VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of Mr G

A report for
NHS South of England

May 2013

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Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries.

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1. Introduction

1.1 Mr G stabbed his wife, Mrs P, in the family home on 5 March 2011. Their three children were at the address at the time. She died of her injuries in hospital a short while after the attack. She was 34 years old.

1.2 Mr G had been assessed by staff from Kent and Medway NHS and Social Care Partnership Trust (the trust) in the months before the incident. He had also consulted his GP.

1.3 On 21 November 2011 Mr G was found guilty of manslaughter. Mr G is in HMP Swaleside in Kent.

1.4 In her closing statement the judge criticised the trust's decision not to admit Mr G to hospital on 24 February 2011. The judge recommended that an inquiry be carried out to establish why Mr G had not been admitted.

1.5 The trust commissioned an internal investigation into Mr G's care and treatment in March 2011 that was completed in April 2011. Kent Police also carried out an individual management review in April 2011. In 2012 agencies in Kent decided not to conduct a domestic homicide review into Mrs P's death. Mrs P's family were told about this decision.

1.6 The trust commissioned a service review of Thanet Community Mental Health Team (the CMHT) based at CMHT site 1 in Kent in response to the findings of the internal investigation and other concerns it had about the performance of the service. The review resulted in the creation of a Thanet 'task and finish' group to address the performance of the community mental health team.

1.7 In accordance with HSG (94) 27, NHS South of England commissioned Verita to undertake an independent investigation into the care and treatment of Mr G. The work started in August 2012 and was completed in January 2013.

1.8 Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries. Ed Marsden, managing partner of Verita, led the

investigation. Kathryn Hyde-Bales, senior consultant, and Geoff Brennan, professional advisor, were also on the investigation team. Dr Mostafa Mohanna was a clinical advisor for the investigation. Derek Mechen, partner, was the peer reviewer.

2. Terms of reference

Commissioner

2.1 This independent investigation is commissioned by NHS South of England in accordance with guidance published by the Department of Health in circular HSG (94) 27 (updated in June 2005), *The discharge of mentally disordered people and their continuing care in the community*.

Terms of reference

2.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr G to include:

- a review of the trust's internal investigation to assess its rigour, objectivity and completeness against the investigation's terms of reference including an assessment of the adequacy of its findings, recommendations and action plans
- reviewing the progress made by the trust in implementing the action plan from the internal investigations
- involving Mr G and his wife's family
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- an examination of the mental health services provided to Mr G and a review of the relevant documents
- the extent to which Mr G's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- the appropriateness and quality of assessments and care planning
- a review of his care from an expert in post conflict stress disorders
- consideration of the effectiveness of interagency working
- consideration of other such matters as the public interest may require.

2.3 The full terms of reference are at appendix A.

3. Executive summary and recommendations

3.1 Mr G stabbed his wife, Mrs P on 5 March 2011. Their three children were at home at the time and saw Mrs P after she had been stabbed. She died of her injuries later the same day. Mr G was 42 years old at the time of the incident and Mrs P was 34. Mr G had a history of violence and substance misuse, and was known to the police. He had previous convictions for criminal damage and assault.

3.2 Mr G was first referred to mental health services in October 2005. GP 1 referred him for anger management. This service was not offered by the CMHT, and the referral was therefore rejected. Senior nurse practitioner 1 at the CMHT wrote to GP 1 to explain that there was no anger management service and that the referral contained no evidence that Mr G was experiencing "*mental illness*". The CMHT rejected two further referrals in 2006 for the same reasons.

3.3 In April 2006, at the request of GP 1, an appointment was arranged for Mr G to have a psychiatric assessment with the CMHT. This was a different type of referral request to those previously submitted by GP 1. Mr G did not attend this appointment. When commenting on the draft report Mr G told us that he did not receive the appointment. Mr G did not use mental health services again until 2010.

3.4 In 2007 Mr G received a suspended sentence for assaulting a man. During 2008 and 2009 Mr G spent 84 weeks in prison for assaulting Mrs P. The suspended sentence for assault was taken in to account when he was sentenced for assaulting Mrs P.

3.5 Soon after his release from prison in August 2009, Mr G returned to the family home, and soon thereafter began to abuse drugs and alcohol.

3.6 In October 2010, Mr G was first noted to be showing signs of psychotic symptoms. He went to the police and complained that he was being harassed by the Taliban and that electronic equipment such as his phone was under surveillance. Mr G's family and friends became increasingly concerned about him up to and throughout the Christmas period of 2010.

