done. Arrangements were made over the telephone for another meeting to be held on the 27 February 2003[98].

27 February 2003. The Care Coordinator met with Mr. X and his parents at his Lincoln home. Mr. X had spent the previous three weeks at his parent's home. The Care Coordinator was told that Mr. X planned to collect his medication from his GP and he was going to go with his parents to sort out his benefits. It was agreed that the Care Coordinator would take Mr. X to his Out Patient appointment with the Consultant Psychiatrist on the 4 March 2003. It was recorded that Mr. X's mental state remained unaltered and that he was '*economical*' with conversation[99].

4 March 2003. Mr. X attended his Out Patient appointment to see the Consultant Psychiatrist. He was accompanied by his Care Coordinator. On this occasion Mr. X was described as being self contained. He denied his mental illness, but paranoid features concerning the Police remained evident. It was recorded that Mr. X was no longer writing letters of complaint. It was recorded that Mr. X was probably going to live with his parents in Swindon for a further two or three weeks. A further Out Patient appointment was planned for three months time[100]. This was the last time that Mr. X was seen by the Consultant Psychiatrist.

5 March 2003. The Consultant Psychiatrist wrote to Mr. X's GP. In this letter he stated that his opinion was that Mr. X had a paranoid disorder which had been partially responsive to antipsychotic medication, with the result that his delusional ideas had been '*encapsulated*' but still persisted in the background. He referred to the likelihood that Mr. X would be allocated a new Care Coordinator and expressed the view that he may not engage with a new person. The Psychiatrist recommended that the GP continued to prescribe Olanzapine 10 mg at night. This letter also noted the view that Mr. X was thinking of moving to Swindon[101].

10 March-15 April 2003. The Care Coordinator spoke to Mr. X several times over the telephone whilst he was in Swindon regarding his benefits. The Care Coordinator also

98. File 1A P.150
99. File 1A P.150
100. File 1A P.151
101. File 1A P.88

informed Mr. X that he was leaving his post and that a new Care Coordinator would be allocated to his case[102].

25 April 2003. Mr. X was visited at his Lincoln home by both his previous Care Coordinator and his newly allocated one. Mr. X informed the new Care Coordinator that he did not have, and never did have, a mental health problem. Mr. X did however say that he would remain compliant with his medication and it was agreed that the new Care Coordinator would make arrangements directly with Mr. X regarding future appointments[103]. It would appear that this was the last time that Mr. X was seen by Lincolnshire Mental Health Services.

16 May 2003. The Care Coordinator recorded in the clinical notes that he had made '*continuous attempts*' to contact Mr. X. He had left several messages requesting that Mr. X contact the Community Mental Health Team base. The Care Coordinator wrote to Mr. X and informed the Consultant Psychiatrist and also the Police Officer who had been leading Mr. X's case. The Care Coordinator was informed by the Consultant that Mr. X had been written to, advising him to attend the ward round on the 26 June 2003[104].

9 June 2003. The Care Coordinator recorded that there had been no response to his calls or to his letter[105].

26 June 2003. Mr. X did not attend the ward round. The Consultant Psychiatrist was of the view that Mr. X should be discharged and the Lincolnshire Police informed. However this did not occur on this date[106].

Partially completed CPA documentation from this period records that Mr. X had started to write letters of complaint regarding the Consultant Psychiatrist and the Police. This had been noted as a sign of relapse in the health of Mr. X. An additional note was made that recorded a conversation which had been held with Mr. X's father who said that Mr. X only now visited Lincoln once a month to sort out his mail[107].

102. File 1A P.151
103. File 1A P.153
104. File 1A P.154
105. File 1A P.155
106. File 1A P.155
107. File 1A PP.15-17

10 July 2003. The Care coordinator documented the fact that Mr. X wanted access to his clinical records. He also wrote that the Police Officer leading Mr. X's case had telephoned him to say that Mr. X was writing many letters of complaint and he wondered whether this may be an indication that Mr. X's mental state might be deteriorating. The Care Coordinator discussed this with the Consultant Psychiatrist who suggested that Mr. X should be invited to attend a ward round on the 24 July 2003[108].

11 July 2003. The Care Coordinator telephoned Mr. X's father. Mr. X refused to come to the phone. A letter of invitation was sent to Mr. X's home address[109].

24 July 2003. Mr. X did not attend the ward round. The Care Coordinator discussed a possible discharge with the Consultant Psychiatrist[110].

25 July 2003. A risk profile was partially completed by the Care Coordinator. This documentation recorded that Mr. X was on enhanced CPA. No current risks were identified.

29 July 2003. On this day the sister of Mr. X telephoned the original Care Coordinator to inform him that Mr. X's mental health appeared to be deteriorating. Mr. X was laughing inappropriately and sending a '*vast amount of letters*'. The sister of Mr. X was advised to register Mr. X with a Swindon-based GP so that he would be able to access services there. The original Care Coordinator telephoned Mr. X's current Care Coordinator to inform him of this conversation[111].

1 August 2003. The Care Coordinator contacted the Community Mental Health Team (CMHT) in Swindon on this day and discussed Mr. X's situation with Community Team Leader 1 over the telephone. He recorded that the Swindon Team would discuss Mr. X at their next team meeting and contact Lincoln services regarding how they wished to proceed[112].

4 August 2003. The Consultant Psychiatrist wrote to the Lincoln-based GP stating that Mr. X had not attended his Out Patient appointments with himself and the Care Coordinator and that

108. File 1A P.155
109. File 1A P.155
110. File 1A P.155
111. File 1A P.156
112. File 1A P.156

he had no alternative but to discharge him from his Out Patient service. He commented that Mr. X did not appear to be writing any unpleasant or harassing letters at the current time, and that he may have already returned to Swindon. This letter also recommended that if he needed a future mental health referral in Lincoln it should be to the appropriate sector team as the Consultant had originally taken Mr. X onto his caseload via the No Fixed Abode Scheme. The Consultant also explained that he did not enjoy a good relationship with Mr. X and that this future plan would also be a good idea from that point of view.[113].

18 August 2003. The Care Coordinator telephoned the Swindon CMHT and told them he wished to hand over Mr. X's after-care to them. On this occasion he spoke to Team Leader 1. The Care Coordinator then wrote to a different Swindon-based worker, Team Leader 2, summarising some of the background to Mr. X's case and care. This letter referred to the fact that Mr. X lived most of the time in the Swindon area and also stated that he was eligible for Section 117 aftercare. The Care Coordinator requested a transfer of Mr. X's aftercare and asked the Swindon Team to inform him of their decision. This letter was copied to both the Consultant Psychiatrist and the Lincoln-based GP[114].

23 October 2003. The Care Coordinator wrote to Swindon Community Team Leader 2 once again. In this letter he referred to a recent telephone conversation and enclosed background information regarding Mr. X[115].

28 October 2003. The Care Coordinator recorded that there had been two telephone conversations between himself and the Swindon Community Team Leader 2. It had previously been agreed that background information was to be sent to the Swindon Team, this was so that if Mr. X's mental health broke down and came to their notice they would have some background information to work on. The Care Coordinator recorded that Mr. X would not be taken on by the Swindon Team at the current time as he was not registered with a Swindon GP, and he was '*unlikely to engage anyway'*. The Care Coordinator's intention was to discharge Mr. X from his caseload, and to offer him the opportunity to contact him again if he needed to do so[116].

113. File 1A P.90
114. File 1A PP.156-157
115. File 1A P.159
116. File 1A P.157

4 November 2003. The Care Coordinator discharged Mr. X from his caseload and wrote letters to Mr. X, the Consultant psychiatrist and the GP confirming this. He recommended that Mr. X registered with a GP in Swindon. There was no discharge care plan or formal transfer of care[117].

Mr. X continued to stay with his parents between January 2003 and March 2004. During this time he travelled to Lincoln each month to collect his prescription from his GP for Olanzapine and have it dispensed at a local pharmacy. During this period he continued to write a large number of letters of complaint to numerous bodies, including the Health Service Ombudsman. Clinical Records cite that some 35 letters alone had been sent prior to his discharge as an inpatient. It would appear that this behaviour remained unabated following his discharge.

25 March 2004. The sister of Mr. X telephoned the Lincoln-based GP on this day to ask for help for her brother. The electronic notes recorded '*Living in Swindon with elderly parents. Parents bring him to Lincoln once a month to collect Olanzapine and check his house. Won't seek medical advice in Swindon. Mental state has deteriorated over last month. Advised she/parents must seek help from local GP/psychiatric services unless he returns to Lincoln for assessment. No further Olanzapine to be issued from this surgery*'. Mr. X's prescription was stopped from this date[118].

10 May 2004. Mr. X's GP wrote to him explaining that as he had not attended for a review the Practice could no longer offer medical services to him and asked him to register with a GP near to where he now lived[119].

March 2004 – February 2007. The sister of Mr. X made numerous telephone calls to both Lincoln and Swindon services during this period, asking for help and intervention for her brother and her parents. At no time did either service initiate a visit or an assessment. During this period Mr. X continued to live at his parents' home. According to his sister he applied for many jobs and spent long periods in the library. It is estimated that he wrote between 50-100 letters each week. Occasionally Mr. X visited his sister so that he could use her computer. He had no other relationships outside of his parents' home.

117. File 1A P.158
118. File 2 P.22
119. File 2 P.25

Clinical History in Wiltshire

By 2007 it was evident to Mr. X's family that his mental health had deteriorated severely. The situation was becoming such that they could no longer manage Mr. X alone and once again began to seek help.

13 or 14 February 2007. The sister of Mr. X went to the Citizen's Advice Bureau (CAB) to seek information and support. She felt that her parents were becoming increasingly at risk from Mr. X's behaviour. The CAB contacted the Police who then contacted the sister of Mr. X and said they would contact the Emergency Duty Social Work Team. The sister of Mr. X then received a telephone call from the Emergency Duty Team who took details, but told her there were insufficient grounds for a Mental Health Act assessment. However the Duty Social Worker who took the call said that she would pass on the information to the Community Mental Health Service (CMHT). She advised the sister of Mr. X to get him registered with a local GP. There is a record of this conversation in the Swindon Emergency Duty Team notes, written by the Duty Social Worker. The record states that she was told about the violence, but the impression gained was that this risk was historical and not current and therefore did not require any emergency action. The notes of this exchange were faxed to the Swindon CMHT for follow up[120]. The Police then closed their log.

February and June 2007. Mr. X's family became increasingly concerned about his mental health. Mr. X was writing letters on a constant basis and had begun to get into trouble with corporate solicitors acting on behalf of the people and companies that he was harassing. The sister of Mr. X also felt that his behaviour towards her parents was a constant worry and she was concerned that they were in actual physical danger from him.

13 and 14 June 2007. The sister of Mr. X visited the Police station and then made numerous telephone calls to the Swindon Crisis Team, CAB, Healthcare Commission, Mental Health Act Commission, Lincoln Mental Health Services, and the Local Authority asking for help. It would appear that none of the telephone calls resulted in practical help. However, the Consultant Psychiatrist's Medical Secretary in Lincolnshire told the sister of Mr. X that she could send information on about Mr. X if she received a request on headed letter from Swindon Mental Health Services.

120. File 1 Wilts. PP.1-3

There is a degree of ambiguity regarding the following events. This will be discussed at length in the appropriate sections of Chapter 14. For the purpose of the chronology the account given in Mr. X's clinical record is set out below.

19 June 2007. On this date Swindon Crisis Team records note that the sister of Mr. X had telephoned in an attempt to access help for her brother Mr. X. A Crisis Team Worker took the call, and from this point on, until the deaths of Mr. and Mrs. X senior, effectively became the main worker involved with the case. She recorded that the sister of Mr. X was very concerned about her brother's mental state. Mr. X was living with his parents and had done so since being discharged from a Section 3 in Lincolnshire in 2002. The record noted that Mr. X was unwell, sending abusive letters and making abusive telephone calls. He was also threatening his parents. It was apparent that Mr. X was not registered with a GP and that he had had no contact with mental health services for several years and as a result was not compliant with his recommended medication regimen. The record stated that Mr. X was not aware that his sister was asking for help and that his parents may be at risk from his threatening behaviour. The Crisis Team Worker recorded that the referrer's expectation of the Crisis Team (his sister) was Mr. X would be assessed and treated for his mental illness[121].

The Crisis Team Worker telephoned the Lincolnshire Consultant Psychiatrist's Medical Secretary. The Worker was told that the Medical Secretary would not be available until the next day. The Worker sent a fax asking for information regarding Mr. X to be sent to her urgently[122].

20 June 2007. On this day the Crisis Team Worker telephoned the Lincolnshire Consultant Psychiatrist's Medical Secretary again. This time she was able to ask directly for background information and Mr. X's clinical records[123].

The Crisis Team Worker's records note that she contacted the Vulnerable Adults Unit in order to discuss Mr. X's case. The record notes that the Worker was unable to speak to anyone directly and left a voicemail message[124].

121. File 1 Wilts. PP.1-3
122. File 1 Wilts. PP.4-5
123. File 1 Wilts. P.5
124. File 1 Wilts. P.5

21 June 2007. The Lincolnshire Medical Secretary faxed through some letters and psychiatric reports to the Swindon Crisis Team Worker. She also requested that the Lincolnshire Medical Records Department send a copy of Mr. X's clinical documentation to Swindon as soon as was possible.

The Crisis Team Worker was an unqualified worker, and so she discussed Mr. X's situation with a colleague who was an approved social worker. It was decided that more information was required before action could be taken, and the Crisis Team Worker was advised to contact the sister of Mr. X again.

The Crisis Team Worker contacted the sister later that same day. She explained that her brother was both articulate and plausible and may therefore appear well when assessed. The sister of Mr. X was concerned about her parents' continued safety if Mr. X was not detained following an assessment as she believed that he would be extremely angry about the situation and that this could place her parents at further risk from him. It was agreed that more information was needed and the sister agreed to bring in some of Mr. X's correspondence which illustrated well his disordered thinking. During this telephone conversation the Crisis Team Worker explained that conducting a Mental Health Act assessment was a potentially complicated task as it would necessitate the presence of an appropriately qualified team to attend Mr. and Mrs. X senior's house[125].

22 June 2007. The sister of Mr. X took copies of his correspondence to the Crisis Team offices as had been previously agreed[126].

25 June 2007. Mr. X's clinical records were dispatched by registered post from Lincolnshire Mental Health Services to the Swindon Crisis Team[127].

26 June 2007. On this day the Crisis Team Worker discussed Mr. X's case with the Mental Capacity Programme Manager for Swindon Borough Council. It was agreed that there was not enough information to warrant a Mental Health Act assessment, however in the light of Mr. X's past history it was agreed that:

1. '*the Crisis Team Worker should follow up the case with the Vulnerable Adults Unit*

125. File 1 Wilts. PP.5-6
126. File 1 Wilts. P.5
127. Witness transcription and witness diary

2. *A meeting with Mr. X's parents should be arranged so their concerns could be discussed and a plan agreed. e.g. to use the parents' GP as a means of making a referral'*

The Mental Capacity Programme Manager stressed the importance of obtaining Mr. X's clinical records as rapidly as possible[128].

The Crisis Team Worker's records note that she telephoned the Vulnerable Adults Unit again, but once again the records state that she could not get through and left a message on their voicemail service.

Mr. X's clinical records arrived at the Crisis Team offices on this day.

29 June 2007. The Crisis Team Worker discussed Mr. X's case with her Team Manager. Once again the Crisis Team records state that a telephone message was left on the Vulnerable Adults Unit voicemail system. The Crisis Team Worker also contacted the sister of Mr. X to explain to her that more information was being sought prior to further action being taken[129].

4 July 2007. The Crisis Team Worker telephoned the sister to request a meeting with Mr. and Mrs. X senior. It was agreed that the sister would discuss a suitable time with them and that the meeting would be held either at their home or at the Crisis Team offices. It was agreed that the Crisis Team Worker would call the sister the following Monday after 16.00 hours[130].

7-8 July 2007. Mr. X killed Mr. and Mrs. X senior.

10 July 2007. The Crisis Team Manager telephoned the sister of Mr. X and apologised for not ringing the day before as agreed. It was arranged that Mr. and Mrs. X senior would come to the Crisis Team Offices the following Thursday at 14.00 hours. The Crisis Team Worker discussed the case once again with her manager to decide whether or not she required another person to be present from the Crisis Team during the planned meeting. It was decided that this would not be necessary as the meeting was for information gathering purposes only. The plan was that following this meeting the Lincolnshire Consultant Psychiatrist would be

128. File 1 Wilts. P.7
129. File 1 Wilts. P.7
130. File 1 Wilts. P.7

contacted, that the Vulnerable Adults Unit would be chased up and that a case conference would be arranged[131].

11 July 2007. Mr. X was arrested on suspicion of murdering Mr. and Mrs. X senior.

131. File 1 Wilts. PP.7-8

13. Timeline and Identification of the Critical Issues

Root Cause Analysis (RCA) Second Stage

13.1. Timeline

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

13.2. Critical Issues Arising from the Timeline

On examining the timeline the Independent Investigation Team initially identified three critical junctures that rose directly from the care and treatment that Mr. X received from the Lincolnshire Partnership NHS Foundation Trust and the Avon and Wiltshire Mental Health Partnership NHS Trust. These critical junctures are set out below.

1. Interagency communication and working did not provide a seamless system of monitoring, treatment and review between 2000 and 2003. This allowed Mr. X to disengage from services.

2. Adherence to local policy and procedure was sporadic, with particular regard to CPA and risk management. This led to a less than effective delivery of service to Mr. X between 2000 and 2007.

3. Assessment and care planning did not occur in an effective and timely manner at several critical junctures between 2002 and 2007.

The critical junctures listed above are incorporated under the relevant headings listed directly below. They are examined in detail under these headings in Section 14 of this report.

13.3. Critical Issues Arising from the Review of other Data

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

13.3.1. Lincolnshire

1. **Diagnosis.** The Independent Investigation Team found that the diagnosis of delusional disorder was appropriate based on the clinical evidence available at the time Mr. X received his treatment and care in Lincolnshire. However a disorder of this kind requires a long-term treatment strategy and this failed to occur. Mr. X was allowed to disengage from the service even though he had an enduring mental illness which had been characterised by non compliance, lack of insight and engagement, and associated risk behaviours. The nature and presentation of Mr. X's condition were not taken into sufficient account and this contributed to the breakdown of his mental health care.

2. **Medication.** It is the view of the Independent Investigation Team that the prescription of antipsychotic medication was appropriate for Mr. X. However the decision to change from depot to oral mediation was regrettable and this contributed to the breakdown of Mr. X's engagement with mental health care services.

3. **Mental Health Act (1983).** The initial assessment process when Mr. X was first admitted in September 2002 to inpatient services was sound. The subsequent decision to treat Mr. X under Section 3 of the Mental Health Act (1983) was appropriate. Unfortunately on the sudden discharge from his Section 3 by a Mental Health Act Tribunal Mr. X discharged himself from hospital with immediate effect. No care plan was put in place and the duty to provide care under Section 117 of the Mental Health Act (1983) was not achieved. The duty to provide aftercare under Section 117 only ceases once the Primary Care Trust, Strategic Health Authority or Local Authority are satisfied that the person is no longer in need of services. Mr. X was allowed to completely disengage and therefore slip through the safety net of care without any decision formally having been made about his future care and treatment requirements.

4. **Care Programme Approach (CPA).** There was no robust CPA assessment or care planning process in place following Mr. X's discharge from Lincolnshire inpatient

services. The extant documentation would suggest that a weak approach was taken. The Care Coordinator that was finally allocated to Mr. X was not experienced in working in a community context and was lacking in supervision, this exacerbated the difficulties that ensued regarding the lack of engagement with Mr. X and his gradual withdrawal from the service. The CPA policy in operation at the time was not adhered to with regard to service users who disengage from the service.

5. **Risk Assessment.** Several risk assessments were partially completed; they did not illustrate fully the history and known forensic activities of Mr. X. This had the effect of minimising his presentation and needs, both during his time as an inpatient and also upon his discharge back into the community. The risk assessments did not led to a dynamic management plan of Mr. X's risk. Multidisciplinary team work was not evident in the risk assessment process, the Trust policy in operation at the time stated that this was expected. In the case of Mr. X this contributed to weak assessment and planning as there was no 'pooling' of ideas or understanding of his full risk profile. Another important factor that led to poor risk assessment was the failure to appreciate the importance of Mr. X's lack of engagement. Information sharing between agencies e.g. Probation, General Practice and Police Services, was poor and also contributed to the minimisation of Mr. X's risk.

6. **Referral and Discharge.** 1) The referral to MAPPA during 2002 was not documented properly. It is not possible to understand why Mr. X was referred or whether this referral was rejected or not. 2) On discharge from inpatient services there was no adherence to Section 117 arrangements, no care plan was developed and no multidisciplinary follow up occurred. 3) The transfer to Swindon services never actually occurred; instead an informal communication took place between the Care Coordinator and Swindon Community Mental Health Team Managers. The Trust policy was not adhered to and this policy stated that all responsibility remained with the originating service until the new one had formally accepted the case. The eventual decision to discharge Mr. X from Lincoln-based services took place in the full knowledge that this would sever all links to specialist care and treatment from secondary services.

7. **Carer and Service User Experience.** Mr. X's carers were communicated with sporadically. We understand that Mr. X did not give his permission for ward staff to

talk to his parents and that this is a very difficult area for services to navigate. However as Mr. X's parents were elderly and Mr. X did present a significant risk to them, this should have been considered. Their needs as carers should also have been considered with special regard to the fact that they had to travel with their son on a regular basis between Swindon and Lincoln in order to obtain his medication.

8. **Clinical Supervision.** Lincolnshire Partnership NHS Trust had a clinical supervision policy which made clear that all staff who were involved in direct patient care should have both management supervision and practice supervision. In 2003 in Lincolnshire Mr. X's second Care Coordinator, was a newly appointed community nurse who had until recently worked in one of the local inpatient wards. It would appear that he received no clinical supervision until December 2003. This means that the Community Mental Health Team in Lincoln was operating outside of the Trust's supervision policy in allowing a relatively junior member of the team to carry the responsibility for the care coordination of a service user on enhanced CPA who was disengaging from the service.

9. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This occurred persistently over a seven-year period regardless of which agency or service Mr. X was involved with.

13.3.2. Swindon

1. Management of the Case in Swindon

This area needs to be divided into two separate episodes.

- **2003.** The Care Coordinator in Lincolnshire spoke to a Swindon Community Mental Health Team (CMHT) Manager over the telephone and also wrote to him on two occasions to arrange for Mr. X's case to be transferred between the Lincolnshire mental health services to those in Swindon. Mr. X was at this time eligible for Section 117 aftercare. It was agreed over the telephone that Mr. X's records would be sent to the Community Mental Health Team Manager and that Swindon Services would discuss how best to manage the case. The Lincolnshire records noted that Swindon refused to accept the referral but that it had been agreed that the notes would be kept

on file at the Swindon CMHT base in case Mr. X required future interventions. This was clearly an inadequate response. During the Independent Investigation Swindon witnesses stated that no letters or clinical records were ever received. No records of this episode can be found within the Trust. It is the view of the Independent Investigation Team that Mr. X's care transition was poorly managed at this stage.

- **June 2007.** The sister of Mr. X tried to access help for her brother from the Swindon Crisis Team. On the 19 June she spoke to a Crisis Team Worker over the telephone. This led to the Crisis Team Worker contacting Mr. X's Lincolnshire Consultant Psychiatrist's Medical Secretary. The Medical Secretary sent a fax directly which contained some letters and a medical report from a previous Mental Health Act (1983) Tribunal. A copy of Mr. X's entire clinical record followed on the 26 June 2007. The Independent Investigation Team was told that these records remained partially read. These records clearly contained Mr. X's past history and risk. It is the view of the Independent Investigation Team that had these records been read in a timely manner Mr. X's case would have been managed differently.

2. **Liaison with Lincolnshire Trust and Transfer Process.** Liaison with Lincolnshire Services was not managed in a proactive manner either in 2003 or in 2007. At no time did anyone from the Swindon Service contact the Lincolnshire Consultant Psychiatrist directly to ascertain more details about Mr. X. On two separate occasions the Trust received and held sufficient information of a nature that should have led to a direct communication. This did not occur. The Independent Investigation Team has found that Avon and Wiltshire Partnership Mental Health Trust did not act appropriately concerning a patient eligible for Section 117 aftercare living in their area.

3. **Mental Health Act.** Swindon-based services did not initiate an assessment under the Mental Health Act (1983) in an appropriate or timely manner.

4. **Adherence to Operational Policy and Use of the Mental Health Act (1983).** It would appear that Mr. X's case was wrongly picked up by the Crisis Team, the case would have been more appropriately allocated to a Community Mental Health Team. The Crisis Team struggled with the idea of conducting a Mental Health Act (1983) assessment as it was not part of their operational policy to do so, however they retained the case as they *'did not want to drop the baton'*. This resulted in Mr. X's

case remaining with the Crisis Team for a period of 22 days during which time no visit was made, no assessment was undertaken and no plan was actually formulated.

5. **Assessment of Risk and Forensic History.** It would appear that the Crisis Team did not take the sister of Mr. X's concerns about her brother seriously. This is because there was not enough information available to the Team in the first instance. However, even when this information did become available, no one took responsibility for arranging the appropriate assessment that the acquired records would have indicated. It is a fact that the records were with the Crisis Team for a period of 16 days without being taken into full account.

6. **Liaison with the Family of Mr. X and Vulnerable Adult Safeguarding measures.** The accounts made available to the Independent Investigation Team from the sister of Mr. X and the Crisis Team vary, however the Independent Investigation Team found that the family were not consulted with appropriately and that the Crisis Team appeared to advocate for Mr. X as a default position without ever having met him or read his clinical records. Vulnerable Adult issues were identified by the Crisis Team but not actioned in a timely manner. This omission ensured that Mr. and Mrs. X senior remained in a situation that presented a significant risk to them.

7. **Documentation and use of Clinical Records.** The Independent Investigation Team have serious concerns regarding the maintenance, storage and clinical use of clinical records in that:

    - the Trust would appear to have lost Mr. X's records sent to them in 2003;
    - communications with the Trust between 2003 and 2007 regarding Mr. X do not appear to have been recorded;
    - the Trust did not make the appropriate use of acquired clinical records in June 2007;
    - the records in Mr. X's file were not entered contemporaneously thus giving rise to serious doubts about what actually occurred between the 19 June and the 10 July 2007.

8. **Supervision and Staff Competency.** Although this case was 'held' by the Crisis Team the case was in reality allocated to one Crisis Team Worker. The Independent

Investigation Team heard that this Crisis Worker was unqualified but was supervised within the Team. Each case was fully discussed by the Multi Disciplinary Team on a regular basis, however it would appear that the Crisis Worker was allowed to attempt to formulate a plan for this case on her own. She was inexperienced and not qualified to do so. The Independent Investigation Team are of the view that significant delays occurred because the Crisis Worker was uncertain how to proceed and that a more experienced person would have acted more decisively.

9. **Performance of Community Services.** The Independent Investigation Team have found that many of the issues identified by NHS Swindon in June 2009 regarding the performance of Avon and Wiltshire Mental Health Partnership NHS Trust services in Swindon are pertinent to the Mr. X Investigation, namely:

    a. unanswered telephones;

    b. difficulty making referrals or getting people admitted into the services;

    c. difficulties in accessing services if a person has no GP;

    d. poor case allocation and skill mix;

    e. difficulty in referrers being signposted to appropriate services.

10. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This persistently occurred over a four year period regardless of which agency or service that Mr. X was involved with.

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

RCA Third Stage

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

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

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

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the significant deterioration of Mr. X's mental health and how it impacted upon deaths of Mr. and Mrs. X senior. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them.

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

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the deaths of Mr. and X senior

need to be drawn to the attention of the Trusts in order for lessons to be identified and the subsequent improvements to services made.

14.1. Lincolnshire Findings

14.1.1. Diagnosis and Medication

14.1.1.1. Diagnosis

14.1.1.1.2. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, mental state examination and observation.

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

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

The diagnosis reached in the case of Mr. X was that of delusional disorder. The ICD 10 diagnostic criteria for this disorder are as follows:

'F22.0 Delusional Disorder

This group of disorders is characterized by the development either of a single delusion or of a set of related delusions which are usually persistent and sometimes lifelong. The delusions are highly variable in content. Often they are persecutory, hypochondriacal, or grandiose, but they may be concerned with litigation or jealousy, or express a conviction that the individual's body is misshapen, or that others think that he or she smells or is homosexual. Other psychopathology is characteristically absent, but depressive symptoms may be present intermittently, and olfactory and tactile hallucinations may develop in some cases. Clear and persistent auditory hallucinations (voices), schizophrenic symptoms such as delusions of control and marked blunting of affect, and definite evidence of brain disease are all incompatible with this diagnosis. However, occasional or transitory auditory hallucinations, particularly in elderly patients, do not rule out this diagnosis, provided that they are not typically schizophrenic and form only a small part of the overall clinical picture. Onset is commonly in middle age but sometimes, particularly in the case of beliefs about having a misshapen body, in early adult life. The content of the delusion, and the timing of its emergence, can often be related to the individual's life situation, e.g. persecutory delusions in members of minorities. Apart from actions and attitudes directly related to the delusion or delusional system, affect, speech, and behaviour are normal.'

Diagnostic Guidelines

Delusions constitute the most conspicuous or the only clinical characteristic. They must be present for at least three months and be clearly personal rather than sub cultural. Depressive symptoms or even a full-blown depressive episode may be present intermittently, provided that the delusion persists at times when there is no disturbance of mood. There must be no evidence of brain disease, and no history of schizophrenic symptoms (delusions of control, thought broadcasting, etc.).

A delusion can be defined as a fixed false idea held in the face of evidence to the contrary, and out of keeping with the patient's social milieu. It is held unshakeably, it is not modified by experience or reason, the content is often bizarre, it is not dependent on disintegration of general intellectual functioning or reasoning abilities, it is often infused with a sense of great personal significance.

14.1.1.1.2. Findings

Mr. X first came to the attention of psychiatric services in October 2000[132]. He was assessed by a Forensic Psychiatrist at the request of the Lincoln Court Assessment scheme prior to sentencing after having been convicted on a charge of harassment. The information sources used by the Forensic Psychiatrist for his report were copies of the case depositions, a probation report, contact with Mr. X's GP in Swindon, and a lengthy (two hour) interview with Mr. X himself.

On this basis the Forensic Psychiatrist made a diagnosis of '*delusional disorder*', he expressed the opinion that Mr. X had '*no insight*' and '*would at present be reluctant to consider use of medication*'. The Forensic Psychiatrist went on to say that '*Although behaviour such as that displayed by Mr. X is of concern I believe factors at present suggest that he is at low risk'*.

The Forensic Psychiatrist considered a Probation Order appropriate but was not able to make a recommendation that probation be given with a condition of psychiatric treatment as Mr. X was at this time living in Bolton. The psychiatrist recorded '*However I have advised his Probation Officer that, if he registers with a GP locally in Bolton, I will make contact with his local psychiatric service in order to arrange follow up*.' The Forensic Psychiatrist concluded that if all else failed and Mr. X's mental state deteriorated, he could be assessed under the Mental Health Act (1983).

Mr. X's next contact with the psychiatric services was in 2002. He was arrested on the 2 August 2002 and had a formal Mental Health Act (1983) assessment whilst in Police custody. This assessment noted the presence of a '*long standing paranoid delusional disorder'* and recommended further psychiatric assessment. However, this did not happen and Mr. X was released from custody back to his own home in Lincoln[133].

Mr. X was subsequently detained under the Mental Health Act (1983) on 19 September 2002 and admitted to hospital. He remained there under the Mental Health Act (1983) until 27 November 2002 and his diagnosis on a discharge was that of Delusional Disorder[134].

132. File 1 A PP.14 – 22
133. File 1 A PP. 41 – 42
134. File 1 B PP. 6 -7

Throughout the remainder of his contact with psychiatric services in Lincoln, his diagnosis was accepted as being that of delusional disorder.

14.1.1.1.3. Conclusion

The Independent Investigation Team are of the opinion that a diagnosis of delusional disorder was appropriate based on the clinical evidence. Mr. X presented with a fixed set of beliefs which were not amenable to change or reason. There was evidence that they had been present for a considerable period of time on first presentation and they persisted throughout his contact with services.

Mr. X's first presentation was in the context of difficult life events (a court case and dismissal from his employment) when he was in his mid thirties. His mood speech and behaviour, other than in reference to his abnormal beliefs, were not affected and he appeared to function independently and relatively well. These characteristics all fit the diagnostic criteria for delusional disorder as outlined in ICD 10.

A diagnosis of delusional disorder should prompt a number of considerations for the clinician and treating team in terms of a treatment plan. Delusional disorder is usually a long standing condition and therefore requires a strategy on the part of the treating team for long term engagement. By the very nature of the disorder a lack of insight is usual and problematic and needs to be taken into consideration with regard to engagement. Delusional disorders can be resistant to treatment with medication because adherence to a medication regimen can be difficult to maintain if the service user has no insight into its continued requirement. A clear understanding of the nature and depth of the delusional beliefs is vital when understanding the service user's presentation and thereby clarifying issues around risk assessment, risk management, triggers, early warning signs of relapse and therapeutic interventions.

Some of these issues appear to have been recognised by the Forensic Consultant Psychiatrist who assessed Mr. X in 2000. He followed up his report with an undated letter to the Probation Officer requesting that he be informed of the outcome of Mr. X's case so that he could determine if follow up needed to be arranged by him or through psychiatric services in Bolton[135]. The Probation Officer wrote to him on 19 December 2000 after Mr. X had been given a 12 month Probation Order, asking for advice on how to encourage Mr. X to engage

135. File 1 A P.65

with the Bolton mental health services. This letter was subsequently mislaid for a number of months and the Forensic Consultant Psychiatrist responded on 26 March 2001 advising a referral through the local Mentally Disordered Offender Panel.

During Mr. X's inpatient admission in 2002 the clinical team appear to have had limited success in engaging him. It became clear that he was paranoid about both the Police and the providers of Lincolnshire mental health services. This was characterised by the writing of numerous letters of complaint. Mr. X was litigious and refused to cooperate with his doctors[136]. He was discharged from his Section 3 on 27 November 2002 by a Mental Health Review Tribunal without Mr. X's clinical team having discussed and documented a treatment and risk management plan as is required under Section 117 of the Mental Health Act (1983)[137].

Mr. X's subsequent community follow up was characterised by missed appointments, and later by an increase in his letter writing. It is important to note that Mr. X's letter writing had been identified as being a significant indicator of relapse. During this period, between the 27 November 2002 and the 4 November 2003, there is little evidence of a concerted effort by Mr. X's clinical team to try to engage or re-assess his mental state. This is considered to be of significant importance by the Independent Investigation Team when considering Mr. X's clinical team knew that he was suffering from an enduring mental illness which had been characterised by non compliance, lack of insight and engagement, and associated with high level risk behaviours (harassment and Public Order Offences).

It is the view of the Independent Investigation Team that while the diagnosis of delusional disorder was appropriate, the clinical team treating Mr. X during 2002 and 2003 did not take sufficient account of the nature and presentation of Mr. X's mental disorder and this contributed to the breakdown of Mr. X's clinical care.

- ***Contributory Factor Number One. The Clinical Team did not take sufficient account of the nature and presentation of Mr. X's mental disorder and this contributed to the breakdown of Mr. X's clinical care. This had both short-term and far reaching consequences.***

136. File 1 B P. 136, 137, 139, 140, 141
137. File 1 B P. 144

14.1.1.2. Medication

14.1.1.2.1. Context

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

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Delusional disorder falls within the broad category of psychotic disorders and so treatment with an antipsychotic medication is regarded as appropriate.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders. Neither source gives specific advice regarding the pharmacological treatment of delusional disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practise to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a treatment order (Section 3 or 37), medication may be administered without the patients' consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be

reviewed by a Second Opinion Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

14.1.1.2.2. Findings

Mr. X was admitted to hospital under Section 2 of the Mental Health Act (1983) (Assessment Order) on 19 September 2002. He was re-graded to Section 3 (Treatment Order) on 24 September 2002 after a brief period of assessment during which Mr. X was noted to be making harassing phone calls and sending harassing letters[138].

On 2 October Mr. X was given a test dose (100mg) of intramuscular Clopixol – a depot antipsychotic medication. Mr. X needed to be restrained using approved techniques in order to administer the medication and was reported to be very angry afterwards[139]. He was then prescribed Clopixol 200mg every two weeks, his next dose was given one week later on the 9

138. File 1 B P. 137
139. File 1 B P. 261

October. It was noted that he had some extrapyramidal side effects but refused medication to deal with this[140]. While he resisted the initial depot he accepted following depot injections, albeit reluctantly.

There was some evidence of improvement in Mr. X's presentation noted at the end of October 2002 in that he was more approachable and less argumentative[141]. He was given increasing periods of Section 17 leave, and when reviewed at ward round on 21 November it was noted that his paranoid ideas seemed diminished but he continued to have side effects[142]. The Clopixol dose was decreased to 150mg every two weeks.

On 27 November 2002 a Mental Health Tribunal hearing discharged Mr. X from his liability to detention and he chose to discharge himself from hospital immediately. He continued to be visited at home by his Care Coordinator who was also his Community Psychiatric Nurse. The Care Coordinator continued to administer the depot as prescribed, Mr. X continued to accept it.

Mr. X was reviewed at the out-patient clinic by his Consultant Psychiatrist and Care Coordinator on 21 January 2003 when his medication was changed from depot Clopixol to oral Olanzapine tablets (also an antipsychotic). The reasons for the change were that Mr. X '*was not much different'* and as a gesture '*it was better to work with a more co-operative stance'*[143]. At this time Mr. X did not appear to have any overt evidence of side effects from his depot injection. The Olanzapine tablets were to be collected by Mr. X from his GP. There is evidence that Mr. X did collect his prescription every month for the next year, although no evidence can be brought forward to suggest that he took it[144]. Mr. X was reviewed again at the out-patient clinic on 4 March 2003 when he was advised not to decrease the dose of his medication. He was not seen by his Consultant Psychiatrist or any other psychiatrist again after that review until after the index offence in July 2007.

14.1.1.2.3. Conclusion

The Independent Investigation Team concludes that the prescription of antipsychotic medication prescribed to Mr. X was appropriate and recognises that delusional disorder can be very difficult to treat. We agree that it was initially appropriate to prescribe intramuscular

140. File 1 B P. 139
141. File 1 B P. 265, and P. 142
142. File 1 B P. 143
143. File 1 B P.144 and witness transcriptions
144. GP records P. 3 – 4

medication as Mr. X was a man who clearly had an enduring mental illness, who had no insight, was difficult to engage and with whom compliance with medication would be an ongoing issue. It was important to ensure Mr. X received medication as treatment for his mental illness. Administering the depot allowed the Care Coordinator regular contact with Mr. X and the fostering of both a working relationship and engagement with services. It also ensured that Mr. X was medicated particularly as there was some evidence of improvement in that he was less querulous and the harassing letter writing had stopped.

The Independent Investigation Team is of the view that the depot medication was stopped too soon and for the wrong reasons. Mr. X had only been receiving it for three months and there was some evidence of positive change as stated above, there was evidence that he was 'different' from the man who was initially detained. Mr. X was not refusing the depot at that time. The depot allowed the Care Coordinator to work on building a relationship with Mr. X, and at this stage he was not suffering any overt side effects. We find that the motivation for a change in medication prompted by a wish to work together to be admirable but ill founded, it assumed a level of insight and a positive working relationship, neither of which existed.

There were always going to be concerns about compliance with oral medication. We are aware that monthly prescriptions were collected by Mr. X but this does not necessarily mean that the medication was being taken. There was no way of checking Mr. X was taking his tablets regularly and that his mental illness was therefore being treated. If Mr. X was taking his medication, there was evidence of its relative ineffectiveness as his letter writing to the Police began again during the summer of 2003. By this time he had completely disengaged from all contact with the mental health services.

It is the view of the Independent Investigation Team that the prescription of antipsychotic medication was appropriate for Mr. X. The decision to change from depot to oral medication was regrettable and in our opinion contributed to the breakdown of Mr. X's engagement with mental health care.

- ***Contributory Factor Number Two. The decision to change from depot to oral medication contributed to the breakdown of Mr. X's engagement with mental health care.***

14.1.2. Medical Management of the Clinical Care and Treatment of Mr. X

14.1.2.1. Context

Standards and practice guidance for all psychiatrists are laid down by two organisations: the General Medical Council and the Royal College of Psychiatrists. The General Medical Council (GMC) is responsible for the registration and regulation of all practising doctors in the United Kingdom. Its purpose is '*to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine'* (GMC website). It publishes regular guidance for doctors on a variety of areas of practice. The duties of a doctor registered with the GMC are described in their *Good Medical Practice* guidance (2006), the *Good Medical Practice* guidelines published at the time Mr. X first made contact with the psychiatric service were as follows:

The duties of a doctor registered with the General Medical Council (May 2001)

'Patients must be able to trust doctors with their lives and health. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- *Make the care of your patient your first concern*
- *Treat every patient politely and considerately*
- *Respect patients' dignity and privacy*
- *Listen to patients and respect their views*
- *Give patients information in a way they can understand*
- *Respect the rights of patients to be fully involved in their care*
- *Keep your professional knowledge and skills up to date*
- *Recognise and work within the limits of your competence*
- *Be honest and trustworthy*
- *Respect and protect confidential information*
- *Make sure that your personal beliefs do not prejudice your patients' care*
- *Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice*
- *Avoid abusing your position as a doctor; and*
- *Work with colleagues in the ways that best serve patients' interests.*

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them'.

The Royal College of Psychiatrists (RCPsych) published guidance on *Good Psychiatric Practice* in 2000: Council Report CR83 which set out standards for psychiatrists under a number of headings:

- *'The duties of a doctor registered with the GMC*
- *Core attributes*
- *The trusting relationship*
- *Good clinical care*
- *Consent to treatment*
- *Note keeping and inter-agency / inter-professional communication*
- *Confidentiality*
- *Availability and emergency care*
- *Working as a member of a team*
- *Referring patients*
- *Clinical governance*
- *Teaching and training*
- *Research*
- *Being a good employee and employer'*

These Good Psychiatric Practice standards have since been reviewed both in 2004 and 2009.

Psychiatric practice, and doctors' part within that, is also underpinned by a raft of other statutory guidance and law including the Mental Health Act and Care Programme Approach which are dealt with in a separate sections.

14.1.2.2. Findings

There were two Consultant Psychiatrists who had dealings with Mr. X, a Forensic Consultant Psychiatrist in 2000 and his Responsible Medical Officer between 2002 and 2003. The Forensic Psychiatrist saw Mr. X on one occasion on the 17 October 2000 at the request of the Lincoln Court Assessment Scheme for the purposes of preparation of a psychiatric report advising the courts on the relevance or otherwise of psychiatric matters[145]. The Forensic Psychiatrist completed a thorough assessment and submitted his report in a timely manner (the report is dated 23 October 2000). He established that Mr. X was indeed suffering from a mental illness and made efforts through Probation to ensure Mr. X's follow up by psychiatric services as Mr. X was not at that time resident in Lincoln where the Forensic Psychiatrist was practising. This doctor had no further contact with Mr. X.

Mr. X's Responsible Medical Officer first had contact with him on the 19 September 2002 when he was part of a Mental Health Act (1983) assessment team who forcibly entered Mr. X's home under Section 135 of the Mental Health Act[146]. The Mental Health Act assessment was prompted by an increasingly bizarre and offensive series of letters to the Police, which accused them of persecuting him and included a letter which stated he was going to arm

145. File 1 A PP. 14 – 22
146. File 1 B P.1

himself with a legal weapon to defend himself[147]. The assessment team had had access to the Forensic Psychiatrist's court report and Police records[148]. These records included copies of the letters Mr. X had written to the Police and his custody record from August 2002 when he was arrested and charged with three counts of Section 5(1) Public Order Acts[149]. This custody record also had information from a psychiatric assessment while in custody on 3 August 2002 which recommended that Mr. X be charged and if possible remanded '*in a secure ward for further assessment*'[150].

The Mental Health Act Assessment Team recommended that Mr. X be detained under Section 2 of the Mental Health Act (1983) (Assessment Order) and he was admitted under the care of the Consultant Psychiatrist that was to become his Responsible Medical Officer. It is noted here that Mr. X was not at that time registered with a local GP although he lived in Lincoln. The local system for deciding how patients were assigned to consultants was in line with their GP registration policy. As Mr. X was not registered he came under the care of the duty consultant at the time of his admission[151].

The risk related information known at the time of Mr. X's admission was:

- diagnosis of delusional disorder, untreated, and of at least two years plus duration, probably longer;
- a conviction for the harassment of a female work colleague relating to actions in the late 1990's; [152]
- delusional ideas regarding being persecuted and harassed by the Police and American Rangers on which he had acted by sending multiple letters of complaint and stating that '*I will now be purchasing a legal weapon to carry to protect myself*';[153]
- Public Order charges from 3 August 2002 relating to his intensified letter writing campaign, Mr. X was approaching Policemen on their own property who lived on the same street as him, knives were found hidden in a number of places around his house, and the Police considered him a '*bomb waiting to go off*'. The Police were so concerned that they had Mr. X under surveillance[154].

147. File 1 B P. 8
148. File 1 A PP.14-64
149. File 1 A P. 42
150. File 1 A PP. 41 – 42
151. File 1 B P.1
152. File 1 A P. 18 – 21
153. File 1 A PP. 23 – 35
154. File 1 A P. 44

- he had not previously been engaged with psychiatric services and was therefore an unknown quantity.

Mr. X was admitted to hospital on 19 September 2002, the admitting junior doctor recommended he be placed on '*close observations for the first 24 – 48* hours'[155]. Nursing staff put him on 15 minute observations to '*ensure safety'*[156]. The following day he was given escorted hospital ground Section 17 leave until the 24 September by the Responsible Medical officer – this was in line with local hospital practice which dictated that all detained patients who left the ward (which was on the first floor of the building) must have Section 17 leave in order to do so.

On 24 September 2002 the Responsible Medical Officer (RMO) recommended that Mr. X be detained under Section 3 of the Mental Health Act (1983) (Treatment order) recording that '*we should stop him making harassing phone calls or sending harassing letters'* and that the '*patient completely refuses to interact with the psychiatric services and is hostile. He has harassed others and written accusatory letters'*[157]. This recommendation was completed and Mr. X was subject to Section 3 of the Mental Health Act (1983) for the rest of his in-patient stay.

Mr. X had been given escorted Section 17 leave initially in the hospital grounds, and then within the community until 17 October 2002 with the instruction that should he abscond the Police should be informed. By this time there was some evidence that Mr. X's mental state had improved and he was given unescorted hospital ground leave on the 17 October[158]. He was granted unescorted community leave on the 24th October.

Mr. X appealed to the Hospital Managers and to the Tribunal Office about his detention under both Section 2 and Section 3 of the Mental Health Act (1983). He had hearings on 30 September, 6 November and 27 November 2002. His RMO completed a report for these hearings and attended them[159]. The nursing notes on 6 November state that '*a compromise was reached between the RMO and Mr. X (at the Tribunal) where he will remain on Section 3 with Section 17 leave which will require Mr. X to return to the ward two weekly so that his depot can be administered*'. On 7 November 2002 Mr. X was given overnight leave to his

155. File 1 B P. 134
156. File 1 B P. 227
157. File 1 B PP.57 and 137
158. File 1 B PP. 191 – 195
159. File 1B PP. 36, 46 and 230

own home[160]. This arrangement continued until he was discharged from hospital by a Mental Health Tribunal on 27 November 2002.

After discharge Mr. X was followed up by his Care Coordinator. The RMO wrote to the Care Coordinator on 9 January 2003 enquiring after Mr. X as he had not attended his Care Programme Approach meeting[161]. The RMO next saw Mr. X at his outpatient clinic on 21 January 2003 where he was accompanied by his Care Coordinator. The outcome of that meeting was to change Mr. X's medication from depot antipsychotic (Clopixol) to oral antipsychotic medication (Olanzapine) and to also give consideration to issues around work and benefits[162].

The RMO reviewed Mr. X again with the Care Coordinator on 4 March 2003 at which time he advised Mr. X not to reduce his medication, discussed his diagnosis, concerns regarding his benefits and noted the improved relationships with his family and that Mr. X was thinking of moving to Swindon. The RMO also noted that the Care Coordinator '*might be moving on to a different post and I am not sure whether Mr. X will engage with another Care Coordinator or not*'[163]. The RMO arranged another review for three months time but Mr. X was not actually seen by the RMO again.