3.7 Mr G went to his GP surgery on 30 December 2010 with Mrs P. He was in crisis. He was paranoid, depressed and reported that he was experiencing auditory and visual

hallucinations. Another GP at the surgery, GP 2, prescribed medication and requested that he return the next day for a follow-up appointment which Mr G attended. GP 2 sent an urgent referral to the CMHT on 31 December, asking for Mr G to be assessed within 24 hours. The CMHT telephoned Mr G on 31 December to arrange an appointment.

3.8 Mr G was seen by the CMHT Access Team on 10 January 2011. He was assessed by CPN 1 and occupational therapist 1. Mrs P attended the appointment. Mr G's crisis had passed, his psychosis appeared to be under control and his drug and alcohol use had reduced.

3.9 During the assessment, Mr G said that he had experienced troubles in his youth and had joined the army. He admitted that he had recently taken illegal drugs with a friend. He reported that he and Mrs P had disposed of electronic equipment within their home that was causing him concern. A risk assessment was carried out. Mr G was not seen by a psychiatrist during this assessment.

3.10 The assessment concluded that Mr G did not have mental health problems that required support from the CMHT, but that he needed counselling and psychological intervention to help him address his "*unresolved issues with his past*". Arrangements were to be made for Mr G to have an appointment with the Improving Access to Psychological Therapies service, however this did not happen before the incident on 5 March 2011.

3.11 Mr G went to his GP surgery on 24 February 2011. He had cut his wrists. He was agitated, anxious and asked to see a GP urgently. Mr G reported that his wife and children had left the family home and that he had destroyed items in the home. GP 2 contacted the CMHT asking that Mr G be assessed urgently within four hours. The CMHT advised GP 2 that it could not review Mr G until the following day. GP 2 paid for Mr G's taxi to the Queen Elizabeth The Queen Mother Hospital (QEQMH) accident and emergency department (A&E) for a mental health assessment. Mr G was subsequently seen in A&E by junior doctor 1 who referred him for assessment by the psychiatric liaison service. Junior doctor 1 worked for East Kent Hospitals University NHS Foundation Trust, not the mental health service.

3.12 A&E liaison nurse 1 assessed Mr G. A&E liaison nurse 1 did not complete a full psychiatric assessment but conducted both a needs and a risk assessment, neither of which

were in keeping with trust policy. The nurse did not view Mr G to be a risk to himself or others. A&E liaison nurse 1 recommended that he go home and tidy the family home. Mr G was advised to contact the CMHT Access Team for further assessment of his paranoia, and to consider self referring to KCA (previously called Kent Council on Addiction) for his drug use. Mr G was not admitted.

3.13 Mr G briefly returned home before spending the next three nights sleeping in the woods. He contacted the CMHT Duty Team on 2 March 2011 to request an appointment. The call was received by a CMHT administrator who passed the message on to the duty team. This contact was recorded in the duty log and an appointment was arranged for 18 March, however duty worker 1 was unable to later recount the actual details of the phone call.

3.14 On 5 March 2011 Mr G stabbed Mrs P in their family home. He subsequently pleaded guilty to manslaughter in November 2011.

Our analysis

3.15 Mr G was prone to violent outbursts. His violent behaviour was exacerbated by drug and alcohol abuse. Mr G had engaged with mental health services briefly but was not receiving ongoing treatment. He had attended appointments for assessment.

3.16 Both of Mr G's GPs generally demonstrated a good level of care in their treatment and follow up of Mr G. GP 1's request for a psychiatric assessment in April 2006 would have provided an opportunity to establish a baseline of Mr G's mental health. The actions of GP 2 between December 2010 and February 2011, further illustrate an appropriate level of care.

3.17 Mr G sought help from his GP when experiencing a crisis, such as an episode of anger. When help was arranged for him however, in the form of counselling or a psychiatric assessment, he usually failed to attend.

3.18 The numerous referrals by Mr G's GP to the CMHT for anger management should have prompted further enquiry by the CMHT. That said the CMHT recommended that GP 1 try counselling for Mr G, or to seek further help from the Soldiers, Sailors, Airman and

Families Association (SSAFA) or the British Legion. This was a reasonable response as the CMHT did not offer an anger management service and therefore could not accept the referral.