On 10 July 2003 the new Care Coordinator, who was also to act as Mr. X's Community Psychiatric Nurse, noted that the Police Officer who had led on Mr. X's case '*phoned today, claimed Mr. X had sent notes of complaint against Police, queried whether this may relate to deterioration of Mr. X's mental state*'[164]. The Care Coordinator spoke to the RMO and suggested that a review took place. Mr. X was invited but did not attend.

The RMO wrote to Mr. X's GP on 4 August 2003 saying that he had not turned up for appointments with either him or with the Care Coordinator. The RMO wrote '*I have no alternative but to discharge him from my out-patient service'*. The RMO went on to note that '*He does seem to be writing letters of an unpleasant or harassing type. These should initially*

160. File 1 B PP. 180 – 182

161. File 1 A P. 98
162. File 1 B P.148
163. File 1 B P. 147
164. File 1 A P. 82

be dealt with by the Police and if he does seem to be committing an offence, action, I suggest, should be taken through the criminal justice system'. He noted that Mr. X was likely to move back to Swindon if he had not already done so. Finally the RMO stated that because Mr. X was not from his catchment area, and he had formed '*an adverse relationship with myself*' it would be better '*to refer him, if necessary, to the sector team for your part of Lincoln*'[165].

During 2004 and 2007 Mr. X's sister contacted the RMO's secretary on a number of occasions expressing concern about the deterioration in Mr. X's mental health and seeking assistance. The RMO was aware of these contacts and gave advice through his secretary regarding Mr. X accessing services in Swindon. It is evident that by this time the mental health Trust had received somewhere in the region of 35 letters of complaint from Mr. X regarding the care and treatment that he had received from the Trust. It is also evident that Mr. X was targeting his RMO in these letters of complaint. The RMO was reluctant to offer advice regarding Mr. X's care and treatment because of this, and as a result did not see fit to speak to the sister of Mr. X directly[166].

14.1.2.3. Conclusions

The Independent Investigation Team is aware of how difficult it can be to engage, treat and manage patients like Mr. X. We are also aware that at the time of Mr. X's presentation to the Lincoln service, assertive outreach services had not been developed locally. We broadly agree with the initial medical management of Mr. X during his presentation in 2002. We have discussed separately the issues around the prescription of medication and will not re-iterate them here. We also have concerns regarding risk assessment and appreciation which is also dealt with in a separate section.

The area we wish to concentrate on here is the medical management Mr. X received after his discharge in November 2002. Although there is no written care planning around Mr. X's discharge (see CPA section) his initial Care Coordinator appeared to be developing a relationship with Mr. X that allowed him to visit Mr. X regularly at his home. It is unfortunate that this health worker moved on to another post. The risk of disengagement was recognised by the RMO on 4 March 2003 but there was no reference to contingency planning for this eventuality.

165. File 1 A P.17
166 Witness transcriptions and written witness statements

Mr. X did not turn up for further out patient appointments, and the Police enquired after Mr. X's well being in July 2003 because they had started to receive complaint letters again. Despite this, knowing Mr. X's history and diagnosis, and the fact that Mr. X was still subject to Section 117 aftercare, the RMO felt he had '*no alternative'* but to discharge Mr. X from his outpatient clinic and effectively absolved himself of further responsibility for Mr. X. The Independent Investigation Team is critical of this decision.

Mr. X had an enduring mental illness, he had no insight, was difficult to engage and had displayed risk behaviours that were linked to his mental illness. Assertively managing patients like Mr. X is an integral part of psychiatry and doctors have a duty of care to ensure that care and treatment needs are met as far as possible. The Independent Investigation Team is of the opinion that more could have been done to fulfil the duty of care owed to the patient.

At the Independent Investigation hearings there was a discussion about the proportionality of any response, with a view from the RMO that a Mental Health Act (1983) assessment would have been disproportionate following Mr. X's disengagement with services. The Independent Investigation Team can understand this argument although do not necessarily agree with it.

In the knowledge that Mr. X was likely to be relapsing, and being aware of the amount of concern that Mr. X had caused previously, as well as the difficulties with engagement and lack of insight, the Independent Investigation Team are of the opinion that the least the RMO could have done was to have taken responsibility for alerting an appropriate consultant colleague or Community Mental Health Team in Swindon thereby ensuring that an appropriate named individual was responsible for Mr. X's care and treatment. We are aware, as was the RMO, that while Mr. X had been allocated a replacement Care Coordinator in March 2003, he had only met Mr. X once when being handed over his care and had never established a relationship with him. In our opinion the Care Coordinator should not have been left with sole responsibility for the case.

We recognise that the RMO gave advice to Mr. X's sister via his Medical Secretary, but again, knowing Mr. X's history and previous presentation, we are of the opinion that the RMO could have taken a more robust position in alerting others of the particular risks and concerns that Mr. X posed.

There are concerns amongst the Independent Investigation Team about the recognition of the apparent identifiable level of risk by the RMO and the Lincoln Clinical Team. Mr. X had a clear risk related presentation and despite that body of knowledge, the risks that Mr. X posed appeared to have been minimised and were not acted upon. This in turn appears to have influenced decision making.

It is the view of the Independent Investigation Team that Mr. X's medical management was not optimal and was a key contributory factor in the breakdown of his mental health care provision.

We are of the opinion that there are lessons to be learned about the robust management of those difficult to treat patients who will not engage.

- ***Contributory Factor Number Three. It is the view of the Independent Investigation Team that Mr. X's medical management was not optimal and was a key contributory factor in the breakdown of his mental health care provision.***

14.1.3. Mental Health Act

14.1.3.1. Context

The Mental Health Act 1983 is an Act of the Parliament of the United Kingdom but applies only to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people suffering from a mental disorder can be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

Section 117 of the Mental Health Act 1983 (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money.

Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.

14.1.3.2. Findings

Mr. X was referred to Lincolnshire County Council Social Services Directorate on 18 September 2002 by a Senior Nurse Manager at the Trust[167]. The referral was taken by an Approved Social Worker attached to the mental health services. The referral noted that two years previously Mr. X had been found guilty of harassing a female colleague and received a Probation Order. Mr. X had written many letters of complaint to the Home Office and to the Chief Constables of Lincolnshire and Cambridgeshire Police saying that he was being victimised and harassed by both the Police force and the United States of America Rangers. The content of the letters was described as bizarre and offensive. Mr. X said that he intended to arm himself with a legal weapon to defend himself against the Police. The Approved Social Worker recorded in her notes that the Police had stated that Mr. X could be violent and aggressive.

The Approved Social Worker arranged to visit Mr. X at his home at 2 pm on 19 September 2002 with a GP and a Consultant Psychiatrist (the future RMO of Mr. X) from the Mental Health Trust. The assessing team were accompanied by the Police. Mr. X did not answer the door and a decision was made to apply to Magistrates for a Warrant under Section 135 of the Mental Health Act (1983) to enter the house to assess him. A Warrant was granted by Lincoln District Magistrates Court and the team returned to Mr. X's house at 6 pm. They entered the house and an assessment was made. The decision was taken to admit Mr. X to hospital for assessment under Section 2 of the Mental Health Act (1983). Mr. X's property was secured by the Police following his detention.

The Approved Social Worker noted in her report that Mr. X had been arrested by the Police on the 2 August 2002 for a public order offence, namely, harassment of Police officers at their home near to Mr. X's house. At that time the Police searched the house of Mr. X and found knives, cleavers and '*other dangerous weapons'* hidden in his home[168]. Mr. X was admitted to an acute inpatient admission ward in the Mental Health Trust.

166. File 1B P. 347
167. File 1B P. 399

The assessment process showed good use of the powers of the Mental Health Act (1983) to secure an admission for assessment. The use of Section 135 to gain entry to Mr. X's house was appropriate given his lack of cooperation and the known risk as described by the Police.

Following admission to an acute admission ward, Mr. X was assessed under Section 3 of the Mental Health Act (1983) on the 26 September 2002. The medical recommendations were made by both the GP and the Consultant Psychiatrist who had previous knowledge of Mr. X from their assessment on the 19 September 2002 at Mr. X's home. The application for treatment was made by an Approved Social Worker with Lincolnshire County Council. The medical recommendation noted that Mr. X '*has a delusional system and is extremely paranoid…he is very aggressive and abusive when dealing with doctors and social workers who he believes are working for the Police*'[169]. In his record of the assessment the Approved Social Worker noted that Mr. X was very paranoid and deluded and was refusing any medication, and that he was verbally aggressive during the assessment. There is a record that Mr. X was informed of his rights under the Mental Health Act[170].

The decision to treat Mr. X under Section 3 of the Mental Health Act (1983) was appropriate. Although he had been an in-patient a relatively short time (one week) the clinical team had been able to complete their assessment and wished to move on to treat Mr. X. The treatment order enabled this process to begin and Mr. X was fully informed about his rights to appeal against the treatment order.

Mr. X decided to appeal to the Mental Health Review Tribunal against the treatment order and a hearing took place on the 30 September 2002. In a nursing report for the tribunal a staff nurse on the acute admission ward said '*it has been difficult to engage Mr. X in a therapeutic relationship and therefore assessments in many areas have been completely minimal. Mr. X has minimal insight into his illness. Diagnosis/prognosis and education, coupled with medication compliance remain primary issues in an effort to facilitate Mr. X's insight'*[171]. The Tribunal refused the appeal. In its written comment the Tribunal said that '*the Tribunal accepts the medical evidence… (and) agrees with the Responsible Medical Officer that the*

168. File 1B P. 241
169. File1B P. 256
170. File 1B P. 377
171. File 1B P. 235

section needs to remain in force to prevent deterioration of an already chronic and potentially unpredictable mental illness'[172].

Mr. X continued to be treated on the inpatient ward and made a further application to the Tribunal against the treatment order on the 22 October 2002. He also appealed to the Hospital Managers and they arranged a hearing for the 6 November 2002. The nursing notes record that an agreement was reached at this hearing to the effect that Mr. X would remain on his Section 3. In return his Section 17 leave would be continued and he would be able to return to his home on the condition that Mr. X came into the ward every two weeks for his depot injection. The clinical record stated that Mr. X '*presented very well'* at the Hospital Managers meeting[173].

A Mental Health Act (1983) Tribunal Hearing was held on the 27 November 2002 and received written evidence from the Consultant Psychiatrist of Mr. X, an Approved Social Worker, a ward-based Staff Nurse and from Mr. X himself. The Tribunal also took oral evidence from Mr. X and his Care Coordinator and those who had furnished them with written reports.

The Tribunal decision was to discharge Mr. X from the Order. The Tribunal President said that '*there is no doubt that the original detention of the patient was justified by his psychotic state at that time. However he has responded to treatment and is no longer expressing persecutory delusions. He remains, however, guarded and suspicious. He has now been on continuous home leave for three and a half weeks and this has passed without untoward incident. He is accepting medication, albeit reluctantly. All this being so, the tribunal could find no justification for further liability to detention in hospital*'[174].

Mr. X discharged himself and left the ward immediately following the Tribunal. He was then followed up by the Care Coordinator who also acted as his Community Psychiatric Nurse. This individual was able to build a rapport with Mr. X. The Care Coordinator visited Mr. X at home and administered Clopixol injections. He tried to help Mr. X with a number of practical problems, including welfare benefits. The Care Coordinator had some telephone contact with Mr. X's parents; and also met with them when they visited the Lincoln area with Mr. X.

172. File 1B P. 230
173. File 1B P. 225

Mr. X attended an out-patient appointment with the Consultant Psychiatrist on the 21 January 2003 when a decision was made to change his medication to oral Olanzapine. Mr. X attended a further clinic on the 4 March 2003 to see his Consultant Psychiatrist and Care Coordinator. Mr. X's final out-patient appointment was held on the 26 June 2003 which he did not attend.

The Care Coordinator managed to maintain some contact with Mr. X until the 25 April 2003 when he handed over the case responsibility to a new Care Coordinator, a Community Psychiatric Nurse colleague, in a joint visit to Mr. X at his home. The new Care Coordinator made efforts to meet with Mr. X but had little response to either home visits or letters.

The new Care Coordinator wrote to Mr. X on the 4 November 2003 saying that it was his intention to discharge him from the case load. The Care Coordinator believed that Mr. X was now spending the majority of his time in the Swindon area (living at his parents' address) and advised Mr. X to register with a GP in the Swindon area. The Consultant Psychiatrist wrote to Mr. X's GP in Lincoln on the 4 August 2003 to say that Mr. X had not attended appointments with him and that he had '*no alternative but to discharge him from my outpatient service*'[175]. In this letter the Consultant Psychiatrist wrote that he thought Mr. X had moved to Swindon.

In his case recording the Care Coordinator noted a number of telephone conversations with Mr. X senior, Mr. X's father. In a note made on the 11 July 2003 the Care Coordinator recorded that Mr. X's father said that he (Mr. X) only returned to Lincoln once a month to collect his prescription and was now living in Swindon.

Following this conversation with Mr. X senior the Care Coordinator made contact with the Community Mental Health Team in Swindon, for the first time on the 1 August 2003. A discussion was held between the Care Coordinator and a Swindon Community Team Manager who said that the Team would discuss the case at their next Team meeting.

On the 18 August 2003 the Care Coordinator spoke to a Community Team Manager in Swindon. The Swindon Team had spoken to the GP of Mr. X's father asking him to visit Mr. X as he had no GP of his own. The GP made the visit and reported back that Mr. X was not willing to engage with him. It was reported that this visit had appeared to raise Mr. X's

174. File1B P. 296
175. File 1A PP. 156-157
176. File 1A P.157

suspicions regarding his family. The Lincolnshire Care Coordinator however made it known to the Swindon services that he wished to hand Mr. X's aftercare over to them. It was agreed that the Swindon Team would discuss Mr. X's allocation for Section 117 aftercare[176].

On the 23 October 2003 background information was sent from the Lincolnshire Care Coordinator to the Swindon Team. On the 28 October 2003 the Lincolnshire Care Coordinator recorded two conversations with a different Community Team Leader in Swindon regarding Mr. X[177]. During these conversations he was informed that the Swindon Team would not be taking Mr. X's case. The reason that was given was that Mr. X was not registered with a GP in the Swindon area and was not likely to engage with services anyway. It was agreed that the Swindon team would keep Mr. X's information on file in the event that his mental health broke down and he required services from them in the future. In the same file note the Lincolnshire Care Coordinator recorded his intention to discharge Mr. X from his caseload.

14. 1.3.3. Conclusions

The decision to discharge Mr. X from his Treatment Order under Section 3 of the Mental Health Act (1983) meant that his clinical team had no further statutory power to compel Mr. X to accept treatment. Following his discharge from inpatient services Mr. X was largely non-compliant with requests to meet to review his progress and did not form a relationship with his second Care Coordinator, the Community Psychiatric Nurse who took over his care after his original Care Coordinator left the service. Therefore the duty to provide aftercare under Section 117 of the Mental Health Act (1983) was not achieved. Similarly, the Care Programme Approach was ineffective in maintaining contact and monitoring his mental state, because Mr. X was uncooperative. There is no record that the responsibility for aftercare under Section 117 was formally transferred to the mental health services in Wiltshire, or that Mr. X's status under the Act was considered when his Consultant Psychiatrist discharged him to the care of his Lincoln GP.

The duty to provide aftercare services under Section 117 ends when the Primary Care Trust or Health Authority and Local Social Services Authority are satisfied that the person concerned is no longer in need of such services. The authorities can only be satisfied that the

person concerned is no longer in need of aftercare services if they have monitored that person's progress in the community since discharge. The duty to provide services continues until both authorities have come to a decision that the person no longer requires any services. Therefore, if any part of the care plan is continuing, such as regular outpatient appointments, it is not possible to say that the person no longer has aftercare needs.

In the Health Service Circular 2000/003: LAC (2000)3 Aftercare under the Mental Health Act 1983: section 117 aftercare services**,** the Department of Health made clear that aftercare provision under Section 117 does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under section 117 should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted.

In the case of Mr. X both the duties under section 117 and the Care Programme Approach (see Section 14.1.4.) lapsed without formal consideration of implications of losing contact with him. If it was believed that he had transferred to the Swindon area, then a formal transfer of his care was appropriate. The transfer was not satisfactorily achieved by the contact between the Lincolnshire Care Coordinator and the Swindon Community Mental Health Team.

The Independent Investigation Team found that the Mental Health Act was initially used effectively in Lincoln to assess Mr. X and to treat his mental illness. The use of Section 135 to gain entry to his house was appropriately assertive and facilitated an assessment that led to his hospital admission. The use of a Treatment Order under Section 3 of the Act was effective in ensuring his compliance with treatment, in particular medication.

Mr. X had access to the appeals procedures of the Act and used them to appeal to both the Hospital Managers and the Mental Heath Review Tribunal. The decision of the Tribunal to discharge him was a surprise to the clinical team and there was not an aftercare plan in place to which Mr. X was committed. Contact with him was maintained through the efforts of his Care Coordinators.

Mr. X gradually withdrew his cooperation and without the structure of statutory supervision, he became non-compliant with treatment and did not attend out-patients appointments or maintain contact with the Care Coordinators allocated to his case. He was discharged from the care of the mental health clinical team to that of his GP in Lincoln without formal consideration of his after care needs under Section 117 Mental Health Act (1983) or the Care Programme Approach.

- ***Contributory Factor Number Four. The aftercare needs of Mr. X were not adequately followed up via the provision of Section 117. This ensured that there was no statutory form of supervisory arrangement in place, as a result mental health services lost contact with Mr. X.***

14.1.4. The Care Programme Approach

14.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[178]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 (Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach) to incorporate lessons learned about its use since its introduction and again in 2008 (Refocusing the Care Programme Approach)[179].

'*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services*[180].' (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

177. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

178. Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

179. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

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

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

The essential elements of any care programme include:

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

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

The Social Services Inspectorate carried out a review of mental health services in Lincolnshire County Council in 2003 and commented that:

'In the integrated service, care management arrangements have been integrated operationally and procedurally with the CPA, to form a single approach. A new and comprehensive CPA policy has been produced and is being consulted upon. Much remains to be done to obtain full commitment to the CPA by all staff at the Trust. There is a strong commitment on the part of senior management to make this happen and there are plans to re-launch the policy accordingly.[181]

The Inspectorate recommended that '*a strategy should be developed to secure greater commitment to the CPA*.'

The Lincolnshire Partnership NHS Trust agreed its first CPA policy on the 23 February 2001[182]. This version was in use at the time of Mr. X's contact with the Lincoln service. The policy referred to national policy and guidance, and made a link between risk assessment and CPA. On page 7 the policy referred to the need for staff conducting an assessment to consult the full records before reaching conclusions about risk and that they should record whether the patient's clinical records were available at the time of assessment or review.

There were a number of requirements and guidance points in the policy which outlined the role of the care coordinator and review timescales. There were two sections which the Independent Investigation Team has found to be particularly relevant to the review of Mr. X's care and treatment, namely transfer of responsibility and a service user's refusal to engage whilst on enhanced CPA.

Transfer of Responsibility

This section of the CPA policy stated that decisions about transfer to another area must be made at a formal CPA review. Until transfer arrangements were complete, the current Care Coordinator retained full responsibility for the case.

Refusal to Engage - Enhanced CPA

This policy section referred to service users on enhanced CPA who had made it clear that they refused to engage with services, including the assertive outreach service. The policy stated that a risk assessment should be undertaken and the multi-disciplinary team should

[181] Social Services Inspectorate. 2003 Inspection of Mental Health Services Lincolnshire County Council.

182 Lincolnshire Partnership NHS Trust. Care Programme Approach Policy, version 1.

discuss the case as soon as possible. Consideration should then be given to carrying out a Mental Health Act assessment, and of informing the Police if any action on their part was deemed to be necessary. An action plan should be drawn up to include:

- a formal review during the initial six months following failure to engage;
- widespread consultation of those involved;
- a multi-disciplinary decision on the minimum type of contact with the service user, e.g. attempt to visit, offer of outpatient appointment.

The policy states that a register of service users who failed to engage should be held centrally. Exceptionally service users could be discharged from CPA after they had had no contact with services for a period of one year. This step required the full agreement of the multidisciplinary team once it had been ascertained that the service user presented no risks either to themselves or to others. Many of the same requirements were also set out in the section headed 'Loss of Contact'.

14.1.4.2. Findings

The Following Care Programme Approach actions took place between Mr. X's inpatient admission on the 19 August 2002 and discharge from services on the 4 November 2003. This information has been drawn from the extant clinical record.

Undated. Blank CPA documentation is placed within Mr. X's clinical file[183].

Undated. Partially completed CPA documentation is placed within Mr. X's clinical file. This documentation is neither dated nor signed. The Summary of Needs/assessment was filled in however all of the other fields on the documentation were left blank. The blank fields included:

- Care Programme Action/Intervention;
- Contingency Plan;
- Crisis Plan[184].

183 File 1 B. PP.218-221
184 File 1 B. PP. 363-367

Mr. X's signature was absent from this documentation so it is apparent that it was completed in his absence.

14 November 2003. A brief file note was entered into the medical records by the Care Coordinator. *'Agreed to home visit by CPN.'*[185]

Dated 18 September 2000 (clearly the wrong date but probably sometime in late November 2002). The first Care Coordinator allocated to Mr. X wrote to the Consultant Psychiatrist. This letter stated that Mr. X had been registered at a General Practice and that advice had been given regarding his financial situation[186].

18 November 2002. The first Care Coordinator visited Mr. X at home[187].

19 November 2002. The first Care Coordinator visited Mr. X at home[188].

25 November 2002. The first Care Coordinator took Mr. X to the Benefits Office[189].

Mr. X was seen three times at home between these dates.

9 January 2003. A letter was sent to the Care Coordinator by the Consultant Psychiatrist enquiring whether Mr. X had made contact as he had failed to attend his CPA review[190].

10 January 2003. The Care Coordinator wrote to the Consultant Psychiatrist thanking him for letting know that Mr. X did not attend his CPA meeting and explaining that he also had not attended as he was on holiday. This letter stated that the Care Coordinator was seeing Mr. X on a weekly basis[191].

21 January 2003. Mr. X was seen at ward round with the first Care Coordinator in attendance[192]. CPA review documentation is present in the clinical record. The CPA level

185 File 1 B. P. 307
186 File 1 B. P. 307
187 File 1 A P. 140
188 File 1 A P. 141
189 File 1 A. P.142
190 File 1 B. P. 294
191 File 1 A P. 87
192 File 1 B. P. 333

was indicated as being 'Standard' which was clearly erroneous. It would appear that this review was only partially completed; it was not signed by either the Care Coordinator or Mr. X. At a later date it would appear that the second Care Coordinator added a few planned interventions regarding arranging benefits, these entries must have been made some three months later. The contingency and crisis plan sections were left blank. It is the second Care Coordinator's signature that is appended[193].

Mr. X was seen at his home twice between these two dates.

4 March 2003. Mr. X was seen at an outpatient appointment with his Care Coordinator in attendance.

5 March 2003. The Consultant Psychiatrist wrote to the GP with a progress report. This letter stated that Mr. X's current Care Coordinator was moving on and that it was uncertain whether or not he would engage with another[194].

15 May 2003. The second Care Coordinator wrote to Mr. X at his Lincoln address explaining that he had been unable to make an appointment with him and requesting him to make contact[195].

26 June 2003. Mr. X did not attend his CPA review. It was noted that Mr. X was refusing to see his Care Coordinator and it was not clear whether he was taking his medication. It was recorded that Mr. X appeared to be spending a lot of time in Swindon[196].

11 July 2003. The Care Coordinator wrote to the Consultant Psychiatrist to invite him to a CPA review on the 24 July 2003[197].

25 July 2003. CPA documentation and risk assessments were partially completed. Over 50% of the risk assessment data was ticked as being *'not known'.* Identified needs were documented as requiring:

- *'assessment of mental state;*

193 File 1 A PP. 78-82
194 File 1 B. P. 336
195 File 1 A. P.165
196 File 1 B. P. 339
197 File 1 B. P. 287

- *support visits to monitor medication;*
- *assistance with claims for benefits.'*

The planned outcomes were identified as being:

- *'engagement with services;*
- *prevent relapse.'*

Agreed actions were to undertake:

- *'regular visits to assist assessment;*
- *liaison with relevant agencies.'*

A crisis and contingency plan were in evidence in that relapse indicators were identified, however no plan was developed to indicate what actions would be required if a) Mr. X relapsed, or b) Mr. X went into crisis[198].

4 November 2003. The Care Coordinator wrote to Mr. X at his Lincoln address. This letter said that as Mr. X had not attended CPA reviews he was going to be discharged from the Community Mental Health Services[199].

Whilst the Care Coordinators and the Consultant Psychiatrist wrote to Mr. X's General Practice summarising their clinical decisions regarding Mr. X, there is no evidence to suggest that the GP was ever invited to attend CPA reviews or received copies of CPA documentation.

The Independent Investigation Team acknowledges that the two Care Coordinators made regular attempts to contact Mr. X by telephone and also made attempts to visit him at his Lincoln home even though mostly he was not available. This being said, the extant CPA related documentation in the clinical record of Mr. X speaks for itself. There was in effect no Care Programme Approach in place for Mr. X.

Mr. X was on enhanced CPA during his entire episode with Lincoln-based services. Mr. X was recorded briefly, in early 2003, as being on standard CPA but that appears to have been

198 File 1 A PP. 115-122
199 File 1 B. P. 289

an error. Enhanced CPA was appropriate in the light of both the Trust's CPA policy and national guidance. The CPA documentation was partially completed by Mr. X's first Care Coordinator and then simply re-signed with minimal updating by the second Care Coordinator. The care plan was minimal and rather reactive with no crisis or contingency planning. There was therefore no proactive care planning at the following critical times:

- on his sudden self-discharge from the inpatient unit;
- when it became clear that he was disengaging with services, in the early part of 2003;
- when it became clear that contact had been completely lost in the middle of 2003.

These omissions were a breach of the Trust's own CPA policy.

The Role of the Care Coordinator

The Trust CPA policies past and present state that the Care Coordinator should be *'the most appropriate member of the care team who is best placed to meet the individual's needs and to oversee care planning and resource allocation for an individual on enhanced CPA will be appointed as the Enhanced Care Coordinator for that individual. The most complex cases need to be coordinated by the most experienced and skilled practitioners.'*

Mr. X's first Care Coordinator was an experienced CPN who may have developed an element of rapport with him. The second Care Coordinator was an inexperienced community nurse, who had just moved from an inpatient ward, and was employed as an E grade staff nurse in the Community Mental Health Team. It appears that the second Care Coordinator was given at least one inappropriately complex (enhanced CPA) client in Mr. X. The Independent Investigation Team was told that he operated during this period without either management or caseload supervision. There was no F or G grade CPN who was providing him with an opportunity to discuss the case. The Investigation Team was told that the only difference at that time between the job descriptions of a staff nurse and a higher graded nurse would be that the staff nurse would *not* carry out assessments. The Care Coordinator said that it was not his role to undertake assessment or care planning. However in this particular case where there was no service user engagement and no development of any therapeutic rapport, assessment could not be a once and for all activity. Rather assessment would need to take place at every contact in order to review Mr. X's mental state and his circumstances. This should have then led to the required adaptations and developments to his care plan being

made. At interview the Care Coordinator agreed that this case was, on reflection, not an appropriate one for him to have been allocated at that time.

In the letter that the Consultant Psychiatrist wrote to the GP on the 5 March 2003 he stated that the person who had been initially allocated as Mr. X's Care Coordinator was *'moving* on' and that it was unlikely that he would engage with a replacement[200]. Knowing that Mr. X was complex and almost impossible to engage with, it is the view of the Independent Investigation Team that Mr. X's case should have been judged at the time to be inappropriate to be placed on an E grade's caseload.

Multi Disciplinary Team Work

At the time of his admission Mr. X was assessed under the Mental Health Act (1983) and subsequently admitted by the Consultant Psychiatrist who was to become his Responsible Medical Officer. This doctor was the Consultant on the No Fixed Abode Rota as Mr. X did not have a GP in the Lincoln area at the time of his initial assessment. This Consultant did not belong to the Community Mental Health Team which covered Mr. X's home address. Subsequently Mr. X was allocated a Care Coordinator who belonged to the team which covered his post code area; this was a different team from the one of which his Responsible Medical Officer was a member. Both of Mr. X's Care Coordinators therefore operated within a geographically separate Community Mental Health Team to that of Mr. X's Consultant Psychiatrist.

This appears to have made multi-disciplinary working difficult, as there were no opportunities for regular updates or discussions, and CPA reviews were simply fitted into ward rounds or outpatient appointments. It is also less likely that there would be any team ownership, by either team, of this quite challenging case, although there is evidence that other members of the Care Coordinator's team did become involved, for example during his annual leave.

14.1.4.3. Conclusions

The absence of a definable clinical team for Mr. X led to there being little adherence to the Trust policies on failure to engage and loss of contact. Both of these elements of the CPA

200 File 1 B. P. 336

policy require thorough multidisciplinary team discussion and decisions, including whether someone who has lost contact may be discharged, attempts to be made to make contact etc. The fact that there was no real team in place led to an inevitable breach of the CPA policy.

It is the conclusion of Independent Investigation Team that there should have been a transfer of consultant responsibility at some point between Mr. X's admission to hospital in 2002 and his loss of contact with services in 2003. The most appropriate time would have been when he became registered with a local GP, in November 2002. This would have enabled full community mental health team involvement in his case.

Another factor in the mismanagement of Mr. X's CPA was that the Care Coordinators, past and present, failed to take into account the fact that Mr. X was in effect living in Swindon. At no point was this discussed in detail with Mr. X and with his carers. Care Coordinators continued to visit him at home, having previously been told that he would not be there. Letters were persistently sent to his Lincoln home advising him of appointments and reviews when it was known he only accessed his post on a four-weekly basis and that appointment and review dates often came and went without Mr. X being any the wiser. Why letters were not sent to him at his Swindon address is difficult to understand. This made a definite contribution to the failure of Mr. X's CPA.

Obviously the most significant issue regarding the CPA that Mr. X received was that the process was never really implemented or managed in a comprehensive and systematic manner. CPA is more than ensuring that a Care Coordinator makes regular visits to a service user, or that the service user is required to attend periodic CPA reviews. CPA is the national framework by which mental health services are delivered to individuals with severe mental illness. Assessment and care planning are crucial components. In the case of Mr. X the *raison d'être* of CPA was not achieved and mental health services were not delivered effectively.

- ***Contributory Factor Number Five. Failure to implement the Care Programme Approach ensured that Mr. X was not appropriately assessed and was not in receipt of an appropriate care, crisis or contingency plan. As a result his care and treatment was entirely compromised and this lack of clinical management ensured that he slipped through the safety of care.***

14.1.5. Risk Assessment and Forensic History

14.1.5.1. Context

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

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

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

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

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

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

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[201].

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

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

Whilst the guidance quoted above post dates the period in which Mr. X received his care and treatment in Lincolnshire, the basic local and national requirements and expectations were similar. In 2003 the Lincolnshire Partnership NHS Trust was using Version 1 of their Clinical Risk Assessment and management Policy[202]. This policy stated that risk assessment should be a multi-disciplinary process, with the lead responsibility lying with the Responsible Medical Officer, although this may be delegated to another, for example the Care Coordinator. The policy referred to national guidance and indicated that those responsible for formulating risk management plans should ensure that certain standards were adhered to including (amongst others):

- *'All service users with severe mental illness and a history of self harm or violence should receive enhanced level CPA;*
- *Individual care plans should specify action to be taken if the service user is non-compliant or fails to attend an appointment;*

201 Best Practice in Managing Risk; DoH; 2007

202 Lincolnshire Partnership NHS Trust (2003) Clinical Risk Assessment and Management Policy, version 1.

- *All service users with severe mental illness should be followed up within seven days of discharge from in-patient care.'*

The policy also referred to risk assessment as an ongoing process rather than a single event. However it identified certain critical points in a service user's journey when extra attention may be required:

- *Point of first contact*
- *Change of Care Coordinator or transfer of care*
- *Change of legal status under the Mental Health Act*
- *Change of life circumstances*
- *Profound change in mental state*
- *Discharge or move to a less restrictive care setting, e.g. going on leave.*

14.1.5.2. Findings

In order to illustrate Mr. X's risk presentation and his subsequent clinical assessment and management key relevant findings have been set down below. This has been done in order to clarify what was both known and acted upon by clinical services in Lincolnshire between 2000 and 2007.

1998-1999. Mr. X was suspended and then dismissed in December 1999 from his post following allegations from a female colleague of harassment over many months. Mr. X was investigated for harassment, which he continued to deny. The Cambridgeshire Police Force led this case.

23 October 2000. A psychiatric report was prepared by a Forensic Consultant Psychiatrist whilst Mr. X was awaiting sentence having been found guilty of harassment. The Forensic Psychiatrist noted that Mr. X had no previous psychiatric history, and his opinion was that Mr. X suffered from distorted thinking and a discrete delusional disorder. He recommended a Probation Order and a voluntary referral to mental health services.

2 November 2000. Mr. X was convicted of harassment at Huntingdonshire Magistrates Court. He was placed on probation for 12 months.

5 July 2002. Mr. X sent letters to the Chief Constable of the Lincolnshire Police, complaining that he had been assaulted, bullied, harassed and had lies spread about him by the Police, since December 1999.

28 July 2002. Mr. X went to the home of a Lincolnshire Police Officer and demanded to know if, in fact, he was a Police Officer, telling him he had complaints against the Police. He was abusive and threatening in tone.

31 July 2002. Mr. X subjected another Police Officer to abusive gestures outside the Officer's home. The Officer had had no previous contact with Mr. X.

1 August 2002. Information sharing took place between Lincolnshire and Cambridgeshire Police Forces. It was stated that '*numerous communications received from Mr. X ranging from assault by Senior Police Officers to collusion between this force (Lincolnshire) and United States Special Forces to cause him harm.*' It was reported in Police records that Mr. X had applied for the post of HQ manager and there was some concern regarding the content of his application. The Police held concerns that Mr. X had '*an unhealthy interest in the Police and was displaying some aspects of Obsessional Behaviour*.' Following a discussion between the two forces Mr. X was described as '*dangerous and having a personality disorder'.* Arrangements were made to install alarms in Police houses.

2 August 2002 14.48pm. Mr. X was arrested in the rear garden of his home and taken to the Police station and kept in custody. He was reported as having been violent on arrest as he had secateurs in his hand which he refused to put down. There was a struggle and he was handcuffed.

2 August 2002, 20.35pm. Mr. X was seen by the Police Surgeon, for a psychiatric assessment. He reported that Mr. X was not cooperative and recommended a formal psychiatric assessment by a consultant psychiatrist. He assessed him as being fit to be detained and fit to be interviewed.

3 August 2002. A review of Mr. X's detention was made by a Police Sergeant. The Officer noted that Mr. X had stated in writing that he intended to purchase a '*legal weapon*', and

reported that he felt grave concern and that he was a '*bomb waiting to go off*.' It was agreed that his detention should continue. Mr. X was charged with three counts under the Public Order Act.

7 August 2002. Mr. X sent letters to the Police Complaints Authority and to the Lincolnshire Chief Constable complaining that he had been arrested with excessive force and assaulted in his back garden.

August – September 2002. Mr. X sent numerous letters to the Police Complaints Commissions and the Lincolnshire Chief Constable complaining of Police harassment and assaults.

17 September 2002. Mr. X was referred by the Police to the Lincolnshire Multi-Agency Public Protection Panel because of '*his rapidly deteriorating mental health combined with his move towards arming himself with knives*.'

19 September 2002. Mr. X was referred for Mental Health Act (1983) assessment by a Senior Nurse Manager from the low/medium secure unit. Police forcibly entered Mr. X's home with a Duty Consultant Psychiatrist, GP and Approved Social Worker. The assessment report recorded that '*the Police state that he can be violent and aggressive. To treat with caution. Level of aggression and violence not known but predicted to be dangerous'.* On admission his risk of aggression was assessed as '*unpredictable but medium to high'*.

19 September 2002. A risk assessment checklist was completed by the staff nurse. Mr. X was described as paranoid, deluded and feeling that the Police were watching him. Evaluation of the risk posed was:

> *'Risk of suicide – low*
> *Risk of violence or aggression according to this risk assessment - low to moderate*
> *Risk of self neglect - low.*

Currently low risk based on index offence and according to the scoring on this particular risk assessment'.

However, under personal impressions there was an entry which stated '*I believe he has the*

potential to commit greater acts of violence etc.'

21 September 2002. An Initial Risk Indicator form was completed by a ward nurse. This assessment found Mr. X as being a low risk to himself, and a low to moderate risk to others. No care plan was in evidence.

26 September 2002. Mr. X's Section 2 was regraded to Section 3 of the Mental Health Act (1983). The reasons for this regrading were that he was becoming increasingly hostile and aggressive and he was refusing all treatment.

30 September 2002. The Responsible Medical Officer wrote to the Mental Health Review Tribunal prior to their review of Mr. X's status under Section 3. He stated his diagnosis was delusional disorder and quoted ICD 10, '*This group of disorders is characterised by the development either of a single delusion or a set of related delusions which are usually persistent and sometimes lifelong'.* He also indicated that Mr. X represented a danger to the safety of others. The Tribunal upheld the Section 3.

29 October 2002. An Occupational Therapy risk assessment was conducted which recorded that Mr. X had been violent and aggressive on admission and that weapons had been found in his home. This risk assessment noted that Mr. X had no insight into his mental illness and that he believed staff on the ward were conspiring with the Police against him. Mr. X was described as '*dominating*' and '*smirking*'.

27 November 2002. Mr. X appealed against his Section 3 detention to the Mental Health Act Tribunal. The Tribunal discharged him from the Section, and he immediately discharged himself from the ward. The reasons for the Tribunal's decision were that they had no doubt that the original detention was justified by his psychotic state at the time. However he had responded to treatment and was no longer expressing persecutory delusions. He remained, however, '*guarded and suspicious*.'

21 January 2003. Risk assessment documentation was completed by the Care Coordinator. The assessment noted in relation to risk of harm to others, that Mr. X had a long history of grievances against the Police and that he was suspicious and mildly hostile, and difficult to

engage, but that he did not give the impression of being a violent personality, although his illness had affected this. In the assessment conclusion the Care Coordinator noted under 'known factors which may reduce risk' that Mr. X was '*Now taking medication – complains much less and much less paranoid'.*

29 January 2003. The Care Coordinator met a Police Officer at the Police station to look at the letters that Mr. X had written to the Chief Constable and the Police Complaints Authority. It was his view that the letters indicated disordered thinking and a belief that there was a conspiracy against him, involving the American Rangers from RAF Waddington. The Police had had no further complaints from Mr. X, but they continued to believe that he could be violent.

30 January 2003. A home visit from the Care Coordinator took place. Mr. X became irritable and angry and said that the Police officer across the road had '*got it in for him*' because he had made a complaint about him. It appeared that Mr. X thought that the Care Coordinator was '*siding' with the Police*'. The Care Coordinator discussed this matter with the Consultant and then informed the Police of Mr. X's continuing views and possible continuing risk to the Police.

25 April 2003. The Care Coordinator visited Mr. X at home with the newly assigned replacement Care Coordinator. Mr. X appeared to be somewhat hostile and suspicious. Mr. X said he no longer was being harassed by the Police officer over the road. He said he would continue with the Olanzapine as if he did not his consultant would take him back into hospital. This appears to be the last time he was seen by the Lincolnshire mental health service.

10 July 2003. A Lincolnshire Police Officer telephoned the Care Coordinator to say that Mr. X had sent notes of a complaint against the Police and he wondered if this might relate to deterioration in his mental state. The Care Coordinator discussed this with the Consultant Psychiatrist and it was agreed that Mr. X would be contacted to ask him to attend the ward round on a Thursday.

25 July 2003. CPA documentation was completed by the Care Coordinator. Under 'Current

Signs' it was recorded that Mr. X had started to write letters complaining about his Consultant's care and about Police actions. There had been no contact with Mr. X since April, despite '*numerous telephone calls and written correspondence asking him to make contact'*. This document recorded that Mr. X was on Enhanced CPA. In the section headed Crisis and Contingency Plan it was recorded that 'Known Triggers': include '*non-concordance with medication regime'*, and 'Under Signs of Possible Relapse': there is '*increased suspiciousness and increase in letters of complaint about both medical team and Police'.*

29 July 2003. The previous Care Coordinator was contacted by the sister of Mr. X. She expressed concern over Mr. X's mental state and thought there was some deterioration. He had been laughing inappropriately and sending '*vast amounts of letters'*. This information was passed to the new Care Coordinator. The sister of Mr. X has stated that she told him that her parents were struggling to cope with Mr. X. Mr. X '*was bombarding people with letters of complaint*'.

4 August 2003. The Consultant wrote to Mr. X's GP stating that he had not attended his outpatient appointments with either himself or his Care Coordinator and he had no alternative but to discharge him from his outpatient service. He commented that he did not appear to be writing any unpleasant or harassing letters, and that he may have already returned to Swindon. This letter also recommended that if he needed future mental health referral in Lincoln it should be to the appropriate sector team as he had taken him on via the 'No Fixed Abode scheme'. There was no reference in this letter to Enhanced CPA or Section 117.

12 March 2004. Mr. X wrote a large number of letters of complaint to numerous bodies, including the Health Service Ombudsman. The last letter in this file is dated 12 March 2004 and is written from Mr. X's Lincoln address.

2003-2007. The sister of Mr. X reported to the Independent Investigation that she made numerous telephone calls to the Lincoln service and numerous telephone calls to the Crisis Team and other parts of the Swindon-based service during this period, asking for help and intervention for her brother and her parents.

2004-2007. Mr. X continued to live in his parents' home. He became increasingly threatening towards his parents.

Mr. X's family grew increasingly concerned about his mental health. There was growing tension between Mr. X and his parents.

The sister of Mr. X visited the Police station and then made numerous calls to the Crisis Team, CAB, Care Quality Commission and Mental Health Act Commission, Lincoln Mental Health services, and the Local Authority asking for help. The Lincoln Consultant's Medical Secretary told the sister she could send information if she received a headed letter from Swindon Mental Health Services.

The sister of Mr. X telephoned the Swindon Crisis Team. In A referral form completed by a Crisis Team Worker it was recorded that the referrer's expectation of the Crisis Team was '*assessment and treatment of mental illness'*. Under 'details of current problem' it was stated that Mr. X had been '*untreated for years, has no GP, and that his parents may be at risk*'. A worker from the Crisis Team telephoned Lincoln services to speak to the Medical Secretary of Mr. X's Consultant to arrange the transfer of his clinical record.

Risk Assessments and Management Plans

Several risk assessments were completed for Mr. X when he was an inpatient and by the Care Coordinator once Mr. X was back in the community. There are several important issues that require consideration.

First. The quality of risk assessment is poor. The Risk Assessment Checklist, (19 September 2002) and the Initial Risk Assessment (21 September 2002) do not appear to have been developed in a robust or coherent manner. Significant fields are marked as being '*not known'* or have been assessed as not being areas of risk. No other risk assessments were conducted by the ward staff prior to Mr. X's discharge. The 21 September 2002 risk assessment for Mr. X is set out below:

Table Two[203]

Risk of Harm to Others Field

	Not Known	No	Yes
Has the service user committed any acts of violence?		✓	
Who/what was assaulted or damaged?		✓	
What was the severity of the assault?		✓	
Have any weapons been used in any incidents?		✓	
Have any threats against anyone been made?			✓
Any evidence of preparations to commit violence?	✓		
Does the service user express high levels of anger or hostility?			
Any evidence of stalking behaviour?			✓
Has the service user ever been convicted of any violent offence?			✓
Any history of inappropriate sexual behaviour?			✓
Is there any evidence of fire setting?		✓	
Any evidence of taking or attempting to take hostages?		✓	
A formal diagnosis indicative of increased violent/impulsive behaviour?			✓
Does the service user experience command hallucinations?	✓		
Any delusional beliefs evident?			✓
Is alcohol or substance misuse a significant factor?	✓		
Have there been any admissions to a high, medium or low secure unit?		✓	
Has the service user failed to comply with previous interventions?			✓

The Independent Investigation Team were able to find several entries in Mr. X's clinical records, which would have been available to the ward staff compiling the risk assessments, either at the time of the assessments or in the days immediately following the assessments, that would have indicated that Mr. X's potential levels of risk were high. The ward staff received, and signed for receipt of Mr. X's Section documents on his admission. These documents clearly stated his intention to arm himself[204]. All clinical staff would have had access to the Approved Social Worker's report made on the 20 September 2002. This report stated that '*Mr. X is reported by Police to be violent and aggressive and has had knives; his*

203 File 1 B P. 357
204File 1 B P. 272

behaviour was assessed [by the Police] as posing a significant risk to others'[205]. This report also stated that the Police gave the clinical team who made the Mental Health Act Assessment a detailed brief regarding Mr. X's behaviour and risk. The Police are recorded as having advised that a meeting should be held so that a full briefing could take place regarding Mr. X's history '*given Mr. X's history with weapons'*[206].

The Occupational Therapy risk assessment conducted on the 29 October 2002 mentioned that '*weapons were found in the patient's home*'. This assessment also stated that the Police reported on admission that Mr. X was '*violent and aggressive and should be treated with caution'*[207]. It is unclear why this assessment was accurate, but the ward-based assessment was not.

Despite the ward staff being aware of Mr. X's identified risks this information did not support the development of a comprehensive risk assessment which took into account all of the information known to services at the time of Mr. X's admission. There is ample evidence to demonstrate that significant fields in the risk assessment documentation, those regarding weapons and threats of violence, were incorrectly assigned.

Second. The format of the risk assessment documentation at the time Mr. X was receiving his care and treatment served to guide staff to minimise of the risks that Mr. X posed. The severity rating guidance for clinical staff is set out below in Table three:

Table Three

Severity Rating Scale[208]

Severity Grade 0	No evidence
Severity Grade 1	Is any incident which threatens others with the use of violence including sexual threats and property damage
Severity Grade 2	Any assault not resulting in any detectable injury, including minor sexual assaults
Severity Grade 3	An assault resulting in minor physical injuries such as bruising, abrasions or small lacerations more persistent series sexual assault i.e. indecent sexual assault
Severity Grade 4	An assault resulting in major physical injuries including large

205 File 1 B P. 397
206 File 1 B P. 399
207File 1 B P. 191
208 File 1 B P. 358

	lacerations, fractures, loss of consciousness, or assault requiring subsequent medical investigation and treatment. Also included is sexual assault of rape or buggery, fire setting, both non specific and fire that endangers life

Once the data required in Table Three had been ascertained the Severity Rating Scale as set out in Table Four was applied to Mr. X's clinical presentation. Mr. X was graded a severity rating of '1' in relation to his assessed risk to others. It is the view of the Independent Investigation Team that the severity rating deployed in the Lincolnshire Initial Risk Indicator Assessment was unhelpful for use in a normal psychiatric clinical context. The Severity Rating Scale actually required a service user to have been violent, and severely so, in order to gain a score high enough to merit specific appropriate clinical interventions. A risk assessment is simply that, an assessment of potential risk. As such it can never be seen as a definitive and exact science. However to try and predict future risk solely on the severity of a service user's past acts of violence alone completely misses the point. It is the view of the Independent Investigation Team that this assessment tool raised the bar so high that Mr. X's substantial level of risk was entirely minimised. The severity of risk cannot be determined by the severity of injury that a person may have received at the hands of a service user in the past. An assault that results in minor injury is no less significant that an assault that results in a major injury as chance and circumstance have to be seen to be as major contributing factors.

On the 21 January 2003 Mr. X's first Care Coordinator conducted a 'First Contact Risk Assessment Checklist'. This assessment recorded under the section 'Risk of Aggression/Violence Towards Others' most of the known information about Mr. X's history with very little being omitted as it was taken directly from the Police records[209]. The Care Coordinator gave Mr. X a score of '2', the highest that he had been given to-date. Unfortunately there is no evidence of a care plan in the clinical record that would have managed the risk identified.

On the 22 July 2003 Mr. X's second Care Coordinator conducted a risk assessment as part of a 'First Contact Risk Profile'. This was good practice. However it is clear that this assessment was not undertaken in the presence of Mr. X, neither was it undertaken with his cooperation. Much of Mr. X's previous risk history as set down on the form was taken directly from

209 File 1 B. PP. 124-131

previous risk assessments and therefore contained all of the omissions that were to be found in them. The First Contact Risk Profile documentation contained 34 risk indicators. Out of these 34 indicators 24 were ticked as being 'not known', one was left blank, seven were ticked as being 'no' (e.g. not being an area of risk), and two were ticked as being a 'yes'. The Independent Investigation Team have to question the validity of an assessment where 25 out of 34 criteria were either not known or left blank, especially as these criteria focused on the signs of early relapse[210]. The two risk criteria that were ticked with a 'yes' tellingly were as follows:

- failure to attend appointments;
- unplanned disengagement with services.

The resulting plan from this risk assessment stated simply '*engagement with services, prevent relapse, regular visits to assist assessment process*'[211]. The Care Coordinator and the Consultant Psychiatrist were responsible for putting a crisis and contingency plan in place but what this plan actually consisted of and who would trigger it was not determined.

Third. It appeared to the Independent Investigation Team that clinicians worked in relative isolation. Mr. X did not appear to be discussed by the multidisciplinary team. Although there were a small number of reviews which involved the Care Coordinator and the Consultant psychiatrist there was little evidence that there had been joint formulation of risk assessments or management plans and true multi-disciplinary discussion or ownership.

Fourth. Mr. X consistently refused to engage with services. Despite continuous attempts to work with Mr. X clinical staff were consistently rebuffed by him. This hindered an accurate clinical picture for Mr. X being compiled which could then be assessed within the context of his previous forensic history. Mr. X's consistent refusal to engage also meant that the risk assessment, and resultant somewhat embryonic plans that were formulated as result, were never discussed with Mr. X. During Mr. X's time with Lincolnshire services he made it quite clear that he did not wish for his parents to be told about any aspect of his clinical care or treatment. This effectively excluded Mr. X's family from being informed about either his forensic history or his risk profile.

210 File 1A P. 119
211 File 1A PP.120-121

Fifth. Information sharing between agencies was sporadic. The Lincolnshire Police Force maintained a steady and consistent level of communication and information sharing. This high level of practice was not always reciprocated by mental health services. It is clear from the clinical record that potential criminal proceedings against Mr. X were not taken forward as the Police felt that, '*he was in the best place'*. This referred to Mr. X's admission under section to inpatient services.

There were a number of critical information sharing junctures. There was a referral made to the Multi Agency Public Protection Panel (MAPPA) on 17 September 2002 by the Lincolnshire Police and mental health services. This referral was recorded in the clinical record. The reasons for the referral and what actually happened as a consequence is not recorded in the clinical record. Any MAPPA referral is a serious step, reserved only for offenders who are regarded a real and certain threat to society. This referral was not used in any subsequent risk assessments.

During Mr. X's time with Lincolnshire mental health services the Police made it clear that they were willing to attend a case review meeting with Mr. X's Care Coordinator and Consultant Psychiatrist. This suggestion was not taken up, hence information from the Police was not acted upon and multi-agency communication was not optimal.

It is certain that Mr. X's GP was not advised appropriately of either Mr. X's history or of his potential risk. Communications from the Consultant Psychiatrist to the GP served to minimise Mr. X's history, condition, likely future behaviours and ongoing care and treatment needs.

Sixth. The development of sound management plans did not occur. It is the view of the Independent Investigation Team that Mr. X had nothing that could be seen as constituting a care and management plan which had been dynamically constructed as a consequence of a detailed risk assessment.

14.1.5.3. Conclusions

In the case of Mr. X the poor quality of the risk assessment tool utilised by the Mental Health Trust was compounded by the fact that significant data was not entered onto it. It is the view of the Independent Investigation Team that the clinicians who filled in the original risk assessments were concerned about the risk that Mr. X posed. However there was a mismatch

between the risk assessment tool criteria and checklists and the professional judgements of the clinical staff. On the risk documentation commenced on the 21 September 2002 the Ward Nurse who conducted the assessment recorded *'currently low risk according to the scoring on this particular risk assessment'* and that *'I believe he has the potential to commit greater acts of violence'*[212].

During Mr. X's time with Lincolnshire mental health services there was an absence of referring back to previous assessments, history or summaries, with particular regard to Mr. X's forensic history. The importance of a strong link between risk assessment and management and care planning does not appear to have been fully recognised. Relapse signs were identified once Mr. X was living back in the community. However when these were identified and observed (increased letter writing and increased suspicion towards the Police and others) these observations did not appear to lead to any further review or changes in Mr. X's care plan.

During Mr. X's admission to the unit, he remained generally quite hostile and suspicious. He denied that he was ill, and continually contested his detention. Mr. X consistently denied that he had a mental illness, and only agreed to his medication because he believed that his Consultant Psychiatrist would take him back into hospital if he refused to comply. This refusal to engage with the service was not fully recognised or managed by his care team and there was therefore no connection made between this failure to engage and the adjustments that needed to be made to Mr. X's risk assessments and management plans. It is the view of the Independent Investigation Team that Mr. X's failure to engage and his loss of contact should have been viewed as important elements of both his risk assessment and management plan.

It is clear to the Independent Investigation Team that Lincolnshire mental health services had in their possession detailed information about Mr. X's forensic history and potential clinical risk during the time that he received his care and treatment from them. The Trust did not undertake an appropriate multidisciplinary and multiagency risk assessment for Mr. X. No adequate management or treatment plan was constructed as a result. As a consequence Mr. X's risk was in effect minimised and was not communicated effectively to either his family or to other health care services.

212 File 1 B P. 358

Had Mr. X's risk been appropriately assessed and managed it is possible that the information communicated to both primary care medical services in Lincoln, and community mental health services in Swindon, could and should have triggered a different clinical response to the care, treatment and supervision that Mr. X required.

In conclusion Mr. X did not have an appropriate multidisciplinary risk assessment. No care, treatment or management plan was developed and implemented as a result. Mr. X's history, risk profile and ongoing care and treatment needs were not adequately communicated. This failure made a direct contribution to Mr. X's serious and enduring mental health illness being untreated for a period of four years.

- ***Contributory Factor Number Six. The failure to complete multidisciplinary risk assessments in the full context of Mr. X's forensic and psychiatric history meant that he remained an 'unknown' quantity. As a consequence the care and treatment that he received was not fit for purpose. This had a long-term detrimental effect on his future mental health.***

14.1.6. Referral, Transfer and Discharge

14.1.6.1. Context

Trust Discharge Policy (Inpatient)

The Lincolnshire Trust Discharge Procedure in 2003 set out requirements for the planned discharge of service users from inpatient units[213]. The previous policy which was in operation at the time Mr. X was discharged from inpatient services was not available to the Independent Investigation Team; however it is known that this policy and the previous policy followed 1998 Department of Health Guidance.

The aim of the policy was to ensure that service users experienced a '*smooth transition'* from one care context to another. This policy made provision for both planned discharges and discharges *'which occur at short notice; and are considered as unplanned or against medical advice'.* It was the function of the care team to undertake:

213 Lincolnshire Partnership NHS Trust (2003) Discharge Procedure.

- *'a needs assessment, analysis of unmet needs, level of clinical risk and plan of follow up care;*
- *seven day follow up;*
- *Level of CPA;*
- *Current health and social needs;*
- *Carers assessment'*[214].

The policy noted that when a discharge was unplanned the above points should be followed as closely as possible and a contingency plan should be considered.

Discharge and Transfer Policy

Lincolnshire Mental Health Services had a robust policy in place during the period that Mr. X's discharge and transfer from services was being arranged. The policy stated that the discharging care team had the responsibility to:

- liaise closely with the team to whom the transfer was being made;
- ensure that the appropriate documentation was completed (to include the 48 hour discharge/transfer notification);
- ensure that the discharge plan included risk assessments, unmet needs and eligibility under Section 117;
- develop crisis and contingency plans.

When a service user was to be discharged from community services the Policy stated that the Care Coordinator or nominated lead was responsible for ensuring that families and carers were kept informed of the arrangements. The Care Coordinator or nominated lead was also expected to:

- ensure the roles and responsibilities of the receiving care team were detailed in the discharge plan;
- ensure that the safeguarding adults/children screening tool had been completed;
- attend any meetings or reviews that relate to the transfer of a specific service user.

214 Lincolnshire Partnership NHS Trust (2003) Discharge Procedure

On discharge a copy of an agreed plan or review summary should be given to each service user.

If the plan was to discharge or transfer a service user to another provider then the Policy stated that:

- *'all transfers should be planned in advance, with the service user actively involved and informed of the transfer process;*
- *referral to the receiving team/organisation should be made in a timely fashion to facilitate the appropriate sharing of information...;*
- *plans for transfer must be recorded as a review, detailing who attended the review, who is involved in the transfer plans and the support in place to enable a seamless transfer of care;*
- *...service user consent should be sought for the sharing of clinical information'*[215].

Section 117

The Section 117 Lincolnshire Partnership NHS Trust (2002) Joint Policy stated that *'where a service user takes their own discharge from hospital, the multidisciplinary team should meet as soon as practicable to identify any after care needs and draw up a written after-care plan'*[216].

14.1.6.2. Findings

There are three particular junctures with regard to how referral, discharge and transfer arrangements were managed in the care and treatment of Mr. X by the Lincolnshire Mental Health Services. These junctures include Mr. X's unplanned discharge from inpatient services, the decision to discharge Mr. X from Outpatient and Community Services and the transfer arrangements which were made with the Swindon Community Mental Health Services.

First: on the 27 November 2002 Mr. X appealed against his Section 3 at a Mental Health Act Tribunal. The Tribunal discharged him from his Section. The Tribunal felt that while they

215 Lincolnshire Partnership NHS Foundation Trust Discharge/transfer Policy 2003-2009
216 Lincolnshire Partnership NHS Trust (2002) Section 117 – Joint Policy.

had no doubt that the original detention was justified by his psychotic state at the time of his admission Mr. X was now responding to treatment and was no longer expressing persecutory ideas. The Tribunal noted that Mr. X had been living at his own home for a three week period '*without untoward incident*' and that there could be no justification for further detention[217]. Mr. X immediately discharged himself from the ward.

It could have been no surprise to the clinical team of Mr. X that once released from his detention he formally discharged himself from inpatient services. The possibility of Mr. X being discharged from his Section was something that Mr. X's care team should have been prepared for but were not. There had been no CPA care plan developed for this eventuality, nor were explicit plans made afterwards. There is very little extant in Mr. X's clinical record to assist the Independent Investigation Team in understanding what plans were put into place to maintain Mr. X in the community. At interview clinical witnesses were unable to explain why the clinical team who had been concerned enough about Mr. X to want to maintain his Section 3 appeared to go from a high level of concern to virtually none over a period of 24 hours. It is at this juncture that Mr. X effectively started to disengage from mental health services.

Second: In the summer of 2003 the Consultant Psychiatrist and the Care Coordinator began discussions about discharging Mr. X from their caseloads. This is a confusing period to understand. The chronology is as follows:

26 June 2003. Mr. X did not attend the ward round. The Consultant Psychiatrist was of the view that Mr. X should be discharged and the Lincolnshire Police informed.

24 July 2003. Mr. X failed to attend another ward round. The Care Coordinator discussed the possibility of discharge with the Consultant Psychiatrist.

1 August 2003. The Care Coordinator contacted the Community Mental Health Services in Swindon regarding the possibility of a transfer.

217 File 1B P. 225

4 August 2003. The Consultant wrote to Mr. X's GP stating that he had no alternative but to discharge Mr. X from his Outpatient Clinic. In this letter the Consultant said that he thought Mr. X was living in Swindon. In effect Mr. X was discharged from the Consultant's caseload at this point.

18 August 2003. The Care Coordinator contacted the Swindon Team once again expressing his wish to transfer Mr. X's care to them. The Care Coordinator followed this communication with a letter explaining that Mr. X was eligible for Section 117 aftercare.

23 October 2003. The Care Coordinator wrote to the Swindon Team and enclosed background information regarding Mr. X.

28 October 2003. The Care Coordinator recorded in the Lincolnshire clinical records that he had made two telephone calls to Swindon services. He was informed that Swindon services would not take Mr. X on at this stage as he had no GP in the area and was '*unlikely to engage'.*

4 November 2003. The Care Coordinator discharged Mr. X from his caseload. There was no care plan put into place and no formal transfer of care was made.

It is the view of the Independent Investigation Team that Mr. X did not receive a planned discharge in accordance with Trust policy and procedure. Whilst the decision to discharge Mr. X was initially made at ward rounds in June and July 2003 no coherent action plan was put into place. It has to be acknowledged that Mr. X presented a distinct challenge to the Lincolnshire Mental Health Services in that he refused to engage and was effectively domiciled in Swindon. However it was clear that Mr. X was exhibiting many of the identified relapse indicators such as letter writing and making detailed complaints. It was a fact that at this stage Mr. X had written some 35 letters of complaint both to and about the Lincolnshire Partnership Trust. Mr. X was reported as being suspicious and hostile and on the 29 July 2003 his family had contacted Lincolnshire services to voice their growing concerns about his deteriorating mental health. In the face of such evidence the fact that Mr. X no longer wished to be engaged, in itself, should not have been reason enough to prompt a discharge from both the Outpatient Clinic and the Community Team Caseload.

Third: transfer arrangements between Lincolnshire and Swindon Mental Health Services were negotiated between the 1 August and the 28 October 2003. It is evident that the Lincolnshire-based Care Coordinator made several attempts to facilitate a formal transfer during this period. Once again the Independent Investigation Team acknowledges the difficulties that were faced by the Care Coordinator when seeking to formally transfer an informal patient who refused to engage and who had appeared to have moved out of the geographical area. It is unclear why the Care Coordinator did not seek assistance from the Consultant Psychiatrist when trying to negotiate a way forward with the Swindon services. It would appear that the Consultant Psychiatrist had also disengaged from the process by this stage.

14.1.6.3. Conclusion

The decision to discharge Mr. X from the Lincolnshire Mental Health Services was not made because his mental illness had improved to the point where this was deemed clinically expedient but because Mr. X refused to engage. There can be no doubt that Mr. X's discharge from inpatient and community services and possible transfer to Swindon could have been managed more assertively and effectively.

It is a fact that Mr. X's disengagement from mental health services began to occur as soon as his Section 3 was discharged in November 2002. This was further compounded when his depot medication was ceased on the 21 January 2003. Mr. X did not attend appointments with his Consultant Psychiatrist after the 4 March 2003 and saw his Care Coordinator for the last time on the 25 April 2003. It was clear that Mr. X still held his delusional beliefs and that his letter writing and relapse indicators were in evidence. It is not possible to understand why Mr. X was not followed up in a more assertive manner.

The Trust CPA policy that was in operation during this period recommended that if a service user refused to engage and was subject to enhanced CPA the following actions should be considered:

- a risk assessment should be conducted and review meeting held;
- consideration should be given for an assessment under the Mental Health Act (1983);
- an action plan should be developed.

If a total loss of contact occurred then the following was recommended:

- if two scheduled visits failed to occur then a risk assessment and CPA meeting was required;
- the Care Coordinator was responsible for coordinating efforts to re-establish contact;
- the MDT were required to consider whether the Police should be informed of the situation;
- service users who were designated out of contact with the service for one year could be discharged from CPA. The decision to do so should be recorded in the clinical record;
- service users eligible for Section 117 who were deemed to be out of contact with the service could not be discharged unless a formal Section 117 review meeting took place.

It is clear from examining Mr. X's clinical record that the above steps and stages were not followed. Whilst the Independent Investigation Team acknowledges the challenges that Mr. X presented to the clinical team in Lincolnshire, service user disengagement is not an uncommon feature when treating those with mental illness. Mr. X was allowed to disengage over a period of eleven months from the 27 November 2002 on his discharge from inpatient services to the 4 November 2003 when he was discharged from the Care Coordinator's caseload.

Mr. X's psychiatric condition remained effectively unchanged in as much as the signs and symptoms of his delusional disorder persisted throughout both 2002 and 2003. His letter writing remained an unabated preoccupation and his family were expressing their concerns about his deteriorating mental health. All this was known to Lincolnshire Mental Health Services but no action was taken even though Mr. X's lack of compliance and refusal had been identified as presenting a serious risk to his long-term health and wellbeing.

Transfer to Swindon service

The first contact with Swindon Mental Health Service was made via a telephone call by the Lincolnshire Care Coordinator. At no stage was there any input from the Consultant Psychiatrist. No formal transfer took place. The Lincoln team were aware that the Swindon

team did not intend to intervene but rather to keep Mr. X on file so that interventions could be made if he became unwell at a future time. Lincolnshire services were unable to formally transfer Mr. X's care.

It is the view of the Independent Investigation Team that Mr. X's discharge was not managed in an effective or professional manner. Policy and operational procedure guidance was not adhered to by Mr. X's clinical team. This had the long-term effect of allowing an individual with a long-term enduring mental illness to slip through the safety net of care.

- ***Contributory Factor Number Seven. The non-adherence to Trust policy and procedure guidance led to an ineffective attempt to transfer Mr. X to Swindon-based services. This had the long-term effect of allowing an individual with a long-term enduring mental illness to slip through the safety net of care.***

14.1.7. Carer Assessment and Carer Involvement

14.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that '*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'. In particular the National Service Framework for Mental Health (DH 1999) states in its guiding principles that '*People with mental health problems can expect that services will involve service users and their carers in planning and delivery of care*'. Also that it will '*deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed*'.

Carer involvement

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability

to care. It ensures that services take into account information from a carer assessment when making decisions about the cared for persons' type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to carers. It also gave carers the right to an assessment independent of the person they care for.

Then The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan which is given to them and implemented in discussion with them.

14.1.7.2. Findings

At the time of their deaths Mr. and Mrs. X senior were 83 and 76 respectively. Despite their age they were in effect to become the main carers for Mr. X in as much as he lived in their home and was dependent upon them financially. The clinical record would suggest that Mr. X lived with his parents from the time of his discharge from hospital in November 2002 to time of their death in July 2007.

The degree of communication and liaison that took place with the family of Mr. X on the part of the Lincolnshire services is set out below:

2000. Mr. X's first recorded contact with psychiatric services was when he was assessed by a Forensic Psychiatrist under the Lincoln Court assessment scheme on 17 October 2000. The

Forensic Psychiatrist recorded that '*at the time of preparing this report I was unable to make contact with Mr. X's family although I will make further efforts to do so*'[218].

It is obvious that contact did occur. In an undated letter from the Forensic Psychiatrist to Mr. X's Lincoln Probation Officer, he stated that Mr. X's father been in touch '*to express great concern about his son's health*'. It goes on to give the father's phone number and to say that the father had not heard from his son for over a year. The Forensic Psychiatrist had suggested he contacted the Probation Officer so that she could '*acquaint him with the outcome of the court case and so that his supervising Probation Officer will be able to contact his family if necessary*'[219].

2 October 2002. The sister of Mr. X telephoned the acute admission ward. The ward staff would not discuss Mr. X's case with her other than to say that he was agitated and abusive, rude and uncooperative[220].

9 October 2002. Mr X's father telephoned the acute admission ward to enquire as to his son's condition and to express his concerns regarding Mr. X's financial position as he was expecting to be evicted from his Lincoln-based home[221].

4 December 2002. Mr. X's father telephoned the Care Coordinator to enquire after his son. He left his telephone number so that a return call could be made.

12 December 2002. Mr. X's father contacted the Care Coordinator to express concerns regarding his son. He said that Mr. X had telephoned him regarding fears that he would be evicted from his home. Mr. X's father posted a mobile telephone to his son so they could '*remain in contact*'. Mr. X's father asked whether he should visit his son and he was told that services would encourage Mr. X to use the mobile telephone to contact his parents[222].

17 December 2002. Mr. X's father left a message for the Care Coordinator to contact him. The Care Coordinator tried to do so but to no avail[223].

218 File1A P.16
219File1A P. 65
220 The sister of Mr. X Witness Evidence
221 The sister of Mr. X Witness Evidence
222 File 1A P.143
223 File 1A P.143

18 December 2002. The Care Coordinator contacted Mr. X's father. Mr. X had been in touch with his parents and also with his sister. Arrangements had been made for him to visit his parents over the Christmas period. Mr. X's father was concerned that his son did not miss a depot injection whilst away[224].

24 December 2002. Mr. X's father was telephoned by the Care Coordinator and learnt that Mr. X was with them[225].

3 January 2003. An entry in the clinical records stated that Mr. X was visited on this day at home for his depot injection and his parents were present[226].

8-10 January 2003. Mr. X's father telephoned the Care Coordinator: it was recorded that '*Father confirms that it would be OK for [Mr. X] to stay with them in the event he sells his house*'[227].

It was reported by the Care Coordinator in his letter of 10 January 2003 to the Consultant Psychiatrist that Mr. X had '*established contact with his parents and spent Christmas and New Year with them*'. He went on to say that '*his parents have been in contact with me and are willing to support him*'[228].

21 January 2003. A CPA and Section 117 Review took place: on the documentation it was recorded that Mr. X '*does not appear to have close relationships with his parents, according to Mr. X's father they have not spoken to one another for approximately three years...*'[229].

On this date Risk Assessment paperwork completed by the Care Coordinator also stated that '*Rather difficult to gain information – no relatives about or contact with them*'[230].

29 January 2003. The Care Coordinator recorded that Mr. X's father had made a formal complaint to the Lincolnshire Mental Health Trust as he did not feel that services were supporting his son effectively enough in pursuing help for his financial difficulties[231].

224 File 1A PP.143-4
225 File 1A P.144
226 File 1A P.145
227 File 1A PP. 146-147
228 File 2 GP Notes, Lincolnshire P.7
229 File 1A P.79
230 File 1A P.125
231 File 1A P.148

27 February 2003. Mr. X was seen at his Lincolnshire home, his parents were present. Mr. X had spent three weeks with them at their home in Swindon. The Care Coordinator recorded that '*He [Mr. X] will go to DSS together with parents to sort benefit. Parents aware*'[232].

5 March 2003. The Consultant Psychiatrist wrote to the GP of Mr. X's GP to update him. In this letter he wrote that Mr. X '*has much better relationships with his family and is thinking of moving to Swindon*'[233].

27 June 2003. The Consultant Psychiatrist discharged Mr. X from his caseload. Mr X's family were not informed about this.

29 July 2003. The previous Care Coordinator was contacted by the sister of Mr. X. She expressed concern over Mr. X's mental state and thought there was some deterioration. He had been laughing inappropriately and sending '*vast amounts of letters'*. This information was passed to the new Care Coordinator. The sister has stated that she told him that her parents were struggling to cope with Mr. X. Mr. X '*was bombarding people with letters of complaint*'.

It is evident that once Mr. X was 'reunited' with his family the mental health services in Lincolnshire maintained a steady telephone communication with Mr. X's father. This communication was however of the most basic kind and was limited to the giving and receiving of the most simple information. The ward clinical records continually stated that little was known about Mr. X because he refused to talk to the clinical team. In this kind of situation it would be seen as best practice to collect collateral information from family members. The opportunity was there but this was not taken up.

It would appear that neither of the Care Coordinators involved in Mr. X's care saw the necessity of trying to build a rapport with Mr. X's parents, in order to develop both a better understanding of Mr. X and to also understand whether the parents of Mr. X needed any support. It was evident that Mr. and Mrs. X senior were elderly but no one approached them to see whether or not would have welcomed a carer assessment. Another frustrating aspect is that although the father of Mr. X left a constant stream of messages (which are detailed in the clinical record) as to his son's whereabouts when he was in Swindon the Lincoln Community Services still insisted on going round to Mr. X's house to give him his depot and made

232 File 1A P.150
233 File 2 GP Notes P.11

appointments with him when they knew that he would not be there. As the clinical team knew that Mr. X was intending to spend most of his time in Swindon from January 2003 it is regrettable that they did not make arrangements for his transfer to take place at this stage. The family of Mr. X had tried to initiate a transfer in the January of 2003. From their point of view they got caught in a 'catch 22' scenario. Swindon Services would not accept Mr. X without a formal referral from Lincoln and Lincoln refused to send documentation to Swindon until Swindon services formally requested them. Most worryingly the evidence given by the family of Mr. X to the clinical team during this period suggested that Mr. X's mental health was deteriorating but nothing was done to assess the situation.

Between 2004 and the deaths of Mr. and Mrs. X senior in July 2007 the sister of Mr. X made many telephone calls to Lincolnshire-based services seeking assistance and support on behalf of her parents. The GP clinical notes recorded that she telephoned the surgery on the 25 March 2004. It was documented that *'[Mr. X] living in Swindon with elderly parents. Parents bring him to house once a month to collect Olanzapine and check his house. Won't seek medical advice in Swindon. Mental State has deteriorated over last month. Advised she/parents must seek help from local GP/Psychiatric services unless he returns to Lincoln for assessment. No further Olanzapine to be issued from this surgery*'[234].

30 March 2004. The GP completed an IB113 (A) Re-referral form for Incapacity for Work Benefits. On this form it stated that Mr. X was '*living in Swindon with parents who come to Lincoln once per month to collect medication and check his home. Has not sought psychiatric help in Swindon despite advice to do so. Mental state reported to be worse'*[235]. It also stated on the form that Mr. X was last seen on the 25 March 2004.

During this period the family of Mr. X managed his deteriorating behaviour as best they could. Once Mr. X's Lincoln-based GP stopped prescribing for him he was not receiving medication for his psychiatric condition. Mr. X's father was paying all of his bills as Mr. X's benefits had not been sorted out. The sister of Mr. X told the Independent Investigation Team at interview that:

'Mum and dad, we would just bundle along from one crisis to the next. His [Mr. X's] normal behaviour was unacceptable but it became the norm. They just trod on eggshells. They just did everything they could to keep him happy. They just tried to live their lives as normal as

234 File 2 GP Notes P.22
235 File 2 GP Notes P. 20

possible between episodes and every time he would have an episode dad would come round and say, "Alarm bells we've got to start doing the rounds again." That would be his saying. So we would ring the Crisis Team in Swindon first and then we would ring Lincoln. Sometimes we would ring the Consultant Psychiatrist's Secretary, sometimes we would ring ward then the ward would say to ring the Consultant Psychiatrist's Secretary and we would go round like this."[236]

6 February 2007. Mr. X's behaviour suddenly declined, he had become threatening and abusive. Mr. X was trying to control his parent's movements and was paranoid and suspicious. Mr. and Mrs. X senior began to fear for their safety. The parents of Mr. X thought that as mental health services could not assist them the answer laid in sorting out Mr. X's finances so that he could leave home and live independently from them[237]. The family visited the Citizens Advice Bureau.

13 February 2007. The family returned to the Citizens Advice Bureau (CAB). On this occasion they mentioned the physical attack that Mr. X had made against his parents in 1999 and discussed his previous psychiatric history. The CAB felt that this was a matter for Police intervention and with the permission of the family contacted the Swindon Police. The Police made contact with the family that evening and suggested that it was a matter for mental health services. The family contacted the Swindon-based services at this juncture (Please see Section 14.2.5. below analysing the Swindon Mental Health Services response).

14 February 2007. Following the refusal of Swindon Mental Health Service to make an intervention the sister of Mr. X telephoned the Lincolnshire Consultant Psychiatrist and spoke to his Medical Secretary. The Medical Secretary sympathised with the family's situation but could not come up with a solution. The sister was not offered the opportunity to speak to the Consultant.

14-27 February 2007. The sister of Mr. X made numerous telephone calls to the Lincolnshire Primary Care Trust, the Lincoln GP, and the Swindon Police but could find no one who could advise the family as to what to do in order to get help for Mr. X.

236 The sister of Mr. X Witness Evidence
237 The sister of Mr. X Witness Evidence

May-June 2007. Mr. X had been writing up to 80 letters each week. The primary focus of these letters was to secure employment. However job application rejections from companies led to Mr. X writing threatening and abusive letters which had led to the threat of legal action on the part of the recipients. Mr. X's parents were becoming increasingly worried and his sister once again tried to get help for Mr. X.

15 June 2007. Following the advice of the Mental Health Act Commission the sister of Mr. X telephoned the Lincolnshire Consultant Psychiatrist. The sister had been advised to lodge an official complaint against the Consultant who had acted as Mr. X's RMO. The sister explained to the Consultant's Medical Secretary that she did not have the time to make a complaint because the priority was to help for her parents immediately. The sister was advised that the responsibility for action needed to be taken by Swindon services, but that if a request for Mr. X's clinical records were made on headed notepaper she could arrange to have copies sent down to a local Crisis Team.

20-21 June 2007. The Swindon-based Crisis Team contacted the Lincolnshire Consultant Psychiatrist on the 20 June and spoke to his Medical Secretary. It was agreed that background information would be sent to Swindon. This was duly done on the 21 June.

25 June 2007. Copies of Mr. X's clinical records were dispatched to Swindon.

14.1.7.3. Conclusions

It is the view of the Independent Investigation Team that the family of Mr. X were never dealt with in an appropriate or timely manner. There are three points that need to be summarised.

First, Mr. X was a man who presented distinct challenges to his clinical team in Lincolnshire. He was uncooperative, hostile and suspicious. Clinical team members recorded on a consistent basis that there were profound difficulties when talking to him and obtaining information from him. It is evident that the family were in contact with both the inpatient and community teams. Whilst Mr. X had the right to confidentiality there should have been no barriers to the teams in obtaining collateral information from his family. Mr. X had been diagnosed with a delusional disorder and had been regraded to a Section 3 of the Mental

Health Act (1983). It was evident that he was not well and the clinical team failed to do everything within their gift to understand Mr. X better.

Second, whilst Mr. X was adamant that his right to confidentiality was maintained the clinical teams had a duty of care to the elderly parents of Mr. X. This was not discharged adequately. Whilst no one working within the Lincolnshire services could have predicted the future events of July 2007 the discharge policy *in situ* at the time Mr. X was receiving his care and treatment made clear the expectation that both safeguarding adult and children assessments should be conducted as part of the discharge process. Mr. and Mrs. X senior were elderly and the sister of Mr. X had two young daughters. Mr. X's forensic history and clinical record detailed acts of violence, aggression and sexually inappropriate behaviour. Mr. X always presented in an extremely assertive and determined manner. He was adamant that the details of his clinical history should not be disclosed to his family. The clinical teams involved in his care and treatment appear to have taken their lead from Mr. X and disclosed nothing. Even without the benefit of hindsight this undoubtedly put the family of Mr. X at risk.

Third, the clinical teams in Swindon made no attempt to assess and support the needs of Mr. X's parents who were in effect his carers. This elderly couple ended up shouldering the burden of Mr. X's financial crisis. They also commuted from Swindon to Lincoln on a regular basis during 2003 and 2004 to ensure that Mr. X received his prescribed medication. Mr. and Mrs. X senior made several attempts to enquire about transferring Mr. X's care to mental health services in Swindon but each time their suggestions were dismissed. The Lincolnshire Trust CPA Policies and Procedures in place during the time that Mr. X was receiving his care and treatment placed great importance in the statutory rights of carers to an assessment and placed this responsibility with the Care Coordinator.

The Independent Investigation Team acknowledges that clinical teams are often put into a very difficult situation when the wishes of a service user conflict directly with the needs of their carers. This is a challenging position for clinicians working in mental health. However it is a common situation and can never be given as a reason for doing nothing. The facts are that the clinical teams in Lincoln did not discuss the needs of Mr. X's family either as part of a Multidisciplinary Team process or with the family members themselves. As a result this family were placed in an impossible position being left to care for a man with a profound

delusional disorder, a disturbing history of violence and obsession, no insight and zero levels of compliance.

- ***Contributory Factor Number Eight. Lincolnshire Services did not work with the family of Mr. X in accordance with Trust policy and procedure guidance. As a consequence this placed Mr. X's elderly parents in a situation that they were ill equipped to manage, and consequently this was to impact negatively on the mental health of Mr. X.***

14.1.8. Service User Involvement in Care Planning

14.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:
'*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*'.

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that '*people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care*'. It also stated that it will '*deliver continuity of care for a long as this is needed*', 'offer choices which promote independence' and 'be accessible so that help can be obtained when and where it is needed.

The Lincolnshire CPA Policy in place at the time Mr. X was receiving his care and treatment strongly advocated a service-user focused approach. This approach would ensure that all aspects of assessment and care planning would be discussed and developed in conjunction with the service user where appropriate and possible.

14.1.8.2. Findings

The policy and procedure framework in place at the time Mr. X was receiving his care and treatment with Lincolnshire Mental Health Services was robust with regard to service user involvement. Mr. X adamantly refused to become involved with any aspect of his care and

treatment assessment, planning and delivery. This was probably due to his psychiatric condition coupled with an extreme aversion to receiving psychiatric treatment against his will.

The Independent Investigation Team acknowledges that Mr. X presented a challenge to his care team when ensuring that he engaged with them and became involved in his care planning. Mr. X's strong desire to disengage totally from all contact with mental health services however was never managed in a professional manner. Mr. X's aggression, hostility and continuous written threats of litigation against his clinical team served to keep them at arm's length. Instead of this behaviour (which should have been seen as part of his psychiatric presentation) being assertively managed as part of a coherent treatment plan Mr. X was allowed to avoid most therapeutic interventions which would have been to his advantage. Opportunities were lost whilst Mr. X was detained under Section 3 of the Mental Health Act (1983) and opportunities continued to be lost after his discharge.

14.1.8.3. Conclusions

Whilst understanding the challenges that Mr. X presented to his clinical team it is the view of the Independent Investigation Team that more could have been done to engage Mr. X with all aspects of his care and treatment plan. Service users of mental health services often refuse to engage, and whilst this creates difficulties the management of such service users should be a familiar and 'well worn path' for mental health care professionals to navigate. At no stage was the guidance present in Trust policies and procedures utilised, as a result this contributed to Mr. X slipping through the safety net of care.

- ***Contributory Factor Number Nine. Mr. X was allowed to disengage from services. Trust policy and procedure was not adhered to and as a consequence Mr. X's mental illness was to go untreated for a period of four years.***

14.1.9. Interagency Communication and Working

14.1.9.1. Context

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion.'[238]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme approach when used effectively should ensure that both interagency communication and working takes place in a service user centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and have a history of criminal offences cannot be met by one agency alone[239]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively[240]. The Department of Health *Building Bridges* (1996) sets out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. This level of expectation was firmly in place during the time that Mr. X first came to the attention of mental health services in Lincolnshire.

14.1.9.2. Findings

Over a seven-year period Mr. X became involved with many different care providers and agencies. This is set out in the Chronology above. It would appear that Mr. X was able to effectively disengage from most of the situations that he found himself in over the years.

In 2000 Mr. X was referred for a psychiatric assessment for the first time by a Forensic Psychiatrist on behalf of the Lincoln Court Assessment Scheme. At this time Mr. X was awaiting sentencing. The Consultant noted that Mr. X had no previous psychiatric history and was of the opinion that Mr. X suffered from distorted thinking and a discrete delusional

238 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P.121

239 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). P.144.

240 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

disorder. He recommended a Probation Order and voluntary referral to mental health services.

It is known that Mr. X did receive a Probation Order. However correspondence between the Forensic Psychiatrist and Mr. X's Probation Officer illustrates the fact that Mr. X did not comply with the notion of a voluntary referral. The Probation Order was made with the specific purpose of monitoring Mr. X and encouraging him to access mental health services. It would appear that interagency communication took place but this did not lead to Mr. X receiving the care and treatment that he had been identified as requiring.

The incident that Mr. X received a conviction for in 2000 appears to have involved the Cambridgeshire Police Force and the Lincolnshire Court Assessment Scheme. It is unclear what triggered Mr. X's involvement with the Lincolnshire Police Force in the summer of 2002, but it would appear to have been unconnected to his previous conviction.

When Mr. X became involved in a series of incidents with members of the Lincolnshire Police Force a check was undertaken and it was discovered that Mr. X had been involved with the Cambridgeshire Police and that he had been previously issued with a restraining order. The Cambridgeshire Police confirmed that Mr. X was well known to them and that he had the habit of bombarding them with '*bizarre communications'* and that he had been assessed as being mentally unstable. His behaviour was such that they had refused to communicate with him any further and that he was only dealt with by two particular designated officers. Cambridgeshire Police also described Mr. X as '*dangerous*'. As a result of this information it was agreed that a risk assessment would be conducted the following day and an action plan would be developed. This information was passed on to the Lincolnshire mental health services in the fullness of time once Mr. X had passed into their care.

The level of communication flowing from the Lincolnshire Police Force to Lincolnshire Mental Health Services was high between the summer of 2002 and the spring of 2003. This high level of communication whilst not exactly being a 'one way' communication did not appear to flow as effectively from the Mental Health Services back to the Police Service. Obviously Mental Health Services had to consider patient confidentiality. However the Police Service and Mental Health Services had agreed to liaise regarding either Mr. X's future progress or deterioration. Mental health services were aware that Police concerns were so

great in the autumn of 2002 that they had made a MAPPA referral. This referral was not successful and consequently mental health services appear to have reverted to a more traditional approach to interagency communication and working with the Police. In practice this meant that Mental Health Services only communicated with the Police on a strictly 'need to know' basis. Mr. X's clinical risk was increasingly minimised by his clinical care team. As a result the Police Service was viewed as simply being the future means of dealing with Mr. X's behaviour once he had been discharged from mental health services.

In 2007 when Mr. X's behaviour started to deteriorate his family sought assistance from Lincolnshire Mental Health Services, Lincolnshire Primary Care Services, Swindon Mental Health Services and the Swindon Police Force. At no stage did any of these organisations think to speak to each other or to seek collateral evidence from each other.

14.1.9.3. Conclusions

It is evident that interagency communication and working occurred on a very basic level in Mr. X's case. At times communication did flow between organisations and agencies. However this fell short of what could be described a full interagency working. Mr. X's case fell sub-MAPPA and as a result this served to render Mr. X 'invisible'. No processes were in place to ensure that identified problems could be managed as they arose. Each organisation worked within its own silo either intentionally or because there was no pre-existing protocol that facilitated a joined-up approach. This ensured that as time progressed Mr. X was not only able to disengage from services but also from their consciousness. Mr. X literally became out of sight and out of mind.

- ***Contributory Factor Number Ten. The different agencies and services involved with Mr. X over a period of seven years did not work in a system that facilitated interagency working. As a result the required levels of management and supervision of Mr. X's case did not occur.***

14.1.10. Clinical Supervision

14.1.10.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations [241] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:
'....a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations'[242]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

In Lincolnshire Partnership Trust there was a supervision policy in place during the time Mr. X was receiving his care and treatment. This policy made clear that all staff who were involved in direct patient care should have both management supervision and practice supervision. Management supervision would, amongst other things, ensure that work was carried out according to job descriptions, enable the staff member to receive feedback on their performance and discuss both their work and caseload. Practice supervision was available for all front-line staff to enable them to reflect on their practice and identify solutions to problems. [243] The policy made it clear that staff were expected to undertake a minimum number of supervisory sessions each year.

241 Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses.
242 Nursing and Midwifery Council, Advice Sheet C. (2006)
243 Lincolnshire Partnership NHS Trust. (2004) Staff Supervision and Support Policy., version 1.

14.1.10.2. Findings

In 2003 Mr. X's second Care Coordinator was a newly appointed community nurse who had until then worked on one of the local inpatient wards. He was appointed to an E grade staff nurse post with the Lincoln Community Mental Health Team. On his appointment it was not expected that he would carry out assessments as this was a function reserved for the G grade post holders. His role was intended to focus on the more routine care and treatment needs of service users once their care plans had been determined.

Mr. X was on Enhanced CPA. This indicated that he was considered a complex case, one which required a Care Coordinator to have well-developed community-based skills and experience. The CPA Policy in place at the time Mr. X was receiving his care and treatment stated that the most complex cases required care coordination from the most experienced and skilled practitioners. Undoubtedly Mr. X met all of the criteria required for the allocation of an Enhanced CPA status. It is the view of the Independent Investigation Team that a more experienced Care Coordinator should have been appointed to manage Mr. X's ongoing care and treatment needs. This was essential not only because Mr. X's case was complex and challenging, but because Mr. X refused to engage with services.

The Independent Investigation Team asked the Care Coordinator about how clinical supervision was managed in the team in 2003. We were told that he had looked back at his notes and could find no record of having participated in any supervision, whether management or practice, at the time of his contact with Mr. X. Neither did he recall there having been a more senior member of staff within the team who had specific responsibility for providing him with supervision and support. According to his records the Care Coordinator only began to receive supervision from around the November or December of 2003, when the G grades in the team began to provide it.

Mr. X was a complex individual with challenging behaviour. The second Care Coordinator to be allocated to him was not experienced within a community context and being an E grade was not expected to manage every aspect of his caseload without supervision and support. This situation was compounded by the fact that the Consultant Psychiatrist who acted as the RMO for Mr. X belonged to a different geographical community mental health team. This meant that the Care Coordinator could only engage in relatively formal correspondence with the Consultant either by letter or telephone. Working in different teams meant that there was

no opportunity for any informal or *ad hoc* discussion to occur regarding Mr. X's progress. The Care Coordinator appears to have been left to his own devices in managing Mr. X's case.

14.1.10.3. Conclusion

The Independent Investigation Team is of the view that the Community Mental Health team in Lincoln was operating in breach of the both the Trust's supervision and CPA policy in allowing an inexperienced and relatively junior member of the team to carry the responsibility for the care coordination of a service user on enhanced CPA, particularly one who was disengaging from the service. It is possible that the lack of both management and practice supervision for the Care Coordinator meant that he had nobody with whom to discuss the difficulties he was having with Mr. X. Neither did he have an opportunity to reflect upon his practice. In effect there was nobody in the team who advised him appropriately. Mr. X required a thorough review and a plan of care to be developed. The implications of Mr. X's eligibility for Section 117 aftercare were never worked through. The Independent Investigation Team is of the view that the lack of supervision contributed to the weaknesses evident in Mr. X's care and treatment plan, his disengagement with services and the subsequent lack of an appropriate transfer of care.

- ***Contributory Factor Number Eleven. Mr. X was both complex and challenging. The lack of clinical supervision afforded the Care Coordinator compounded the difficulties that he faced in managing the case.***

14.1.11. Adherence to Local and National Policy and Procedure

14.1.11.1. Context

Evidence-based practice has been defined as '*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*[113]' National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all

healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of clinical governance which is explored in Section 14.1.12 below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said Polices or procedures or to raise any implementation issues as they arise with immediate effect.

14.1.11.2. Findings

During the period that Mr. X was receiving his care and treatment from Lincolnshire Mental Health Services it was evident that the Trust had robust policies and procedures in place for the clinical management of service users. The Trust policies and procedures for this period of time were well written, clear and concise and took full account of all national best practice guidance. The only possible exception to this was the risk assessment tool which clearly did not serve to assist clinicians when assessing and prioritising the risk that Mr. X potentially posed to the people around him.

When examining the care pathway that Mr. X actually underwent it is apparent that it was significantly different to the one that he should have undergone in line with both the national and local policy guidance that was in place during 2002 and 2003. As has been already discussed in the sections above the Trust discharge, CPA and risk policies were not adhered to. What became apparent during the course of this investigation was that the clinical witnesses, when interviewed, had a very poor understanding of what was actually contained

within both their corporate and local policies and procedures. Clinical witnesses described to the Independent Investigation Team on many occasions practices that ran counter to Trust policy and procedure. No explanation could be found for this. The Independent Investigation Team understands that clinical witnesses were being asked to remember policy, custom and practice which were in place some seven to eight years ago. It would not have been reasonable to have expected clinical witnesses to retain clear recollections of how policy and procedure worked at that time. However the fact remains that policy and procedure were not adhered to when Mr. X was receiving his care and treatment from the Trust.

Significant departures from policy and procedure were found to have taken place in the following areas:

CPA

- CPA assessment, care planning and review;
- service user disengagement;
- multidisciplinary working;
- carer support and assessment of need.

Risk

- service user involvement and non compliance;
- multidisciplinary communication and working;
- dynamic risk management care planning;
- discharge planning.

Discharge, Referral and Transfer

- care planning;
- Section 117 planning and delivery;
- consent for clinical record transfer;
- carer and service liaison;
- interagency liaison.

In the case of Mr. X the Independent Investigation Team found that individual clinicians did not fulfil their professional obligations satisfactorily regarding the implementation of clinical

policy guidance. Clinical leaders and managers did not fulfil their professional obligations regarding the monitoring and supervision of the case.

14.1.11.3. Conclusions

It cannot be asserted with certainty that had Mr. X received his care and treatment in accordance with the Lincolnshire Partnership Trust's policy and procedure guidance that his mental illness could have been treated in such a way that a more positive clinical outcome was achieved. However it is evident to the Independent Investigation Team that this lack of adherence was of such a comprehensive nature that it made a direct contribution to Mr. X not receiving the care and treatment that he required. This ensured that his mental illness was not treated effectively in Lincolnshire and perpetuated the problem once he had moved to Swindon. This policy and procedure non adherence allowed Mr. X to effectively disengage from mental health services and to slip through the safety net of care.

The issues regarding the care pathway that Mr. X actually underwent as opposed to the one that he should have undergone are explored in detail in Section 14.4. below.

- ***Contributory Factor Number Twelve. The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical team ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to his future mental health.***

14.1.12. Clinical Governance and Performance

14.1.12.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[244]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and

244 Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation.

14.1.12.2. Findings

The Commission for Health Improvement (CHI), the NHS regulator in place at the time, produced and published performance indicators and ratings for every NHS trust in England for 2002-2003. The ratings highlighted areas in which the trust achieved high standards of performance, as well as identifying areas where performance was not so good. The report summarised the Trust's performance relative to that of national performance during 2002 / 2003. The NHS performance ratings system placed performance into one of four categories ranging from three stars, performance at the highest level, to a rating of zero stars, reflecting poorest levels of performance. The star rating applied across the whole organisation, not to individual services.

Independent Performance Ratings

In 2002-2003 the Lincolnshire Partnership Trust received a one star rating from the Commission of Health Improvement. A one star rating indicated that a Trust was considered to be performing at a level significantly below average. The Lincolnshire Partnership NHS Trust also received a one star rating for the management and implementation of its CPA systems. In the year 2003-2004 the Trust received a two star rating which demonstrated that systems were generally good, but was still considered to be significantly underachieving in CPA systems implementation. Clearly this aspect of care and treatment provision was deemed to be an area which required a high degree of corporate attention. This is borne out by the quality of CPA that Mr. X received from the Trust during this period.

Clinical Governance Review

In 2003-2004 and in 2004-2005 the rating for the Trust was two stars. When the Healthcare Commission replaced the Commission of Health Improvement the Trust rating for 2005-2006 was 'good' for quality and 'fair' for resources. For 2006-2007 the Trust received an

'excellent' for quality and a 'good' for resources. For 2007-2008 the Trust was rated as 'excellent' for quality and 'excellent 'for resources. This trend is expected to continue.

Trust Internal Clinical Governance Management and Monitoring

In order to manage clinical governance within the organisation the Trust has had in place a clinical governance committee since 2000. Part of the function of this committee over time has been to conduct annual audits based upon the findings of incidents. In the past this has included themes such as falls, absconsion and suicide.

The clinical leadership for the development of policy and procedure and the monitoring and review of its implementation has always rested with either the Executive Medical Director or the Executive Director of Nursing. The only exception to this has been the Trust Care Programme Approach implementation which has always rested with Corporate Management functions. To this day CPA remains the responsibility of the Director of Operations which serves to provide a degree of clinical disconnect and dislocation with the management and monitoring of other interconnected clinical processes.

14.1.12.3. Conclusions

During the period that Mr. X received his care and treatment the Trust was independently reviewed as having internal structures and systems that required further development, a situation common to many Mental Health Trusts across the country at that time. Over a period of time the Trust has been able to demonstrate that this development has taken place in accordance with national best practice expectation.

14.2. Swindon Findings

The findings in this section of the report detail the clinical inputs that Mr. X and his family received from the Swindon-based Mental Health Services managed by the Avon and Wiltshire Partnership NHS Trust. The headings of the findings have been set out in a sequence that runs in line with the chronology in Section 12.

14.2.1. Transfer and Referral Processes

14.2.1.1. Context

The Avon and Wiltshire Partnership NHS Trust were not able to locate the policy documentation in place during 2003 pertinent to this particular section. The Independent Investigation Team has used clinical witness statements and interview evidence in order to understand what may have occurred during this period.

Mr. X was referred to the Avon and Wiltshire Partnership NHS Trust Swindon-based services on three occasions between August 2003 and June 2007.

14.2.1.2. Findings

First Referral

On the 1 August 2003 the Lincoln-based Care Coordinator of Mr. X contacted the Community Mental Health Team (CMHT) in Swindon. On this occasion Mr. X's situation was discussed over the telephone. The Care Coordinator recorded that the Swindon Team would discuss Mr. X at their next team meeting and would inform him about how they wished to proceed. This conversation was held with Swindon Team Leader1.

On the 18 August 2003 the Lincoln-based Care Coordinator telephoned the Swindon CMHT and told them he wished to hand over Mr. X's after-care to them. On this occasion he spoke to Team Leader 1. The Care Coordinator then wrote to Team Leader 2 at Swindon, summarising some of the background to Mr. X's case and care. This letter referred to the fact that Mr. X lived most of the time in the Swindon area and also stated that he was eligible for Section 117 aftercare. The Care Coordinator requested a transfer of Mr. X's aftercare and asked the Swindon Team to inform him of their decision. This letter was copied into both the Lincolnshire Consultant Psychiatrist and the Lincoln-based GP. At around this time the Swindon Team had spoken to the GP of Mr. X's father asking him to visit Mr. X as he had no GP of his own. The GP made the visit and reported back that Mr. X was not willing to engage with him. It was reported that this visit had appeared to raise Mr. X's suspicions regarding his family.