3.19 We were told at interview that the CMHT had not functioned well for a number of years. The duty system was busy and managed by non-medical staff. There was no care coordination. Staff at the CMHT reported that historically there had been little supervision and that managerial support was lacking. As a result of this the CMHT was undergoing significant managerial and structural change at the time when Mr G's mental health was deteriorating.

3.20 Mr G was assessed by mental health services twice, in January and February 2011.

3.21 Those who assessed Mr G in January 2011 did not view him to be in crisis, rather they felt that he would benefit from counselling.

3.22 The assessment on 10 January 2011 of Mr G's mental state was reasonable, based on the information available at the time. We do not know if Mr G's deterioration in mental health would have been picked up if he had been seen sooner, as requested by GP 2. It would have been best practice for Mr G to have been seen by a psychiatrist and the use of antipsychotic medication explored.

3.23 Those assessing Mr G did not consider this because they assumed that his crisis had been a relapse as opposed to the first presentation of psychotic symptoms. As a result, they decided that counselling was an appropriate course of action. Mr G's long-term care would have benefitted from follow-up monitoring and crisis planning.

3.24 The assessment carried out by A&E liaison nurse 1 on 24 February 2011 was inadequate. Junior doctor 1 in A&E had noted that Mr G was experiencing visual and auditory hallucinations, yet A&E liaison nurse 1 did not read the A&E/medical notes and act on this. Based on the information available, a full psychiatric assessment should have taken place. The failure to do this was a missed opportunity to fully assess Mr G. A&E liaison nurse 1 who assessed Mr G in February 2011 did not view him as a risk to himself or others.

3.25 We did not interview A&E liaison nurse 1 but did review the assessment records. A review undertaken by the trust in relation to A&E liaison nurse 1's practice found it to be inadequate. A&E liaison nurse 1 did not carry out a full psychiatric assessment, and the risk and needs assessments undertaken were not in keeping with trust policy. A disciplinary hearing was held in the nurse's absence. It concluded that the nurse's conduct constituted gross misconduct and the nurse would have been dismissed had they not already left the trust. Our review did not identify anything that would conflict with the trust's assessment of A&E liaison nurse 1's actions.

Preventable or predictable

3.26 We conclude that it was reasonable that the CMHT and his GPs could predict that Mr G would be violent again in the light of his escalating behaviour and alcohol and drug abuse. He had a history of violence and was known to the police. He had admitted in January and February 2011 that he was taking drugs and alcohol, and that he had destroyed items in the family home. The A&E junior doctor recorded in the medical notes that Mr G had made threats against Mrs P during the February assessment. Because Mrs P attended the assessment on 10 January this made it difficult for staff to foresee that Mr G's violence would escalate to the extent that he would kill his wife.

3.27 The dates of the two assessments - 10 January and 24 February 2011 are key. It is possible that events might have been different if action had been taken on either of these dates. If the CMHT had arranged further monitoring for Mr G in the event of him experiencing another crisis, it is possible events may have been different. However, Mr G was not in crisis at the time of the assessment in January. He attended the appointment with Mrs P and did not give either of the assessors cause for concern.

3.28 Mr G's assessment by A&E liaison nurse 1 in A&E on 24 February 2011 was a missed opportunity to fully assess the risk that Mr G posed.

Findings

F1 Both of Mr G's GPs generally delivered a good level of care in their treatment of Mr G and referral to the CMHT for assessment when required. However, there were two

areas where Mr G's care could have been improved. GP 1 should have considered the reasons why the CMHT repeatedly refused his referral. If he was concerned about Mr G's mental health he should have made it clearer. GP 2 might usefully have explored with the CMHT the option of prescribing Mr G with antipsychotic medication after he had been referred to the psychological services. We do not suggest that there is a link between these two points and the death of Mrs P.

F2 The CMHT did not function well. It had experienced a number of problems historically and was undergoing significant managerial and structural change during the period when Mr G's mental health was deteriorating. If Mr G has been accepted into the service he would have joined the caseload of a poorly functioning team.

F3 The assessment conducted by CMHT staff on 10 January 2011 was reasonable based on the information available to them at the time. However in this case based on Mr G's history and the nature of the referral by GP 2, best practice would have been for Mr G to have been assessed by a psychiatrist, and the use of antipsychotic medication explored.

F4 The CMHT staff assumed that the crisis Mr G had experienced over Christmas was a relapse as opposed to the first presentation of psychotic symptoms. The assessors were unaware of the true nature and seriousness of Mr G's recent psychotic symptoms.