On the 23 October 2003 the Lincoln-based Care Coordinator wrote to the Swindon Community Team Leader 2 once again. In this letter he referred to a recent telephone conversation and enclosed background information regarding Mr. X.

On the 28 October 2003 the Lincoln-based Care Coordinator recorded that there had been two telephone conversations between himself and the Swindon Community Team Leader 2. It had previously been agreed that background information was to be sent down to the Swindon Team, this was so that if Mr. X's mental health broke down and came to their notice they would have some background information to work on. The Care Coordinator recorded that Mr. X would not be taken on by the Swindon Team at the current time as he was not registered with a Swindon GP, and he was '*unlikely to engage anyway'*.

No clinical records are extant for this transaction within the Avon and Wiltshire Partnership NHS Trust. The events relating to the attempted transfer of Mr. X from one service to another can only be pieced together by using Mr. X's Lincolnshire clinical records. From the Lincolnshire records it would appear that Swindon Mental Health Services did not respond back to the Lincoln-based Care Coordinator in a timely manner as the communications relating to Mr. X's transfer spanned a period of some three months. It would appear that all of the communications were initiated by the Lincoln-based Care Coordinator.

Three issues became apparent to the Independent Investigation Team that required analysis, they were:

- missing documentation;
- the Swindon based-delays in communicating decisions back to the Lincoln Care Coordinator;
- the apparent refusal to accept Mr. X because he was not registered with a GP in the Swindon area.

Missing Documentation

Clinical witnesses when interviewed could not understand why the documentation regarding Mr. X had not been archived. None of the witnesses interviewed could recall any of the letters or documentation being received at the Community Mental Health Team base. The practice in place during 2003 was explained to the Independent Investigation Team. This

practice consisted of the Team Administrator setting up a new file on the immediate receipt of any new service user information being received. The new files would then be brought to the attention of the Community Team Leaders on a daily basis first thing each morning. All files would then be kept archived. It appears that this practice was not observed in the case of Mr X.

Delays in Communicating Team Decisions

At interview Swindon-based clinical witnesses found it difficult to remember the communication that took place regarding Mr. X and a possible transfer to their caseload in 2003. Clinical witnesses were at a loss to explain why the case had been handled in the way that it apparently was. The Independent Investigation Team was told that robust systems were in place to discuss all new possible transfers. The practice during 2003 was for each Community Team to discuss all potential new referrals at each Team meeting. Potential new referrals would normally have been formally discussed within a few days of the referral being made and plan of action developed. It appears that this practice in the case of Mr. X was not observed.

Transfer of Service Users with no GP

Clinical witnesses told the Independent Investigation Team that in 2003 having no GP would not have prevented a service user from being accepted by the Community Mental Health Team (CMHT). There was a distinct process in place. This process involved the four Consultant Psychiatrists who were allocated to the CMHTs operating a rotation system. Basically each Consultant took it in turns to accept individuals on to their lists if they came to the attention of the service and were not registered with a GP in the area. It appears that in the case of Mr. X this practice was not observed or fully understood.

Second Referral

On the 13 and 14 of February 2007 the sister of Mr. X went to the Citizen's Advice Bureau (CAB) to seek information and support. The sister felt that her parents were becoming increasingly at risk from Mr. X's behaviour. The CAB contacted the Police who then contacted the sister and said they would contact the Duty Social Work Team. The sister then received a telephone call from a member of the Duty Team who took details, but told her there were insufficient grounds for a Mental Health Act (1983) assessment. However the Duty Social Worker who took the call said that she would pass on the information to the

Swindon Community Mental Health Service (CMHT). She advised the sister to get Mr. X registered with a local GP. There is a record of this conversation in the Swindon Emergency Duty Team notes, written by the Duty Social Worker. The record states that she was told about the violence, but the impression gained was that this risk was historical and not current and therefore did not require any emergency action. The notes of this exchange were faxed to the Swindon CMHT base for follow up.

The Swindon Community Mental Health Services held no record of this exchange when questioned by the Independent Investigation Team. No follow-up action was taken by any of the Swindon CMHTs. Once again clinical witnesses were at a loss to explain why one of the four Swindon CMHTs had not followed up the Duty Worker's communication. The usual practice was for the CMHT to log the communication in a diary and telephone the Duty Office to discuss the case further. The initiating referrer, in this case the sister of Mr. X, would then have been contacted so that more information could be collected and a decision made about the required action that needed to be taken. It appears that this practice was not observed in the case of Mr. X.

Third Referral

On the 19 June 2007 the Swindon Crisis Team records noted that the sister of Mr. X had telephoned in an attempt to access help for her brother. A Crisis Team Worker took the call, and from this point on, until the deaths of Mr. and Mrs. X senior, effectively became the main worker involved with the case. She recorded that the sister was very concerned about her brother's mental state. Mr. X was living with his parents and had done so since being discharged from a Section 3 in Lincolnshire in 2002. The record noted that Mr. X was unwell, sending abusive letters and making abusive telephone calls. He was also threatening his parents. It was apparent that Mr. X was not registered with a GP, that he had had no contact with mental health services for several years and as a result was not compliant with his recommended medication regimen. The record stated that Mr. X was not aware that his sister was asking for help and that his parents may be at risk from his threatening behaviour. The Crisis Team Worker recorded that the referrer's expectation of the Crisis Team (the sister) was Mr. X would be assessed and treated for his mental illness.

Between the 19 June 2007 and the deaths of Mr. and Mr. X senior on the 7-8 of July 2007 the Crisis Team Worker attempted to resolve a dilemma. This dilemma revolved around how to

organise a mental health assessment for a person who was informal, unknown to the service, had no prior knowledge of his sister's intervention, and was likely to resent and reject any offer of help. The sister of Mr. X was certain that he needed to be assessed under the Mental Health Act (1983) and the Crisis Worker was uncertain whether this kind of approach was in Mr. X's best interests or not.

We asked the Crisis Team Manager, whether the referral should have been accepted by the Crisis Team. He said:

'In 2007 we worked very much on an open referral system. So at that point any referral into service could be made by anybody who met our criteria, being in a crisis. The sister of Mr. X came through to our service and although probably didn't meet the initial criteria was obviously in need and we continued to work with her until we could identify or try to identify exactly what that need was'.

The Crisis Team was ill equipped to manage assessments under the Mental Health Act (1983). The sister of Mr. X's insistence that her parents were at risk from Mr. X still did not prompt a more timely response from the Crisis Team. Clinical Witnesses from the Crisis Team told the Independent Investigation Team that it was not normally their function to undertake Mental Health Act (1983) assessments. Neither was it usual for the Crisis Team to accept individuals onto their caseload who did not have a GP and who were also unlikely to engage. Clinical witnesses explained at interview that the Crisis Team saw their main role as working with individuals in their own homes who wished to engage, or to undertake rapid assessments/information gathering for those who did not and then refer them on to more appropriate services such as the CMHTs. It appears that this practice was not observed in the case of Mr. X.

14.2.1.3. Conclusions

The Independent Investigation Team found that Mr. X's case was not managed according to Trust policy, custom or practice on the three occasions that he was referred to Swindon services.

On the first occasion in the summer of 2003 Mr. X was assessed as not being eligible for transfer on to the Swindon CMHT caseload. The reasons given were that he had no GP and

was unlikely to engage. This does not appear to be a satisfactory response in that Swindon services routinely accepted individuals onto CMHT caseloads when they had no GP and service users are often reluctant to engage. The Independent Investigation Team acknowledges the fact that Mr. X was an informal patient and that engagement may have been difficult, if not impossible. However he was living in the Swindon area, eligible for Section 117 aftercare and had an enduring mental illness. Most importantly Swindon Mental Health Services had received a formal request to accept the transfer from another Community Mental Health Team in the best interests of the service user. Whilst the difficulties that Mr. X's case may have presented are easy to sympathise with, it was not a satisfactory response on the part of the Swindon Team to refuse to accept Mr. X as a seemingly default position.

The second referral of Mr. X to the Swindon Duty Social Work Team by the Police did not lead to any intervention by mental health services. On this occasion the CMHT appears not to have conducted the required follow up procedures having been notified of the Duty Worker's contact with the sister of Mr. X the night before by fax. This failure to follow up the sister's request for help meant that Mr. X remained unassessed and unsupervised in the community in the home of his elderly parents while his mental health continued to deteriorate.

The third referral to the Crisis Team made by the sister of Mr. X was not managed well. The Crisis Team was clearly not the best-placed team to deal with the situation that Mr. X's case presented them with. Instead of providing a rapid 'same day' assessment and triage service the Crisis Team held onto Mr. X's case for three weeks. It is the view of the Independent Investigation Team that Mr. X was inadvertently referred to the wrong service by his sister, and that the Crisis Team did not act to refer the case on correctly. The Crisis Team should have rectified this mistake and ensured that Mr. X's case was managed by a more appropriate service that could have provided a more suitable clinical response.

Mr. X failed to receive appropriate referral and/or transfer responses from Swindon Mental Health Services on three separate occasions over a four-year period. Mr. X was a difficult man to engage. It is unlikely that Swindon services would have been able to ensure that Mr. X worked with them to maintain his mental health at the time he left Lincolnshire services. By the time he came to live in Swindon he was an informal patient who could not be *compelled* to adhere to any care or treatment regimen. However the fact remains that transfer and referral processes failed and that as a consequence he was not assessed and remained an

unknown quantity. Even once it was apparent that his mental health had deteriorated no sure footed response was in evidence.

- ***Contributory Factor Number One. Mr. X failed to receive appropriate referral and/or transfer responses from Swindon Mental Health Services on three separate occasions over a four-year period. This meant that he did not receive the care and treatment that he required.***

14.2.2. Mental Health Act

14.2.2.1. Context

In this section we consider the response of services in Swindon to Mr. X and his family and the manner in which arrangements were put into place for a Mental Health Act (1983) assessment to occur.

During 2003 Mr. X moved back to live with his parents in Swindon. He continued to visit Lincoln once a month to check his property and pick up medication from his GP surgery. In May 2004 the GP realised that Mr. X was receiving repeat prescriptions for psychotropic medication without monitoring and stopped the prescription. The GP wrote to Mr. X on 10 May 2004 advising him to register with a local GP in Swindon. Mr. X did not follow this advice. Between 2003 and 2007 the family of Mr. X observed that his behaviour was becoming difficult to manage and that his mental health appeared to be deteriorating. Throughout 2007 the family of Mr. X sought help and advice from mental health services as they believed he required detention under the Mental Health Act (1983).

14.2.2.2. Findings

Contact with the Duty Team

The sister of Mr. X contacted the Police on 14 February 2007 because she was concerned about her brother's mental state. The Police contacted the social services emergency duty team and an Approved Social Worker on the team spoke to the sister on the telephone. On this occasion the sister described some of Mr. X's history of treatment and said that he was currently living with his parents and that they had concerns about his mental health. The Approved Social Worker's recollection of this conversation was that the discussion with the

sister was advisory and that she had made no specific request for a mental health assessment under the Mental Health Act (1983).

The primary function of the Emergency Duty Team is to provide out of hours cover. The problems described by the sister of Mr. X were long-standing and did not, at that time, justify an emergency use of the Mental Health Act (1983). It was appropriate to give advice and to pass on the information for action by the CMHT. However there was a failure to ensure that the information had been received by the CMHT and a failure by the CMHT to act upon the information. There was a missed opportunity to gather more background information at this stage e.g. requesting case notes from Lincolnshire, and exploring the concerns expressed by the sister.

Contact with the Crisis Team

The sister of Mr. X contacted the Swindon Crisis Team on 19 June 2007. The sister had been frantically seeking advice from many different agencies. In June she had been told by Lincolnshire services that it would be possible for them to send copies of Mr. X notes to services in Swindon if a request was formally received.

The sister of Mr. X spoke to a support Crisis Worker on the telephone about her concerns for her brother. The Crisis Team Worker completed a referral form on which she summarised the problems described by the sister. These problems were identified as Mr. X sending abusive letters, making abusive phone calls and '*threatening parents'*. The problems were compounded by the fact that Mr. X was living at the same address as his parents who were elderly[245]. She also noted that Mr. X was not registered with a GP and had received no mental health input for several years since his treatment in Lincolnshire had ceased.

The Crisis Team Worker faxed a request to Lincolnshire Mental Health Services the same day asking for information to be sent urgently[246].

The Crisis Team Worker spoke to the Lincolnshire Consultant's Secretary on 20 June 2007 and requested a copy of Mr. X's clinical records. Four pages of notes were sent with immediate effect which included the last letters that were written by the Consultant

245 File AW 1A P. 3
246 File AW 1A P. 4

Psychiatrist and the Care Coordinator when Mr. X was discharged from the care of Lincolnshire Trust services. The Crisis Worker also called the Vulnerable Adults Team in Swindon to discuss the referral but received no answer and left a message on the answer phone[247].

On 21 June 2007 the Crisis Worker discussed the possibility of a Mental Health Act (1983) assessment with an experienced Approved Social Worker, and agreed to follow advice to gather more information. She also spoke to the sister of Mr. X and asked her to bring to the office some documents that illustrated her concerns about Mr. X's habit of writing abusive letters (these were delivered to the CMHT base on 22 June 2007). The Crisis Worker told the sister that '*it would be very difficult to turn up at someone's home with two doctors and an approved social worker'* without a sound reason for doing so[248].

On the 26 June 2007 the Crisis Worker had a telephone discussion with the Approved Social Worker Advisor for the Local Authority, about the case. Apparently Mr. X's father was reluctant to cooperate with the Mental Health Act (1983) as the nearest relative because he was afraid of his son. The Crisis Worker wanted to know if this presented a management problem. A discussion took place to ascertain whether there were sufficient grounds to apply for a warrant and it was decided on balance that at this stage there was not[249]. It was agreed that the Crisis Worker would follow up the referral with the Vulnerable Adults Team and arrange a meeting with Mr. X's parents to assess their level of concern and agree a plan of action. It was also agreed that the Crisis Worker should consult the Swindon Forensic Service and also speak to the Lincolnshire Consultant Psychiatrist[250].

Later on the 26 June 2007 the Crisis Worker telephoned both the Vulnerable Adults Team and the Forensic Service and left messages on voicemail. On this day a full copy of Mr. X's clinical records arrived at the Crisis Team base for the attention of the Crisis Team Worker. However, the Crisis Worker did not read these notes thoroughly and she certainly had not read any of the records relating to Mr. X's forensic history. She said at interview that:

247 File AW 1A P. 5
248 File AW 1A PP. 5-6
249 Witness Interview
250 File AW 1A PP. 6-7

'I started the process of reading through them but I as I previously said they weren't indexed in any way and I was working in the Crisis Team on other cases. So I had started to make my way through them but certainly hadn't completed them.'

On the 29 June the Crisis Worker discussed the case with the Manager of the Crisis Team. She also left a further message for the Vulnerable Adults Team. The Crisis Worker spoke once again to the sister to say that there was a need to gather more information before any action could be taken[251].

On the 4 July 2007 the Crisis Worker telephoned the sister of Mr. X and asked for a meeting with Mr. X's parents to discuss their concerns. She rang again on 10 July 2007 and it was agreed that Mr. and Mrs. X senior would come to the Crisis Team office for a meeting[252].

Three significant issues arise from these findings.

- The information gathering process used to inform the decision whether or not to proceed with a Mental Health Act (1983) assessment.
- The appropriateness of the Crisis Team to carry this particular case.
- The competence and supervision of the Crisis Support Worker.

Information Gathering and Utilisation

It is a fact that by the 26 of June the Crisis Team held a significant amount of information about Mr. X. Normally it would have been quite correct for the Crisis Worker to discuss Mr. X with his parents prior to developing or instigating a plan of action. However in this case it did not appear to be something that was pursued with any degree of rigour. This served to cause a further delay in ensuring Mr. X was assessed in a timely manner.

Neither the Crisis Team Worker nor her Manager read through the notes in an organised way. It appears that they received little attention. If the notes had been read through systematically then the case may have been managed entirely differently. This was the opinion of the Local Authority Social Work Lead when interviewed by the Independent Investigation Team. This individual had given advice to the Crisis Team Worker regarding Mr. X in the weeks leading up to the deaths of Mr. and Mrs. X senior. She was also present at the Police Station as part

251 File AW 1A P. 7
252 File AW 1A P. 7

of the Duty Response to the incident after the arrest of Mr. X following his parents' deaths. Once Mr. X had been arrested the Local Authority Social Work Lead had access for the first time to the documentation that had been sitting with the Crisis Team. This information had not been discussed during telephone conversations with the Crisis team Worker. At interview she had the following to say.

'I looked at the information that was available and my first thought was "I think I've gone mad"... I know I'm methodical, I know that I'm systematic. I know that I place enormous emphasis on evaluating information. It's the core part of my working practice. And I looked over that information and it was a different order of information. I couldn't not have reacted to that information had I known it. I would have had a totally different order of reaction.'

It was the view of the Local Authority Social Work Lead that the content of Mr. X's clinical record was of a sufficiently serious nature to have merited a sharper response with immediate effect, such as liaising with the Police Service. It is a fact that the Crisis Team held information about Mr. X which would have been sufficient to have informed a decision about the implementation of Mental Health Act (1983) assessment. This information was not used.

Appropriateness of the Crisis Team to Carry the Case

It was clear to the Independent Investigation Team that both the information gathering processes and the advice sought by the Crisis Team Worker centred on whether Mr. X required an assessment under the Mental Health Act (1983) or not. The evidence given to the Independent Investigation Team from the family of Mr. X was that they had requested a Mental Health Act (1983) assessment. This was their main reason for contacting mental health services at this juncture as the behaviour of Mr. X was so bizarre and threatening they felt they could no longer manage it.

As part of the Independent Investigation process we asked the Crisis Team Manager whether it was the function of the Crisis Team to conduct assessments under the Mental Health Act (1983). It was the view of the Manager that while it may have been appropriate for Mr. X to have been referred initially to the Crisis Team the function of the Crisis Team was to gather information and then make an appropriate referral. It was not the function of this team to conduct Mental Health Act assessments. No explanation could be given as to why this case

took so long to be referred to a more appropriate team that could have initiated the necessary interventions in a timely manner.

The Competence and Supervision of the Crisis Worker

Clinical Witnesses to this Investigation described the Crisis Team in June 2007 as being a *'fledgling service'*. The team had had difficulties in developing as a truly multidisciplinary entity. On its inception many of the team members had been nurses recruited from inpatient services. By June 2007 the team had access to a Psychiatrist, Psychologist, Occupational Therapist and Social Worker. The team had also recruited support workers. Clinical Witnesses also told this Investigation that caseloads were heavy and that the team was under pressure on a regular basis. It is in this context that we examine the competence and supervision of the Crisis Team Worker.

In June 2007 the Crisis Team Worker was employed as an unqualified worker with the Crisis Team. In effect she was a Support Worker. Clinical Witnesses to this Investigation explained that all Crisis Team cases were held by *'the whole team'* and not by individuals. However in effect, even though she discussed Mr. X with her Manager, the Crisis Team Worker appeared to be the sole individual actively involved in the management of Mr. X's case.

Whilst the Independent Investigation Team appreciate the need for the Crisis Worker to have gathered information about the case prior to initiating any action, it appears that this individual sought advice that a more experienced worker would not have needed to take. In this particular case this constant advice seeking served to slow down the process to an unacceptable level. Another aspect is that once advice and information was sought and gained, the Crisis Worker did not seem to understand the significance of it. At interview the Crisis Worker recalled discussing the case with the multidisciplinary team, however the outcome of this discussion was not recorded.

The family of Mr. X was under the impression that the Crisis Worker had arranged for a Mental Health Act to be conducted on the 25 June 2007. The family had explained to the Crisis Worker that Mr. X would be very hostile and the planned assessment would put both Mr. and Mrs. X senior at risk if he became aware of it in advance. According to the family of Mr. X a plan was devised with the Crisis Worker so that she would alert the sister of Mr. X and her parents prior to the visit so that they could be placed safely out of the house. The

assessment did not take place. At interview the Crisis Team Worker stated that this assessment had never been planned. It is unclear what exactly occurred or of what the plan actually comprised, as the family version of events and the Crisis Team Worker version of events differ entirely. It may be that once again the inexperience of the Crisis Team Worker contributed to this confusion and the misunderstanding that ensued.

The Independent Investigation Team considered the following when assessing whether the Swindon Team should have considered whether a Mental Health Act (1983) assessment was indicated or not for Mr. X.

Past History:

- diagnosis of delusional disorder;
- harassment, violent and aggressive behaviour;
- evidence of harbouring weapons with the intention to 'defend himself';
- forensic history and previous convictions directly linked to his psychiatric condition;
- relapse indicators identified as being compulsive letter writing which featured abusive and inappropriate content;
- no insight regarding mental illness;
- non compliance with voluntary treatment;
- non engagement with services;
- detention under the Mental Health Act (1983);
- previous MAPPA referral.

Presentation in 2007:

- exhibiting identified relapse indicated behaviour (letter writing);
- no insight regarding mental illness;
- not engaged with mental health services;
- not taking medication;
- evidence of threatening, abusive behaviour towards his elderly parents;
- request for urgent help from family members because they were afraid of being harmed.

It is the view of the Independent Investigation Team that any mental health team when presented with this kind of information has a duty of care to conduct a swift risk assessment as a multidisciplinary team and to plan an intervention of which assessment under the Act should be a part, especially if family members are requesting it.

14.2.2.3. Conclusions

The Independent Investigation Team found that there was a failure to use the powers of the Mental Health Act (1983) to assess Mr. X. Mr. X was exhibiting bizarre behaviour and had been reported by his family as being abusive and threatening towards his elderly parents with whom he lived. By the time Mr. and Mrs. X senior met their deaths the Swindon Crisis Team was in receipt of information that detailed Mr. X's psychiatric and forensic history. The information that was both known to and was in the possession of the Swindon Crisis Team should have instigated an assessment under the Act. The use of the Mental Health Act (1983) to assess the mental state of Mr. X might have ensured that he received the care and treatment he required to treat his long standing delusional disorder. This may have prevented the deaths of his parents. There were several significant failures, they are set out below.

- There was a failure of communication between the Emergency Duty Team in February 2007 and the CMHT. This represented a missed opportunity whereupon Mr. X may have come to attention of mental health services.
- Following the referral to the Crisis Team in June 2007, there was a lack of urgency in assessing Mr. X and a failure to read and to use the information sent from Lincolnshire Mental Health Services. This information, in conjunction with the recent concerns raised about Mr. X, was of a nature that should have prompted a formal and swift assessment under the Act.
- Mr. X was inadvertently referred to the Crisis Team as his family mistakenly thought this would lead to a Mental Health Act (1983) assessment. At the point of referral there was a case for referring Mr. X immediately to the CMHT since he did not meet the Crisis Team operational criteria and the Crisis Team were not 'geared up' to assess him under the Act.
- There was no written evidence brought forward to the Independent Investigation Team to indicate that the Crisis Team discussed the case as part of their daily review of allocated work. It would appear that an unqualified Crisis Team Worker held onto

a case that was clearly too complex for her to manage. The Crisis Worker was not adequately supervised and this lack of supervision slowed further the process of assessing and triaging Mr. X in an appropriate and timely manner.

The Swindon services did not use the provisions afforded by the Mental Health Act (1983). In the three-week period before the incident the sister of Mr. X made contact with the Crisis and Home Treatment Team in Swindon. A number of discussions took place between professionals about the case and information was sought from Lincoln. The case notes from Lincoln were not used effectively to inform decision-making by the Crisis Team. There was uncertainty about how to take the case forward and a number of avenues were explored e.g. referral to the Vulnerable Adults Team, and the Forensic Service all of which were unproductive and all of which caused delays.

A more assertive intervention under the Mental Health Act (1983) could have secured a direct assessment of Mr. X's mental state and opened the possibility of compulsory detention for assessment in a hospital. A key feature of the case in Swindon was the failure to gather and use information effectively.

- ***Contributory Factor Number Two. No assertive action was taken to initiate a Mental Health Act (1983) assessment. As a consequence Mr. X's mental illness continued to deteriorate and he did not receive the care and treatment that he required.***

14.2.3. Risk Assessment

14.2.3.1. Context

The statutory obligation for the Avon and Wiltshire Partnership NHS Trust to undertake comprehensive clinical risk assessments for service users are the same as those identified under the risk section for Lincolnshire services above (Section 14.1.51).

Between 2003 and 2007 the Trust had comprehensive risk assessment policies and procedures in place to address the management of service user risk. These policies were particularly sound in that they clearly defined the roles and responsibilities of all personal at

all levels in the organisation. The Trust 2006 Policy to Manage Care Pathways and Risk provided a robust framework for all mental health teams working within the Trust.

This Policy provided a risk screen process that did not have to be completed with the service user and was designed so that it could be used at the point of referral and as part of an initial information gathering exercise. The Policy stated that this risk screen had to be completed:

- *'whenever a person new to the service is initially assessed;*
- *whenever a person is re-referred to a service.'*[253]

The Swindon Crisis Team Operational Policy in place during 2007 set out under 'Referral Criteria: Clinical Aspects' that in order to be accepted by the service a person either had to be:

- *'at risk of immediate and significant self harm, and / or;*
- *Is an immediate and significant risk to others due to their mental health.'*[254]

The Trust Risk Screen made provision for the following to be considered. All of the issues listed below were pertinent to Mr. X's presentation either in the past or during 2007 (NB this is not the complete risk screen).

Risk to others

- non-violent offences;
- record of violent incidents;
- serious violence;
- subject to MAPPA/considered for referral;
- threats to specific persons;
- possession of dangerous weapons;
- poor anger control;
- violent fantasies;
- pending charges/court cases;
- domestic violence to others.

253 Policy to Manage Care Pathways and Risk P. 22
254 Swindon Crisis Team Operational Policy P. 6

Additional risk factors

- serious mental health problems;
- risk of loss of contact.

Social risk factors

- poor housing/ housing issues;
- conflict in personal relationships;
- problems regarding employment;
- significant debts/financial problems.

14.2.3.2. Findings

Swindon-based services took part in several communications regarding Mr. X between 2003 and 2007. These communications were triggered by Lincolnshire Mental Health Services, the Swindon Police Force, and the family of Mr. X. Few details were recorded by Swindon services and as a result no risk picture for Mr. X was developed over time. Each referral and enquiry occurred in isolation one from the other.

In 2007 the situation intensified when Mr. X's mental state began to deteriorate rapidly. Neither the Emergency Duty Team nor the Crisis Team appeared to have considered Mr. X in the light of the immediate risk profile that he was described as presenting with. It would appear that risk decisions regarding Mr. X were coloured through the lens of concerns about contravening his human rights rather than the preservation of the health and wellbeing of those around him.

In 2007 every clinical team within the Avon and Wiltshire partnership NHS Trust had access to the Risk Screen Tool. This tool was available in order to support risk assessment decisions. Whilst it may not have been appropriate for the Emergency Duty Team to have utilised the Risk Screen it would have been entirely appropriate for the Crisis Team to do so. Had the Risk Screen been used it would have become apparent that Mr. X presented with a degree of risk that should not reasonably have been left unmanaged for the time that it was.

14.2.3.3. Conclusion

Even though Mr. X did not meet *all* of the service criteria for being accepted by the Crisis Team, he most certainly did meet one of the most important decisive factors namely '*...is an immediate and significant risk to others due to their mental health'.* Mr. X was never seen by the Crisis Team and members of the team maintain a degree of ambivalence as to whether he had actually been accepted onto the caseload or not. However it is the view of the Independent Investigation Team that Mr. X had been accepted by the Crisis Team by default. The Crisis Team did not conduct either an assessment or a triage service as is set down in the Operational Policy. Mr. X's case was effectively held in limbo for a period of three weeks in which his risk was never assessed, understood or managed appropriately in accordance with Trust policy and procedure. This ensured that the mental health of Mr. X continued to deteriorate placing all those around him at risk.

- ***Contributory Factor Number Three. The Crisis Team failed to assess Mr. X in the context of his known risk. This led to a critical delay in the assessment of his mental health.***

14.2.4. Management of Clinical Processes

14.2.4.1. Context

Three major factors affected the management of Mr. X's case. First, neither Mr. X nor any member of his family was ever actually seen by Swindon-based Mental Health Services. Second, although referrals were attempted on several occasions they were never successful in accessing mental health services for Mr. X. Third, clinical documentation was poorly managed between 2003 and 2007, and this meant that each fresh enquiry relating to Mr. X was always seen in isolation from any previous communication.

Whilst the Independent Investigation Team was not able to access policy documentation from the Trust for 2003 when Mr. X first came to the attention of the organisation, a full set of policy documentation for the period relating to the events of 2007 was available. Avon and Wiltshire Partnership NHS Trust policy documentation for 2007 provided a clear and robust clinical framework within which clinical teams were expected to work.

14.2.4.2. Findings

Between August 2003 and July 2007 Mr. X came to the attention of the Swindon-based Mental Health Services on many occasions. Between August and November of 2003 Lincolnshire Mental Health Services attempted to arrange the transfer of Mr. X to Swindon Community Mental Health Services. This attempted transfer did not meet with success. The reasons for the rejection of Mr. X onto the Swindon caseload cannot now be either fully known or understood as no suitable record is extant and no one can remember the case in sufficient detail to offer an explanation as to why this was so. The records still held by Lincolnshire services state that this referral was unsuccessful because Mr. X had no GP and was unlikely to engage. No reason can be found as to why Mr. X, who was eligible for Section 117 aftercare, was never formally assessed in a face-to-face meeting and a clinical decision based on his situation and condition at that time. This was the first lost opportunity to assess Mr. X and provide suitable mental health services to him.

The sister of Mr. X told the Independent Investigation Team at interview that she telephoned Swindon-based Mental Health Services on many occasions between 2004 and 2007. On these occasions she sought to access support for her parents and assistance for her brother. Whilst it is not possible to prove what was discussed, it is evident that no action ever occurred as result. The sister of Mr. X did not receive assistance, was not signposted appropriately and could find no one to help her in her quest for accessing treatment for her brother. No logs appear to have been kept by Swindon Mental Health Services regarding these communications. This ensured that Mr. X's situation did not raise an alert over time as communications from his sister accumulated. This was the second lost opportunity to assess Mr. X and provide suitable mental health services to him.

In February 2007 the sister of Mr. X sought advice from the Citizen's Advice Bureau. At this stage the family of Mr. X had been unable to think of any other service available to them that could offer them some assistance. The Bureau telephoned the Swindon Police. The Swindon Police felt that Mr. X was presenting with problems that would be best managed by mental health services and made a call to the Emergency Duty Team. The Emergency Duty Team did not think that the situation was one that merited an out of hours response and referred the case on to the Swindon Community Mental Health Team base. The Independent Investigation Team understands that the referral to the Community Mental Health Team resulted in no further action being taken. No records were kept regarding this referral and no one can

remember any referral having been made. This was the third lost opportunity to assess Mr. X and provide suitable mental health services to him.

On the 19 June 2007 the sister of Mr. X contacted the Swindon-based Crisis Team seeking help for her brother. On this occasion Mr. X's case was held for consideration while an information gathering process took place. This information gathering took three weeks and was still ongoing at the time that Mr. and Mrs. X senior met their deaths. The case did not appear to receive multidisciplinary review or input. The case did not adhere to Trust policy and procedure guidance. This was the fourth lost opportunity to assess Mr. X and provide suitable mental health services to him.

Between 2003 and 2007 it would appear that Swindon-based Mental Health Services presented an 'impenetrable barrier', through which neither statutory agencies nor the family of Mr. X could gain entry. The sister of Mr. X and her family were not the only individuals to experience difficulties during this period. This is evidenced by additional information provided to the Independent Investigation by NHS Swindon.

NHS Swindon is the Primary Care Trust which serves the population of Swindon, the evidence it gave to this Investigation forms the narrative below. An NHS Primary Care Trust (PCT) is a type of NHS Trust that provides primary and community services, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts. In 2008 and 2009 the Primary Care Trust received complaints about the delivery of services from the Community Mental Health and Crisis Teams in Swindon. The complaints came primarily from the users of their services and their families. An extensive analysis took place which involved 150 stakeholders, some 200 witness statements were submitted during this period. Some of the problems that were identified are as follows:

- telephones not being answered;
- a general lack of helpfulness when people telephoned services asking for help;
- professional staff not turning up for appointments;
- refusal of the Crisis Team to accept new referrals;
- individuals not being able to get into the Swindon mental health system when in need;

- a lack of advice giving and signposting for people in need to access appropriate services.

The reasons given for the poor delivery of service were:

- the geographical remoteness of the Service Director which led to 'management by email';
- freezing of staff posts which led to excessively large caseloads.

The purpose of setting out these difficulties experienced both by service users and their families, and the Swindon Mental Health Teams is to provide a degree of evidence triangulation. It is clear that Mr. X's family were not alone when experiencing difficulties in accessing Swindon-based services. It would appear that for a period spanning several years profound service delivery problems were apparent. These service delivery problems appear to have affected every aspect of service function.

14.2.4.3. Conclusions

During 2007 the Community Mental Health Teams had sound policies and procedures that were developed in accordance with national best practice guidance. Despite this, service delivery fell short of both local and national policy expectation. The Swindon-based Community Mental Health Teams had difficulty in providing services at even the most basic levels and this undoubtedly had an impact on the way that Mr. X and his family were managed. Whilst there is no conclusive evidence that can be brought forward it is possible that this situation was of a long standing nature and these conditions were also present in 2003 when the first attempt was made by Lincolnshire to refer Mr. X to services close to where he was living.

It would appear that the clinical leadership structure, both at corporate and local team level, was unable to ensure an acceptable standard of care delivery. This impacted upon record keeping and storage, referral procedures, caseload management and supervision. Mr. X was an articulate man with no insight, a forceful personality and an extreme reluctance to engage. The Independent Investigation Team acknowledges that Mr. X presented as an extremely challenging individual. However due to the lack of organisation within Swindon-based

Mental Health Services he remained without assessment and consequently went untreated, in effect he was rendered invisible. This impacted upon his mental state and this situation made a direct causal contribution to his mental illness continuing to be untreated. The mental illness of Mr. X and his past history indicated that he posed a significant risk to those around him. The evidence from his family about the last six months of Mr. and Mrs. X senior's lives would indicate that he was mentally ill and they were at risk. The services in place to ensure both Mr. X's mental health was treated and the safety of those around him was maintained failed.

- ***Contributory Factor Number Four. The clinical leadership structure, both at corporate and local team level, was unable to ensure an acceptable standard of care delivery to Mr. X. This led to critical delays and ensured that his mental health continued to deteriorate.***

14.2.5. Interagency Communication and Working

14.2.5.1. Context

The context for this section is the same as that in Section 14.1.9 above.

14.2.5.2. Findings

Between 2003 and 2007 there is little evidence to demonstrate how Swindon-based Mental Health Services worked with other agencies and out of area service providers. Trust policy and procedure set out the Trust's expectation regarding how clinical teams were expected to work. Policies advocate joint *'discussion, information exchange, decision making and prioritisation.'*[255] The Trust Care Pathways approach to managing CPA, risk and clinical management has at its centre the service user. A holistic and systematic process is advocated for the assessment and care planning of mentally ill individuals and their families. This approach advocated joint working with multiple services and agencies in order to offer seamless care packages for the following:

- *'child protection;*
- *housing;*

255 Swindon Crisis Service Operational Policy P.7

- *physical care;*
- *employment;*
- *criminal justice;*
- *financial difficulties.'*[256]

In the case of Mr. X there is no evidence that his situation was ever managed in accordance with extant Trust policy and procedure. Whilst there was a rudimentary attempt between the 19 June and 10 July 2007 to seek advice from Forensic Services and the Vulnerable Adults Unit, no other discussion was either initiated or reciprocated between 2003 and 2007. Further issues regarding Safeguarding Vulnerable Adults are addressed in Section 14.2.6. below.

14.2.5.3. Conclusions

There were three distinct opportunities for interagency discussion to have taken place between 2003 and 2007. The first being the failed transfer initiated by Lincolnshire Mental Health Services between August and November 2003, the second being the Police generated referral to the Emergency Duty Team in February 2007, the third being the carer referral to the Crisis Team initiated by the sister of Mr. X in June 2007.

These three separate occasions bear the consistent hallmark of a distinct lack of assertive clinical management. It would appear that Swindon-based Mental Health Services took a fairly passive approach regarding the requests made to them and displayed what could be described at best as a profound lack of professional curiosity and at worst a consistent disregard of the concerns being presented to them. It is not possible to state how interagency working was routinely managed in Swindon seen through the lens of single case, however it would appear to have consisted of a 'one way flow' of information coming into services with little follow through taking place as result.

- ***Contributory Factor Number Five. Swindon-based services did not adhere to Trust operational policy guidance. As a consequence Trust services presented an impenetrable barrier through which it was impossible for Mr. X's case to be successfully referred.***

256 Policy to Manage Care Pathways and Risk 2006

14.2.6. Liaison with Carers and Vulnerable Adults

14.2.6.1. Context

Liaison with Carers

Avon and Wiltshire Partnership NHS Trust policy and procedure places great importance on the need to work with the carers and families of service users. The Policy to Manage Care Pathways and Risk (2006) stated that:

'Effective partnership working with carers needs to be underpinned by the incorporation and delivery in practice of key principles that promote effective modern partnership working...Characteristics of services that are effective at engagement [with carers] include services that are seen:

- *as accessible and welcoming;*
- *as relevant and well integrated with their local communities;*
- *to promote effective understanding and communication;*
- *to work to prevent escalation of crisis;*
- *to respect all service user, carers, families and communities and ensure that all voices are heard.'*[257]

At interview the sister of Mr. X said that apart from the contacts with the Crisis Team in 2007, she had had many other telephone contacts with services in Swindon. No records of these contacts were retained by the Avon and Wiltshire Partnership NHS Trust. In order to build up a picture of events the Independent Investigation Team interviewed the sister and her husband and considered carefully the evidence that they presented to this inquiry process.

Vulnerable Adults

A vulnerable adult is a person aged 18 years or over who may be unable to take care of themselves, or protect themselves from harm or from being exploited. This may be because they have a mental health problem, a disability, a sensory impairment, are old and frail, or have some form of illness.

257 Policy to Manage Care Pathways and Risk 2006 P.22

Swindon Borough Council has provided clear Safeguarding Vulnerable Adults guidance, this guidance was in place at the time that Mr. and Mrs. X senior met their deaths. This guidance advocated clear functions within the Local Authority Emergency Duty Team to notify relevant bodies if a potential safeguarding adult referral was made to them. The guidance also set out clearly the roles and responsibilities of the Wiltshire Police and Mental Health Services who formed part of the Swindon Safeguarding Alliance.[258]

The Policy and Procedure for Safeguarding Vulnerable Adults in Swindon and Wiltshire 2006-2007 stated that *'all staff who work for agencies that have signed up to the Safeguarding Vulnerable Adults in Swindon and Wiltshire...have a duty to report any allegations or suspicions of abuse.'*[259] This policy stated that the Police Vulnerable Adults Unit in Swindon has a responsibility to liaise with Health and Social Care personnel as required when notified of a potential Safeguarding Vulnerable Adult issue. The policy provided the following instruction:

'The Vulnerable Adults Unit Manager, or outside normal working hours the relevant Duty Inspector, will establish any known history of the vulnerable adult and the family which will include Domestic Violence, Child Protection, Police National Computer check, ViSOR check and intelligence records held across the Force within the Optimus system. The Vulnerable Adults/Persons Unit Manager or relevant Duty Inspector will have responsibility for consulting with the appropriate Adult Services Department and Emergency Duty Teams/Emergency Duty Service prior to any investigation being commenced. Such consultation will take place ***in all cases*** *of alleged or suspected adult abuse.'*[260]

14.2.6.2. Findings

When asked if the family of Mr. X had attempted to make contact with Swindon-based Mental Health Services prior to June 2007 the response from the sister of Mr. X was *'constantly'.* These attempts were made between 2004 and 2007. When asked who the family made most contact with the sister said:

258 Swindon Borough Council Safeguarding Vulnerable Adults Annual Report 2006 P.28
259 Safeguarding Vulnerable Adults in Swindon and Wiltshire 2006-2007 P. 71
260 Safeguarding Vulnerable Adults in Swindon and Wiltshire 2006-2007 P. 76

"The Crisis Team. Every time we rang the Crisis Team they kept to a two minute conversation every time. Regardless of what had happened. 'Mum and dad, we would just bundle along from one crisis to the next. His [Mr. X's] normal behaviour was unacceptable but it became the norm. They just trod on eggshells. They just did everything they could to keep him happy. They just tried to live their lives as normal as possible between episodes and every time he would have an episode dad would come round and say, "Alarm bells we've got to start doing the rounds again." That would be his saying. So we would ring the Crisis Team in Swindon first and then we would ring Lincoln...and we would go round like this."

The family of Mr. X offered the following sequence of events to the Independent Investigation Team based on memory and supported by telephone bill evidence.

9 January 2003. The father of Mr. X contacted Swindon Mental Health Services to enquire as to whether Mr. X's care could be transferred from Lincolnshire to Swindon. He was told that this could not be achieved without a local GP referral.

Between 2003 and February 2007 the sister of Mr. X recalls making many telephone calls to Swindon-based Mental Health Services to no effect.

13 February 2007. The sister of Mr. X and her father went to the Citizen's Advice Bureau (CAB) because they needed advice on how to manage Mr. X's financial affairs and also because his behaviour had become so frightening and threatening the family did not know what to do. The family were grateful that the CAB suggested telephoning the Police on their behalf because they reported being *'too frightened to do this ourselves for fear of him [Mr. X] finding out'.* The Police telephoned the sister later that evening. She explained to them the danger that she believed her parents were in. She informed the Police that they thought he needed to be sectioned and that the family felt they would be at increased risk if Mr. X found out that they had been in contact with the Police. The Police informed the sister that they felt this was a matter for Mental Health Services who they contacted immediately on the family's behalf.

A member of the Emergency Duty Team telephoned the sister that evening. The sister explained the situation to her. This explanation included the fact that Mr. X had physically hurt his parents in the past and that he was currently being abusive, intimidating, terrorising and threatening towards them. The sister explained the dilemma the family faced. Mr. X

would not be amenable to an informal 'chat' with mental health services to have his situation assessed as he had no insight and was hostile to such an approach. The sister and her family believed that unless Mr. X was sectioned and removed her parents would be placed in a situation of increased danger for daring to bring Mr. X to the attention of Mental Health Services.

The sister of Mr. X recalled the Emergency Duty Worker as telling her that her brother had rights and that until he *'crossed the line'* there was nothing that could be done.

14-27 February 2007. The sister of Mr. X telephoned Lincolnshire Services once again in an attempt to obtain help and advice. She also rang several statutory government agencies for information as to how to proceed.

1 March -6 June 2007. The CAB continued to support the family. On the 6 June 2007 as the situation continued to deteriorate a CAB worker telephoned the Swindon Crisis Team in order to gather information that could support Mr. X's family. This worker was told that in order for Mr. X to be referred to the Team a referral would be required from his GP. Basically with no GP no help could be sought.

13 June 2007. The sister of Mr. X went to the Police Station. Once again she informed them of the situation and the danger that she felt her parents were in. She explained that their previous referral on the family's behalf to Mental Health Services had not been successful. The sister was informed once again that this was a mental health issue and she was given two telephone numbers for Swindon Mental Health Services. The sister was told to tell these services that she was accessing them on the direct advice of the Police. One of these numbers was for the Crisis Team.

Later on the same day the sister telephoned the Crisis Team. The sister told the Crisis Team that she was contacting them on the advice of the Police whom she had contacted earlier that day. The sister was told that without a GP Mr. X could not be accepted by them.

14. June 2007. The sister of Mr. X rang both the Care Quality Commission and the Mental Health Act Commission. She was advised to make contact with Mr. X's Lincoln-based RMO

in order to instigate communication between Lincolnshire and Swindon Mental Health Services.

15 June 2007. The sister of Mr. X telephoned the Lincoln RMO's Medical Secretary. The Medical Secretary advised her to contact the Crisis Team in Swindon. On this occasion she told the sister that if Swindon requested copies of Mr. X's clinical records then she would send them.

Following this communication the sister and her family discussed the situation over the weekend and eventually felt that they had no choice but to push to have Mr. X sectioned.

19 June 2007. The sister of Mr. X telephoned the Crisis Team once again and spoke to a Crisis Team Worker. She emphasised the danger that she felt her parents were in and the frustration that she felt.

21 June 2007. The sister of Mr. X recalled speaking to the Crisis Worker and being informed that the Team had made the decision to section Mr. X and this would take place on the 25 June. The plan was that the Crisis Worker was going to telephone the sister in advance of the visit occurring so that she could safely *'get them [Mr. and Mrs. X senior] out of the way.'*

25 June 2007. No visit was made by the Crisis Team. No telephone call was made by the Crisis Team Worker to explain what was happening or why the assessment visit had not taken place. The family were devastated and did not know what to do but continued to obtain support from the CAB.

4 July 2007. The Crisis Team Worker telephoned the sister. She made no apology for the Mental Health Act (1983) assessment not taking place as planned. The Crisis Worker stated that the Team had reconsidered the situation and that they had decided a discussion needed to take place with Mr. and Mrs. X senior before a decision regarding action was reached.

9 July 2007. The Crisis Team Worker telephoned to make an appointment for Mr. and Mrs. X senior to meet with the Team.

Unbeknown to either the sister or the Crisis Worker Mr. and Mrs. X senior were already dead.

The Independent Investigation Team was given two entirely different accounts regarding what occurred between the 21 June and the 4 July 2007. The family of Mr. X were insistent that a Mental Health Act (1983) assessment had been arranged and failed to happen, and the Crisis Team was equally insistent that it had never been arranged in the first place. This is explored in more detail in Section 14.2.7. directly below.

Safeguarding Vulnerable Adults

At the time of his death Mr. X senior was 83 years of and his wife was 76 years of age. They had been placed in the role of main carers to their severely mentally ill son who lived with them in Swindon. Between February and July 2007 their daughter had made repeated attempts to obtain help for her parents because they were being threatened and verbally abused in their own home.

It would appear that contacts with the Emergency Duty Team and the Swindon Police failed to raise a Safeguarding Vulnerable Adult alert in accordance with local policy guidance. No explanation can be found for this omission.

During June and July 2007 following the sister's contact with the Crisis Team, it has been recorded that on three occasions the Crisis Team Worker telephoned the Vulnerable Adults Unit. The first contact was on the 20 June 2007, on this occasion there was no one available to take the call and a telephone message was left. The second contact was on the 26 June 2007, on this occasion there was no one available to take the call and a telephone message was left. The third contact was on the 29 June 2007, there was no one available to take the call and a telephone message was left. There are two pertinent issues that arise from this.

First. Safeguarding Vulnerable Adults issues regarding the wellbeing of Mr. and Mrs. X senior had been identified by the Trust, this was evidenced by the contact that the Crisis Team made to the Vulnerable Adults Unit. However, once the Crisis Team had established that there were Vulnerable Adult concerns it is inexplicable why the formal alert process had not been instigated. This would have led to an immediate and prescribed response from all the appropriate statutory agencies.

Second. It is also inexplicable how a statutory agency (the Vulnerable Adults Unit), operating normal office hours, did not respond to three urgent referrals (made within office hours) requesting their input into this case. It would not be unreasonable for the Police Services to have responded rapidly after having been approached by a Mental Health Crisis Team. The very function of such a team, e.g. working in situations of crisis, should have provoked an immediate response in keeping with local policy guidance. This did not occur. The Swindon Police Force hold a record of two recorded messages from the crisis Team Worker. All Police telephone communications are logged in accordance with strict policy guidelines. It is the view of the Swindon Police Public Protection Department that whilst the Crisis Team Worker made two telephone calls, the agreed Vulnerable Adults policy and procedure was not correctly instigated by either the Crisis Team or the Police Service.

14. 2.6.3. Conclusions

Carer Liaison

It is the view of the Independent Investigation Team that the family of Mr. X was subjected to a frustrating and totally unacceptable level of service from the Avon and Wiltshire Partnership NHS Trust Swindon-based Teams. It is difficult to understand what this family could have done or said differently to access the help that both they and Mr. X needed. The Swindon Crisis Team was clearly in breach of the Trust Care Pathway Policy and neither worked within the spirit of this policy nor its practice.