F5 Mr G did not wish to engage further with mental health services. Despite this, the CMHT should have arranged close liaison and support to GP 2 in order to monitor Mr G after his assessment on 10 January 2011.

F6 The assessments conducted by A&E liaison nurse 1 on 24 February 2011 were inadequate. The nurse did not carry out a full psychiatric assessment and the risk and needs assessments were not in keeping with trust policy.

F7 Despite evidence of Mr G's drug and alcohol abuse and violent behaviour, the healthcare professionals involved in Mr G's care were not given cause for concern in relation to the safeguarding of his children.

F8 Mr G had a forensic history which included assaults against his wife and destruction of family property. He was a concern to his GP and had been referred to the mental health services. On this basis there should have been shared intelligence between the police, the

children's services and the mental health service about Mr G. The police and children's services had worked together but not with mental health services.

F9 It would have been reasonable to predict that Mr G would be violent again in light of his escalating drug and alcohol use, and behaviour. However, it could not have been foreseen that his violence would escalate to the extent that he would kill his wife.

F10 The trust has implemented a number of changes as a result of their reviews undertaken in March and April 2011.

F11 Staff at the CMHT report that there continue to be problems within the service. They reported that their caseloads remained too high given their complexity and that there continued to be a lack of resources within the service.

Recommendations

3.29 The trust has made a number of changes to the service in recent years, some of which continue. We have therefore discussed with the trust how recommendations arising from our findings can be made without impeding this work.

3.30 We identified four issues for further action by the trust.

- How can the trust mitigate risk to do with patient safety during change?
- How can the trust continue to provide support to the CMHT now that the 'task and finish' group has completed its work?
- How can the trust maintain safe practice during periods of service change?
- What steps has the trust taken to strengthen the CMHT's interagency links and particularly sub MAPPA communication?

3.31 We recommend that these issues should be part of a short independent review commissioned by the trust. The review should take place within 12 months and be used to examine the extent to which changes have become effectively embedded within the trust's structure and services.

4. Approach and structure

4.1 The investigation was held in private. We interviewed 10 members of staff from the trust. We also interviewed GP 1 and GP 2. We spoke to the head of Kent Police Public Protection Unit. We also asked for information from Kent County Council Specialist Children's Services about contact with the family.

4.2 We met with CMHT staff as a group and asked them about the organisation and management of the service at the time of the incident and about the improvements made as a result of the Thanet 'task and finish' group.

4.3 We visited Mr G at HMP Swaleside at the outset of our work to explain that we were undertaking an investigation into his care and treatment. We asked for his written consent to our having access to his medical and other records and he agreed to this. We visited him on a second occasion to ask him about his care and treatment. We sent him some written questions in advance of our visit to prompt his memory about the events of 2011. He declined to see us. The reader should bear in mind this lack of evidence when going through the report.

4.4 We told Mr G that NHS South of England was likely to publish the report and visited him as part of this process to hear his comments on the draft report. This was a discussion limited to the content of the report.

4.5 We met Mrs P's mother and sister to discuss their recollection of events. They were supported at their interview by representative 1 from the charity Advocacy After Fatal Domestic Abuse.

4.6 We did not interview A&E liaison nurse 1 because they had left the trust. A disciplinary hearing held by the trust on 15 June 2011 concluded that the nurse would have been dismissed had they not already left. The nurse did not attend the hearing. The findings of the hearing were reported to the Nursing and Midwifery Council. The comments we have made about the nurse's practice are based entirely on our review of the records and the findings of the trust's internal review, an A&E psychiatry service liaison review and the outcome of the disciplinary hearing.

4.7 We wrote to A&E liaison nurse 1 to share the findings from our investigation. We offered to meet with A&E liaison nurse 1 as part of this process. A&E liaison nurse 1 provided a written response which we considered as part of our final assessment.

4.8 We saw the trust's papers produced at the time of the internal review. We obtained up-to-date information from the trust about the performance of the CMHT. We had access to Kent Police's individual management review. They asked us not to use the review in our report because it contained confidential information. We agreed to this request. We obtained a full transcript of Mr G's trial.

Structure of the report

4.9 The report is prefaced by an executive summary (section 3) and then falls into five further sections.

- Section 5 contains a narrative chronology. This includes Mr G's offending history.
- Section 6 sets out our analysis of the themes from the chronology, diagnosis and forensic history. Where appropriate we have referenced factual events too. The purpose of this was to provide further context to our assessments.
- Section 7 reviews the trust's internal investigation.
- Section 8 provides an assessment of the implementation of the recommendations.