The elderly parents of Mr. X were placed in a position of unacceptable risk. Safeguarding Vulnerable Adults issues had obviously been identified by the Crisis Team Worker, as evidenced by her telephoning the Vulnerable Adults Unit. However once concerns had been identified it was not acceptable to wait for an interval of three weeks for the Vulnerable Adults Unit to respond to the voicemail messages that she had left for them. The fact that Mr. and Mrs. X senior were in their eighties and seventies respectively, were being threatened, abused and terrorised by their mentally ill son in their own home, should have elicited an immediate response. This did not occur.

Vulnerable Adults

The Independent Investigation Team is not convinced that the appropriate Safeguarding Vulnerable Adult procedures were implemented to ensure both the safety and wellbeing of Mr. and Mrs. X senior. Local policy and procedure is exceedingly clear as to how local

services were expected to respond as part of the Swindon and Wiltshire Safeguarding Alliance.

It has been suggested that three telephone contacts were made by the Crisis Team Worker to the Vulnerable Adults Unit, none of which resulted in anything other than a one-way voicemail communication. No evidence could be brought forward by the Trust to explain this grave omission. The Police Unit failed to respond appropriately, in which case the Crisis Team should have taken a more proactive stance (e.g. the formal alert procedure).

Evidence heard at the trial of Mr. X stated that Mr. and Mrs. X senior were living in fear of their son during the last six months of their lives. Mr. X threatened them with violence on a regular basis and verbally abused them. The Crisis Team's failure to act in an assertive manner regarding the real and continued threat to the safety of Mr. and Mrs. X senior ensured that they remained in a situation of extreme danger. The Crisis Team were aware of these dangers and had identified that potential Vulnerable Adult issues were present but failed to follow local policy and procedure.

The issues regarding record keeping are addressed in Section 14.2.7. below.

- ***Contributory factor Number Six. Communication, consultation and liaison with the family of Mr. X did not provide the assistance that they needed in an appropriate and timely manner. The fact that the parents of Mr. X were vulnerable adults did not trigger the appropriate safeguarding processes. As a result the parents of Mr. X were placed in a position of unacceptable risk.***

14.2.7. Documentation and Use of Clinical Records

14.2.7.1. Context

'The Data Protection Act gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.
The Act works in two ways. ... it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- *fairly and lawfully processed;*
- *processed for limited purposes;*
- *adequate, relevant and not excessive;*
- *accurate and up to date;*
- *not kept for longer than is necessary;*
- *processed in line with your rights;*
- *secure;*
- *not transferred to other countries without adequate protection*[261]*.'*

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

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

The GMC states that:
'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off[262]*'*

Pullen and Loudon writing for the Royal College of Psychiatry state that:
'Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised.[263]*'*

261 Information Commissioner's Office Website 2009

262 http://www.medicalprotection.org/uk/factsheets/records

263Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP. 280-286

14.2.7.2. Findings

There were two main findings regarding documentation and the use of clinical records that became apparent when examining this case. The first involved clinical record access and archiving, the second involved the development of accurate and contemporaneous clinical records.

First: it became apparent when examining the case of Mr. X that no communications regarding this individual were either made or kept on file between 1 August 2003 and 19 June 2007. This had the effect of rendering Mr. X entirely invisible to services over time.

It would appear that contrary to the practice of recording telephone enquiries and potential referrals in diaries and log books described by clinical witnesses, no written evidence could be brought forward in relation to Mr. X and the numerous telephone communications that occurred between Swindon Services, Lincolnshire Services, the Police and his family. No explanation could be given as to why this was the case.

Due to this consistent omission between 2004 and 2007 it would be a reasonable assumption to make that record keeping is not rooted within the culture of the Swindon-based Mental Health Teams.

Second: as has been identified above, the family of Mr. X and the Crisis Team recounted two entirely different and contradictory versions of events regarding the potential assessment of Mr. X under the Act in June 2007 to the Independent Investigation Team.

On examining the Crisis Team clinical record it became apparent that there were nine consecutive, separate date anomalies. This was highly suggestive of the clinical record not having been contemporaneously made.

There are three initial entries made, one on the 19 June and two on the 20 June. All three of these entries have been overwritten thus changing the ‘7’ to a ‘6’, the ‘7’ and ‘6’ representing July and June respectively. This indicated to the Independent Investigation Team that these entries had actually been written in July and then overwritten to suggest that they had been written in June.

Six further consecutive entries were made with an uncorrected ‘7’ representing July which should actually have represented June. This once again indicated that the clinical record had not been contemporaneously made.

At interview the Crisis Team Worker who was the author of the clinical record admitted that the entire record had been made following the deaths of Mr. and Mrs. X senior and that none of the record was in fact contemporaneous. The record was then delivered to the Police, the Trust internal investigation, and in the fullness of time to the Independent Investigation Team. This raised several issues.

The Avon and Wiltshire Partnership NHS Trust record keeping policy provides clear instruction regarding the development of clinical records. In accordance with national best practice guidance the instruction states that all entries should be contemporaneously made. However, if for whatever reason this is not possible, the person making the entry should clearly state the actual date that the entry has been made together with the date to which the entry applies. The fact that the entry has been made from memory and at a later date should be explicitly stated so that any subsequent reader is entirely clear as to the origin of the record. This was not done.

This creates a distinct difficulty when assessing the veracity of the account as set out in the clinical record. It is a fact that this record spanning some three weeks was not contemporaneously made, and given the circumstances, could be seen as having been adapted and written with the benefit of hindsight especially as there are two distinct accounts of what actually occurred during this three-week period.

The Independent Investigation Team have had to consider whether there was a degree of ‘sinister’ intent regarding the writing of the clinical record with the intention to mislead any future investigation. It is evident that the authors of the record knew it was not contemporaneous and did not explicitly create this record so that any future reader would understand this to be the case. This action cannot be excused in any way as both national and local policy regulation regarding the development of clinical records should be well known to any health or social care professional working anywhere in the country. Whatever the intent the facts are that:

- a clinical record was created that was not contemporaneously made;
- the record was handed over to various agencies as a contemporaneous record as vital evidence to be used in forthcoming inquiries;
- the written clinical record content is at variance with the witness statements of the family of Mr. X.

The Independent Investigation Team asked the author of the clinical record directly whether or not the content of the clinical record had been fabricated. This was strongly denied. However it is unfortunate that the circumstances regarding the creation of the record was concealed, either knowingly or unknowingly, and had to be brought to light by an inquiry process. This raises an inevitable doubt which cannot be removed.

14.2.7.3. Conclusions

Between 2003 and 2007 the Avon and Wiltshire Partnership NHS Trust services in Swindon appear to have been in breach of all clinical records and data protection policies. This consistent and persistent failure made a direct contribution to the lack of timely intervention that Mr. X received.

The Independent Investigation Team cannot state with any degree of confidence whether the mismanagement of clinical records was sinister in intent or the result of poor professional standards. It is a fact however that this mismanagement has impacted on the quality of care that Mr. X received and has also left the Trust and Crisis Team Workers vulnerable to accusations of unacceptable practice.

- ***Contributory Factor Number Seven. The mismanagement of clinical documentation over a period of four years made a direct contribution to the lack of timely intervention that Mr. X received.***

- ***Service Issue Number One. The Crisis Team clinical documentation for the period 19 June -10 July 2007 was not contemporaneously made. The entire series of entries were made in breach of Trust policy and procedure guidance and had left both the Trust and Crisis Team workers vulnerable to criticism as a result.***

14.2.8. Clinical Supervision and Staff Competency

14.2.8.1. Context

The external context for this section is the same as that for Section 14.1.10. set out above.

The Trust had a sound policy in place for the period that covers the events of 2007. This policy stated that *'in general, the Trust requires every member of staff to have a minimum of 20 hours identified for personal and professional development each year. Ideally, all those involved in direct patient care should receive a minimum of 40 hours of identified time for personal and professional development each year. In addition, professionally qualified staff should receive an equivalent amount of professional supervision each year... It is therefore recommended that as an absolute minimum standard, staff should receive no less than one hour of Clinical Supervision per month'.*[264]

14.2.8.2. Findings

In Swindon in 2007 the most prolonged period of liaison with the sister was undertaken by a community support worker who was a member of the Crisis Team. She was employed as an Unqualified Social Worker. The Independent Investigation Team was told that the Crisis Team discussed all the cases on their caseload regularly at twice daily handovers and that no single worker ever 'held' a case, however it appears that the Crisis Worker did in fact hold Mr. X's case by default. There is no written record of any Team discussion regarding Mr. X, although the Crisis Worker did record two discussions that she had with the Team Leader about how to proceed. It appears that there was no single person within the Crisis Team who had responsibility for the supervision of the Crisis Worker. Instead a rather *ad hoc* arrangement was in place where access to social workers outside the Crisis Team itself was available on request.

It would appear that this arrangement constituted a breach of the Trust's supervision policy, as the Independent Investigation Team was told that the Crisis Worker did not have an allocated supervisor either within the team, or outside of the team, that had been formally agreed by her Team Manager. The Trust's policy was clear that there should have been an identified supervisory relationship with a formally approved supervisor.

264 Policy and Procedure for Clinical Supervision 2005-2008 P.7

14.2.8.3. Conclusions

The Crisis Worker was an unqualified support worker. This being so a complex case such as the one Mr. X presented with should not have been managed so exclusively by this individual. It is unlikely that formal clinical supervision would have impacted positively upon the management of this case due to the necessary intervals between sessions that would not have worked effectively within the three-week timescale that Mr. X's case ran within.

However it is the view of the Independent Investigation Team that there was a lack of day-to-day supervision for the Crisis Worker regarding this case. A more experienced worker would not have needed to make so many enquires as to how to proceed, for example with the Local Authority Social Work Lead, the Forensic Service and the Vulnerable Adult's Unit. A more experienced worker should have been able to make an assessment and formulate a plan within the specifications set out within the Crisis Team Operational Policy. This should have led to a suitable triaging of the case. This did not occur. In effect the Crisis Worker was allowed to hold this case without any evidence of a sure-footed and professional overview being *in situ.*

- ***Contributory Factor Number Eight. The level of supervision provided to the Crisis Team Worker with regard to Mr. X was not sufficient to ensure that the case was managed in an effective and timely manner in accordance with trust operational policy guidance. As a consequence unacceptable levels of delays occurred and Mr. X's mental health continued to deteriorate.***

14.2.9. Adherence to Local and National Policy

14.2.9.1. Context

The external context for this section is the same as that for Section 14.1.11. set out above. As has been mentioned above in previous sections the Avon and Wiltshire Mental Health Partnership NHS Trust had policies and procedures in place that were of an exemplary standard. These policies and procedures were developed in line with national best practice expectation as should be expected. The thing that sets these policies and procedures apart is the explicit, detailed level of instruction that works on a whole system basis.

14.2.9.2. Findings

Despite the robust nature of the policies and procedures in place at the time it would appear that there was an almost zero level of adherence to them on the part of the clinical staff based within the Swindon Mental Health Community Teams. The NHS Swindon Rapid Improvement Plan, that came into being in the summer of 2009, understood that Swindon-based Community Mental Health Services had not been working at optimum levels for an extended period of time. Trust management structures, service recruitment difficulties and heavy caseloads had all been identified as contributing to this situation. It would appear that the non adherence to policy and procedure could be seen as an additional symptom of a service in crisis.

14.2.9.3. Conclusions

Clinical policies and procedures serve to set out the duty of care of both statutory organisations and the professionals that work within them. When policy and procedure is constructed well a vital safety net is placed beneath the clinical interventions made on behalf of service users.

In the case of Mr. X policy and procedure persistently failed to deliver the standard of service that could reasonably have been expected when set against both national and local best practice expectation. This undoubtedly contributed to the less than effective service response that Mr. X and his family received.

- ***Contributory Factor Number Nine. Trust operational policy and procedure was not adhered to by Swindon-based clinical teams. This ensured a less than effective service response to the management of Mr. X's case.***

14.2.10. Clinical Governance Processes

14.2.10.1. Context

The external context for this section is the same as that for Section 14.1.12. set out above.

14.2.10.2. Findings

The independent Healthcare Commission annual ratings for the Avon and Wiltshire Partnership NHS Trust for 2006/2007 showed that the Trust was fully compliant with 11 out of the 12 Governance Standards set. These standards covered issues such as record keeping and clinical policies and procedures. The Trust met four out of five of the Clinical and Cost Effectiveness Standards set. These standards covered issues such as care planning, clinical supervision, audit and interagency working. The Trust was deemed to be compliant with nine out of nine of the Patient Focus Standards. These standards covered issues such as carer support and information giving. The main areas that the Trust did not fully comply with were those to do with mandatory training and staff development.

As has been mentioned above the Trust had robust clinical policies and procedures in place during this period. Trust Governance and Board reporting processes would appear to have been in line with those of other NHS Trusts.

14.2.10.3. Conclusions

It would appear that the findings of this inquiry partially concur with the Trust compliance ratings as published by the Healthcare Commission. This is not an uncommon occurrence with an investigation of this kind.

Undoubtedly the findings pertaining to a single case cannot be generalised across an entire organisation that encompasses a geographical region as large of that of this particular Trust. It would appear that the Trust was compliant with both corporate and clinical governance processes during the period that Mr. X came to their attention. However it would also appear that these processes, no matter how robust, failed to be effective in the Swindon area as evidenced both by the case of Mr. X and the NHS Swindon analysis and review in the spring of 2009.

It should be remembered that the basic building blocks that constitute care often fall sub-audit. As a result the failure to provide the basic building blocks of care can remain undetected even by the most sophisticated systems until a series of events bring these omissions to light. It is the view of Independent Investigation Team that mental health services in Swindon were working at a sub-optimal level for a period of years. It is a fact that there are some 70 homicides perpetrated each year by individuals who are in receipt of

mental health services, or have been within six months of the homicide occurring. In at least 60% of these cases no direct causal links can be made between any failures on the part of the NHS, the mental state of the perpetrators, and the deaths that occur. In short, homicides perpetrated by people with mental health problems cannot always be prevented, and clinical governance systems cannot serve as a 'magic solution' to guarantee public safety.

That being said it would appear that the tragic events of July 2007 were incidents waiting to happen. Whilst sound clinical governance processes cannot guarantee public safety, processes which have broken down or have ceased to be effective cannot act as the preventative measures that they were designed to be.

14.3. Lincoln Primary Care Medical Services

14.3.1. Context

A General Practitioner or GP is a medical practitioner who provides primary medical services and specialises in family medicine. A General Practitioner treats acute and chronic illnesses and provides preventive care and health education for all ages and both sexes. They have particular skills in treating people with multiple health issues and co morbidities.

Two principles underpin most current English Health Policy and Practice Guidance on the design of effective mental health services. These are:

- Stepped care: the principle of incrementally and systematically increasing the level and complexity of interventions as the severity and complexity of the presented condition increases. A sound service delivery system should therefore include a range of evidence-based interventions that can be matched to different levels of need. These interventions should be provided on the basis of an assessment of the needs of the individual – and may also involve an assessment of the needs of the family – and should be reviewed on the basis of regular re-assessments. This is commonly called stepped care, and is for example incorporated into the Department of Health (CSIP & NIMHE 2008) guidance on Improving Access to Psychological Therapies (IAPT). It

is also implicit in the earlier filter theory approach of Goldberg and Huxley (1980), and the balanced care systems approach of Thornicroft & Tansella (2004).

- Care pathways: the principle of clearly setting out the sequence of assessments and interventions for the main clinical groups or clusters typically using a service. An individual care pathway should show a clear sequence of action for individual service users, sequentially showing the main phases of intervention from initial information, contact and assessment through to differentiated interventions according to need, with care taken on negotiation of transitions between elements of care. The set of care pathways for a service should exhaustively cover all possible categories of users. Hall (2004) gives a useful analysis of care pathways for mental health services from a review of ten integrated care pathways from different United Kingdom mental health providers.

Stepped Care and Care Pathways start with the GP and other services in Primary Care and then, if the 'simpler' forms of treatment fail to improve the patient's symptoms, then referral to Secondary Care provided by a specialist Mental Health Trust follows. This also works the other was round.

14.3.2. Findings

On the 2 December 2002 the Consultant Psychiatrist's Senior House Officer sent a discharge summary to Mr. X's GP a few days after he registered with the Practice. This letter briefly outlined Mr. X's admission to inpatient services under Section 2 of the Mental Health Act (1983) and his subsequent rapid upgrading to a Section 3. The letter went on to explain that Mr. X had been discharged from his Section 3 by a Tribunal and that he had immediately discharged himself from hospital. Very little was mentioned about Mr. X's forensic history and nothing was mentioned about his risk profile[265].

The Practice undertook a clinical assessment of Mr. X following his registration with them on the 25 November 2002 and his current medication requirements were confirmed with specialist services before prescriptions were issued. This was good practice. At this time Mr.

265 Lincolnshire File 1 A PP. 85-86

X was still under the care of his RMO and a Care Coordinator from the Lincoln Community Mental Health Team[266].

On the 5 March 2003 the Consultant Psychiatrist wrote directly to Mr. X's GP. This letter reviewed Mr. X's progress. The Consultant had met with Mr. X the previous day. During this meeting the Consultant had been very frank with Mr. X about the fact that he had a paranoid disorder which had been only been partly managed by antipsychotic medication. The Consultant informed the GP that Mr. X was thinking of moving to Swindon, but that he was planning to review him again in three months time. The Consultant advised the GP to continue to supply prescriptions for Olanzapine 10mg *nocte*[267].

On the 4 August 2003 the Consultant Psychiatrist wrote once again to Mr. X's GP. In this letter he informed the GP that Mr. X had not attended appointments and that he had no choice but to discharge him from his outpatient service. The letter went on to say that Mr. X appeared not to be writing letters of an unpleasant or harassing type. However the GP was advised to contact the Police if it appeared that Mr. X was committing any kind of offence in the future. The letter stated once again the view that Mr. X may be moving to Swindon, and it finished off by suggesting that if the Practice required any support in the future they should refer Mr. X to the sector team for their part of Lincoln and not back to him personally[268].

On the 4 November 2003 the Care Coordinator wrote to the GP to say that Mr. X was to be discharged from the Community Mental Health Team because of his failure to engage. The letter stated that the referral to Swindon Mental Health Services had not been achieved and that if the Practice required help for him in the future they should refer Mr. X to the sector team for their part of Lincoln[269].

At no time did the Practice receive copies of Mr. X's risk profile or CPA documentation. He was discharged into the care of the Practice with the most basic level of information having been sent o them.

266 GP File 2 P. 3
267 Lincolnshire File 1 A P. 88
268 Lincolnshire File 1 A P.90
269 Additional GP records File. P.11

The Practice monitored Mr. X's care whilst he remained with Lincolnshire Mental Health Trust services and prescribed medication as directed by the Consultant Psychiatrist. The Practice continued to prescribe medication following Mr. X's discharge from Psychiatric Outpatient Services and subsequent discharge from the Community Mental Health Team[270].

Between the time of Mr. X's discharge from inpatient services in November 2002 and his removal from the Lincoln Practice's list prescription requests continued to be received, prescriptions issued and subsequently collected. This indicated the patient's probable compliance with treatment and continued prescribing was therefore justified[271].

The Practice became aware in March 2004 that Mr. X had not had a clinical review of either his condition or medication at the Practice for 14 months. There is a record of a telephone consultation that took place between the GP and Mr. X's sister on 25 March 2004. This record detailed the fact that Mr. X was living with his elderly parents in Swindon and that they were bringing him to Lincoln once every month to collect his medication and check his house. It was also recorded that Mr. X's mental state had deteriorated over the previous month. The GP advised that Mr. X's relatives should seek help from a local GP or from psychiatric services in Swindon unless Mr. X was willing to return to Lincoln and be seen by the Practice for assessment, which Mr X would not do. The GP advised that no further medication would be issued to the patient without a clinical review. Subsequently Mr. X's repeat prescription for Olanzapine was discontinued *'until [he] attends for assessment'*[272]. The GP's advice and actions at this time were appropriate as there was nothing else that could have been done for an informal patient living out of the area who refused to engage with the Practice.

The GP wrote to Mr. X on the 10 May 2004 informing him that the Practice was aware that he had not attended for a review[273]. The letter explained that the Practice would no longer be able to provide him with health care if he continued to live elsewhere unless he committed to attend the practice on a regular basis. The letter requested that he register with a GP nearer to his current place of residence which appeared to be Swindon. This approach could be viewed as an example of good practice. The patient received written communication which highlighted the reasons why a review of his condition was needed whilst on repeat

270 GP File 2 PP. 23-24
271 GP File 2 PP. 23-24
272 GP File 2 PP. 22- 23
273 GP File 2 P. 25

medication. It offered continuation of care if he were to attend on a regular basis but recommended registration with a new GP nearer to his current place of residence as an alternative.

The practice did not actively remove Mr. X from their list at this stage which gave him the opportunity to seek further care if he chose to take it. This was also an appropriate course of action for the practice to take as it 'left the door open' to him to access care if he chose to do so. Mr. X did not wish to comply and ultimately the Practice had no choice but to remove Mr. X from their list.

14.3.3. Conclusions

The Practice kept comprehensive contemporaneous records. These included hand-written notes of consultations, copies of all letters and communications with the Lincolnshire Mental Health Trust, computerised records of prescribing, telephone encounters, incapacity for work benefit forms, and a letter to Mr. X. The Practice had a system in place for receiving and reviewing clinical letters from specialist services. These letters were read, acted upon as required and filed chronologically in the patient record. The Practice also had an appropriate repeat prescribing system in place.

It is the view of the Independent Investigation Team that the Practice provided adequate primary care services to Mr. X and exhibited some examples of good practice. The Investigation Team considered whether or not the Practice could have done more to support Mr. X and his family.

Prescribing: Should the Practice have continued to prescribe for Mr. X?

Mr. X was no longer living in Lincoln. The Practice suggested that a clinical review was required on two separate occasions, once in a telephone consultation with the sister on the 24 March 2004 and once in a letter to Mr. X on the 10 May 2004. The Practice also recommended registration with a Swindon-based GP and/or Swindon-based Mental Health Services. The Practice had identified that Mr. X had not attended for review and rightly could not continue to prescribe for him without a face-to-face assessment. The Practice had no power to compel Mr. X to attend for review. It would have been inappropriate for them to continue prescribing without clinical review. It is unlikely that Mr. X would have attended for a face-to-face assessment even if further attempts had been made to invite him.

Should the Practice have informed Lincoln Mental Health Services of their decision to stop prescribing for Mr. X?

It is not a requirement for GPs to inform specialist services of decisions to stop medication for informal patients who have been discharged from psychiatric services. It could be argued that it would be good practice to inform a patient's previous Care Coordinator, or Psychiatrist, over concerns regarding non compliance or signs of relapse. However in case of this kind it would not be usual especially as he was no longer domiciled in the area.

The Consultant Psychiatrist indicated in his discharge letter that he had formed *'an adverse relationship'* with Mr. X and *'it would be better to refer him if necessary to the sector team for your part of Lincoln'*.[274] This effectively told the Practice that the Consultant Psychiatrist did not want further involvement with Mr. X's case. Furthermore, Mr. X was living in another part of the country and not under psychiatric care there either. At this point in time the Practice did not appear to have an address for Mr. X in Swindon. It would therefore have been difficult for the Practice to know who to inform. However, that being said, it is possible that although Mr. X was no longer under the Lincoln Psychiatrist's care if the Practice had contacted him it may have prompted the Consultant to make a proactive contact with services in Swindon.

It is the view of the Independent Investigation Team that the Practice managed Mr. X's case as well as it was possible to do so under the circumstances. At the time of his discharge from inpatient services Mr. X was subject to enhanced CPA. Mr. X was also entitled to Section 117 aftercare. As such the medical management for Mr. X should have been retained by secondary care services and not passed onto primary care at such an early stage. The Independent Investigation Team also noted that the Practice was not made aware of Mr. X's history or risk profile in an appropriate manner. This information appears to have been minimised to the point where it lost all meaning. It is possible that had the Practice been made more fully aware of Mr. X's history they would have taken a different approach to his ongoing monitoring and review.

274 GP File 2 P. 16

14.4. Care Pathway

Mr. X was known to mental health services for a period of some seven years. It can be difficult to apply a root cause analysis technique to multiple interventions that occurred over such a long period of time. When examining every facet of care and treatment in a case of this kind Investigators need to be aware of the dangers of examining evidence with the benefit of hindsight. Investigators must only evaluate interventions based on what was known, or should have been known, to Health and Social Care Services at time care and treatment was being delivered.

On occasion Investigators may be tempted to view any care that has been found to be in some way deficient as representing a definite causal link to an act of homicide. This is not always the case. Deficient care, whilst regrettable, may not have made a contribution. On other occasions critical factors on examination can be disaggregated to such an extent during analysis that nothing can be seen to have made a direct causal contribution to an incident.

In the case of investigations that consider the quality of the care and treatment of mental health service users, causal factors are usually due to acts of omission rather than to acts of commission on the part of health and social care professionals. Another significant factor that has to be constantly in the minds of investigators is that the decision to commit an act of homicide remains that of the service user alone. This decision is sometimes the direct result of a mental illness and sometimes it is independent of it. Sometimes a homicide can be predicted and at other times it cannot be. Sometimes a homicide can be judged as having been preventable and once again, at other times it cannot.

A case of this kind is complicated. A great many lost opportunities appear to have occurred with regard to the management of the care and treatment of Mr. X over a period of seven years. Not all of these, no matter how regrettable, may be seen to have made a direct causal link to the deaths of Mr. and Mrs. X senior in July 2007, however they may definitely be seen to have had a direct causal link to Mr. X's mental illness remaining untreated.

In the interests of extracting the learning the Independent Investigation Team have compiled a care pathway. This pathway charts what *actually* occurred regarding the care and treatment

of Mr. X over a seven year period, and sets alongside it the pathway that *should* have occurred. What *should* have occurred is based on both local and national best practice policy guidance. The Care Pathway identifies the missed opportunities when a different series of actions may have ensured that Mr. X received a more effective approach to the management of his care and treatment. This Care Pathway is set out in full as Appendix Two.

The main intention of taking this approach is to demonstrate the complexity of the case over time and to illustrate how actions of omission, no matter how far in the past, have a ripple effect into the future, and how they also impact one upon the other. It is also a means by which to identify the causal and contributory factors that ensured Mr. X's condition remained only partially treated between 2002 and 2004, and entirely untreated between 2004 and 2007.

The missed opportunities are summarised below. Please read them in conjunction with Appendix Two.

2000-2001. The first missed opportunity to provide care and treatment for Mr. X occurred following his arrest and conviction for stalking and harassment in 2000. Mr. X was interviewed by a Forensic Consultant Psychiatrist on behalf of the Lincoln Court Assessment Scheme. At this time Mr. X was awaiting sentencing. This report described Mr. X's perspective on the events that had led up to his prosecution. The Consultant noted that Mr. X had no previous psychiatric history. He was of the opinion that Mr. X suffered from distorted thinking and a discrete delusional disorder. He recommended a Probation Order and voluntary referral to mental health services. Mr. X did not comply with a voluntary referral and his Probation Officer was unable to change his mind. **Mr. X's condition went untreated.**

3 August 2002. The second missed opportunity occurred following Mr. X's detention in Police custody following his arrest on three Public Order offences. A Mental Health Act (1983) assessment occurred at this time. A delusional disorder was diagnosed. The Forensic Psychiatrist assessed Mr. X as being a risk to others and requiring assessment. The recommendation was that Mr. X should be remanded into custody and that he should remain in a secure environment. The Forensic Psychiatrist's recommendations were not followed and Mr. X was released on bail. **Mr. X's condition remained untreated.**

17 September 2002. A MAPPA referral was made by the Police. It is not clear what happened to this referral, what discussion occurred, or what the outcome was. **The level of Mr. X's risk was not ascertained.**

19 September 2002. The third missed opportunity occurred when Mr. X was admitted to an inpatient ward under Section 2 of the Mental Health Act (1983), following a Section 135 at the instigation of the Lincolnshire Police Force. Mr. X was allocated to a Consultant Psychiatrist on the 'No Fixed Abode' list as he had no GP. This served to fragment the future care of Mr. X as his medical management was separate to that of his care coordination. Mr. X's previous forensic history appears to have been largely discounted at this stage as he passed into the care of general psychiatric services. **Mr. X received a fragmented care and treatment provision where his forensic history and assessments were not incorporated into his care and treatment plan, his risk profile was minimised as a result.**

30 September - 27 November 2002. The fourth missed opportunity occurred during Mr. X's inpatient admission. Mr. X was upgraded to a Section 3 on 26 September 2002 due to his aggression and non-compliance with treatment. He appealed against his detention on three occasions. During this period the care team produced poor quality risk assessments and care plans and this served to minimise the risk that Mr. X presented. As a result Mr. X was given Section 17 leave and on his third appeal the Tribunal assessed him as no longer requiring detention as he had been able to successfully undertake a period of Section 17 leave at his home without incident. As a result Mr. X discharged himself with immediate effect. Mr. X left inpatient services with no care and treatment management plan. **Mr. X left hospital two months after his admission without his mental illness having been successfully treated.**

January - July 2003. The fifth missed opportunity occurred following his discharge. During this period Mr. X received care and treatment from his Consultant Psychiatrist, his Care Coordinator and his GP. All three health care professionals worked in isolation one from the other and the care and treatment that Mr. X received continued to be fragmented. Mr. X failed to attend Outpatient appointments with his Psychiatrist and failed to take part in CPA reviews. Risk assessments and CPA care planning were minimal and incomplete. Mr. X was living in Swindon. No attempt was made to transfer him to Swindon services at this stage, no Section 117 aftercare arrangements were put into place. **Mr. X was effectively allowed to disengage from services and it would appear that services disengaged from him.**

August - November 2003. The sixth missed opportunity occurred during this period. The Consultant Psychiatrist discharged Mr. X because he did not engage. The Care Coordinator failed to initiate a transfer to Swindon Mental Health Services. The Care Coordinator also discharged Mr. X because he did not engage. No assertive follow up was considered. By this stage Mr. X was 'invisible' to the service, despite growing concerns from the Lincolnshire Police and Trust Administrators regarding his obsessive letter writing which had begun once again. The letter writing had been previously identified as a key relapse indicator. **Mr. X was discharged because he lost contact with services and did not engage. These discharges were not managed in accordance with Trust Policy and Procedure.**

4 August 2003- May 2005. In effect Mr. X was discharged to the care of his GP at this time. Mr. X failed to attend for clinical review and as a result the GP Practice ceased to prescribe in May 2005. **Mr. X was no longer receiving treatment from this time.**

Between 2004 and 2007 Mr. X's family sought care and treatment for Mr. X. He refused to register with a GP and refused to consider the notion that he had a mental illness. During this period Mr. X exhibited increasingly difficult and bizarre behaviour. He began once again to write abusive letters, was aggressive and threatened his elderly parents, with whom he was living, with violence. The family of Mr. X were not successful in obtaining help from either Lincoln or Swindon-based services. **Mr. X's mental illness was not treated for the majority of this period, the evidence suggests that his condition deteriorated during this time.**

13 February 2007. The seventh missed opportunity occurred when Mr. X was referred to the Emergency Duty Team by the Swindon Police. No action was deemed necessary by the out of hours service and the case was passed onto the Community Mental Health Team Base. No follow up was undertaken. **This ensured that Mr. X continued to be unassessed and untreated and placed his parents in a continued situation of risk.**

February - June 2007. The family of Mr. X continued to seek help for Mr. X. **His mental illness and behaviour continued to deteriorate.**

19 June - 10 July 2007. The eighth missed opportunity occurred between these dates when Mr. X came to the attention of Swindon-based Mental Health Services. A three-week period

of information gathering ensued. No assessment or triage occurred in timely manner and the Crisis Team did not make adequate use of the information that they had within their possession. This was compounded by Swindon-based Safeguarding Vulnerable Adults systems failing to operate which left Mr. and Mrs. X senior at significant risk. **Mr. X's condition continued to deteriorate and this culminated in the death of his parents.**

It is the view of the Independent Investigation Team that the missed opportunities apparent in the management of the care and treatment of Mr. X were cumulative in nature. Mr. X did not want to engage with services and this was a consistent hallmark of his presentation. The cumulative effects of the mismanagement of Mr. X's case enabled him disengage completely with the final effect of his being rendered 'invisible' to services. This ensured that his mental illness went untreated and that his elderly parents were placed at increasing levels of risk culminating in their deaths.

At any stage had mental health services, either in Lincoln or in Swindon, utilised fully the information available to them at the time Mr. X's Care Pathway could have been retrieved at each of the stages labelled as missed opportunities.

It has long been recognised that service users are at increased risk as they pass from one service provision to another. In the case of Mr. X this appears to have been poorly managed at each stage of his care pathway. As a result Mr. X was never assessed in the context of both his forensic and psychiatric history. In effect he was allowed to reinvent himself anew on a consistent basis and to disengage entirely from mental health services. Mr. X had a profound delusional disorder and this aspect of his care and treatment need was never considered appropriately when developing a management strategy. Mr. X's assertion, aggression and litigatious nature, instead of being understood as part of his delusional disorder, was seen as a justification for not being able to work with him.

As has already been stated, at any stage the Care Pathway as it has been set out above could have been retrieved had mental health services followed a more assertive management strategy. At each stage, whether in Lincoln or in Swindon it is evident that services did not utilise the information that they had available to them in a timely and professional manner and that Mr. X's case was not managed assertively in order to treat his mental illness.

- ***Causal Factor Number One. The Independent Investigation Team assigns direct causality to the poor management of Mr. X's Care Pathway over time to his untreated mental state, this has been determined in the Crown Court to have made a direct contribution to the deaths of Mr. and Mrs. X senior. Mr. X's delusional disorder was partially treated at best and untreated at worst. The nature of his delusional disorder had been assessed on numerous occasions as presenting a significant risk to the safety of other people. That being said no appropriate strategies were put into place, either in Lincoln or in Swindon, to mitigate this risk.***

15. Findings and Conclusions

This has been a complex case to analyse. It has involved conducting a comprehensive investigation into the care and treatment that Mr. X received from three statutory health service providers over a seven-year period. Two main issues provided a consistent challenge to the work of the Independent Investigation Team, the first being the passage of time which hindered the recollection of clinical witnesses, and the second being the poor standard of the information available within the clinical record of Mr. X. In combination these two issues have made the provision of a full analysis difficult.

It must be noted that it is not possible to make comprehensive and generalisable statements about the quality of the care and treatment a statutory health service provides for an entire population when seen through the lens of an individual case. Both the Avon and Wiltshire Mental Health Partnerships NHS Trust and the Lincolnshire Partnership Foundation NHS Trust have been independently assessed by national regulatory bodies as having in place sound governance procedures. This investigation does not wish to discredit the work of either organisation. However in the spirit of learning and in the public interest the Independent Investigation has identified serious failings with regard to the care and treatment that Mr. X received from mental health services over a period of seven years. It is the view of the Independent Investigation Team that these failings were accumulative over time and that each separate failing impacted one upon the other in a 'snowball effect' over the years. It is also the view of the Independent Investigation Team that at any time during this sequence of events the assertive clinical management of Mr. X would have prevented the steady deterioration of his mental illness and the subsequent deaths of both Mr. and Mrs. X senior.

Findings

Mr. X had a severe and enduring mental illness. This had been diagnosed for a period of some seven years prior to the deaths of his parents. Mr. X was a guarded and socially withdrawn individual and had been so all of his life. In 2002 when he came to the attention of the Lincolnshire Partnership NHS Trust this personality trait became a significant barrier to the provision of the care and treatment that he required. Mr. X's refusal to engage was never assertively managed and as a result, even though his clinical presentation did not merit it, he was allowed to lose contact with services. The Independent Investigation Team

acknowledges that it is difficult to work with service users who reject the care and treatment offered to them. However it has long been recognised that this is often the hallmark of individuals such as Mr. X who suffer from psychosis and delusional disorder. National best practice since the 1999 Confidential Inquiry into homicides perpetrated by the users of mental health services has required mental health Trusts to have policies in place to manage actively this kind of situation. Mr. X's refusal to engage was compounded by the fact that clinical systems and safety nets across both geographical location and time persistently failed to operate.

The Independent Investigation Team found a persistent failure on the part of both Mental Health Trusts to provide Mr. X with care and treatment in accordance with either local or national best practice guidance. Frustratingly both Mental Health Trusts had in place clear, concise, fit for purpose clinical policies and procedures during the period that Mr. X was known to them. No sound explanation could be offered to this inquiry to clarify why such an extensive series of policies and procedures failed so completely in relation to every aspect of Mr. X's care and treatment. In mitigation it is known that Mr. X was hostile, suspicious and litigatious in the extreme. However this still does not serve to offer a full explanation as to why his care and treatment was so seriously compromised over time. Systems that failed to work were identified as follows:

Lincoln

The following findings were identified.

1. **Diagnosis.** The Independent Investigation Team found that the diagnosis of delusional disorder was appropriate, based on the clinical evidence available at the time Mr. X received his treatment and care in Lincolnshire. However a disorder of this kind requires a long-term treatment strategy and this failed to occur. Mr. X was allowed to disengage from the service even though he had an enduring mental illness which had been characterised by non compliance, lack of insight and engagement, and associated behaviours. The nature and presentation of Mr. X's condition were not taken into sufficient account and this contributed to the breakdown of his mental health care.

2. **Medication.** It is the view of the Independent Investigation Team that the prescription of antipsychotic medication was appropriate for Mr. X. However the decision to

change from depot to oral mediation was regrettable and this contributed to the breakdown of Mr. X's engagement with mental health care services.

3. **Mental Health Act (1983).** The initial assessment process when Mr. X was first admitted in September 2002 to inpatient services was sound. The subsequent decision to treat Mr. X under Section 3 of the Mental Health Act (1983) was appropriate. Unfortunately on the sudden discharge from his Section 3 by a Mental Health Act Tribunal Mr. X discharged himself from hospital with immediate effect. No care plan was put in place and the duty to provide care under Section 117 of the Mental Health Act (1983) was not achieved. The duty to provide aftercare under Section 117 only ceases once the Primary Care Trust, Strategic Health Authority or Local Authority are satisfied that the person is no longer in need of services. Mr. X was allowed to completely disengage and therefore slip through the safety net of care without any decision formally having been made about his future care and treatment requirements.

4. **Care Programme Approach (CPA).** There was no robust CPA assessment or care planning process in place following Mr. X's discharge from Lincolnshire inpatient services. The extant documentation would suggest a weak approach was taken. The Care Coordinator that was finally allocated to Mr. X was inexperienced and lacking in supervision, this exacerbated the difficulties that ensued regarding the lack of engagement with Mr. X and his gradual withdrawal from the service. The CPA policy in operation at the time was not adhered to with regard to service users who disengage from the service.

5. **Risk Assessment.** Several risk assessments were partially completed; they did not fully illustrate the history and known forensic activities of Mr. X. This had the effect of minimising his presentation and needs, both during his time as an inpatient and also upon his discharge back into the community. The risk assessments did not lead to a dynamic management plan of Mr. X's risk. Multidisciplinary team work was not evident in the risk assessment, the Trust policy in operation at the time stated that this was expected. In the case of Mr. X this contributed to weak assessment and planning as there was no 'pooling' of ideas or understanding of his full risk profile. Another important factor that led to poor risk assessment was the failure to appreciate the importance of Mr. X's lack of engagement. Information sharing between agencies e.g.

Probation, General Practice and Police Services, was poor and also contributed to the minimisation of Mr. X's risk.

6. **Referral and Discharge.** 1) The referral to MAPPA during 2002 was not documented properly. It is not possible to understand why Mr. X was referred or whether this referral was rejected or not. 2) On discharge from inpatient services there was no adherence to Section 117 arrangements, no care plan was developed and no multidisciplinary follow up occurred. 3) The transfer to Swindon never actually occurred; instead an informal communication took place between the Care Coordinator and a Swindon Community Mental Health Team Manager. The Trust policy was not adhered to and this policy stated that all responsibility remained with the originating service until the new one had formally accepted the case. The eventual decision to discharge Mr. X from Lincoln-based services took place in the full knowledge that this decision would sever all links to specialist care and treatment from secondary services.

7. **Carer and Service User Experience.** Mr. X's carers were communicated with sporadically. We understand that Mr. X did not give his permission for ward staff to talk to his parents and that this is a very difficult area for services to navigate. However Mr. X's parents were elderly and Mr. X did present a significant risk, this should have been considered, also their needs as carers should have been considered with special regard made to the fact that they had to travel with their son on a regular basis between Swindon and Lincoln in order to obtain his medication.

8. **Clinical Supervision.** In Lincolnshire Partnership Trust there was a supervision policy which made clear that all staff who were involved in direct patient care should have both management supervision and practice supervision. In 2003 in Lincolnshire Mr. X's second Care Coordinator, was a newly appointed community nurse who had until then worked in one of the local inpatient wards. It would appear that he received no clinical supervision until December 2003. It appears that the community mental health team in Lincoln was operating outside of the Trust's supervision policy in allowing an inexperienced and relatively junior member of the team to carry the responsibility for the care coordination of a service user on enhanced CPA who was disengaging from the service.

9. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This occurred persistently over a seven-year period regardless of which agency or service Mr. X was involved with.

Lincolnshire Partnership Foundation NHS Trust Contributory Factors

- ***Contributory Factor Number One.*** The clinical Team did not take sufficient account of the nature and presentation of Mr. X's mental disorder and this contributed to the breakdown of Mr. X's clinical care. This had both short-term and far reaching consequences.

- ***Contributory Factor Number Two.*** The decision to change from depot to oral medication contributed to the breakdown of Mr. X's engagement with mental health care.

- ***Contributory Factor Number Three.*** It is the view of the Independent Investigation Team that Mr. X's medical management was not optimal and was a key contributory factor in the breakdown of his mental health care provision.

- ***Contributory Factor Number Four.*** The aftercare needs of Mr. X were not adequately followed up via the provision of Section 117. This ensured that there was no statutory form of supervisory arrangement in place, as a result mental health services lost contact with Mr. X.

- ***Contributory Factor Number Five.*** Failure to implement the Care Programme Approach ensured that Mr. X was not appropriately assessed and was not in receipt of an appropriate care, crisis or contingency plan. As a result his care and treatment was entirely compromised and this lack of clinical management ensured that he slipped through the safety net of care.

- ***Contributory Factor Number Six.*** The failure to complete multidisciplinary risk assessments in the full context of Mr. X's forensic and psychiatric history meant that

he remained an 'unknown' quantity. As a consequence the care and treatment that he received was not fit for purpose. This had a long-term detrimental effect on his future mental health.

- ***Contributory Factor Number Seven.*** The non-adherence to Trust policy and procedure guidance led to an ineffective attempt to transfer Mr. X to Swindon-based services. This had the long-term effect of allowing an individual with a long-term enduring mental illness to slip through the safety net of care.

- ***Contributory Factor Number Eight.*** Lincolnshire Services did not work with the family of Mr. X in accordance with Trust policy and procedure guidance. As a consequence this placed Mr. X's elderly parents in a situation that they were ill equipped to manage, and consequently this was to impact negatively on the mental health of Mr. X.

- ***Contributory Factor Number Nine.*** Mr. X was allowed to disengage from services. Trust policy and procedure was not adhered to and as a consequence Mr. X's mental illness was to go untreated for a period of four years.

- ***Contributory Factor Number Ten.*** The different agencies and services involved with Mr. X over a period of seven years did not work in a system that facilitated interagency working. As a result the required levels of management and supervision of Mr. X's case did not occur.

- ***Contributory Factor Number Eleven.*** Mr. X was both complex and challenging. The lack of clinical supervision afforded to the Care Coordinator compounded the difficulties that he faced in managing the case.

- ***Contributory Factor Number Twelve.*** The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical team ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to his future mental health.

13.3.2. Avon and Wiltshire

1. Management of the Case in Swindon

This area needs to be divided into two separate episodes.

- **2003.** The Care Coordinator in Lincolnshire spoke to a Swindon Community Mental Health Team (CMHT) Manager over the telephone and also wrote to him on two occasions to arrange for Mr. X's case to be transferred between the Lincolnshire mental health services to those in Swindon. Mr. X was at this time eligible for Section 117. It was agreed over the telephone that Mr. X's records would be sent to the Community Mental Health Team Manager and that Swindon Services would discuss how best to manage the case. The Lincolnshire records noted that Swindon did not want to accept the referral but that it had been agreed that the notes would be kept on file at the Swindon CMHT base in case Mr. X required future interventions. This was clearly an inadequate response. During the Independent Investigation Swindon witnesses stated that no letters or clinical records were ever received. No records of this episode can be found within the Trust. It is the view of the Independent Investigation Team that Mr. X's care transition was poorly managed at this stage.

- **June 2007.** The sister of Mr. X tried to access help for her brother from the Swindon Crisis Team. On the 19 June the sister spoke to a Crisis Team Worker over the telephone. This led to the Crisis Team Worker contacting Mr. X's Lincolnshire Consultant Psychiatrist's Secretary. The Secretary sent a fax directly which contained some letters and a medical report from a previous Mental Health Act (1983) Tribunal. A copy of Mr. X's entire clinical record followed on the 26 June 2007. The Independent Investigation Team was told that these records remained unread. These records clearly contained Mr. X's past history and risk. It is the view of the Independent Investigation Team that had these records been read in a timely manner Mr. X's case would have been managed differently.

2. **Liaison with Lincolnshire Trust and Transfer Process.** Liaison with Lincolnshire Services was not managed in a proactive manner either in 2003 or in 2007. At no time did anyone from the Swindon Service contact the Lincolnshire Consultant Psychiatrist directly to ascertain more details about Mr. X. On two separate occasions the Trust received and held sufficient information of a nature that should have led to a direct communication. This did not occur. The Independent Investigation Team has found

that Avon and Wiltshire Partnership Mental Health Trust did not act appropriately concerning a patient subject to Section 117 living in their area.

3. **Mental Health Act.** Swindon-based services did not initiate an assessment under the Mental Health Act (1983) in an appropriate or timely manner.

4. **Adherence to Operational Policy and Use of the Mental Health Act (1983).** It would appear that Mr. X's case was wrongly picked up by the Crisis Team, the case would have been more appropriately allocated to the CMHT. The Crisis Team struggled with the idea of conducting a Mental Health Act (1983) assessment as it was not part of their operational policy to do so, however they retained the case as they *'did not want to drop the baton'*. This resulted in Mr. X's case remaining with the Crisis Team for a period of 22 days during which time no visit was made, no assessment was undertaken and no plan was actually formulated.

5. **Assessment of Risk and Forensic History.** It would appear that the Crisis Team did not take the sister's concerns about her brother seriously. This is because there was not enough information available to the Team in the first instance. However, even when this information did become available, no one took responsibility for arranging the appropriate assessment that the records would have indicated. It is a fact that the records were with the Crisis Team for a period of 16 days without being taken into full account.

6. **Liaison with the Family of Mr. X and Vulnerable Adult Safeguarding measures.** The accounts made available to the Independent Investigation Team from the sister of Mr. X and the Crisis Team vary, however the Independent Investigation Team find that the family were not consulted with appropriately and that the Crisis Team appeared to advocate for Mr. X as a default position without ever having met him or read his clinical records. Vulnerable Adult issues were identified by the Crisis Team but not actioned in a timely manner. This omission ensured that Mr. and Mrs. X senior remained in a situation that presented a significant risk to them.

7. **Documentation and use of Clinical Records.** The Independent Investigation Team has serious concerns regarding the maintenance, storage and clinical use of clinical records in that:

    - the Trust would appear to have lost Mr. X's records sent to them in 2003;

- communications with the Trust between 2003 and 2007 regarding Mr. X do not appear to have been recorded;
- the Trust did not make the appropriate use of acquired clinical records in June 2007;
- the records in Mr. X's file do not appear to have been entered contemporaneously thus giving rise to serious doubts about what actually occurred between the 19 June and the 10 July 2007.

8. **Supervision and Staff Competency.** Although this case was 'held' by the Crisis Team the case was in reality allocated to one Crisis Team Worker. The Independent Investigation Team heard that this Crisis Worker was unqualified but was supervised within the Team. Each case was fully discussed by the Multi Disciplinary Team on a regular basis, however it would appear that the Crisis Worker was allowed to attempt to formulate a plan for this case on her own. She was inexperienced and not qualified to do so. The Independent Investigation Team are of the view that significant delays occurred because the Crisis Worker was uncertain how to proceed and that a more experienced person would have acted more decisively.

9. **Performance of Community Services.** The Independent Investigation Team have found that many of the issues identified by NHS Swindon in June 2009 regarding the performance of Avon and Wiltshire Mental Health Partnership NHS Trust services in Swindon are pertinent to the Mr. X investigation, namely:

    a. unanswered telephones;

    b. difficulty making referrals or getting people admitted into the services;

    c. difficulties in accessing services if a person has no GP;

    d. poor case allocation and skill mix;

    e. difficulty in referrers being signposted to appropriate services.

10. **Care Pathway.** The care pathway that Mr. X should have followed was not the one that he actually followed. This meant that both national and local policy, procedure and good practice were not followed. This persistently occurred over a seven year period regardless of which agency or service Mr. X was involved with.

Avon and Wiltshire Mental Health Partnership NHS Trust Contributory Factors

- ***Contributory Factor Number One.*** Mr. X failed to receive appropriate referral and/or transfer responses from Swindon Mental Health Services on three separate occasions over a four-year period. This meant that he did not receive the care and treatment that he required.

- ***Contributory Factor Number Two.*** No assertive action was taken to initiate a Mental Health Act (1983) assessment. As a consequence Mr. X's mental illness continued to deteriorate and he did not receive the care and treatment that he required.

- ***Contributory Factor Number Three.*** The Crisis Team failed to assess Mr. X in the context of his known risk. This led to a critical delay in the assessment of his mental health.

- ***Contributory Factor Number Four.*** The clinical leadership structure, both at corporate and local team level, was unable to ensure an acceptable standard of care delivery to Mr. X. This led to critical delays and ensured that his mental health continued to deteriorate.

- ***Contributory Factor Number Five.*** Swindon-based services did not adhere to Trust operational policy guidance regarding referral. As a consequence Trust services presented an impenetrable barrier through which it was impossible for Mr. X's case to be successfully referred by any external agency.

- ***Contributory factor Number Six.*** Communication, consultation and liaison with the family of Mr. X did not provide the assistance that they needed in an appropriate and timely manner. The fact that the parents of Mr. X were vulnerable adults did not trigger the appropriate safeguarding processes. As a result the parents of Mr. X were placed in a position of unacceptable risk.

- ***Contributory Factor Number Seven.*** The mismanagement of clinical documentation over a period of four years made a direct contribution to the lack of timely intervention that Mr. X received.

- ***Contributory Factor Number Eight.*** The level of supervision provided to the Crisis Team Worker with regard to Mr. X was not sufficient to ensure that the case was managed in an effective and timely manner in accordance with trust operational policy guidance. As a consequence unacceptable levels of delays occurred and Mr. X's mental health continued to deteriorate.

- ***Contributory Factor Number Nine.*** Trust operational policy and procedure was not adhered to by Swindon-based clinical teams. This ensured a less than effective service response to the management of Mr. X's case.

- ***Service Issue Number One.*** The Crisis Team clinical documentation for the period 19 June -10 July 2007 was not contemporaneously made. The entire series of entries were made in breach of Trust policy and procedure guidance and have left both the Trust and Crisis Team workers vulnerable to criticism as a result.

Joint Trust Findings

Causal Factors

Causal Factor Number One. The Independent Investigation Team assigns direct causality to the poor management of Mr. X's Care Pathway over time to Mr. X's untreated mental illness. It was determined in court that Mr. X's mental state directly influenced the deaths of Mr. and Mrs. X senior. Mr. X's delusional disorder was partially treated at best and untreated at worst. The nature of his delusional disorder had been assessed on numerous occasions as presenting a significant risk to the safety of other people. That being said no appropriate strategies were put into place, either in Lincoln or in Swindon, to mitigate this risk.

Conclusions

Local and National policy and procedure guidance is in place to provide a safety net under both the care of service users and the practice of health and social care professionals. Whilst

on occasions there may be a requirement to deviate from formal guidelines this should only be done in a considered manner were the rationale has been discussed and recorded as a multidisciplinary team. In the case of Mr. X, policy and procedure was systematically ignored to the detriment of safe and effective patient care.

Mr. X had a well-documented risk profile developed by Lincolnshire Police Services. This risk profile was minimised by both Lincoln-based and Swindon-based Mental Health Services. It is the view of the Independent Investigation Team that whilst the deaths of Mr. and Mrs. X senior could *not* have been predicted, it *was* possible to predict that Mr. X was capable of acts of violence when his mental health broke down. It was evident that Mr. X's mental health had indeed broken down in 2007 and that the risk to those around him was significant as a result.

Whilst the deaths of Mr. and Mrs. X senior may not have been predictable, the deterioration in Mr. X's mental health which directly contributed to their deaths was most definitely preventable had it been managed in a professional and robust manner. It is the finding of this Independent Investigation that there is a direct causality between the inadequate management of Mr. X's care and treatment over a seven-year period and the deaths of Mr. and Mrs. X senior. Both the Avon and Wiltshire Mental Health Partnership NHS Trust and the Lincolnshire Partnership Foundation NHS Trust failed to deliver the required standard of care and treatment to Mr. X.

16. Lincolnshire Partnership NHS Foundation Trust's Response to the Incident and Internal Investigation

The following section sets out the Trust response to the events of July 2007. It also sets out the view of the Independent Investigation Team with regards to how effective the Internal Investigation Panel was in conducting its work. The Independent Investigation Team acknowledges the fact that the Lincolnshire Partnership Foundation NHS Trust has experienced few incidents of this kind before and that the requirement to manage an Internal Investigation of this nature was something that was largely outside of its experience. The following comments are intended to provide helpful feedback whilst offering a contextual background to assess the progress the Trust has made against the action plan developed from the findings of its own internal investigation.

16.1. The Trust Serious Untoward Incident Process

The Trust policy in place at the time of both the incident and the Internal Investigation was designed to '*assist all staff with the identifying, reporting and management of all incidents that affect the Trust's services and the Service Users, staff members and public in the delivery of Trust business.'* It is the view of the Independent Investigation Team that this policy was comprehensive and provided a sound framework for all Trust personnel.

This policy was developed in order to conduct internal investigations in accordance with HSG (94) 27 and National Patient Safety Agency guidance. This policy stated that the intention of undertaking investigations was not to apportion blame but to create a culture of safety and openness. This is to be commended.

The policy set out guidance as to how incidents should be graded according to severity. Three main categories served to assess the appropriate level of investigation that would be required. In order to identify the appropriate incident category a standard 'Likelihood of Occurrence/Impact' grading tool was recommended.

1. **Category yellow and green incidents.** These incidents represented relatively low risk situations which in many instances would lend themselves to an aggregate review. It was recognised that individual investigations would be required on occasions according to particular circumstances.

2. **Category amber incidents.** The policy stated, *'as a guide less time should be expended on investigating category amber incidents than for category red incidents. However an attempt must be made to identify root cause(s) but this will be on a smaller scale than for category red incidents.*

3. **Category red incidents.** Homicides committed by servicer users of the Trust were allocated to this category. The policy stated that *'all category red incidents must be the subject of a full root cause analysis investigation.'*

All investigations were expected to:

- identify good practice;
- identify reasons for substandard performance;
- identify underlying failures in management systems;
- learn from incidents and make recommendations;
- implement improvement strategies to help prevent, or minimise recurrences thus reduce future risk of harm;
- satisfy mandatory and reporting requirements.

In order for this to be achieved the policy recommended that investigations needed to be led by individuals with the status and knowledge to make authoritative recommendations. For most yellow and green graded incidents these individuals were identified as being at Team Leader level. Amber graded incidents were identified as needing to be at General or Service Manager level. Red graded incidents were identified as requiring the leadership of a Trust Non-Executive Director supported by risk, management and clinical advisors as deemed appropriate.

16.2. The Trust Internal Investigation

The incident was not initially made known to health services in Lincolnshire because Mr. X had been discharged from mental health services since November 2003. Once the incident was made known the Trust agreed with the Strategic Health Authority that a peer review be undertaken of the care and treatment provided to Mr. X. The Internal Investigation Report was commissioned by the Trust Director of Nursing and Strategy. It would appear that the review was graded and managed as an amber incident even though it would have been normal practice for a homicide to have been graded as red. This appears to have been because the incident did not meet the HSG (94) 27 guidance. The guidance states that homicides are regarded as requiring NHS investigation when a service user has been in receipt of mental health services within a six month period of the incident occurring. In the case of Mr. X the interval between his discharge and the incident was four years. Therefore it was not unreasonable for Lincolnshire services to proceed with caution. The Internal Investigation was completed on the 3 April 2008 independently of any contact with Avon and Wiltshire mental health services.

The Internal Investigation Panel comprised the following personnel:

4. the Trust Risk Control Manager who served as the Investigation Lead;
5. a Trust Consultant Forensic and Clinical Psychologist;
6. a Trust Assessment and Care Planning Coordinator.

It is the view of the Independent Investigation Team that the Internal Panel would have benefitted from the membership of a Psychiatrist. Many of the issues regarding the quality of the care and treatment that Mr. X received revolved around medical management. These issues were not explored within the internal investigation report and this should have been made more of priority in the interests of learning lessons.

The Terms of Reference were to:

- review the healthcare records of Mr. X;
- establish the care and treatment provided between October 2002 and November 2003;
- review the discharge procedure for transferring Mr. X to Swindon.

It is the view of the Independent Investigation Team that the terms of reference did not enable the Internal Investigation Panel to explore fully all of the necessary clinical aspects of the care and treatment that Mr. X underwent. The terms of reference should have been both more comprehensive and explicit. As a result the subsequent findings tend to be 'two dimensional' in that they focus on the actions of individuals alone and do not explore the systems in which they worked. Consequently issues such as history taking, risk assessment, care planning and service user disengagement do not feature within the Trust findings. This is to the detriment of the possible learning that could have been achieved.

Methodology

The Panel conducted a desktop review of the healthcare records relating to Mr. X's inpatient stay and follow up in the community. Interviews were conducted with the Community Psychiatric nurse who became Mr. X's Care Coordinator in April 2003, and clinical practice was reviewed against the Trust policies current during the time of contact with Mr. X.

It is not clear why the Internal Investigation Panel chose only to interview a single clinician. By selecting a single individual it would appear that the Panel had already made assumptions as to where the key issues were prior to conducting a full and objective inquiry process. It would appear that a supposition had been made as to the key critical juncture being Mr. X's failed transfer to Swindon-based Mental Health Services. This served to prevent the analysis of Mr. X's risk assessment history, his CPA management, his disengagement when seen through the lens of his diagnosis and the Trust's failure to adhere to its own policy and procedure guidance. Too much emphasis was placed on a single part of his care pathway for organisational lessons to be learned.

Key Findings

1. *'The key principles of the Care Programme Approach and Section 117 were outlined within the policies that were current at the time of contact with Mr. X. These were not followed by either the inpatient or the community teams involved in the episode of care.*

2. *A current Section 117 register did not appear to have been accessed neither were actions followed up when Mr. X moved away from Lincolnshire*

3. *During the attempted transfer [to Swindon] the clinician was not in receipt of supervision. Hence the transfer process was not adequately managed.'*[275]

Lessons Learnt

- *'Consideration should be given for an appropriate forensic assessment by relevant services in such cases where initial risk assessment indicates more specialist assessments are required.*

- *The section 117 register needs to be updated and audited on a regular basis to ensure that all service users eligible are reviewed regularly.*

- *When information is forwarded to another area to ensure receipt, either by a letter of acknowledgement or file note within the record.*

- *Where service users are discharged/transferred documentation should clearly evidence the transfer of responsibility.*

- *The supervision policy should be followed for all staff to enable them to share their difficulties.'*[276]

The Independent Investigation Team would agree that some of the identified findings and lessons learned as set out above are both relevant and useful. However once again we would feedback the observation that the Internal Investigation did not provide an inquiry process that was sufficient in its depth and its breadth to have provided a systematic and comprehensive review. Consequently important learning did not take place and remedial actions could not be addressed in a timely manner. Important issues that were not explored include the following:

- use of the Mental Health Act (1983);
- risk assessment and forensic history;
- interagency working;
- role of the Care Coordinator;
- carer assessment and support;

275 Lincolnshire Internal Investigation Report. P.3
276 Lincolnshire Internal Investigation Report. P. 7

- service user disengagement.

It was difficult to understand whether or not the Internal Investigation Panel was of the view that had the care and treatment of Mr. X been managed differently that this may have affected the outcome of the events of July 2007. Although the Internal Investigation Report is described as being a 'Desktop Root Cause analysis' it is not possible to understand whether any root causes were discovered or not.

Identified Good Practice

1. *'On admission to hospital Mr. X was not registered with a General practitioner. This was facilitated and Mr. X remained with the GP throughout the episode of care.*

2. *A discharge summary was forwarded to the General practitioner following the inpatient stay.*

3. *A letter was written to the General Practitioner outlining concerns regarding Mr. X moving away from the Lincolnshire area.*

4. *The Care Coordinator tried to discuss the transfer of care from LPT to Swindon between August and September 2003.*

5. *Following a request from outside Lincolnshire, immediate documentation was forwarded within two working days and a full copy of the medical reports posted within four working days.'*[277]

16.3. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients

277 Lincolnshire Internal Investigation Report. P.8

and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

At the time the Trust conducted their Internal Investigation robust *Being Open* guidance was available as part of a clear and concise toolkit which was appended to the Trust Incident Reporting Policy. The usual Trust process is to meet with both victim and perpetrator families and to share the findings of any internal investigation.

The Investigation into the care and treatment of Mr. X departed from the usual Trust procedure for several reasons. First, both NHS East Midlands (the Strategic Health Authority) and the Trust were uncertain whether or not this was actually an incident that required investigation as it did not fit HSG (94) 27 guidance. Second, NHS East Midlands rapidly emerged as the lead organisation in the management of this case. As such NHS East Midlands became the information and liaison centre dedicating a Senior Officer for this purpose. NHS East Midlands have ensured that all aspects of the *Being Open* guidance have been met on behalf of the Trust. This degree of coordination has been necessary due to the complexity of the case and the multiple agencies involved in the provision of care and treatment to Mr. X. The family of Mr. and Mrs. X senior have had the Internal Investigation report shared with them.

16.4. Staff Support

Only one member of staff was interviewed as part of the Trust Internal Investigation. This individual did not recall receiving any support in preparation for his contribution to this process. Neither did this individual receive a copy of the Trust Internal Investigation Report. At the time this individual was interviewed by the Independent Investigation Team he still had not seen a copy of the internal review and remained unaware as to what either the findings or recommendations were.

The Independent Investigation Team interviewed 22 Lincolnshire Partnership Foundation NHS Trust staff. All of these individuals received high levels of support from the Trust throughout all stages of the Independent Investigation process.

16.5. Trust Internal Review Recommendations

The Trust Internal Investigation set out the following recommendations:

1. *'For any service that is assessing an individual, even if it is for assessment only, a healthcare record should be opened, both on paper and electronically.*

2. *For any service to ensure receipt of arrival is recorded when forwarding patient related data. This could be either by letter of acknowledgement, or a file note that has the date and time of the telephone conversation.*

3. *For all services to document clearly the transfer or discharge of a service user. This includes the transfer or discharge from individuals, teams, or areas.*

4. *For an annual audit to be undertaken on Section 117 Aftercare, to ensure that the information is still current.*

5. *For all practitioners to raise with their supervisors, any barriers to transfer that might be met. The practitioner should be supported to escalate this through the organisation, if appropriate.'*[278]

278 Lincolnshire Internal Investigation Report. P.7

16.6. Progress against the Trust Internal Review Action Plan

The Lincolnshire Partnership Foundation NHS Trust has been successful in implementing fully the recommendations identified from the findings of their Internal Investigation process.

Recommendation Number One. *For any service that is assessing an individual, even if it is for assessment only, a healthcare record should be opened, both on paper and electronically.*

- **Action Agreed.** All Trust clinical staff were to be notified via service meeting structures of the recommendation and the required changes to the CPA policy made. Policy changes were to be incorporated into the Trust CPA audit tool.
- **Action End Date.** March 2009.
- **Evidence of Completion.** Annual audit results and minutes of operational meetings.

Recommendation Number Two. *For any service to ensure receipt of arrival is recorded when forwarding patient related data. This could be either by letter of acknowledgement, or a file note that has the date and time of the telephone conversation.*

- **Action Agreed.** All Trust clinical staff were to be notified of the recommendation via service meeting structures and the required changes to the CPA policy made. Policy changes were to be incorporated into the Trust CPA audit tool.
- **Action End Date.** March 2009.
- **Evidence of Completion.** Annual audit results and minutes of operational meetings.

Recommendation Number Three. *For all services to document clearly the transfer or discharge of a service user. This includes the transfer or discharge from individuals, teams, or areas.*

- **Action Agreed.** All clinical staff were to be reminded through service meeting structures of the Section 117 Policy requirements. The Section 117 Policy was to be incorporated into the Trust clinical audit programme.
- **Action End Date.** March 2009.
- **Evidence of Completion.** Annual audit results and minutes of operational meetings.

Recommendation Number Four. *For an annual audit to be undertaken on Section 117 Aftercare, to ensure that the information is still current.*

- **Action Agreed.** An audit tool was to be developed for annual implementation.
- **Action End Date.** March 2009.
- **Evidence of Completion.** Annual audit results and minutes of operational meetings.

Recommendation Number Five. *For all practitioners to raise with their supervisors, any barriers to transfer that might be met. The practitioner should be supported to escalate this through the organisation, if appropriate.*

- **Action Agreed.** The clinical supervision policy was to be implemented on a more formal basis, and this implementation was to become the subject of an annual audit.
- **Action End Date.** March 2009.
- **Evidence of Completion.** Annual audit results and minutes of operational meetings.

17. Avon and Wiltshire Mental Health Partnership NHS Trust's Response to the Incident and Internal Investigation

The following section sets out the Trust response to the events of July 2007. It also sets out the view of the Independent Investigation Team with regards to how effective the Internal Investigation Panel was in conducting its work.

17.1. The Trust Serious Untoward Incident Process

At the time of the incident the Avon and Wiltshire Mental Health Partnership NHS Trust had a Serious Adverse Incident Policy in place that was comprehensive and fit for purpose. This policy set out clearly the roles and responsibilities of all Trust staff operating at all levels. The main objective of the policy was to ensure that safety was maintained across the Trust at all times.

The Trust policy advocated the notion of 'fair blame'. The policy stated that *'it is impossible to completely remove the possibility that the fault may lie with an individual but the policy makes it clear that an event will be properly analysed before the organisation concludes what caused it to occur.'*[279]

17.2. The Trust Internal Investigation

The Trust Internal Investigation was completed in April 2008. The Internal Investigation Panel set out the difficulties that they had encountered during the investigation and noted that there was a significant difference of both the recollection and perception events between the family of Mr. and Mrs. X senior and Trust service personnel. The Panel were also of the view that it had access to 'very little documentation'. At the time the report was written it was the view of the Avon and Wiltshire Mental Health Partnership NHS Trust that Mr. X had not been formally under their care.

279 Serious Adverse Incident Policy 2006-2009. P. 3

It is the view of the Independent Investigation Team that the Trust Internal Investigation was well-managed and produced a report with findings and recommendations that were comprehensive and robust.

17.2.1. The Internal Investigation Panel comprised the following personnel:

- the Trust Medical Director in post at the time (Investigation Lead);
- the Area Manager for Adults of Working Age, Wiltshire.

The Panel had received prior training in order to be able to undertake the investigation and also had access to additional Trust-based expertise as required.

17.2.2. The Terms of Reference

The Internal Investigation process followed a root cause analysis methodology and was described within the report as providing a sequence of actions that would:

- *'Scope the incident, obtaining as much information as possible.*
- *Generate hypotheses about why the incident happened (the immediate cause).*
- *Investigate the hypotheses.*
- *Determine if there were any care delivery problems, including any missing or inadequate safeguards.*
- *Determine if there were service delivery problems, including any missing or inadequate safeguards.*
- *Identify the factors contributing to the identified care and service delivery problems.*
- *Analyse the contributory factors to determine if the event would have happened if the factor had not been present. Any factors where the answer is 'no' are considered to be root causes.*
- *Make recommendations aimed at ensuring that the identified root causes cannot become root causes for another incident. The recommendations will aim to improve or implement safeguards.*

The methodology set out above served as the terms of reference for the investigation.

17.2.3. Methodology

The Internal Investigation followed a root cause methodology as set out directly above. The following meetings and interviews were held:

- preparatory meeting of the Internal Investigation Panel;
- interviews with individual members of staff;
- meeting with the sister of Mr. X;
- meeting with the Swindon Crisis Team;
- final panel meeting.

Additional expert advice was sought by the Internal Investigation Panel from the Trust Director of New Ways of Working (a Trust Consultant Psychiatrist), Director of Psychology and the Director of Special Projects.

17.2.4. Key Findings

At the time of writing the Internal Investigation report Mr. X had been charged with the murder of his parents but the case had not yet come to court. The Internal Investigation Panel did not have access to any information regarding Mr. X's mental state following his arrest but were of the view that as he had a history of a paranoid psychosis he was probably suffering from paranoid psychosis at the time of the offence and that his mental state directly influenced his actions at the time of the offence. Consequently the Internal Investigation findings focused on understanding the reasons why Mr. X had not been in receipt of services at the time of the incident. The findings were as follows (please note we have omitted any findings that the Avon and Wiltshire Internal Investigation made regarding the appropriateness of care delivery in Lincolnshire as these findings were not theirs to make):

Care Delivery Problems (e.g. acts or omissions arising directly from care provision and usually directly attributable to staff members). Please note the Independent Investigation Team have summarised the findings:

1. **Listening and responding to the family.** This did not occur in such a way that responded to the family's concerns against the context that Mr. X appeared to be presenting with.

2. **Registration with a GP as a requisite for access to treatment.** Swindon-based Community Mental Health Team and Crisis Team Operational policies do not preclude an assessment being undertaken for an individual who does not have a GP. This should not have been seen as a barrier to service provision.

3. **Transfer of care.** This was poorly managed. Mr. X was never discharged from Section 117 aftercare and therefore remained subject to statutory aftercare throughout the period [2004-2007] in which he did not receive any.

4. **Communication between the Swindon Emergency Duty Team and the Crisis Team.** It would appear that the Emergency Duty Team did not communicate the issues discussed with the sister of Mr. X on the 13 February 2007. This was a departure from their usual practice. It was not clear why this omission appeared to take place but it was a critical omission on this occasion in that vital information about risk was not communicated to the appropriate team.

5. **Assessment of risk by the Duty Social Worker Team.** It is not clear from the brief documentation how much information was elicited from the sister of Mr. X regarding his psychiatric history. It is unclear whether the sister of Mr. X was informed of the right of the nearest relative to request a Mental Health Act (1983) assessment.

6. **Communication between the family and the Crisis Team June-July 2007.** There appears to have been a significant degree of miscommunication between the team and the sister of Mr. X. Crucially the sister of Mr. X recalls telling the Crisis Team that Mr. X had been previously violent towards her parents; this was not recorded in the clinical record.

7. **Information gathering when taking referrals.** The information documented by both the Emergency Duty Team and the Crisis Team was overly brief and yet crucial decisions appear to have been made on the basis of what had been recorded.

8. **Documentation of contacts.** The documentation of contacts appears to have been managed poorly. This is evident in that the contact between Lincolnshire and

Swindon services was not recorded in the Swindon files, and neither were key contacts that were made by the family of Mr. X over a period of time.

Service Delivery Problems (e.g. acts or omissions not associated with the direct provision of care):

1. **Lack of clarity about responsibility for individuals who are not registered with general practitioners.** This occurred as a theme throughout the care and treatment of Mr. X. It was evident that services did not know how to respond to somebody who was not registered.

2. **Transfer of care.** Protocols for the transfer of care between services when users move from one part of the country to another were not followed.

Identified Contributory Factors

- **Patient and Individual Factors.** Throughout his adult life Mr. X avoided engagement with health services. His life was characterised by social withdrawal. These personal characteristics meant that no one got to know Mr. X and his mental state was not well understood.

- **Task Factors:**
  - **Risk Assessment.** Much of the information required to inform a good risk assessment was not available and no one appears to have conducted a good risk chronology.
  - **Referral Information and History Taking.** A systematic approach to eliciting history and current behaviour was not apparently undertaken by either the Emergency Duty Team or the Crisis Team so the information available was not as full as it might have been. Decisions about the timing of possible Mental Health Act (1983) assessments were made without full information on Mr. X's current state and past risk indicators.

- **Communication Factors.** There were a number of communication difficulties between Swindon-based services and the sister of Mr. X. This meant that care was not

given to Mr. X at the right time. This also meant that assessment information was not available to team members.

- **Education and Training Factors.** It is a well known fact that interfamilial violence is more common when a family member has a psychotic delusional state. Individuals in the Emergency Duty Team and Crisis Team need to understand the significance of different psychotic symptoms and the importance of very good history taking.

- **Organisational and Strategic Factors:**
  - **Responsibility for transfer of care between agencies.** There was an inadequate transfer of care for Mr. X when he moved to Swindon. The Avon and Wiltshire policy for transfers of care is in line with the National Guidance *'Good Practice for Transfer of service User Care between Mental Health Districts'.* The Trust policy states that care remains the responsibility of the original service until a formal handover has occurred. There was no formal handover.
  - **The responsibility for individuals not registered under primary care.** All agencies must understand that secondary mental health services and Emergency Duty Social Work Teams will assess individuals with mental health problems irrespective of whether they are registered with a general practitioner.

Causal Factors

1. Mr. X had an abnormal state of mind at the time of the incident and this abnormality le him to commit both homicides.

2. Mr. X was not under the care of any service at the time that he committed the homicides and was not receiving any treatment for his psychosis.

3. Mr. X avoided services and had a history of low engagement. This impacted upon what services knew about him.

4. Immediately prior to the incident vital information about Mr. X's history was not available to the crisis Team. This ensured that risk information could not be used to assist timely interventions with regard to the Mental Health Act (1983).

The Independent Investigation would concur with most of the findings of the Trust Internal Investigation. There are only four exceptions to this.

First (finding four). It would appear that the Emergency Duty Team did in fact fax the details of the telephone call that was held between the Social Worker and the sister of Mr. X on the 13 February 2007. There was no extant record of this held at the Community Mental Health Team base and it would appear that it 'got lost' in the system.

Second (organisational and strategic factor). The reason why the transfer of Mr. X's care in 2003 was not successful or 'formal' was that Swindon-based services refused to accept Mr. X. Whilst accepting that Lincolnshire-based services could have managed the transfer more assertively it would appear they met a 'point blank refusal' to process Mr. X's case any further. Seen in this light the contributory factor regarding the transfer of Mr. X rests between the two mental health organisations and not with Lincolnshire services alone.

Third (causal factor 2). It is the view of the Independent Investigation Team that Mr. X was, by default, under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust at the time of the homicides. This is evidenced by the fact that the Trust had requested and received clinical data from Lincolnshire services with the intention of preparing a mental Health Act (1983) assessment. It is not accurate for the Trust to deny that Mr. X had not been accepted by Swindon-based services as he had been undergoing an assessment for a period of some three weeks by the time the incident occurred and his case was in effect being 'held' by them.

Fourth (causal factor 4). The Internal Investigation found that had the crisis Team been in receipt of more information regarding Mr. X's history then they would have been able to make a more appropriate and timely intervention regarding a Mental Health Act (1983) assessment. It is the finding of the Independent Investigation Team that this information was in the possession of the crisis Team but remained unrecognised and unused.

The Independent Investigation Team also found additional issues pertinent to the way Mr. X's case was managed by Swindon-based services that were not identified by the Internal Investigation Panel. This is not unusual when a wide-ranging independent investigation is

commissioned and should not detract from the fact the Trust Internal Investigation was comprehensive and thorough.

17.2.5. Identified Good Practice

The Crisis Team Worker responded immediately to the telephone call of the sister of Mr. X and took responsibility for obtaining information from Lincolnshire. She subsequently discussed the case with senior members of her team. She informed the sister of Mr. X of the progress and decisions that were being taken.

17.3. Being Open

The national guidance for *Being Open* has already been set out in Section 16.1.3. above. The Avon and Wiltshire Mental Health Partnership NHS Trust had a fit for purpose *Being Open* policy in place at the time that the Internal Investigation was commissioned and organised.

The policy recognised that *'...carers may need considerable practical and emotional support after experiencing a patient safety incident. The most appropriate type of support may vary widely...it is therefore important to discuss their individual needs.'*[280]

Every NHS Trust is expected to consider providing the following to victim's/service user's families in the aftermath of a major untoward incident:

- an apology;
- an offer of counselling and support;
- engagement with a transparent investigation process;
- the sharing of key findings and recommendations following the completions of the internal investigation process.

The Trust is aware that Investigation outcomes tend be better when victim's families are worked with directly from the time of the incident occurring. In the case of Mr. and Mrs. X senior's family, Trust policies and procedures did not run smoothly.

280 Being Open Policy 2008. P.9

Engagement with the Investigation Process

The Independent Investigation Team was told that an initial meeting was held with the family by the Trust Medical Director in post at the time of the incident. The family were also interviewed as part of the Investigation enquiry process. Following this, a summarised version of the Investigation report was given to the sister of Mr. X. The Trust are aware that this gave the impression that they were not prepared to be open and transparent with regard to their findings and subsequently this decision caused the family of Mr. and Mrs. X senior a great deal of distress and additional trauma. The Independent Investigation Team would like to acknowledge here that the Trust's duty of care to Mr. X's right to confidentiality also meant that a full disclosure, quite reasonably, was not deemed possible.

Another reason that the Trust was unable to share the findings in full with immediate effect was that the Police placed an initial embargo on this information as it could have been prejudicial to the Criminal Justice proceedings that were still ongoing. These proceedings came to an end in January 2009. There appears to have been no additional reason why the full investigation report was not shared with the family at this juncture which would be the normal Trust practice in a case of this kind. This was not done. The family is of the opinion that this delay had a profoundly negative impact upon their health and wellbeing as they were unable to find any degree of closure.

Counselling and Support

Another aspect of the *Being Open* process that did not work well in this case was the degree of counselling and support that the family of Mr. and Mrs. X senior was both offered and received. Both the sister of Mr. X and her family experienced a high of level anxiety and frustration in the seven months prior to Mr. and Mrs. X senior's deaths. The homicides, quite understandably, served to cause a profound degree of psychological trauma to both the sister of Mr. X and her daughters. This has been compounded by the relentless events of the past two and a half years, namely, the Coroner's Inquest, the Internal Investigation, the Court Hearing, the release of Mr. and Mrs. X senior's personal effects and bungalow (in which they were killed) and the Independent Investigation.

The family received no timely offer of initial counselling and support at the time of the incident. As time passed it became evident that members of the family were experiencing severe mental ill health as a direct result of the homicides. Although help and support has

since been offered, the family have lost trust and confidence in local mental health service provision.

The delay in providing counselling and support to the family of Mr. and Mrs. X senior in a timely and sensitive manner has had a catastrophic effect upon them. At the time of writing this report the situation is far from being resolved. It is not possible to place the blame squarely upon any one service for this sad state of affairs. It is a tragic situation that highlights the current inadequacies in national policy guidance when considering how best to work with the families of the victims of homicide.

17.4. Staff Support

On the 8 April 2008 a Trust-wide learning event was held that provided the occasion to feedback the investigation findings of the Mr. X case. On this day other serious untoward incidents were also reviewed. This learning event was an opportunity to disseminate findings and lessons learnt and to obtain feedback from Trust clinicians in order to develop further recommendations and action plans.

It is unclear which of the clinical witnesses involved in the Internal Investigation process attended this learning event. At interview with the Independent Investigation Team most clinical witnesses had not been aware of the content of the Internal Investigation report until the Independent Investigation had commenced, and were not aware of any changes that had been made to-date to services as a direct result of the Internal Investigation process.

Clinical witnesses told the Independent Investigation Team that they felt the Trust had provided them with little or no support during either the Internal Investigation process or the Independent Investigation process.

It is unclear what additional support could have been given to clinical witnesses by the Trust. Individuals were provided with protected time to work with both Internal and Independent Investigation processes. All clinical witnesses attended interview with support from either workplace colleagues or Union representatives. It was not clear what additional support could have been offered, but this perception of clinical witnesses serves to illustrate the stressful

nature of processes of this kind, no matter what measures are put into place to provide support. NHS Trusts should not underestimate the needs of employees in this kind of situation. It is a difficult challenge as investigations form part of the statutory duty of care of all NHS organisations and as such the process has to remain a professional and formal one. It is a difficult balance to maintain. Staff need to be supported, but Trusts have to maintain a formal stance in the interests of objectivity as formal actions against individual employees can never be ruled out as the ultimate consequence of an investigation.

On balance, it is the view of the Independent Investigation Team that the Trust maintained an appropriate level of support to its employees throughout the process.

17.5. Trust Internal Investigations Recommendations

The Trust Internal Investigation set out the following recommendations:

1. *'When a mental health service user is contacted about a patient, known or unknown, by a carer they MUST:*

- *take a full history, a standardised approach to eliciting and documenting this information should be considered;*
- *ask about the risks;*
- *ask the relative if they would like a Mental Health Act assessment, having explained the difference between a formal assessment and information gathering. If the carer says 'yes', an assessment should be organised unless there are well-documented reasons as to why this is inappropriate, with the approved social worker making the application to avoid further risk to the nearest relatives from being in the position of having to do so.*

2. *All services MUST have functional arrangements (e.g. a rota organised by a named person) for allocating patients who have no fixed abode or no GP to a Community Mental Health Team which takes responsibility.*

3. *A system for Teams to record all contacts by users and carers about individuals who do not go on to have a full assessment should be explored. The system should be*

linked so that contacts are visible to other services. Access to Local Authority systems, e.g. SWIFT should be explored.

4. *(Swindon Specific recommendation)Training for multi-agency staff in Swindon in communication and risk assessment. A series of training sessions using this case history should be held with staff from all agencies in the Swindon area.'*

17.6. Progress against the Trust Internal Review Action Plan

The Avon and Wiltshire Mental Health Partnership NHS Trust has been successful in implementing fully the recommendations identified from the findings of their Internal Investigation process. The Trust in conjunction with the Strategic Health Authority took a whole systems approach and developed recommendations and an action plan which took into account the findings of other serious untoward incidents. In this way the Trust was able to look at thematic findings and address persistent issues that required corporate priority attention.

Following the Internal Investigation findings and recommendations, each required action was assigned to an Executive Lead for implementation. The resulting action plan was subject to direct monitoring from the Trust Board and the Strategic Health Authority. The approach that the Trust has taken to the action plan provides a comprehensive and reflective approach to both service assurance and development.

Recommendation Number One. *'When a mental health service user is contacted about a patient, known or unknown, by a carer they MUST:*

- *take a full history, a standardised approach to eliciting and documenting this information should be considered;*
- *ask about the risks;*
- *ask the relative if they would like a Mental Health Act assessment, having explained the difference between a formal assessment and information gathering. If the carer says 'yes', an assessment should be organised unless there are well-documented reasons as to why this is inappropriate, with the Approved Social*

Worker making the application to avoid further risk to the nearest relatives from being in the position of having to do so.

- **Planned Action:**
  - A standardised approach must be taken to responding to 'out of the blue' telephone calls or contacts.
  - Trust-wide training to be developed for Crisis and Emergency Teams to ensure that standardised practice occurs.
  - Empower the CMHT Duty Officer to assume responsibility until a case is allocated or the issue resolved.
  - Ensure that if someone asks for a Mental Health Act assessment, one is provided unless there is a very good documented reason for not doing so.
  - Information sharing arrangements to be agreed with the Emergency Duty Service.
- **Completion Date.** All actions completed in 2009.
- **Evidence of Completion:**
  - All staff are now aware of the Trust Integrated Care Pathway Approach which provides a standardised response and detailed guidance with regard to Mental Health Act assessments and family and carer rights.
  - Ongoing regular 136 meetings now occur across the Trust with both the Emergency Duty Services and the Police dealing with information sharing and other issues.

Recommendation Number Two. *All services MUST have functional arrangements (e.g. a rota organised by a named person) for allocating patients who have no fixed abode or no GP to a Community Mental Health Team which takes responsibility.*

- **Planned Action.** The arrangements to be developed and integrated into all operational policies across the Trust.
- **Completion Date.** Action completed in 2009.
- **Evidence of Completion.** These arrangements have been included in all operational Polices across the Trust.

Recommendation Number Three. *A system for Teams to record all contacts by users and carers about individuals who do not go on to have a full assessment should be explored. The system should be linked so that contacts are visible to other services. Access to Local Authority systems, e.g. SWIFT should be explored.*

- **Planned Action.** This action to be reviewed by the Information technology Department in order to consider the viability of this with regards to both the current and future systems.
- **Completion Date.** Action completed in 2009. New system building work is ongoing.
- **Evidence of Completion.** This recommendation was reviewed by the Head of Trust Information Technology. The current MaraCIS system can only record contacts with service users and carers where there is a referral in place already. This information can only be shared with the users of the system. Social Services staff within integrated teams and Emergency Duty teams have access to Trust information systems. The future RiO system will link to the national spine and local summary record to facilitate the sharing of information and will provide a more comprehensive electronic record. The requirement for contact recording has been added to the Trust's logging system.

Recommendation Number Four. *(Swindon Specific recommendation)Training for multi-agency staff in Swindon in communication and risk assessment. A series of training sessions using this case history should be held with staff from all agencies in the Swindon area.'*

- **Planned Action.** This to be subsumed into the new Trust-wide risk management training schedule. This to be rolled out to all Swindon-based clinical Teams. Also, for the NHS Swindon Rapid Improvement Plan to be implemented.
- **Completion Date.** Actions completed in 2009.
- **Evidence of Completion.** The Trust Integrated Care Pathway Approach and risk assessment has been developed to ensure best practise in the management of risk assessment is adhered to. Trust-wide training has taken place and this has been monitored through the scorecard system. Phase One of the Swindon Rapid Improvement Plan has been signed off by NHS Swindon with a 60% compliance rating. Work continues on Phase Two.

18. NHS Lincolnshire's Response to the Incident and Internal Investigation

In December 2008 NHS Lincolnshire became aware for the first time of the deaths of Mr. and Mrs. X senior and that a service user who had formerly received care and treatment from the Lincolnshire Partnership Foundation NHS Trust had been charged with their murder. The Primary Care Trust Internal Investigation was completed on the 22 May 2009.

The Internal Investigation was commissioned by the NHS Lincolnshire Performance Decision Making Group following the receipt of the Internal Investigation Reports from the Avon and Wiltshire Mental Health Partnership NHS Trust and the Lincolnshire Partnership Foundation NHS Trust.

18.1. Primary Care Trust Internal Investigation Process

NHS Lincolnshire had not known about the incident prior to the inception of the commissioning of the Independent Investigation. A meeting was held with Senior Officers of the Primary Care Trust (PCT) and the Independent Investigation Team Chair to ensure that any pending PCT internal investigation would not impinge upon or confuse the work of the Independent Investigation. It was agreed that the PCT should conduct their Internal Investigation with immediate effect and that the resulting report would be forwarded on to the Independent Investigation Team prior to its work commencing in Lincolnshire. This would ensure that the PCT fulfilled its statutory duty of care obligations appropriately and objectively. It also ensured that the General Practice that would be the subject of the investigation could be prepared and supported in a constructive manner.

18.1.1. Internal Investigation Lead

The Internal Investigation was led by a single Investigator who was the Clinical Governance Advisor to NHS Lincolnshire. This individual had extensive experience of work of this kind and also served as a 'Fitness to Practice' Panel Member on the General Medical Council.

18.1.2. Terms of Reference

The terms of reference for the Internal Investigations were as follows:

1. *'Seek any clarification required about the issues raised.*

2. *Seek clarification as required about any of the documents provided.*
3. *Consider whether or not the information supplied suggests inappropriate behaviour or clinical variation.*
4. *Meet with the lead General Practitioner, provide information relating to the Serious Untoward Incident as agreed with the commissioning body and seek her response in writing.*
5. *Consider the GP's written response to the issues that have been raised.*
6. *Map all of the issues raised against the General Medical Council's 'Good medical Practice' and determine whether the GP's practice falls below the standard that would be expected of a doctor.*
7. *Provide a written report to the Performance decision Making Group, based on the framework described in 'Clinical reports from Professional Advisors' on the outcome of the Investigation stating:*

- *the process of the Investigation and its findings;*
- *whether or not in the Investigator's opinion the GP's practice falls below the standard that would be expected of a doctor as determined by the professional guidelines referenced above;*
- *the evidence upon which this opinion is based;*
- *recommendations to NHS Lincolnshire's Performance Decision Making Group.*

18.1.3. Methodology

The Investigation Lead interviewed the GP on two occasions.

Documents considered:

1. Desktop Root Cause Analysis, Lincolnshire Partnership Foundation NHS Trust;
2. Root Cause Analysis report, Avon and Wiltshire Mental Health Partnership NHS Trust;
3. written report from the GP;
4. copy of the full GP record for Mr. X including a computer printout;
5. terms of reference for the Internal Investigation as commissioned by NHS Lincolnshire.

18.1.4. Key Findings

The Internal Investigation found:

- the GP records to be full and of good quality;
- Mr. X's care appeared to be relatively straightforward, until the Mental Health Trust discharged him in November 2003 and wrote to the Practice advising that Mr. X was spending most of his time in Swindon;
- Mr. X continued to be prescribed Olanzapine 10mg on a monthly basis until 25 March 2004 when the Practice stopped the prescription pending his attending the Practice for clinical assessment.

The Internal Investigation considered:

1. Was the prescription for Olanzapine continued for too long without review?

The General Medical Council *'Good Medical Practice 3 (b)'* states that *'in providing care you must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs.'* Up until November 2003, Mr. X, as far as the Practice was concerned was being followed up by the Community Mental Health Team. The findings concluded that the Practice had shown a degree of reasonable flexibility and met the requirements in *'Good Medial practice'.*

2. Should the prescriptions for Olanzapine have been stopped in March 2004?

By the time it became apparent that the patient was neither living in Lincoln nor willing to engage with the Practice to assess his treatment, the practice had no alternative but to cease the prescriptions. The Practice made it clear to Mr. X's sister that he should register with a GP in Swindon, but expressed a willingness to continue to see him if he would engage. This was supported by a letter from the GP confirming this advice. The Practice could not have reasonably taken any further action.

18.1.5. Further Actions

The NHS Lincolnshire Internal Investigation Report was delivered to the PCT Performance Decision Making Group, the Strategic Health Authority and the Independent Investigation

Team. The process did not yield any evidence that the Practice acted in either an unreasonable or an unprofessional manner. Therefore no recommendations were made and no further actions were required.

The GP was supported in line with NHS Lincolnshire policy and procedure.

19. Notable Practice

During the course of the Independent Investigation several areas of notable practice were identified. It is the view of the Independent Investigation Team that other Mental Health Trusts could benefit from the work that has been undertaken by both the Lincolnshire Partnership NHS Foundation Trust and the Avon and Wiltshire Partnership NHS Trust.

19.1. Lincolnshire Partnership Foundation NHS Trust

HASCAS is aware that LPFT has long recognised that effective patient care is underpinned by an effective assessment & care planning process. This is evidenced by the Trust's continuing aims of developing consistent processes across services and settings, supported by electronic systems that support better information sharing between teams.

The Trust has won and been highly commended for a number of national awards in the past three years through the Care Programme Approach Association annual awards scheme. These awards have recognised the range of steps the trust has been taking to embed the components of CPA as the foundations of effective care for all service users in contact with secondary mental health services.

LPFT has been nationally recognised in the following areas:

Information for Service Users

The Trust has developed a range of easy-to-read leaflets that set out the key principles of the CPA process, the standards and enabling service users to know what to expect from the process that supports their care and treatment.

CPA Training for Care Coordinators

This one day training package for CPA care coordinators included service users and carers as facilitators, bringing their own experience and perspective to the training.

Monitoring and evaluation of CPA

This award recognised the trust's quarterly CPA audit process that audited a range of the trust's teams and settings on a rolling basis, providing opportunities for team staff to be involved in the audit process and providing local feedback.

Policy and practice standards

Following the publication of the DH guidance '*Refocusing the Care Programme Approach'*, the Trust reviewed its CPA policy, adopting a whole-Trust approach to assessment and care planning processes including CPA, with clear standards and processes set out for both those without complex characteristics who receive treatment outside of CPA, and those with more complex characteristics who are supported by the CPA process.

HASCAS recognise that other Mental Health Trusts can learn from this good practice, particularly in the following areas:

- The benefits of core standards that are applicable across the range of mental health services and settings.

- The value of regular audit that provides targeted feedback to individual teams, enabling them to action plan for identified issues and continually drive up standards, as well as supporting trust wide service line reporting structures.

- A whole systems approach to assessment and care planning processes that recognises the interface with Mental Health Act, Records Management and Integrated Care Pathways through joint training.

19.2. Avon and Wiltshire Mental Health Partnership NHS Trust

The Avon and Wiltshire Mental Health Partnership NHS Trust have an excellent range of clinical policies and procedures. As would be expected from a statutory agency these documents are evidence-based and written well. The policies and procedures become notable practice in that each document the Independent Investigation Team examined sets out the responsibilities of the individual, the team and the corporate body in the delivery of safe and

effective care. This clear demarcation makes explicit the accountabilities, responsibilities and roles of all Trust personnel.

19.3. NHS Lincolnshire

NHS Lincolnshire acted promptly once the deaths of Mr. and Mrs. X senior had been brought to their attention. The decision as to how to proceed was taken through the correct Primary Care Trust governance channels and whilst being rigorous ensured that the clinical witness was appropriately supported.

The General Practice developed and maintained a comprehensive and contemporaneous record for Mr. X which was organised well.

The Practice attempted to engage with Mr. X and did not take the decision to remove him from their list lightly. Appropriate attempts were made to engage with Mr. X and 'the door was left open' to him to access care if he chose to do so.

20. Lessons Learned

The findings within this report conform to those of most other Independent Investigations conducted in recent years. The findings regarding risk assessment, the Care Programme Approach, clinical supervision, and the quality of documentation are all common factors to be found in the Independent Investigation Report literature across the country. There are several lessons to be learnt from this particular Independent Investigation.

First. It is essential that all NHS clinicians adhere to both national guidance and local policy and procedure. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said Polices or procedures or to raise any implementation issues as they arise with immediate effect. **The failure to abide by policy and procedure ensures that the safety nets of care are not effectively in place. This puts the service user at risk and places the clinician in a vulnerable and often indefensible position. The Trust had, and continues to have, sound policies and procedures. However it remains a corporate, local management and individual worker responsibility to ensure that they are used at all times and that audit assures the Trust Board that this is in fact occurring.**

Second. All NHS Trust processes serve a single purpose, to assess and appropriately treat patients in a timely manner. All service users should have a coherent case management plan. Conducting regular visits and making numerous telephone calls can lull services into a false sense of security. Activity alone does not constitute care. Care has to be delivered by the multidisciplinary team and should never be regarded as the responsibility of a single practitioner.

Third. National Independent Investigation and Inquiry Reports over the past fifteen years regularly cite the failure to communicate as being a primary causal factor in less than perfect care and treatment plans being instigated. It remains unclear why this failure continues to occur in Trusts across the country. In the case of Mr. X, communication problems were a consistent feature both with regard to clinical documentation and interagency working. Poor

communication and the lack of timely responses allowed Mr. X, who was always trying to disengage from services, to be rendered invisible. This was exactly the effect that he desired.

Fourth. Clinical leadership has to be both explicit and visible in order to ensure the delivery of good quality care. Coherent clinical leadership and management were not in evidence when analysing the care and treatment that Mr. X received. It was not only agencies and services that appeared to act in silos, individual health and social care workers did too. Nowhere was it evident that anyone took an overview of the case at any period in time, even when senior staff were engaged as part of the clinical team.

Fifth. During the period that Mr. X received his care and treatment, health and social care staff endeavoured to ensure that his human rights were not infringed. This is commendable. However health and social care professionals can sometimes become confused and uncertain with regard to how to proceed when the rights of the service user appear to conflict with those of their carers and the people around them. Mr. X had been identified on several previous occasions as being dangerous and a significant risk to those around him. This information was not enough, even when coupled with the knowledge that his mental health had broken down, to protect his elderly and vulnerable parents. Health and social care services must ensure that they have a robust reaction to safeguarding situations. Once a situation has emerged it has to be dealt with rapidly, services must not indulge in discussing the dilemma over excessively long periods of time if it means vulnerable people are potentially placed at risk.

21. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with both Trusts to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified: that the recommendations set below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

Lincolnshire-based services have developed considerably since Mr. X was discharged from their care in 2003. These changes have been acknowledged below and the recommendations that have been set out here were made so that the Trust can strengthen the good work that has already been achieved and can develop further any other areas that are required.

Avon and Wiltshire Mental Health Partnership NHS Trust has been subject to a comprehensive Rapid Improvement Plan by NHS Swindon during 2009. This has led to significant service improvements and the recommendations below take this into full consideration.