4.10 Our findings and recommendations are given in section 9.

5. Narrative chronology

5.1 This narrative chronology is based on the trust's internal investigation report. Further information has been added to provide a more complete picture. This information has been taken from:

- the court transcript of Mr G's trial held on 3 October 2011
- papers associated with the trust's internal investigation
- medical, nursing and other records concerning Mr G
- input from Mrs P's mother and sister
- trust documentation setting out the action taken to address recommendations.

5.2 The court transcript of Mr G's trial is publicly available. In commenting on our draft report Mr G disputed some of the detail taken from the court transcript. All of the other information we used is not publicly available, but was given to us for the purpose of this investigation.

5.3 The chronology is divided into three time periods. The first period details Mr G's life between 1986 and 2004 when he was not using mental health services. The second period covers 2005 to 2009, when Mr G was in contact with services. The third examines the period 2010 to 2011 leading up to the death of Mrs P.

1986 to 2004: before Mr G's contact with mental health services

5.4 Mr G's first contact with the police was in 1986. He was convicted at Ramsgate Magistrate Court in September 1986 for using threatening and abusive behaviour.

5.5 In 1987 Mr G and another man allegedly assaulted a man in Ramsgate. Mr G was charged with causing grievous bodily harm, but was subsequently acquitted.

5.6 Mr G joined the Parachute Regiment of the British Army in 1989. At some point in 1992 he was discharged from the army because he suffered from a physical medical condition.

5.7 In 1992 Mr G hit a man who was talking to his girlfriend. His girlfriend subsequently told an expert witness involved in Mr G's trial in 2011 that he had a history of domestic violence for which he had previously been arrested.

5.8 In September and November 1992 he was arrested for causing an affray at a restaurant in Peterborough and for burglary and theft. He received fines and a community service order.

5.9 In 1994 Mr G punched his father during an altercation. He was charged with causing grievous bodily harm, but the case was dropped when his father would not support the prosecution.

5.10 In the same year Mr G received a community sentence order for affray and assault occasioning actual bodily harm (ABH). He was separately convicted in November 1994 for burglary and theft for which he received a conditional discharge.

5.11 During the following two years Mr G was charged with criminal damage and assaulting a police officer.

5.12 Mr G was involved in a violent incident in Peterborough on 25 May 1997, for which he was arrested, charged and bailed. He breached his bail conditions and moved to Kent.

5.13 In 1997 Mr G began his relationship with his future wife, Mrs P. They lived in Kent. They were engaged in 1998.

5.14 In 2002 Mr G kicked Mrs P's ankle and slapped her face. When a friend tried to intervene, he punched the friend in the face.

5.15 Although a warrant for his arrest for the violent incident in Peterborough had been issued in 1997, Mr G was not actually arrested until 2004 when he handed himself in at Margate police station. He stood trial but was subsequently acquitted when the case against him collapsed.

2005 to 2009: Mr G's contact with mental health services

5.16 Mr G's trial transcript reported that in September 2005 Mr G had a violent confrontation with "*other workers*" and smashed up their caravan. Mr G told us that this did not happen. We have seen no information in relation to Mr G's employment. It is our understanding that Mr G, for the most part, was unemployed.

5.17 Mr G was first referred to the CMHT via the Intake Team on 18 October 2005 by GP 1. The Intake Team is the single point of access for referrals to the CMHT. The CMHT operated a 'duty' system where team members would be rostered to manage all referrals and emergencies coming into the service.

5.18 GP 1 was concerned about Mr G's ability to control his temper and the fact that he was getting into fights. GP 1 noted that Mr G recognised that "*his behaviour is not good for his family or himself*."

5.19 The referral was rejected by the CMHT because it did not provide anger management services and found no evidence in the referral of mental illness.

5.20 On 23 January 2006, GP 1 referred Mr G to the CMHT's Intake Team for a full psychiatric assessment. GP 1 described Mr G as aggressive at times, withdrawn and depressed. In his referral, GP 1 wrote that he had arranged for Mr G to see a counsellor at the surgery but that Mr G's friends had persuaded him that this would not help. GP 1 stated that Mr G's needs had now surpassed the help of the counsellor and he required a full psychiatric assessment.

5.21 In February 2006 Mr G was issued with a harassment warning by the police after he was abusive to a former neighbour.