21.1. Lincolnshire Partnership Foundation NHS Trust

Due to the long interval that has occurred between the time Mr. X received care and treatment from the Trust and the completion of this report, the following section sets out the progress that the Lincolnshire Partnership Foundation NHS Trust has made. The recommendations focus on the assurance of this progress.

Each recommendation is set out below in combination with the relevant contributory factor and the progress that the Trust has already made in the area. Some contributory factors have been grouped in themes in order to provide a cohesive approach.

21.1.1. Theme: Clinical Management

- **Contributory Factor Number One.** The clinical Team did not take sufficient account of the nature and presentation of Mr. X's mental disorder and this contributed to the breakdown of Mr. X's clinical care. This had both short-term and far reaching consequences.

- **Contributory Factor Number Two.** The decision to change from depot to oral medication contributed to the breakdown of Mr. X's engagement with mental health care.

- **Contributory Factor Number Three.** It is the view of the Independent Investigation Team that Mr. X's medical management was not optimal and was a key contributory factor in the breakdown of his mental health care provision.

In 2002-2003, neither Assertive Outreach teams nor Community Forensic teams were in place throughout the Trust. Initial assessment and treatment of Mr. X predated the full implementation of Assertive Outreach Teams. Mr. X's presentation was described as difficult to engage with a diagnosis of delusional disorder, with a reluctance to engage with medication, and a history of admissions under the Mental Health Act (1983). There was also some potential forensic background, as Mr. X had been involved with the Police and a MAPPA referral had been made in the past. This indicates that should Mr. X be a patient of the Trust currently, he would be placed under an Assertive Outreach Team.

Currently individuals such as Mr. X are managed through an Assertive Outreach Team, which works closely with the Community Forensic Team. This reduces the risk of service user disengagement from service. Regardless of the circumstances of discharge, the in-patient team would contact and refer on to the most appropriate community team – in this case the Assertive Outreach Team. This would enable:

- effective multidisciplinary service user management;
- seven day team-based responsibility for the client;
- ongoing risk assessment including multi-disciplinary risk assessment;
- joint risk assessment and planning with the forensic community team;

- a stable contact point for the family providing in-depth clinical knowledge;
- a coordinated multidisciplinary team approach to medication management.

Assertive Outreach Teams were set up on the back of the Policy Implementation Guidance (PIG), in 2004/5. Medical staff are now integrated fully into the multidisciplinary team. Evidence to support the development of Assertive Outreach Teams in the Trust includes early integrated care pathways, the Assertive Outreach Team Operational Policy, and the Policy Implementation Guidance for Assertive Outreach Teams.

The Trust recognises that the care planning process in the case of Mr. X was remiss. The service user was not discharged appropriately from Lincolnshire services. There was no clear escalation process and no robust Section 117 follow up.

Significant work has since been undertaken within the Trust to strengthen assessment and care planning processes, and to ensure that they are fully embedded within clinical services. There is a robust programme of assessment and care planning training in place for all clinical staff, and regular clinical audit of practice to ensure compliance with Trust policy and continuous improvement.

In addition to this, the Trust has also reviewed the medical cover arrangements for no fixed abode patients when they are acute in-patients and community patients. This means that anyone admitted to an in-patient unit, irrespective of their area of residence, would be managed by the acute in-patient consultant and ward based team. On discharge they would be transferred to the care of the most appropriate local community team, which would include a designated consultant psychiatrist. Therefore, the situation where the responsible medical officer was not a member of the community team would no longer happen.

Discharge planning policy and practice has also been strengthened to ensure that, at the point of admission, the assessment and care planning process includes discharge arrangements. This would include crisis and contingency plans and any Section 117 aftercare requirements. Based upon individual need and assessment of risk, the in-patient team would liaise with the appropriate community team to arrange discharge and ensure that a care coordinator was identified. The patient would be seen within seven days of discharge. This particular patient would have been discharged to the Assertive Outreach Team, working closely with the Community Forensic Team.

Recommendation Number One. All key junctures of the 'Multi Disciplinary Integrated Care Pathway Acute Care' should be subject to a comprehensive audit on the publication of this report. This audit to be Lincoln-based and to ensure compliance with:

- the appropriate completion of all pathway documentation within the preset timescales;
- variance tracking, cause of variance and action taken;
- the views of carers having been sought and recorded.

Recommendation Number Two. All key junctures of the 'Integrated Care Pathway Assertive Outreach' should be subject to a comprehensive audit on the publication of this report. This audit to be Trust-wide and to ensure compliance with:

- the appropriate completion of all pathway documentation within the preset timescales;
- variance tracking, cause of variance and action taken;
- the views of service users having been sought and recorded.

Recommendation Number Three. The Operational Policies of the Community Mental Health and Assertive Outreach Teams must be revised in accordance with any service issues raised from the audit of the Integrated Care Pathways. For example these revisions may need to consider:

- establishment;
- skill mix;
- clinical supervision;
- record keeping;
- joint working with other services;
- referral and discharge process.

The Trust's current assessment and care-planning audit referred to above regularly measures performance against all of these key elements. The Trust accepts the recommendation, and will conduct a targeted audit as suggested.

Recommendation Number Four. On the publication of this report a Lincoln-based service user and carer satisfaction survey should be conducted to ascertain the perceived effectiveness of the Integrated Care Pathway approach. This survey to establish whether:

- good quality, relevant information was provided in a timely manner;
- the wishes and preferences of service users was taken into consideration;
- the service user was introduced to a named nurse;
- conversations on recovery occurred;
- the service user, and where appropriate, the carer was involved in all aspects of assessment and care planning;
- carers assessments were offered;
- copies of relevant information were shared appropriately.

The Trust has introduced a programme of local service user satisfaction surveys that cover the above issues. An additional targeted survey will be conducted as recommended.

21.1.2. Theme: Section 117 Aftercare

- **Contributory Factor Number Four.** The aftercare needs of Mr. X were not adequately followed up via the provision of Section 117. This ensured that there was no statutory form of supervisory arrangement in place, as a result mental health services lost contact with Mr. X.

The Trust has integrated fully Section 117 aftercare arrangements within the current Assessment and Care Planning, Incorporating the Care Programme Approach Policy (2009), and the Discharge/Transfer Policy. Please see section directly below.

21.1.3. Theme: Care Programme Approach

- **Contributory Factor Number Five.** Failure to implement the Care Programme Approach ensured that Mr. X was not appropriately assessed and was not in receipt of an appropriate care, crisis or contingency plan. As a result his care and treatment was entirely compromised and this lack of clinical management ensured that he slipped through the safety of care.

The Trust accepts that the CPA policy was not adhered to between 2002 and 2003 in the case of Mr. X. The current position is that the Assessment and Care Planning, Incorporating the Care Programme Approach Policy was issued in the summer 2009. There is in place a full Trust audit process for the Care Programme Approach, and records management. The successful implementation of the revised Trust CPA is evidenced by recent audit feedback.

There is now better monitoring of the application of the Care Programme Approach through the previously mentioned CPA Audit. Further evidence for this are the national awards that the Trust has been in receipt of for the Assessment and Care Planning Policy (Incorporating CPA) policy and implementation of the Department of Health Refocusing the Care Programme Approach Guidance. This incorporates fully Section 117 aftercare arrangements. In the light of this evidence the Trust is currently providing a service model that has received national assurance and recognition for the quality of its delivery in the following areas:

- information for service users;
- CPA training for Care Coordinators;
- monitoring and evaluating CPA;
- policy and practice standards.

In the light of the evidence available to the Independent Investigation Team no recommendations have been required for the Trust delivery of the Care Programme Approach or Section 117 Aftercare arrangements.

21.1.4. Theme: Risk Assessment

- **Contributory Factor Number Six.** The failure to complete multidisciplinary risk assessments in the full context of Mr. X's forensic and psychiatric history meant that he remained an 'unknown' quantity. As a consequence the care and treatment that he received was not fit for purpose. This had a long-term detrimental effect on his future mental health.

Clinical risk assessment is included in the programme of mandatory training, compliance against which is regularly monitored and reported to the Trust Board, through the Clinical

Quality and Risk Committee. The Trust is scheduled to review its clinical risk assessment processes (including documentation and training) in 2010.

Recommendation Number Five. The risk assessment and management policy should be revised in accordance with national best practice guidance. The revised policy should integrate fully with the Trust Integrated Care Pathway Approach and Care Programme Approach procedures. The new policy should make explicit the requirements for:

- a professional standard of documentation;
- interagency/service liaison;
- safeguarding;
- carer communication and safety alerts (if indicated);
- dynamic care, contingency and crisis planning;
- plans for timed, specific intervention should relapse indicators be evident;
- the responsibilities of all Trust personnel at all levels in ensuring that policy is appropriately implemented.

Recommendation Number Six. The new risk assessment and management policy should be supported by a mandatory comprehensive training programme for **all** health and social care staff within the Trust. This training should make explicit the roles and responsibilities of:

- each health and social care professional;
- each clinical team;
- the corporate body.

21.1.5. Theme: Referral, Transfer and Discharge

- **Contributory Factor Number Seven.** The non-adherence to Trust policy and procedure guidance led to an ineffective attempt to transfer Mr. X to Swindon-based services. This had the long-term effect of allowing an individual with an enduring mental illness to slip through the safety net of care.

At the current time due to policy and procedure revision over the past seven years discharge planning is part of care planning responsibilities from the moment of admission, and this would be instigated by the inpatient team. The inpatient team would have the ability to

discharge to the most appropriate team (in this case of a person like Mr. X the Assertive Outreach team working closely with the community forensic team) within the community. Also, within the Assessment and Care Planning Policy and Discharge/Transfer policy there is a clear idea of what information to send as part of a transfer.

Regarding difficult discharges and transfers, there is a process of escalation within the Assessment and Care Planning Policy (Incorporating CPA), and this has been made more robust. There is now an Assessment and Care Planning Coordinator in post and the post-holder is part of formal networks nationally, which enables the sharing of good practice. These arrangements are robust, but relatively recent. The recommendation below is ensure a degree of assurance and consolidation.

Recommendation Number Seven. On the publication of this report the Trust should conduct an audit against its current Discharge and Transfer (2009) policies and procedures to ascertain their effectiveness. These arrangements are relatively new and good practice would require that they are appraised and any appropriate revisions made as necessary.

21.1.6. Theme: Carer Liaison

- **Contributory Factor Number Eight.** Lincolnshire Services did not work with the family of Mr. X in accordance with Trust policy and procedure guidance. As a consequence this placed Mr. X's elderly parents in a situation that they were ill equipped to mange, and consequently this was to impact negatively on the mental health of Mr. X.

All carers are offered a carers assessment, and this is reported on monthly to the Trust Board. Trust compliance during October 2009 stood at 96.2% and at 95.5% during February 2010. Trust current policy and procedure place great emphasis on the involvement and support of carers. The Trust has a robust audit system in place with Board-level scrutiny. The Trust works closely with the Local Authority and is a signatory to the Countywide Carers Strategy. The further actions required under carer liaison have already been incorporated into recommendation Number Four above.

21.1.7. Theme: Service User Involvement

- **Contributory Factor Number Nine.** Mr. X was allowed to disengage from services. Trust policy and procedure was not adhered to and as a consequence Mr. X's mental illness was to go untreated for a period of four years.

The issues encountered during the management of the case of Mr. X would now be addressed by the Assertive Outreach Teams. Specific future actions required by the Trust have already been incorporated into Recommendations One, Two, Three and Four as set out above.

21.1.8. Theme: Interagency Working

- **Contributory Factor Number Ten.** The different agencies and services involved with Mr. X over a period of seven years did not work in a system that facilitated interagency working. As a result the required levels of management and supervision of Mr. X's case did not occur.

Interagency working has improved in recent years and can be illustrated by the current formal working arrangements between the Probation Service and the Community Forensic Team. The Police and Probation Services are now stakeholders on the Trust's Board of Governors. Further work is needed to develop a formal information sharing agreement between Lincolnshire Police and the NHS in Lincolnshire. The Trust is an active partner in MAPPA, which now works well locally.

Recommendation Number Eight. The Trust, in conjunction with NHS Lincolnshire and NHS East Midlands, should develop a formal memorandum of understanding with the Lincolnshire Police Force.

21.1.9. Theme: Clinical Supervision

- **Contributory Factor Number Eleven.** Mr. X was both complex and challenging. The lack of clinical supervision afforded the Care Coordinator compounded the difficulties that he faced in managing the case.

The Trust has a clinical supervision policy which makes clinical supervision incumbent on all appropriate staff. The uptake of supervision is now monitored through an audit, as are other aspects of staff development. However, the Trust acknowledges that there are some further actions required with regard to clinical supervision, namely to redo the audit, to check the review of the policy as to the expectations regarding supervision, and also to look at how many staff have been formally trained in clinical supervision.

Recommendation Number Nine. The Trust should undertake a full and comprehensive audit against its current clinical and caseload supervision practice. This audit should review:

- the rate of compliance of clinicians undertaking clinical supervision;
- whether the grade of clinicians affects the uptake of supervision;
- sessions *per annum* undertaken by supervisees;
- how many supervisors have been appropriately trained;
- how clinical supervision is recorded;
- how supervision impacts positively on clinical outcomes.

Recommendation Number Ten. The Trust should revise its existing clinical supervision policy in the light of the audit findings. Appropriate training should then be provided for individuals acting in a supervisory role. This policy should also make provision for:

- Clinical Supervision
- Caseload Supervision
- Management Supervision
- Trust internal Professional Regulatory Management systems

21.1.10. Theme: Non-adherence to Trust Policy and Procedure

- **Contributory Factor Number Twelve.** The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical team ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to his future mental health.

In a recent Trust Improving Practice Plan it was noted that clinical staff were not always aware of new or updated policies. This potentially will have an ongoing impact on the quality

of the care and treatment that is delivered. The Trust has developed a series of actions to address this issue. These actions have been incorporated into Recommendation Number Eleven below.

Recommendation Number Eleven. All Trust policies and procedures should make explicit the responsibility of the individual professional, the team and the statutory corporate body in the implementation of all local and national best practice guidance. These responsibilities should be restated at all annual staff development reviews and appraisals. These responsibilities should also be presented to all new staff as part of a formal induction process.

Recommendation Number Twelve. New Policies should be disseminated in a formal and systematic manner. The following actions should be undertaken:

- formal training events should be conducted for both new policies providing guidance for significant clinical frameworks and major policy revisions (mandatory training should be considered for CPA and risk);
- policies and procedures should be provided in both electronic and hard copy formats for access by all clinical staff;
- team briefings and team meetings should highlight new policies and procedures;
- team briefings and team meetings should highlight issues arising from internal Trust investigations that have occurred directly due to non-adherence to policy and procedure guidance;
- team leaders should notify either the Director of Nursing or the Medical Director if they have reason to believe that extant Trust policy and procedure cannot be implemented effectively.
- new staff should have sufficient time made available to them to read and understand Trust policy and procedure requirements.

21.2. Avon and Wiltshire Mental Health Partnership NHS Trust

The Trust has recently undertaken a whole systems review of its services in Swindon. The recommendations below have been framed in the knowledge of the progress that has been made to-date. This progress has been independently verified by the Trust's statutory performance managers.

21.2.1. Referral and Transfer Processes

- **Contributory Factor Number One.** Mr. X failed to receive appropriate referral and/or transfer responses from Swindon Mental Health Services on three separate occasions over a four-year period. This meant that he did not receive the care and treatment that he required.

The Trust is currently undertaking a 'priorities pathway development project'. This project is to ensure that service users and carers are able to access the right services at the right time. This will be underpinned by the Trust Policy to Manage Care Pathways and Risk (2008). This work should be complete by the time this Independent Investigation report is published. Current Trust policy and procedure makes explicit reference to all aspects of referral and transfer procedures. The erroneous notion that a service user requires to be registered with a local GP prior to accessing mental health services is refuted in all clinical policies and procedures relating to referral.

Recommendation Number One. The Trust should undertake a comprehensive audit six months after the publication of this report/one year on from the implementation of the new revised priority pathways (whichever is first). This audit should be developed in conjunction with local stakeholders. As well as auditing adherence to policy and procedure it should review:

- sources of referral;
- reasons for not accepting referrals;
- service user and carer satisfaction with ease of referral to a service;
- stakeholder satisfaction with ease of referral to a service; (e.g. General Practice, Police Service, third sector)

21.2.2. Mental Health Act, Risk Assessment and Clinical Management

- **Contributory Factor Number Two.** No assertive action was taken to initiate a Mental Health Act (1983) assessment. As a consequence Mr. X's mental illness continued to deteriorate and he did not receive the care and treatment that he required.

- **Contributory Factor Number Three.** The Crisis Team failed to assess Mr. X in the context of his known risk. This led to a critical delay in the assessment of his mental health.

- **Contributory Factor Number Four.** The clinical leadership structure, both at corporate and local team level, was unable to ensure an acceptable standard of care delivery to Mr. X. This led to critical delays and ensured that his mental health continued to deteriorate.

Trust systems and procedures are now fully integrated and utilise a Care Pathway Approach system. This ensures that the monitoring, governance and management of processes are inclusive. All Crisis Teams now complete a Comprehensive Risk Assessment Template for every referral. This ensures decisions are framed in a timely manner. Operational Policies between clinical teams are now streamlined and reviewed at the Capacity Meetings and the multi disciplinary team meetings. Mental Health Act and Mental Capacity Act training are regularly monitored. The Trust is planning to incorporate the flexibilities of the revised Mental Health Act (2007) to ensure a more timely implementation of the Act in crisis situations.

Following the NHS Swindon-led Rapid Improvement Plan a single point of entry has been introduced, this includes substantial changes to standard operating procedures. These changes have been recently implemented (September 2009).

Mental Health Act assessments now take place if carers request them unless there is a clearly documented reason for not doing so.

Recommendation Number Two. The Trust needs to make use of the flexibilities contained in the Mental Health Act (2007) to extend further the opportunities to make provisions under The Act. This will assist in ensuring a greater availability of Approved Mental Health Act Practitioners and will ensure a timely implementation of The Act in situations of crisis.

Recommendation Number Three. In conjunction with NHS Swindon the Trust must review the newly revised Single Point of Entry system including the changes to Standard Operating Procedure within a twelve-month period of its inception.

Recommendation Number Four. The Trust must audit the use of the Risk Assessment Template currently being used by the Crisis and Home Treatment Teams. This audit will review:

- adherence to the Trust policy ensuring that *every* person referred to Crisis and Home Treatment Teams has been assessed appropriately;
- the interval of time taken between initial referral and the Risk Assessment Template being completed;
- evidence that the Risk Assessment Template has been discussed by the multi disciplinary team;
- evidence that either appropriate triage and referral occurred within acceptable timeframes, or a comprehensive and dynamic plan of care and treatment was developed.

21.2.3. Interagency Working

- **Contributory Factor Number Five.** Swindon-based services did not adhere to Trust operational policy guidance regarding referral. As a consequence Trust services presented an impenetrable barrier through which it was impossible for Mr. X's case to be successfully referred by any external agency.

A Trust-wide overarching information sharing protocol is being developed to improve information sharing between agencies. This protocol is being developed in conjunction with revised MAPPA guidance and amendments to the Integrated Care Pathway Approach Policy. The recent appointment of Public Protection and Safeguarding Managers will increase the access of advice to staff on information sharing. These processes will facilitate referrals into Trust services.

Recommendation Number Five. The Trust should continue to provide training across the Trust with regard to the new MAPPA guidance arrangements, changes to information sharing and safeguarding arrangements. This training should be monitored and its effectiveness audited and reviewed on a regular basis. Opportunities to review the effectiveness and uptake of training should be taken:

- following any referral from the Police Service, Probation Service or Social Services.
- following any safeguarding process;

- following any related serious untoward incident;
- following any related near miss

21.2.4. Carer Liaison and Safeguarding Vulnerable Adults

- **Contributory factor Number Six.** Communication, consultation and liaison with the family of Mr. X did not provide the assistance that they needed in an appropriate and timely manner. The fact that the parents of Mr. X were vulnerable adults did not trigger the appropriate safeguarding processes. As a result the parents of Mr. X were placed in a position of unacceptable risk.

The Trust has developed a Service Framework for carers, 'Carers are our Business'. The carer component of the Integrated Care Pathway Approach has been developed further and delivers against recommendations arising from internal investigations which seek to address shortfalls in this area, specifically with regard to accessing information and support. Current Trust training programmes are in place which include involving carers in care planning and risk assessment decisions. A psychosocial strategy has also been ratified by the Trust Board and initial workshops for staff have been held. This strategy addresses issues that arise within familial contexts when a family member suffers from mental illness. Carer assessments are now formally monitored against the Balanced Scorecard system.

The Trust has now developed a Safeguarding Adults Policy and has appointed Public Protection and Safeguarding Managers. The Public Protection and Safeguarding Team are established to provide advice on safeguarding procedures, the referral process, access to the relevant referral forms and to advise staff on ensuring that referrals are recorded properly.

2010 will be a significant year for safeguarding and public protection, with major changes to national systems and guidance, and requirements for local multi agency partnerships to work together. Safeguarding in Practice 2010 will launch a number of changes to support AWP practitioners and teams in meeting the increased expectations on them to safeguard and protect.

The Trust has revised its Being Open Policy to ensure it is fully compliant with the requirements of the latest alert from the National Patient Safety Agency, and to also respond

to feedback it has received from Mr X's family. The new policy outlines a set of principles in respect of information disclosure that will achieve a balance between legislative compliance and being open in the way that we and families would wish. Additionally the policy states that the Trust will fund independent counselling and support for the families of homicide victims, should they wish to receive it.

Recommendation Number Six. All Trust health and social care personnel should receive training with regard to their duty of care to both the Trust Safeguarding Adults Policy and the Safeguarding Vulnerable Adults in Swindon and Wiltshire Policy that operates on behalf of all statutory agencies in the County. This training should make explicit:

- what constitutes a vulnerable adult;
- situations that constitute potential risk to vulnerable adults and that require action;
- every individual health and social care workers duty of care as an employee of the Trust;
- each agency's duty of care;
- systems and alerts for initiating formal assessment and action.

Recommendation Number Seven. The Trust and the Swindon-based Police Service should formalise a Safeguarding Vulnerable Adults protocol to ensure a rapid response process is formulated. This protocol should be made available to all clinical team in the Swindon area.

21.2.5. Documentation

- **Contributory Factor Number Seven.** The mismanagement of clinical documentation over a period of four years made a direct contribution to the lack of timely intervention that Mr. X received.

- **Service Issue Number One.** The Crisis Team clinical documentation for the period 19 June -10 July 2007 was not contemporaneously made. The entire series of entries were made in breach of Trust policy and procedure guidance and had left both the Trust and Crisis Team workers vulnerable to criticism as a result.

In 2009 the Trust reviewed its guidelines on clinical records in accordance with the recommendations set by professional regulatory bodies. These revised guidelines were incorporated into the Health and Social Care Records Management Policy. At the time of writing this report, this policy was due to be ratified by the Trust Board meeting (March 2010). Training has been made available to all clinical staff to ensure that they understand the requirements of the new Integrated Care Pathway Approach.

The Crisis Team now has an electronic records system. Shared drives mean that live and contemporaneous notes are kept. A new Medical Records Management system has now been implemented. Implementation of RiO (Trust wide electronic patient record system) will further strengthen this. The Trust is externally audited through the Clinical Negligence Scheme for Trusts via the Litigation Authority. Internal targeted audits have been commissioned by the Trust Director of Operations to ensure the Board receives additional assurance through the Trust clinical audit programme.

Recommendation Number Eight. The new Records Management system will require audit in order to ensure compliance with pre-existing Trust policy and procedure. This audit is due to be undertaken in February 2010 to coincide with introduction of Single Point of Entry and the change to the Operating Procedure.

Recommendation Number Nine. The Trust must disseminate the findings of this Independent Investigation across the organisation as a case study to explore the implications of not producing contemporaneous records. These implications need to underline:

- the risks to the service user and their carers;
- the risks to the individual professional/worker;
- the risks to the corporate body.

21.2.6. Clinical Supervision

- **Contributory Factor Number Eight.** The level of supervision provided to the Crisis Team Worker with regard to Mr. X was not sufficient to ensure that the case was managed in an effective and timely manner in accordance with trust operational policy guidance. As a consequence unacceptable levels of delays occurred and Mr. X's mental health continued to deteriorate.

The Trust Clinical Supervision Policy was revised in 2008. Supervision numbers are reported on a monthly basis to the Trust Board as part of the Performance Scorecard. Each service is held to account on a monthly basis to review issues associated with supervision practice. The Trust is planning to undertake an audit to examine supervision processes for unqualified staff.

Recommendation Number Ten. A quantitative and qualitative audit should take place to examine the supervision status of non-qualified staff. The findings of this audit should be used to revise the Clinical Supervision Policy. This audit should review:

- the percentage of non-qualified staff receiving clinical supervision;
- the number of sessions made available *per annum* to individuals;
- the grade of the person acting as supervisor;
- the links to training and development opportunities arising from the needs identified during supervision;
- the recording process utilised for any discussions and decisions made that are service user focused.

21.2.7. Non-adherence to Trust Policy and Procedure

- **Contributory Factor Number Nine.** Trust operational policy and procedure was not adhered to by Swindon-based clinical teams. This ensured a less than effective service response to the management of Mr. X's case.

The Trust has policies in place that make explicit the duty of care of all health and social care workers, all clinical teams and the statutory corporate body.

Recommendation Number Eleven. New Policies should be disseminated in a formal and systematic manner. The following actions should be undertaken:

- formal training events should be conducted for both new policies, providing guidance for significant clinical frameworks and major policy revisions (mandatory training should be considered for CPA and risk);
- policies and procedures should be provided in both electronic and hard copy formats for access by all clinical staff;
- team briefings and team meetings should highlight new policies and procedures;

- team briefings and team meetings should highlight issues arising from internal Trust investigations that have occurred due directly to the non-adherence to policy and procedure guidance;
- team leaders should notify either the Director of Nursing or the Medical Director if they have reason to believe that extant Trust policy and procedure cannot be implemented effectively.
- new staff should have sufficient time made available to them to read and understand Trust policy and procedure requirements.

Glossary

Akathisia	Akathisia is a syndrome characterised by unpleasant sensations of 'inner' restlessness that manifests itself with an inability to sit still.
Approved Social Worker	A social worker who has extensive knowledge and experience of working with people with mental disorders.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Case management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Clopixol	This drug is used for the maintenance treatment of schizophrenia including agitation, psychomotor disturbances, hostility, suspiciousness, aggression and affective reactions. It is administered via an intramuscular injection.
Delusional Disorder	Delusional disorder is a psychiatric diagnosis denoting a psychotic mental disorder that is characterized by holding one or more non-bizarre delusions in the absence of any other significant psychopathology. Non-bizarre delusions are fixed beliefs that are certainly and definitely false, but that could possibly be plausible, for example, someone who thinks he or she is under Police surveillance.
Depot Injection	This is an intramuscular injection (an injection into the muscle) by which certain antipsychotic medication is

	administered, e.g. Clopixol..
DNA'd	This means literally 'did not attend' and is used in clinical records to denote an appointment where the service user failed to turn up.
Dystonia	is a neurological movement disorder in which sustained muscle contractions cause twisting and repetitive movements or abnormal postures.
Electrocardiography (ECG)	Electrocardiography is a test that measures the electrical activity of the heart
Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support.
Extrapyramidal	Extrapyramidal symptoms include extreme restlessness, involuntary movements, and uncontrollable speech.
Lorazepam	Lorazepam is a drug used for treating anxiety.
Mental Health Act (1983)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Olanzapine	A drug used for treating patients with schizophrenia and manic episodes associated with bipolar disorder.
Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.

Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Section 2 Mental Health Act (1983)	Section 2 of the Mental Health Act (1983) allows compulsory admission for assessment, or for assessment followed by medical treatment, for duration of up to 28 days.
Section 3 Mental Health Act (1983)	Section 3 of the Mental health Act (1983) is a treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year. It is instituted in the same manner as Section 2, following an assessment by two doctors and an Approved Social Worker. Most treatments for mental disorder can be given under Section 3 treatment orders, including injections of psychotropic medication such antipsychotics. However, after three months of detention, either the person has to consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person's best interests.
Section 12 Approved Doctors	A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act.
Section 17 Leave	Section 17 of the Mental Health Act 1983 allows the responsible medical officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These can include a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO can require a patient to take medication while on section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of section 17 leave provided the original authority to detain remains in force. Section 17 leave is not required within the grounds of the hospital. (Code of Practice 20.1). However, the decision to allow the patient to leave the ward area should only be made at the formal multi-disciplinary review and/or following consultation with all involved in the patient's care and following a comprehensive risk assessment. It must be part of a plan and not a response to a patient's request, although the

	patient should be fully involved in the decision to grant leave.
Section 117 Aftercare	Section 117 of the Mental Health Act 1983 (MHA) provides free aftercare services to people who have been detained under sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and local social services authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological needs, crisis planning, accommodation and help with managing money. Aftercare lasts as long as someone needs it for their mental health condition, and it can only end when there is a formal discharge meeting.
Section 135 Warrant	If there is cause to suspect that a person is suffering from a mental disorder and has been ill- treated, neglected, or not kept under proper control; or is living alone and is unable to care for themselves, an Approved Social Worker can seek a warrant from a Magistrate's Court. This warrant allows the Police, accompanied by an approved Social Worker and a Doctor, to enter locked premises. The doctor must attend as he/she can advise whether the patient should be removed to a "place of safety" pending an application under Part II of the Act.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House officer and Specialist registrar in the United Kingdom.
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other.
Trifluoperazine	An antipsychotic used for Schizophrenia, agitation and behavioural problems.
TTOs	A prescription which is prepared for a patient to take out or away. Literally medication 'to take out'.

Zopiclone	Hypnotic Used for the short-term treatment of insomnia (difficulty sleeping).

Appendix One

Trust Updates

Avon and Wiltshire Partnerships NHS Trust

Swindon Rapid Improvement Plan

There has been a rapid service improvement plan underway in Swindon to address the concerns raised about some of the Trust's Community Health Services for Adults of Working Age. The action plan was developed with staff, service users, carers, GPs, third sector providers and commissioners. A significant milestone in the progressing of this plan was achieved in July 2009 with NHS Swindon confirming that the Trust had exceeded the significant improvement requirement. These improvements have been sustained and embedded with the Health Overview and Scrutiny Committee finally signing off the plan as complete.

Care Programme Approach

On Monday 14 June 2010, the Trust launched a revised Care Programme Approach and Risk Policy, together with associated paperwork. The CPA policy review had been completed by a group of 30 Trust practitioners, and now this and all related procedural documents have been approved within the Trust. Their launch was schedule to coincide with the first phase of RiO 'Go Live'; RIO being the Trust's new electronic patient information system.

The revised CPA policy describes a number of phases of contact with AWP services - Triage, Assessment, Provision of Care and Step Down (discharge) from services. It sets out definitions of when someone is subject to either CPA or Non CPA when they are receiving care. Regardless of which level a service user is identified to require, the principles of the delivery of care do not differ between these two groups.

Risk Management remains an essential component of good care delivery and a specific Risk Management Procedure has been developed based on national good practice guidance. In line with planned developments from the National Patient Safety Agency a brief CPA review checklist has also been developed, to ensure that key issues are always considered. The impact of this tool will be monitored and developed based on feedback received.

Service users and carers remain at the centre of the CPA process, and various training and awareness events have been held to ensure all practitioners are familiar with their individual responsibilities.

Staff Satisfaction

The Trust has made concerted efforts over the last two years to fully embed its appraisal and supervision processes throughout the Trust.

The 2009 national NHS staff survey results published by the CQC in March 2010 show improvements in AWP performance, with 52.5% of key findings now scoring average or better compared with 25% last year. Whilst the survey shows that the Trust is moving in the right direction, the findings indicate that there is still more to be done to elicit a universally positive response across all question areas.

Care Quality Commission Registration

The Trust is fully registered with the Care Quality Commission and has no restrictions on its registration.

Being Open

The Trust has revised its Being Open Policy to ensure it is fully compliant with the requirements of the latest alert from the National Patient Safety Agency, but also to respond to feedback it has received from Mr. X's family. The new policy outlines a set of principles in respect of information disclosure that will achieve a balance between legislative compliance and being open in the way that we and families would wish. Additionally the policy states that the Trust will fund independent counselling and support for the families of homicide victims, should they wish to receive it.

Record keeping

In terms of current standards of record keeping in Swindon, we are confident that they are now much more robust. Our assurance on this comes from a range of sources including the checks and record keeping audits done regularly as part of CNST compliance work, our medical records assurance work reported to Information Governance and intermittent clinical audits depending on the clinical audit programme. However we do not wish to be

complacent, and as such the Director of Operations has commissioned some targeted audits and checks to be undertaken.

Safeguarding

Since this case the Trust has now a well established Public Protection and Safeguarding Team that has a key role in facilitating best practice in safeguarding all service users (and their families) who might be involved in a safeguarding process.

The Public Protection and Safeguarding Team are established to provide advice on safeguarding procedures, the referral process, provide access to the relevant referral forms and to advise staff on ensuring that referrals are recorded properly.

2010 will be a significant year for safeguarding and public protection, with major changes to national systems and guidance, and requirements for local multi agency partnerships to work together. Safeguarding in Practice 2010 will launch a number of changes to support AWP practitioners and teams in meeting the increased expectations on them to safeguard and protect.

Lincolnshire Partnership NHS Foundation Trust

Theme:

Clinical Management

No. 1 - The Clinical Team did not take sufficient account of the nature and presentation of Mr. X's mental disorder and this contributed to the breakdown of Mr X's clinical care. This had both short-term and far reaching consequences.

No.2 – The decision to change from depot to oral medication contributed to the breakdown of Mr. X's engagement with mental health care.

No.3 – It is the view of the Independent Investigation Team that Mr. X's medical management was not optimal and was a key contributory factor in the breakdown of his mental health care provision.

Recommendation No.1 – All key junctures of the 'Multi Disciplinary Integrated Care Pathway Acute Care' should be subject to a comprehensive audit on the publication of this report. This audit to be Lincoln-based and to ensure compliance with:

• the appropriate completion of all pathway documentation within the preset timescales;
• variance tracking, cause of variance and action taken;
• the views of carers having been sought and recorded.

Recommendation No.2 - All key junctures of the 'Integrated Care Pathway Assertive Outreach' should be subject to a comprehensive audit on the publication of this report. This audit to be Trust-wide and to ensure compliance with:

• the appropriate completion of all pathway documentation within the preset timescales;
• variance tracking, cause of variance and action taken;
• the views of service users having been sought and recorded.

Recommendation No.3 - The Operational Policies of the Community Mental Health and Assertive Outreach Teams must be revised in accordance with any service issues raised from the audit of the Integrated Care Pathways. For example these revisions may need to consider:

• establishment;
• skill mix;
• clinical supervision;
• record keeping;
• joint working with other services;
• referral and discharge process.

Update May 2011

Recommendations 1, 2, and 3

Elements of the Care Pathways identified above continue to be the subject of audit and survey. Regular internal audits address issues such as CPA and record keeping, and the views of carers are regularly sought through the provision of carers' assessments. LPFT scored above the national median in the 2010 Community Patient Survey on questions relating to service user involvement.

Furthermore, LPFTs services have recently been re-structured to strengthen clinical leadership within the divisions. This restructuring is expected to bring benefits in the areas of appropriate skill mix, clinical management, and effective internal and external referral, transfer and discharge.

LPFT is currently undertaking work on refining the care pathways to make them patient centred rather than service centred. The aim of this is to enable the patient to access the correct services at any time, and so to strengthen clinical management of cases.

Theme:

Section 117 Aftercare

No.4 - The aftercare needs of Mr. X were not adequately followed up via the provision of Section 117. This ensured that there was no statutory form of supervisory arrangement in place, as a result mental health services lost contact with Mr. X.

Recommendation No.4 - On the publication of this report a Lincoln-based service user and carer satisfaction survey should be conducted to ascertain the perceived effectiveness of the Integrated Care Pathway approach. This survey to establish whether:

• good quality, relevant information was provided in a timely manner;
• the wishes and preferences of service users was taken into consideration;
• the service user was introduced to a named nurse;
• conversations on recovery occurred;
• the service user, and where appropriate, the carer was involved in all aspects of assessment and care planning;
• carers assessments were offered;
• copies of relevant information were shared appropriately.

Update May 2011

Recommendation 4

The provision of carers' assessments is monitored monthly as part of the LPFT performance report. The Trust has a new carers leaflet (Jan 11) that encourages carers to consider if they are a carer and supports them to access a carers assessment if they wish. There is a county wide process for carers' assessment across all Lincolnshire agencies and there are a number of ways in which a carer can access an assessment. LPFT now works very closely with the

Local Authority Carers Support Team to ensure consistent processes. These are monitored quarterly by the Local Authority Carers Support Team. Currently, the percentage of carers offered an assessment stands at 98.6%.

LPFT were rated second in the country in the 2010 Mental Health Community Patient Survey. The Trust showed a consistently higher rate of improvement that the national rate, between the years 2006 – 2010, and the percentage aggregate score in that time improved from 64% to 77%. LPFT scored consistently higher than the median in the areas of Care Co-ordinator, care plan, review of care, and support in the community.

Theme :

Care Programme Approach

No.5 - Failure to implement the Care Programme Approach ensured that Mr. X was not appropriately assessed and was not in receipt of an appropriate care, crisis or contingency plan. As a result his care and treatment was entirely compromised and this lack of clinical management ensured that he slipped through the safety of care.

Recommendation No.5 - The risk assessment and management policy should be revised in accordance with national best practice guidance. The revised policy should integrate fully with the Trust Integrated Care Pathway Approach and Care Programme Approach procedures. The new policy should make explicit the requirements for:

• a professional standard of documentation;
• interagency/service liaison;
• safeguarding;
• carer communication and safety alerts (if indicated);
• dynamic care, contingency and crisis planning;
• plans for timed, specific intervention should relapse indicators be evident;
• the responsibilities of all Trust personnel at all levels in ensuring that policy is appropriately implemented.

Update May 2011

Recommendation 5

LPFT CPA training for care coordinators has been reviewed and incorporates a module on transitions and transfers of care. This training also reinforces policy standards and quality. Consistent documentation is used across many settings within services, and the introduction of the Wellbeing Plan, which incorporates review details, care plan & crisis planning promotes a service user focused and collaborative approach. Examples of best practice with regard to crisis and contingency planning have been disseminated into services in November 2010.

Safeguarding is now firmly embedded within LPFT. The Trust is increasing its Safeguarding capacity, and recently gained significant assurance from its internal auditors with regard to the management of vulnerable adults.

All policies are currently being reviewed as part of an overarching project to strengthen the provision of policy and guidance within LPFT. Within this project, roles and responsibilities of all levels of Trust personnel are made explicit within each policy.

For 2011/12, LPFT has used the opportunity of working with Commissioners through the Commissioning for Quality and Innovation scheme (CQUIN) to strengthen these areas. Agreed CQUIN targets for 2011/12 include the increased provision of wellbeing plans as detailed above, and the increased involvement of service users in defining CPA standards.

Theme:
Risk Assessment

No.6 - The failure to complete multidisciplinary risk assessments in the full context of Mr. X's forensic and psychiatric history meant that he remained an 'unknown' quantity. As a consequence the care and treatment that he received was not fit for purpose. This had a long-term detrimental effect on his future mental health.

Recommendation No.6 - The new risk assessment and management policy should be supported by a mandatory comprehensive training programme for **all** health and social care staff within the Trust. This training should make explicit the roles and responsibilities of:

• each health and social care professional;

• each clinical team;

• the corporate body.

Update May 2011

Recommendation 6

A new training programme has been devised which covers the above recommendations. There has been an implementation plan devised to support the new programme. The initial emphasis is on in-patient and crisis staff with plans in place to roll it out to all staff within the organisation. This revised training explicitly focuses on the assessment of risk, and the translation of that assessment into a workable management plan.

At the end of April 2011, almost 200 staff had undertaken the revised risk assessment and management training. Across the Trust, levels of compliance for Risk Training were at 70%. The Trust aims to reach 95% compliance by the end of 2011.

Theme:

Referral, Transfer and Discharge

No.7 - The non-adherence to Trust policy and procedure guidance led to an ineffective attempt to transfer Mr. X to Swindon-based services. This had the long-term effect of allowing an individual with an enduring mental illness to slip through the safety net of care.

Recommendation No.7 - On the publication of this report the Trust should conduct an audit against its current Discharge and Transfer (2009) policies and procedures to ascertain their effectiveness. These arrangements are relatively new and good practice would require that they are appraised and any appropriate revisions made as necessary.

Update May 2011

Recommendation 7

The most recent discharge and transfer audit was completed in March 2011. The results have been widely circulated and each unit is required to complete an action plan and demonstrate compliance in addressing any highlighted areas.

The results of this audit have also been broken down into 'unit specific' blocks and provided to appropriate teams. This allows the results of the audit to remain meaningful to Teams, and aids organisational learning.

Theme:

Carer Liaison

No.8 - Lincolnshire Services did not work with the family of Mr. X in accordance with Trust policy and procedure guidance. As a consequence this placed Mr. X's elderly parents in a situation that they were ill equipped to mange, and consequently this was to impact negatively on the mental health of Mr. X.

Recommendation No.8 - The Trust, in conjunction with NHS Lincolnshire and NHS East Midlands, should develop a formal memorandum of understanding with the Lincolnshire Police Force.

Update May 2011

Recommendation 8

LPFT works within the national memorandum of understanding between the Health and Police forces. Initial discussions have taken place between LPFT, NHS Lincolnshire and NHS East Midlands regarding progressing this work at a local level.

Theme:

Service User Involvement

No.9 - Mr. X was allowed to disengage from services. Trust policy and procedure was not adhered to and as a consequence Mr. X's mental illness was to go untreated for a period of four years.

Recommendation No.9 - The Trust should undertake a full and comprehensive audit against its current clinical and caseload supervision practice. This audit should review:

• the rate of compliance of clinicians undertaking clinical supervision;

• whether the grade of clinicians affects the uptake of supervision;

• sessions *per annum* undertaken by supervisees;

• how many supervisors have been appropriately trained;

• how clinical supervision is recorded;

• how supervision impacts positively on clinical outcomes.

Theme:

Interagency Working

No.10 - The different agencies and services involved with Mr. X over a period of seven years did not work in a system that facilitated interagency working. As a result the required levels of management and supervision of Mr. X's case did not occur.

Recommendation No.10. The Trust should revise its existing clinical supervision policy in the light of the audit findings. Appropriate training should then be provided for individuals acting in a supervisory role. This policy should also make provision for:

• Clinical Supervision;

• Caseload Supervision;

• Management Supervision;

• Trust internal Professional Regulatory Management systems.

Update May 2011

Recommendations 9 and 10

The Supervision Policy was reviewed in 2010, to strengthen and clarify expectations regarding clinical and management supervision. This was then audited in June 2010, and the above issues were included.

The audit will be repeated in June 2011, to identify any further issues and/or areas of progress. The policy is due for review as part of the Trust project to clarify the range of policies in existence.

In addition to the above, there will be an extra audit of supervision documentation within the Trust in 2011. This will help to triangulate the findings of the staff audit, and enable focussed work to take place to strengthen compliance.

Theme:

Clinical Supervision

No.11 - Mr. X was both complex and challenging. The lack of clinical supervision afforded the Care Coordinator compounded the difficulties that he faced in managing the case.

Recommendation No.11 - All Trust policies and procedures should make explicit the responsibility of the individual professional, the team and the statutory corporate body in the implementation of all local and national best practice guidance. These responsibilities should be restated at all annual staff development reviews and appraisals. These responsibilities should also be presented to all new staff as part of a formal induction process.

Update May 2011

Recommendation 11

All relevant LPFT policies were reviewed in 2010 as part of the work undertaken for the Level 2 NHS Litigation Authority assessment. All of these policies have a clear section detailing roles and responsibilities at all levels of the Trust.

All policies are due to be reviewed again in 2011.

Theme :

Non-adherence to Trust Policy and Procedure

No.12 - The consistent non-adherence to Trust policy and procedure on the part of Mr. X's clinical team ensured that his case was not managed effectively. This was to have a negative long-term outcome with regard to his future mental health.

Recommendation No.12 - New Policies should be disseminated in a formal and systematic manner. The following actions should be undertaken:

• formal training events should be conducted for both new policies providing guidance for significant clinical frameworks and major policy revisions (mandatory training should be considered for CPA and risk);

• policies and procedures should be provided in both electronic and hard copy formats for access by all clinical staff;

• team briefings and team meetings should highlight new policies and procedures;

• team briefings and team meetings should highlight issues arising from internal Trust investigations that have occurred directly due to non-adherence to policy and procedure guidance;

• team leaders should notify either the Director of Nursing or the Medical Director if they have reason to believe that existing Trust policy and procedure cannot be implemented effectively.
Mr. X Investigation Report 270

• new staff should have sufficient time made available to them to read and understand Trust policy and procedure requirements.

Update May 2011

Recommendation 12

If appropriate, major clinical policies are backed up by extensive training programmes, such as those developed in 2010/11 for CPA and Risk management. Whilst not fully mandatory, these are targeted at appropriate staff groups (for example in-patient and crisis).

All new policies and policy revisions are available to all staff in both hard and electronic copy through the Trusts intranet site.

If non-adherence to Policy is identified as a Root Cause of any incident, then the lessons learned from this are disseminated through the Trust's Clinical Alert System procedure.

Staff are shown how to access appropriate policies as part of the induction process.

The Trust was successful in late 2010 in gaining Level 2 NHSLA accreditation. This is evidence that the Trust not only has a suite of policies that are fit for purpose, but that these are being employed in practice. LPFT is currently working towards Level 3 assessment.

Appendix Two

Timeline Mr. X

Date and time	Event
27/6/64	Mr. X's date of birth.
1975- 1989	Mr. X was described as quiet and socially withdrawn with few friends or relationships. He was described as having one male friend with whom he lost contact when the friend got married. Mr. X left school at 16 and undertook an electrical apprenticeship. He remained living with his parents.
1989	Mr. X took up a civilian post with RAF, initially close to Swindon.
1994-1999	Mr. X worked at RAF Waddington from 1994-1999. Mr. X bought a house in Lincoln (about four miles away from the base) and lived there during each week and went back to parents' home each weekend.
1998 to 1999.	Mr. X was suspended and then dismissed in December 1999 from his post following allegations from a female colleague of harassment over many months. In January 2000 the female colleague became aware of a series of letters he had written to many people including the Prime Minister alleging that she was endangering others by spreading AIDS and using illicit drugs. She then contacted the Police and Mr. X was subsequently prosecuted and found guilty of harassment, which he continued to deny.
Probably first half of	During this period Mr. X took his dismissal to an Industrial Tribunal. He represented himself and lost the case. He then blamed his parents and '*beat up his father quite badly and hurt his mother. His parents barricaded themselves in the*

Date and time	Event
2000	*bedroom*.' Following this incident he left the parental home and went to live in Lincoln and his parents did not see him for a number of years. Mr. X's parents did not report this incident to the Police.
17/10/00	Mr. X was examined by a forensic psychiatrist for the Court Assessment Scheme.
19/10/00	Communication occurred between the probation officer in Lincoln, and the forensic psychiatrist, enclosing a copy of the Crown Prosecution Case Summary for Mr. X and asking for an opportunity to discuss Mr. X's case with him.
23/10/00	A psychiatric report was prepared by the forensic consultant psychiatrist. Mr. X was awaiting sentence having been found guilty of harassment. This report described Mr. X's perspective on the events which led up to his prosecution for harassment of a female work colleague, and also drew upon prosecution papers. The forensic psychiatrist noted that Mr. X had no previous psychiatric history, and his opinion was that Mr. X suffered from distorted thinking and a discrete delusional disorder. He recommended a probation order and a voluntary referral to mental health services.
2/11/00	Mr. X was convicted of harassment at Huntingdonshire Magistrates Court. He was placed on probation for 12 months and was ordered to pay costs and compensation. He was made subject to a restraining order. The National Identification Service records this as being his only conviction at that time.
Undated possibly Nov or December 2000	The forensic psychiatrist wrote to the probation officer, asking for the outcome of Mr. X's court case as he needed to know whether to arrange further follow up himself, or through psychiatric services in Bolton (where Mr. X had said he was studying). The forensic psychiatrist also commented that he had recently been contacted by phone by Mr. X's father who had expressed concern and said he had had no contact with Mr. X for over a year.

Date and time	Event
19/12/00	The probation officer in Bolton, wrote to the forensic psychiatrist informing him that she was supervising Mr. X, and asked for advice on engaging him with mental health services.
2000-2002	Mr. X continued to live in Lincoln and had no contact with his family, although he continued to send presents to his two nieces on their birthdays and at Christmas time.
26/3/01	The forensic psychiatrist wrote to the probation officer, replying to her letter of 19/12/00, suggesting that Mr. X be referred to the Mentally Disordered Offender Panel in Bolton, and giving permission to the panel to have a copy of his report. It is thought that Mr. X had moved back to Lincoln by this time having resigned from his studies in Bolton.
28/6/01	The senior probation officer in Lincoln, responded to series of letters of complaint from Mr. X, dated between 1/5/01 to 21/6/01, about the Bolton probation officer. None of his complaints were upheld but it was agreed he should have a change of supervisor. He was also sent an appointment to meet the new supervisor on 10/7/01.
13/7/01	Mr. X wrote to the Mental Health Act Commission in which he stated that he was called in to the Lincoln Probation Service on 10/7/01 when his new supervisor had informed him that he 'must seek medical treatment for a medical condition'. Mr. X wished to complain about the forensic psychiatrist's role in this.
July 2001-July 2002	Mr. X wrote letters to the Chief Constables of Greater Manchester and Cambridgeshire Police complaining of harassment and assault.
5/7/02	Mr. X sent letter to the Chief Constable of the Lincolnshire Police, complaining that he had been assaulted, bullied, harassed and had lies spread about him by the Police, since December 1999.

Date and time	Event
28/7/02	Mr. X went to the home of a Police offer who lived in the same street as himself and demanded to know if he was a Police officer, telling him he had complaints against the Police. He was abusive and threatening in tone and the Police officer asked him to leave his property. This incident was formally reported to the local Police station.
31/7/02	It was reported that Mr. X subjected a second Police officer to abusive gestures outside his home (who also lived in the street as himself). This officer had had no previous contact with Mr. X.
1/8/02	Information sharing occurred between Lincolnshire and Cambridgeshire Police. An officer from the Complaints and Misconduct at Lincolnshire Police informed a local Police Inspector that there had been '*numerous communications received from Mr. X complaining about assault from senior Police officers and collusion between this force (Lincolnshire) and United States of America special forces to cause him harm.*' It was reported in Police records that Mr. X had applied for the post of HQ manager and there was some concern regarding the content of his applications. The Police had clear concerns that Mr. X had 'an unhealthy interest in the Police and was displaying some aspects of obsessional behaviour.' Discussions took place with an officer from the Cambridgeshire Police it was noted that '*He knows Mr. X and describes him as dangerous and having a personality disorder'.* Arrangements were made to install alarms in the Police houses if requested.
2/8/02 14.48	Mr. X was arrested in the rear garden of his home, he was taken to the Police station and kept in custody. He was reported as having been violent on arrest as he had secateurs in his hand which he refused to put down. There was a struggle and he was handcuffed.
2/8/02 20.35	Mr. X was seen by a Police surgeon, for a psychiatric assessment. He reported that Mr. X was not co-operative and recommended a formal psychiatric assessment by a consultant psychiatrist. He assessed him as fit to be detained and fit to be interviewed.

Date and time	Event
3/8/02 13.10	Mr. X was seen by a duty psychiatrist, an Approved Social Worker, and the Police surgeon, for a Mental Health Act (1983) assessment. The duty psychiatrist reported that Mr. X refused to answer any questions and was uncooperative. The duty psychiatrist read the previous forensic psychiatrist's report (2000) and a sample of Mr. X's letters and recorded the following opinion. *'I am of the opinion that Mr. X suffers from a long-standing paranoid delusional disorder. He in the long term poses a risk to others and would benefit and needs further psychiatric assessment and treatment. I would recommend that Mr. X be charged for the alleged offences and a request for four weeks remand in a secure ward for further assessment be obtained at the Magistrates Court, or be remanded in custody in a prison where he could be assessed by a forensic psychiatrist with a view to recommendation for section 37. '*
3/8/02 13.50	Mr. X was charged with three counts under the Public Order Act.
3/8/02 14.15	Whilst under review on detention a Police officer noted that Mr. X had stated in writing that he intended to purchase a 'legal weapon', and reported that he felt grave concern and that he was a '*bomb waiting to go off*.' It was agreed that his detention should continue.
5/8/02	There is a reference in Police custody records to Mr. X to appearing in court on this date, but no further information regarding the outcome is available. It would appear that Mr. X was allowed to go back to his home at this stage.
7/8/02	Mr. X sent letters to the Police Complaints Authority and to the Chief Constable complaining that he had been arrested with excessive force and assaulted in his back garden.
13/8/02	Mr. X wrote to the Police Complaints Authority complaining that Police officers had threatened to kill him, sworn through his letter box, banged on his back patio window and brandished two knives stolen from his knife box during an illegal search. This letter also referred to Mr. X's complaint to the European Court of Human Rights for unfair dismissal, and his view that

Date and time	Event
	his conviction for harassment was unlawful.
15/8/02	Mr. X sent letter to the Chief Constable complaining of Police harassment and assaults.
29/8/02	Mr. X sent letters to the Chief Constable and to the Police Complaints Authority in which he alleged that Police officers and United States of America rangers trespassed onto his property and that one had produced a gun which was pointed at the back window.
2/9/02	Mr. X sent letters to the Chief Constable and the Police Complaints Authority complaining of harassment.
6/9/02	Mr. X sent letters to the Chief Constable and the Police Complaints Authority complaining of unlawful arrest with a further reference to a United States of America ranger.
17/9/02	Mr. X was referred to the Lincolnshire Multi-Agency Public Protection Panel because of '*his rapidly deteriorating mental health combined with his move towards arming himself with knives*.'
19/9/02	Mr. X was referred for Mental Health Act (1983) assessment by a senior nurse manager from the low/medium secure unit following discussions with the Police.
19/9/02	On this date the Police records appear to have been faxed over to the Trust.
19/9/02	An initial attempt was made to conduct a Mental Health Act (1983) assessment, without forcible entry, with no success. An

Date and time	Event
	Approved Social Worker, gained a Section 135 warrant. The Police forcibly entered Mr. X's home with a duty consultant psychiatrist, a GP, and the Approved Social Worker. Mr. X was sitting on the sofa facing the front door. Mr. X refused informal admission and was admitted to an acute inpatient admission ward under Section 2 of the Mental Health Act (1983).
19/9/02	The Approved Social Worker (ASW), wrote her Record of ASW Assessment, Part A, including some history. In the section on Nearest Relative she recorded 'unable to ascertain'.
19/9/02	A risk assessment checklist was completed by a ward staff nurse. Mr. X was described as paranoid, deluded and feeling that the Police were watching him. Evaluation of the risk posed was: Risk of suicide – low Risk of violence or aggression according to this risk assessment - low to moderate Risk of self neglect - low. Under personal impressions there was an entry which stated '*I believe he has the potential to commit greater acts of violence etc.'*
19/9/02	A psychiatric assessment and history taken by the Duty Psychiatric SHO. The differential diagnosis was paranoid schizophrenia, but tests to rule out any organic cause were ordered. Plan: '*Admission for assessment* *Regular bloods* *Medication PRN Zopiclone and Lorazepam* *Close observations in first 24-48 hours – placed on 15 minute observations.* *Physical examination to be done by regular team after patient consents.*'
19/9/02	A named nurse was allocated to Mr. X.

Date and time	Event
20/9/02	The Approved Social Worker completed Part B of her Record of ASW Assessment on Mr. X, and gave details of her reasons for the application and the process.
20/9/02	Trifluoperazine prescribed twice daily but consistently refused by Mr. X.
20/9/02	A Section 17 form was completed giving Mr. X escorted leave in the hospital grounds for five days.
23/9/02	A Fax was sent by the ward manager to the Lincoln Magistrates court enclosing a letter from Mr. X asking for an emergency adjournment of the hearing on 26/9/02 for a number of reasons including his detention in hospital under Section 2 of the Mental Health Act (1983).
23/9/02	The Police searched Mr. X's house and found three knives, a meat cleaver and photographs that he had taken of local Police officers.
24/9/02	A Section 17 leave form was completed giving Mr. X escorted hospital grounds leave for one week.
26/9/02	Mr. X's Section 2 was regraded to Section 3 of the MHA 1983. The reasons for this regrading were that he was becoming increasingly hostile and aggressive and he was refusing all treatment.
30/9/02	Mr. X's psychiatrist wrote to the Mental Health Review Tribunal prior to their review of Mr. X's status under Section 3 of the Mental Health Act (1983). He stated Mr. X's diagnosis was delusional disorder and quoted ICD 10, *'This group of disorders is characterised by the development either of a single delusion or a set of related delusions which are usually persistent and sometimes lifelong'*. He also indicated that Mr. X represented a danger to the safety of others.

Date and time	Event
30/9/02	A Section 17 leave form was completed giving Mr. X escorted access to the hospital grounds and escorted community leave, until 3/10/02.
30/9/02	Mental Health Review Tribunal was held to review Mr. X's Section 3. It was the Tribunal's decision that Mr. X's section should remain in force to prevent deterioration of an already chronic and potentially unpredictable mental illness.
1/10/02	Mr. X wrote to the ward staff asking for Section 17 leave to collect some clothes from his home and to go to a cash point to collect some money.
2/10/02	Clopixol 100mg (test dose) was administered to Mr. X on the ward. Mr. X had to be restrained by staff as he continued to refuse medication.
3/10/02	A Section 17 leave form was completed giving Mr. X escorted hospital grounds and community escorted leave for one week.
9/10/02	Clopixol 200mg given on the ward.
10/10/02	Patient Registration Summary recorded Mr. X as being on Enhanced Care Programme Approach and as having schizophrenia.
10/10/02	A Section 17 leave form was completed giving Mr. X escorted leave in the hospital grounds and escorted community leave, for one week.

Date and time	Event
20/9/02 – 28/10/02	A number of entries in medical notes recorded Mr. X's refusal to talk to doctors at times and his continuing belief that he was not ill, and that there was a conspiracy involving the Police and the hospital.
17/10/02	A Section 17 leave form was completed giving Mr. X up to half an hour unescorted leave in the hospital grounds for one week.
21/10/02	An associate nurse, wrote nursing reports for the Mental Health Review Tribunal and the Managers' meeting. She concluded that lifting his section would be detrimental to his well being and a further period of treatment was necessary.
23/10/02	Clopixol 200mg given on the ward.
23/10/02	The ward sister was informed by the Police that Mr. X's court case had been adjourned.
24/10/02	A Section 17 leave form was completed for the period up to 7/11/02 for unescorted leave in hospital grounds and escorted leave in the community.
31/10/02	In the ward round it was recorded that there may have been some improvement, and that Mr. X appeared more communicative to staff and had attended a group that morning.
31/10/02	A report prepared for the Hospital Managers Hearing. This report gave details of and reasons for Mr. X's detention and recommended that he should not be discharged.

Date and time	Event
6/11/02	Mr. X had an appeal against his Section 3 heard by the Hospital Managers. The nursing notes recorded that the consultant psychiatrist and Mr. X agreed that he would remain on Section 3 of the Mental Health Act (1983) but would have extended leave to his home and would return to the ward for his medication.
7/11/02	A Section 17 leave form for overnight leave from 7/11/02 to 14/11/02 was completed.
13/11/02	The nursing notes record a conversation between the Mental Health Act Administrator and Mr. X's solicitor concerning his refusal to accept depot medication, and the advice that he could not be given treatment against his will whilst on Section 17 leave.
14/11/02	A Section 17 leave form for overnight leave from 14/11/02 to 21/11/02 was completed. Mr. X was on a period of leave, but attended the ward round and reported that he was not harassing the Police and they were not harassing him. He agreed to a home visit by a Community Psychiatric Nurse.
18/11/02	A care co-ordinator made a first home visit to Mr. X. The Care Coordinator described Mr. X as being reasonably friendly, willing to have his depot medication administered by him, and not hostile. He had some complaints of motor restlessness and dry mouth.
19/11/02	A home visit from the Care Coordinator took place, who took forms for Mr. X to register with a GP. Mr. X appeared settled, but was concerned that he was running out of money as he had spent most of his savings. He also talked about his case at the European Court of Human Rights and the Police report that they had found knives at his house.

Date and time	Event
20/11/02	The Care Coordinator wrote to the Consultant Psychiatrist describing his first recent home visit to Mr. X.
21/11/02	Mr. X attended the ward round. He complained that he was not sleeping well, and was generally tired.
21/11/02	Clopixol 200 mg given, on the ward.
25/11/02	Mr. X registered with a GP Practice. Mr. X appears to have been seen by one of the GPs and he told them that he was not sure what his illness was and did not think Clopixol helped him but was willing to continue with it.
25/11/02	The Care Coordinator accompanied Mr. X to the Benefits Office. Mr. X appeared mildly suspicious.
25/11/02	Invitations to Mr. X's CPA review on 12/12/02 were sent out.
27/11/02	Mr. X appealed against his Section 3 detention to the Mental health Act Tribunal. The Tribunal discharged him from the section, and he immediately discharged himself from the ward. The reasons for the Tribunal's decision were that they had no doubt that the original detention was justified by his psychotic state at the time. However he had responded to treatment and was no longer expressing persecutory delusions. He remained, however, '*guarded and suspicious.*'
27/11/02	A telephone message was recorded in the GP notes to say that Mr. X had been discharged from the ward that day.
Nov 02	An unknown member of the clinical team made some contact with Mr. X's parents.

Date and time	Event
3/12/02	A discharge summary was written to Mr. X's GP. This letter refers to him having been on section 3, but there is no reference to section 117.
4/12/02	A home visit was made to Mr. X by his Care Coordinator. Clopixol 150 mg injection given.
4/12/02	Mr. X's father rang a social worker asking how Mr. X was. He left his number and the Care Coordinator tried to respond but there was no reply.
5/12/02	Memo from the Trust's Complaints Manager enclosing a copy of a response from the Chief Executive to a complaint from Mr. X. The actual letter of complaint was not attached.
12/12/02	An urgent message was placed in Mr. X's clinical file. This note described a telephone call from Mr. X's father in which he expressed his concern about his son and his lack of money and his need for his benefits to be sorted out. His parents told the person taking the message that they had had no contact with Mr. X for three years and had not known his whereabouts until recently.
12/12/02	Mr. X's father rang and expressing his concern about his son's health. He said that he had posted a mobile phone to Mr. X so that they could keep in touch.
12/12/02	CPA review timetabled for this date. No record in notes. The Care Coordinator was on leave on this date.
18/12/02	A message was left for the Care Coordinator that Mr. X's parents had been in touch with him and had arranged for him to visit them over Christmas.

Date and time	Event
	A home visit was undertaken Clopixol 150mg given. Further help with Mr. X's benefits claim was given.
23/12/02	Two home visits from the Care Coordinator were made. Mr. X was not there.
24/12/02	Two home visits from the Care Coordinator were made. Mr. X was not there. The Care Coordinator telephoned Mr. X's father and was told that he was with them for the Christmas period.
24/12/02-1/1/03	Mr. X spent the Christmas period with his parents in Swindon. He effectively lived with his parents from this period until their deaths.
2/1/03	A home visit from the Care Coordinator was made. Mr. X was at home with his parents and had his Clopixol injection. He appeared settled.
7/1/03	The Police contacted the Care Coordinator about returning Mr. X's property. He also referred to four photographs which Mr. X had taken of Police officers and the Police wished to destroy. The Care Coordinator agreed to discuss this with Mr. X. The Care Coordinator discussed the photographs with Mr. X who did not want the photos destroyed as he said he was advised by his solicitor to take photos of officers trespassing on his property.
8/1/03	Mr. X's property was collected by the Care Coordinator. The Police were withholding four photographs and camera. The Police told the Care Coordinator that he could see Mr. X's letters if he wished. The Care Coordinator returned the property to Mr. X. Mr. X thought some clothing may be missing. He continued to believe that the Police were in some conspiracy with American rangers, although he accepted that the harassment had stopped around the time of his admission.

Date and time	Event
9/1/03	A letter was sent from the consultant psychiatrist to the Care Coordinator asking him if he had any news of Mr. X as he had not attended his CPA meeting.
10/1/03	A letter was sent from the Care Coordinator to the consultant psychiatrist informing him that Mr. X was accepting his fortnightly Clopixol, although somewhat reluctantly. He reported that he still appeared quite suspicious and still insisted there was a conspiracy against him. A copy of this letter was also sent to the GP.
10/1/03	A telephone discussion between Mr. X's father and the Care Coordinator took place. Mr. X's father confirmed that he could stay with them in the event that he sold his house. A home visit to Mr. X from the Care Coordinator took place, further advice on sickness certification and benefits was given.
15/1/03	Mr. X's father visited his MP, Michael Wills, in his constituency office.
16/1/03	Michael Wills, MP, wrote to the chief executive of Lincolnshire partnership Trust, raising matters related to claiming benefits, and the responsibility of the Trust in this matter.
16/1/03	A home visit from the Care Coordinator took place and Clopixol 150mg given. The injection was next due on 30/1/03 but it was not given as Mr. X started oral medication. Mr. X remained distant and suspicious. He said he would be willing to comply with oral medication.

Date and time	Event
21/1/03	The CPA review attended by Mr. X, with the Care Coordinator and consultant psychiatrist. Mr. X appeared to remain somewhat distant but said he was not ill. He continued to appear to be guarded and monosyllabic. His medication was reviewed and it was agreed his Clopixol would be stopped and he would go onto oral medication (Olanzapine) to be prescribed by his GP. The CPA review document was partially completed. Mr. X was recorded as being on **Standard CPA** and there is no reference to Section 117.
21/1/03	Risk assessment documentation was completed by the Care Coordinator . The assessment noted in relation to risk of harm to others, that Mr. X had a long history of grievances against the Police, that he was suspicious and mildly hostile, and difficult to engage, and that he did not give the impression of being a violent personality, although his illness had affected this.
22/1/03	A telephone call took place between a Police officer and the Care Coordinator . Mr. X's solicitor had advised him to let the Police have the photographs. As a result the Care Coordinator was told that the Police would then be willing to drop the harassment charge.
23/1/03	The consultant psychiatrist wrote to Mr. X's GP describing Mr. X's mental state and stating that *'in view of his compliance so far, I suggest a change to oral medication'* , namely Olanzapine 10mg at night. He made a few further comments about employment and benefits and commented that there had been no further conflict with the Police.
29/1/03	The Care Coordinator met an officer at the Police station to look at the letters that Mr. X had written to the Chief Constable and the Police Complaints Authority. It was his view that the letters indicated disordered thinking and a belief that there was a conspiracy against him, involving the American rangers from RAF Waddington. The Care Coordinator also recorded that a Police officer would be available to attend a case conference or review in February if the consultant psychiatrist was happy with this. The Police had had no further complaints from Mr. X, but they continued to believe that he could be violent.

Date and time	Event
30/1/03	A home visit from the Care Coordinator took place. During the session the Care Coordinator mentioned the photos of the off-duty Police officers and asked Mr. X if he would now be willing to have them destroyed. Mr. X then became irritable and angry and said that the Police officer across the road had 'got it in for him' because he had made a complaint about him. Mr. X thought that the Care Coordinator was 'siding' with the Police. The Care Coordinator discussed this matter with the consultant psychiatrist and then informed the Police of Mr. X's continuing views and possible continuing risk to Police officers.
February 2003	The sister of Mr. X reported that she first contacted the Lincoln services to ask for Mr. X's care to be transferred to Swindon.
6/2/03	A letter from the Lincoln Mental Health Services Chief Executive was sent to Mr. X's father, via his MP, saying that the Trust had not received Mr. X's consent to share information about his care.
12/2/03	the Care Coordinator recorded that Mr. X continued to stay with his parents, and that he had had telephone contact mainly around benefits and entitlements.
27/2/03	A home visit by the Care Coordinator took place to see Mr. X who was with his parents. He was told that Mr. X had spent the previous three weeks with his parents and appeared to be well and was more sociable, although still quite '*economical with conversation*'. Further discussion about his benefits.
4/3/03	Mr. X attended an outpatient appointment to see his consultant psychiatrist with the Care Coordinator. The Care Coordinator recorded that Mr. X remained self contained, denied mental illness, but paranoid features concerning the Police remained evident. His delusional ideas had become encapsulated. A further outpatient appointment was planned for three months time.

Date and time	Event
5/3/03	A letter was sent from the consultant psychiatrist to Mr. X's GP. In this letter he stated that his opinion was that Mr. X had a paranoid disorder which had been partly responsive to antipsychotic medication, with a result that his delusional ideas had been 'encapsulated' but still persisted in the background. He referred to the possibility that the current Care Coordinator might be moving to a different job and he wondered if Mr. X would relate to anyone else, and recommended continuing Olanzapine 10 mg *nocte*.
10/3/03 and 14/3/03	Telephone calls took place between the Care Coordinator and Mr. X whilst he was in Swindon, mostly about his benefits. On 14/3/03 the Care Coordinator informed Mr. X that he would be leaving his post and that another Care Coordinator would be identified.
18/3/03	A medical form for Incapacity for Work claim was completed on Mr. X's behalf by his GP.
4/4/03	Liaison between the Care Coordinator and the Department of Social Security (DSS) took place, with the DSS asking for more information. the Care Coordinator tried to contact Mr. X on his mobile telephone with no success.
14/4/03	The Care Coordinator tried to telephone Mr. X on his mobile phone with no response. The Care Coordinator also tried to contact Mr. X's father with no success. He recorded that he would shortly be handing over Mr. X's care to someone else.
15/4/03	Telephone contact was made with Mr. X on his father's telephone. He stated he had already supplied all the requested information to the DSS and may go down the complaints route. An arrangement was made to meet the following week with Mr. X's future Care Coordinator.
25/4/03	A home visit was made to Mr. X by the current Care Coordinator and his replacement. Mr. X told them he did not have, and never had had a mental illness and complained about the consultant psychiatrist in relation to his detention. He also

Date and time	Event
	suggested that the Care Coordinator had backed the consultant psychiatrist, and was hostile and suspicious. Mr. X said he no longer was being harassed by the Police officer over the road. He said he would continue with the Olanzapine as if he did not the consultant psychiatrist would take him back into hospital. The Care Coordinator recorded that the new Care Coordinator would arrange further appointments with Mr. X. This was the last time he was seen by the Lincolnshire mental health service.
15/5/03	The new Care Coordinator wrote to Mr. X asking him to make contact to arrange a further appointment.
16/5/03	The Care Coordinator recorded that he had made 'continuous attempts' to contact Mr. X, and left messages asking him to contact the team base. He had written to Mr. X's home address asking him to make an appointment. He also made contact with the Police.
29/5/03	A letter was sent from the consultant psychiatrist's medical secretary acknowledging that Mr. X had let her know that he would not be able to attend his out-patient appointment on 3/6/03. The appointment was rebooked for 26/6/03.
9/6/03	The Care Coordinator recorded that there had been no response to his letter or telephone calls. He had been in touch with the consultant psychiatrist and had been told that his medical secretary had invited Mr. X to attend the ward round on 26/6/03.
23/6/03	The Care Coordinator wrote to the consultant psychiatrist telling him that he had not be able to see Mr. X and that he planned to come to the ward round on 26/6/03 as he understood that Mr. X may attend.
26/6/03	Mr. X did not attend the ward round. The consultant psychiatrist '*instructed that Mr. X be discharged*', and the Police to be informed.

Date and time	Event
Undated, possibly June 2003	CPA documentation which referred to Mr. X as having been on Enhanced CPA and subject to section 117 was partially completed. There was a section on current signs which recorded that Mr. X had started to write letters complaining about his care under the consultant psychiatrist and about Police actions. There had been no contact with Mr. X since April 2003, despite '*numerous telephone calls and written correspondence asking him to make contact*'.
10/7/03	The Care Coordinator recorded that Mr. X had apparently asked to see his medical and nursing records. A telephone call from the Police informed the Care Coordinator that Mr. X had sent recent letters of complaint against the Police and he wondered if this might indicate deterioration in his mental state. The Care Coordinator discussed this with the consultant psychiatrist and if was agreed that Mr. X would be contacted to ask him to attend the ward round 'on a Thursday'.
11/7/03	The Care Coordinator contacted Mr. X's father and asked if a letter could be sent to his address. Mr. X was present but refused to speak to the Care Coordinator. Mr. X's father said that he would be in Lincoln next Thursday but when his father asked Mr. X if he could attend the consultant psychiatrist's ward round at that time, Mr. X was heard to reply No. A letter of invitation was to be sent to his home address.
11/7/03	The Care Coordinator wrote to Mr. X at his home address inviting him to a review meeting with himself and the consultant psychiatrist on 24/7/03.
24/7/03	The Care Coordinator attended the ward round as planned, but Mr. X did not attend. It was agreed that a possible discharge was to be discussed with the consultant psychiatrist.
25/7/03	A risk profile summary and first contact risk profile was completed by the Care Coordinator . This document recorded that Mr. X was on Enhanced CPA.

Date and time	Event
29/7/03	The current Care Coordinator received a telephone call from the previous Care Coordinator who had been contacted by the sister. She had been expressing concern over her brother's mental state and thought there was some deterioration. He had been laughing inappropriately and sending 'vast amounts of letters'. She had already been advised to register Mr. X with a Swindon GP, so that he may be able to access services there, but Mr. X had refused. Mr. X's parents were struggling to cope with Mr. X. He was bombarding people with letter of complaint.
1/8/03	The Lincoln Care Coordinator contacted the community mental health team in Swindon and gave them information about Mr. X with a view to transferring his care. He recorded that the Swindon team planned to discuss this at their next team meeting and would reply to him.
4/8/03	A letter was sent from the consultant psychiatrist to Mr. X's GP stating that Mr. X had not attended his outpatient appointments with either himself or the Care Coordinator and he had no alternative but to discharge him from his outpatient service. He commented that Mr. X did not appear to be writing any unpleasant or harassing letters, and that he may have already returned to Swindon to live. There was no reference in this letter to Enhanced CPA or section 117.
14/8/03	The Care Coordinator wrote to the consultant psychiatrist telling him that he had had no recent contact with Mr. X and that he had been in contact with Swindon services. It appears that this letter was not copied to Mr.'s GP until 4/11/03.
18/8/03	The Care Coordinator reported that the CMHT in Swindon had asked Mr. X's father's GP to visit him, and that this was done. However Mr. X was not willing to engage with the GP, and it had increased Mr. X's suspiciousness regarding his family. The Care Coordinator contacted Swindon CMHT again and told them he wished to hand over Mr. X's after-care. He was asked to send a letter requesting that Mr. X's case be discussed at the team allocation meeting for Mr. X's after-care needs.
18/8/03	The Care Coordinator wrote to another team leader within the Swindon CMHT service summarising some of the background

Date and time	Event
	relating to Mr. X's past care and treatment. This letter referred to Mr. X spending most of his time in the Swindon area and also stated that he was eligible for Section 117 aftercare. A transfer was requested and the Swindon team were asked to inform Lincolnshire of their decision.
23/10/03	The Care Coordinator wrote a letter to the Swindon team manager that he had previously been in communication with, enclosing information about Mr. X.
28/10/03	There were two further telephone conversations between the Care Coordinator and the Swindon CMHT team manager. The Care Coordinator was advised that background information should be sent down to the Swindon team. If Mr. X came to their notice at a future date they would have some background information to work on. This information was sent down on 23/10/03. The Care Coordinator recorded that Mr. X would not be taken on by the Swindon team as he was not registered with a Swindon GP, and he was 'unlikely to engage anyway'. The Care Coordinator's intention was to discharge Mr. X from his caseload, but to offer him the opportunity to contact him if he needed to.
4/11/03	The Care Coordinator wrote to Mr. X's home address informing him that he intended to discharge him from his caseload, and transfer his aftercare to Swindon. He also recommended that Mr. X registered with a GP in Swindon. There was no discharge care plan or transfer of care plan developed. This letter was also copied to X's GP.
4/11/03	The Care Coordinator sent a letter to the Lincoln-based GP to inform the surgery of the discharge decision. A further letter was also sent to the Consultant Psychiatrist.
11/11/03	The Care Coordinator recorded in the notes that he had sent letters to Mr. X, the Consultant Psychiatrist and the Lincoln-based GP informing them that he had discharged Mr. X from his caseload. This appears to be the last entry written in the Lincolnshire community team notes.

Date and time	Event
2003-04	Mr. X continued to stay with his parents and travel to Lincoln each month to collect his prescription end have it dispensed at a local pharmacy. The GP notes record the following dates for the issuing of prescriptions for Olanzapine: 30/1/03, 27/2/03, 20/3/03, 24/4/03, 22/5/03, 19/6/03, 17/7/03, 21/8/03, 25/9/03, 23/10/03, 27/11/03, 18/12/03, 29/1/04, 1/3/04, 25/3/04, 25/3/04.
March 2004	Mr. X sent large number of letters of complaint to numerous bodies, including the Health Service Ombudsman. The last letter in this file is dated 12/3/04 and is written from X's Lincoln address.
25/3/04	A telephone discussion took place between the GP and the sister of Mr. X. The electronic notes recorded '*Living in Swindon with elderly parents. Parents bring him to Lincoln once a month to collect Olanzapine and check his house. Won't seek medical advice in Swindon. Mental state has deteriorated over last month. Advised she/parents must seek help from local GP/psychiatric services unless he returns to Lincoln for assessment. No further Olanzapine to be issued from this surgery.* '
25/3/04	Medication history in GP notes recorded that Olanzapine prescription was stopped from this date.
March 2004	According to the sister of Mr. X he then said that he was no longer ill and no longer needed medication. He also continued to refuse to register with a local GP.
30/3/04	The Lincoln-based GP completed a medical form for Incapacity for Work claim, and recorded that Mr. X was last seen on 25/3/04.
10/5/04	The Lincoln-based GP wrote to Mr. X saying that as he had still not attended for a review the surgery felt it could no longer

Date and time	Event
	continue to offer medical services and asked Mr. X to register with a GP nearer to his current place of residence.
21/12/04	The Lincoln-based GP completed a medical form for Incapacity for Work and entered '*unable to comment'* in the relevant boxes, and gave information that Mr. X now lived with his parents in Swindon and had not been seen by the practice since 25/4/03.
February 2003 – February 2007	The sister of Mr. X reported that she made 20-30 telephone calls to the Lincoln service and 20-30 to the crisis team and other parts of the Swindon service during this period, asking for help and intervention for her brother and her parents.
2004-2007	Mr. X continued to live in his parents' home. According to his sister he applied for many jobs, spent long periods in the library, and occasionally visited his sister and her family, although his nieces became increasingly uncomfortable in his presence. He had no other relationships outside the home. The sister of Mr. X continued to contact both Lincolnshire and Swindon-based services with no success.
Early 2007	Mr. X's family became increasingly concerned about his mental health and again contacted Lincolnshire and Swindon services, but were told that the local service could do nothing as he was not registered with a GP in the area.
13/2/07 – 14/2/07	The sister of Mr. X went to the Citizen's Advice Bureau (CAB). The CAB contacted the Police who contacted the sister of Mr. X and said they would contact the social work team. The sister of Mr. X then received a telephone call from the Emergency Duty Team (EDT) who took details, but told her there were insufficient grounds for a Mental Health Act (1983) assessment but that they would pass on the information to the mental health service. It is not possible to determine whether this communication took place. There is no record at the CMHT and the EDS records were, at that time, deleted after one month. The Police log was closed following the referral to the EDT.

Date and time	Event
	The EDT advised the sister of Mr. X to get him registered with a GP and to tell her parents to call 999 if he became violent. The EDT closed the case.
February – June 2007	Mr. X's family became increasingly concerned about his mental health. Apparently Mr. X had become worried about the bathroom in his parent's bungalow, the bath had broken and he decided to mend it himself. There was growing tension between Mr. X and his parents.
13 and 14/6/07	The sister of Mr. X visited the Police station and then made numerous calls to the Crisis Team, CAB, Mental Health Act Commission, Lincoln services, and the Local Authority asking for help. None of the provider services would offer any assistance however the Lincoln-based Consultant Psychiatrist's Medical Secretary said she could send information to the Swindon-based mental health services if she received a headed letter from them formally requesting this.
17 or 18/6/07	The sister of Mr. X telephoned the Swindon Crisis Team and spoke to a Crisis Worker. The Crisis Worker agreed to contact the Lincoln-based services to request further information regarding Mr. X.
19/6/07 15.30 hrs	The Swindon Crisis Team referral form was completed by the Crisis Worker, with the sister's name as the referrer. The referrer's expectation of the crisis team was stated as being *'assessment and treatment of mental illness'*. Under 'details of current problem' it was stated that Mr. X had been untreated for several years, that he had no GP, and that his parents may be at risk from him. The Crisis Worker telephoned Lincoln mental health services and spoke to the Consultant Psychiatrist's Medical Secretary, but she was not available. A Fax was sent asking for information to be sent urgently.
20/6/07	The Swindon-based Crisis Worker telephoned the Consultant Psychiatrist's Medical Secretary in Lincoln to get information and request notes.

Date and time	Event
20/6/07	A Fax was sent by the Swindon Crisis/Home Treatment team to the Consultant Psychiatrist's Medical Secretary urgently requesting information regarding Mr. X, in response to the urgent referral made by the sister of Mr. X.
20/6/07	It is recorded that the Crisis Worker telephoned the Vulnerable Adults Unit to discuss Mr. X's case. It is recorded that there was no answer and that a message was left on the answer machine.
21/6/07 Thursday	A Fax was received from the Consultant Psychiatrist's Medical Secretary enclosing Mr. X's discharge summary and a letter from the Consultant Psychiatrist to the Lincoln-based GP at the point when Mr. X was discharged from his care. The fax also stated that Mr. X's full notes were to follow.
21/6/07	The Crisis Worker discussed a Mental Health Act (1983) Assessment with an Approved Social Worker. The Crisis Worker then contacted the sister of Mr. X and discussed a Mental Health Act (1983) assessment with her. The sister of Mr. X was concerned for her parent's safety and told the Crisis Worker about previous violence, however the Crisis Worker did not record any of this in her notes. It was understood the risk was more to do with possibly damaging family relationships rather than violence. The Crisis Worker's notes recorded that they discussed what would happen if Mr. X was not detained and how this could put his parents at risk. The sister of Mr. X agreed to show the Crisis Worker some of the letters Mr. X had written to illustrate her concerns.
22/6/07	Copies of letters written by Mr. X were delivered to the Crisis Team by the sister of Mr. X.
25/6/07 Monday	The sister of Mr. X understood a Mental Health Act (1983) assessment would take place on this date. This did not occur.

Date and time	Event
26/6/07	The Crisis Worker discussed the matter with a senior Approved Social Worker (Local Authority Advisor), and they apparently agreed that there was no clear risk to the parents. However it was agreed that Crisis Worker would follow up the Vulnerable Adult referral and meet Mr. X's parents.
26/6/07	The Crisis Worker's notes recorded a lengthy discussion that had taken place with the Local Authority ASW advisor. They agreed that they did not have enough evidence that Mr. X presented a risk to his parents or others, the plan was to: • Follow up with Vulnerable Adults Unit • Arrange a meeting to discuss the situation with the parents • Speak to the Lincoln-based Consultant Psychiatrist
26/6/07	It is recorded that the Crisis Worker telephoned the Vulnerable Adults Unit and left a further message on the voice mail. Telephone call to SFS, message left on voicemail.
29/6/07	The Crisis Worker's notes recorded that she had a discussion with her team manager regarding her conversation with the Local Authority ASW Advisor, and that they agreed a plan. It was recorded that a further telephone call to the Vulnerable Adults Unit was made and a message left on the answer machine. A telephone call was made to the sister of Mr. X to inform her of the outcome of discussions with the lead ASW.
4/7/07 Wednesday	The Crisis Worker telephoned the sister of Mr. X to request a meeting with her parents. The sister of Mr. X said she would discuss a suitable time with her parents. The plan was for the Crisis Worker to telephone her after 4pm on Monday 3 July 2007.
10/7/07 Tuesday	The Crisis Worker telephoned the sister of Mr. X and apologised for not having telephoned the previous afternoon. It was agreed that Mr. and Mrs. X senior would come to the Crisis Team office at 2pm on Thursday, 12 July 2007.

Date and time	Event
10/7/07	A discussion took place between the Crisis Worker and the Crisis Team Manager, regarding the forthcoming Thursday meeting. The plan was to contact the Lincoln-based Consultant Psychiatrist, and to chase up the Vulnerable Adults Unit (if appropriate), a case conference was also to be arranged. This is the last entry in the clinical notes.
10/7/07	There is a reference in the Avon and Wiltshire Internal Investigation report to a telephone conversation, between the Crisis Worker and the sister of Mr. X on this date. Shortly after this she was contacted by Mr. X and asked to visit him at their parent's home. When she arrived her parents were not there and her brother told her they had gone up to Lincoln whilst he finished the work on the bathroom. She helped with the work that evening. The following day her parents were reported missing.
Between 9/7/07 (Mon) and 12/7/07 (Thurs)	Homicide of Mr. and Mrs. X senior at their home in Swindon. Their bodies were found at Mr. X's house in Lincoln.

Appendix Three

Care Pathway

The proforma below charts the events regarding Mr. X in a chronological order

Date	Actual Care Pathway of Mr. X	Met ✓ Partially Met? Unmet ✘	Agreed Formal Care Pathway Based on Extant Contemporaneous Local and National Policy and Procedure Expectation
	First Contact with Mental Health Services		
17.10.00	An assessment took place by a Forensic Psychiatrist for the Lincoln Court Assessment Scheme following Mr. X's conviction for harassment. Mr. X was diagnosed as having a delusional disorder and a risk assessment was conducted. Mr. X was placed on Probation for 12 twelve months (in Bolton). The order was made with the specific purpose of monitoring Mr. X and encouraging him to access mental health services.	✓	
19.02.00	The Bolton Probation Officer wrote to the Lincoln Forensic Psychiatrist seeking advice as Mr. X refused to access mental health services.		

26.03.01	The Lincoln Forensic Psychiatrist wrote back to the Bolton Probation Officer and suggested that Mr. X be referred to the Mentally Disordered Offenders Panel. This was not done. Mr. X did not comply with the terms of his probation and no further action was successful in ensuring his mental health was monitored.	✘	Probation services should have ensured that Mr. X engaged with mental health services in line with the *Reed Report*. There was a lost opportunity to see Mr. X as a Mentally Disordered Offender. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental health effectively.***
	First Contact with Lincolnshire Police Services and Second Contact with Mental Health Services		
July 2002 28.07.02 2.08.02 3.08.02	Mr. X sent multiple letters of complaint to the Lincolnshire Police. During this period he also indicated that he intended to arm himself with a legal weapon in order to protect himself from the Police. Mr. X '*visited*' Police Officers at their homes and was abusive and threatening. Mr. X was arrested and charged with three public order offences. A Mental Health Act (1983) assessment was conducted whilst Mr. X was in custody. The assessing Psychiatrist recommended that Mr. X was remanded in custody for four weeks and that he required secure care, assessment and treatment due to his mental state and significant risk to others. It was also recommended that a forensic psychiatry assessment was sought with a view for a Section 37 detention.	 ✘	 The Psychiatrist's recommendations were not followed. Mr. X was allowed to return to his home. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental health effectively.***

	Mr. X was sent home.		
	Inpatient Admission and Third Contact with Mental Health Services		
17.09.02	A MAPPA referral was made with reference to Mr. X's mental ill health and plans to arm himself with a legal weapon.	✘	Records regarding the MAPPA referral were held by both the Lincolnshire Mental Health Forensic Services and the Lincolnshire Police. The MAPPA referral was not followed up and no record of why this was the case was recorded by either agency.
10.09.02	Following a Section 135 warrant a Mental Health Act (1983) assessment was conducted in Mr. X's own home.	✓	This process was managed appropriately and in accordance with local policy guidelines.
	Mr. X was admitted to a general adult psychiatry ward.	✘	In the light of the psychiatric assessment on the 3 August 2002 and Mr. X's pending court case it was not appropriate that Mr. X was not considered to have reached the threshold for a secure bed by the Trust. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental health effectively.***
	Mr. X was admitted under the 'no fixed abode' scheme which meant that his allocated Consultant Psychiatrist did not work with the Community Team that was assigned responsibility for his Care Programme Approach.	✘	This situation was not rectified and served to create clinical management issues of Mr. X's case.
26.09.02	Mr. X was regraded to a Section 3 of the Mental	?	The regrading of Mr. X can be considered as good practice as

	Health Act (1983). Mr. X was refusing medication and was hostile, he was also writing copious letters of complaint. Mr. X's court case was adjourned.		it was indicated clinically. However during this period all formal Trust liaison with the Lincolnshire Police ceased. Mental health services should have taken a more proactive stance regarding interagency communication as had previously been agreed.
	Mental Health Act Tribunals and Discharge Arrangements		
30.09.02 2.10.02 6.11.02 27.11.02	First Mental Health Act Tribunal. Mr. X remained on Section 3 of the Mental Health Act (1983). Mr. X commenced Clopixol Depot medication. Hospital Managers Hearing. Mr. X remained on Section 3 of the Mental Health Act (1983). Mr. X was granted Section 17 leave to spend periods of time at home. Second Mental Health Act Tribunal. Mr. X was discharged from Section 3 of the Mental Health Act (1983). At this point Mr. X discharged himself from inpatient care.	✘	Between Mr. X's admission and eventual discharge on the 27 November 2002 the following did not place in accordance with either local or national policy best practice guidance. 1. Risk assessment 2. Care Programme Approach planning 3. Section 117 planning Mr. X refused to comply with assessment processes and would not engage with staff, he remained an unknown quantity. Section 17 leave served to remove him from further assessment opportunities on the ward and also served to create a false sense of security regarding his mental state. The Mental Health Act Tribunal was directly influenced by Mr. X's 'successful' extended home leave. Mr. X was discharged with no completed risk assessment, care plan, crisis or contingency plan. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental***

			health effectively.
	Mr. X was discharged to his home still under the care of the 'no fixed abode consultant'. By this time Mr. X had been registered with a Lincoln-based GP.	✖	Mr. X's care should have been transferred at this stage to ensure that his CPA was provided within the same locality as his medical care and treatment. This would have provided a more effective package of care.
	Care in the Community and Discharge Planning to Swindon Mental Health Services		
December 2002- May 2003	The allocated Care Coordinator attempted to visit Mr. X at his home in Lincoln on a regular basis. However it was evident that Mr. X was in reality living in Swindon with his parents. Mr. X was allowed to disengage from services.	✖	Mr. X's care should have been transferred to Swindon at this stage, OR there should have been a more assertive attempt made to engage him in accordance with extant Trust policy and procedure.
4.03.03	Mr. X was seen for the last time by his Consultant Psychiatrist at the Outpatient Clinic.		
25.04.03	Mr. X was seen for the last time by his care Coordinator.	✖	The team should have recognised that they were losing contact with Mr. X and did not adhere to the CPA policy.
26.06.03	Mr. X failed to attend his Outpatient appointment. His Consultant Psychiatrist proposed his discharge. It was decided that the Lincolnshire Police should be informed.	✖	It would have been more appropriate at this stage for the MDT to have discussed a loss of contact plan in the first instance rather than a straightforward discharge. Mr. X's Section 117 aftercare was neither considered nor discussed. Mr. X was on enhanced CPA and the CPA policy was not followed.
10.07.03	The Lincolnshire Police informed the Care Coordinator that Mr. X was writing bizarre letters and they were concerned that this was an indicator that	✖	Police concerns were not acted upon. It had been agreed when Mr. X had been first admitted that liaison would continue when appropriate concerns were identified.

	his mental health was relapsing.		
01.08.03	The Lincoln-based Care Coordinator contacted Swindon Community Services with a view to discharge Mr. X to them.		The discharge of Mr. X was not managed appropriately by Lincolnshire services. Swindon services should not have refused to accept Mr. X onto their caseload. The Lincoln-based Consultant should have made contact with the appropriate Swindon-based Consultant once it was apparent that a 'stalemate' had been reached. Whilst it has to be recognised that service users who do not wish to engage present distinct management challenges, it was not acceptable for a person on enhanced CPA who was eligible for Section 117 aftercare to fall through the safety net of care in this manner. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental health effectively.***
04.08.03	The Consultant Psychiatrist wrote to Mr. X's Lincoln-based GP informing the Practice of his decision to discharge Mr. X from his care.	✘	
18.08.03	The Lincoln-based Care Coordinator contacted Swindon Community Services and told them he wished to hand over Mr. X's aftercare to them. Mr. X's eligibility for Section 117 aftercare was explained.		
23. 10.03	The Lincoln-based Care Coordinator wrote to Swindon Community Services and enclosed background information regarding Mr. X.		
28. 10.03	The Swindon Community Services told the Lincoln-based Care Coordinator that they would not be taking on Mr. X's care, however it was agreed that his clinical notes would be sent down to them in case his health should deteriorate in the future. A major factor in the decision by Swindon services not to accept Mr. X was the fact that he was not registered with a local General Practitioner.		

04.11.03	The Care Coordinator discharged Mr. X from his care.		
	Primary Care in Lincoln		
10.05.03	Due to Mr. X failing to attend medication reviews at the GP Surgery no further prescriptions could be made available to him. From this time on he remained without medication.		
	2007 Family Attempts to Access Services in Swindon		
2003-2007	Mr. X's mental health deteriorated rapidly on his return to Swindon in 2003. During this period there is substantial evidence to demonstrate that the family of Mr. X attempted to obtain help from both Lincolnshire and Swindon-based mental health services to no effect.	✘	Services in both geographical areas should have responded. For example the Lincoln-based Consultant could have contacted Swindon-based services to facilitate local support for the family. • ***This represents a missed opportunity by statutory services to monitor and manage Mr. X's mental health effectively.***
14.02.07	The sister of Mr. X contacted the Emergency Duty Team following Police intervention. She was given advice to register Mr. X with a local GP. The case was not deemed to be an emergency and the Duty worker said that they would refer the case to the CMHT base in Swindon.	✘	It is not clear whether the case was referred on to the Swindon CMHT base. The case was not followed up and no record was logged.
February-June 2007	Mr. X became very unwell. He was writing on average 80 letters each week and was hostile, aggressive and threatening towards his parents.		

	During this period the sister of Mr. X contacted: • The Police • Citizens Advice Bureau • Swindon Crisis Team • Local Authority • Mental health Act Commission • Lincolnshire Consultant, inpatient ward, GP practice and Community Team • MIND Advice was offered but no assistance given.		
17-19 June 2007	The sister of Mr. X contacted the Swindon Crisis team asking for help.		
19.06.07	The Swindon Crisis Team Worker contacted the Lincoln-based Consultant Psychiatrist's Medical Secretary requesting clinical information regarding Mr. X.	✓	Lincoln-based services sent a full set of clinical records to the Crisis Team on the 25 June by registered delivery.
21.06.07	The Swindon Crisis Worker devised a plan to manage the case which was to gather more information, to arrange a case conference and to report the situation to the Vulnerable Adults Unit. The family of Mr. X thought that a Mental Health Act assessment had been arranged for this day. In the event nothing occurred.	✘	There was hesitancy on the part of the Crisis Team to manage this case as this team did not routinely conduct Mental Health Act assessments. Neither would the Crisis Team normally agree to work with someone who was reluctant to engage with services. At this point the case should have been more appropriately referred to the Community Mental Health Team. This was not done.

26.06.07	Mr. X's Lincoln notes arrived at the Crisis Team base. The plan was for the Crisis Worker to contact the Vulnerable Adults Unit. It has been recorded in the clinical notes that a voicemail was left on the Unit's voicemail regarding Mr. X and the potential risk he presented to his parents. It is recorded that two further voicemail messages were also left on the Vulnerable Adults Unit's voicemail, on the 29 June and the 10 July.	✘	The notes were not read through and important information about Mr. X was not ascertained in a timely manner. If there were concerns about Mr. X's parents and their status as Vulnerable Adults an alert should have been made formally. This was not done. The duty of care was not appropriately discharged by leaving a voicemail on a recording machine (if indeed this was actually done). Mr. and Mrs. X senior were left in a situation of unacceptable risk.
10.07.07	The Crisis Worker discussed how to proceed with the case with the Team Manager. It was agreed that the Crisis Worker would contact the Lincoln Consultant Psychaitrist and the Vulnerable Adults Unit. A case conference was to be arranged and the parents of Mr. X were to be invited to a meeting on the 12 July 2007.	✘	These actions were agreed 24 days after the initial referral was made by the sister of Mr. X, two days after Mr. and Mrs. X senior died. The Crisis Team had enough information of a nature that indicated a rapid response was required. No response was made in either an appropriate or timely manner.

Diagram Showing Agencies Involved with Mr. X 2000-2007


Lincoln GP
Wiltshire Police
Lincolnshire Police Service
Swindon Crisis and Home Treatment Team
Lincolnshire Mental Health Trust
Mr. X and his Family
Swindon CAB
Bolton Probation Service
Swindon Emergency Duty Team
Swindon CMHT
Lincolnshire probation Service