5.22 The Intake Team recommended that Mr G be seen by the CMHT outpatients. Mr G was offered an outpatient appointment with senior house officer 1 on 25 April 2006. Mr G did not attend this appointment. When commenting on our draft report Mr G said that he did not receive the appointment. The CMHT subsequently wrote to GP 1 advising that Mr G would be discharged back to his care unless he was re-referred.

5.23 Mr G saw GP 1 in August 2006 about his anger. This coincided with an incident of domestic violence at home, when Mr G had thrown a plastic tub at Mrs P injuring her. GP 1 prescribed Mr G antidepressants and referred him to the CMHT for anger management. GP 1 referred him for anger management again in October 2006. Both of these referrals were rejected.

5.24 In total, GP 1 referred Mr G to the CMHT for anger management three times in 2006. None of these referrals were accepted because the CMHT did not offer an anger management service, and there was no evidence of mental illness in the referrals. In one of its responses, the CMHT recommended that Mr G might benefit from primary care counselling. In another it suggested to GP 1 that he approach SSAFA (Soldiers, Sailors, Airman and Families Association) or the Royal British Legion for help. Contact telephone numbers were provided.

5.25 GP 1 referred Mr G for counselling with the surgery counsellor, on 30 May 2007 due to his *"emotional problems and problems with his temper"*. Mr G did not attend this appointment.

5.26 Mr G and Mrs P married in June 2007. Mr G and Mrs P had three children, all of whom were born before the marriage.

5.27 GP 1 referred Mr G again for counselling in September 2007. Mr G phoned the surgery in early November to decline any counselling. It was recorded in the surgery notes that this was *"a pity as there are many underlying issues that need to be dealt with to help his anger"*. When commenting on ourdraft report Mr G told us that he had been informed that if he wished to attend counselling he would need to stop drinking. He did not want to do this therefore cancelled the appointment.

5.28 Mr G was arrested for ABH following an unprovoked assault on a man on 12 November 2007. Mr G attended a counselling session at his GP surgery two days after this assault. He subsequently failed to attend another counselling session in February 2008.

5.29 Mr G was convicted in July 2008 of the assault, and received a suspended prison sentence of 42 weeks. GP 1 referred Mr G for counselling again in July 2008. Mr G did not attend this appointment or another that was made for him in October 2008.

5.30 On 24 October 2008, Mr G seriously assaulted Mrs P at home. Mrs P ran up the road where she met her mother, Mrs R in the street. Mr G shouted at Mrs R and then went to a neighbouring house and broke a window.

5.31 On the same day, Mr G attended the QEQMH A&E department with a cut to his right forearm and was taken into police custody. Mrs P subsequently told the police that the assault had lasted about 10 minutes. She said that Mr G had assaulted her before but that she had not reported him to the police. Mrs P later retracted her statement but Mr G was still charged with her assault.

5.32 At the time of the assault on 24 October 2008 Mr G was subject to a suspended sentence for the supermarket assault in November 2007. As a result he went straight from police custody to prison. Mr G was subsequently imprisoned for 84 weeks for assaulting Mrs P.

5.33 Kent County Council Specialist Children's Services met with the family on 28 October 2008. The service met again with the family on 23 April 2009 while Mr G was in prison.

5.34 Mr G was released in August 2009. In prison he had received help for his drug and alcohol abuse and was reconciled with Mrs P who had visited him. He was unable to find accommodation upon his release that was acceptable to him so he slept on the sofa at Mrs P's home. The same month, whilst on a bus, Mr G 'flew at' Mrs P and had to be restrained by a friend.

5.35 By Christmas 2009 Mr G and Mrs P were living as a couple again.

2010 to 2011: the period leading up to Mrs P's death

5.36 At some point after his release from prison Mr G began abusing alcohol and drugs again. The court transcript reported that in April 2010 Mr G lost his temper and threw a cake at Mrs P in the family home.

5.37 Mr G went to Margate police station on 25 October 2010 complaining that someone had hacked into his Facebook account, tapped his mobile phone, and that he was receiving messages from the Taliban.

5.38 By Christmas 2010, Mr G's mental health had started to deteriorate. Mrs P told her mother that Mr G had started to act in a paranoid manner and he thought people in cars were watching him. Mr G's family and friends were concerned about him and had noticed a change in his mental state.

5.39 Mr G was seen by GP 2, another GP, on 30 December 2010. Mrs P attended this appointment. Mrs P and Mr G gave a history consistent with the complaints Mr G had made to the police in October. From this, GP 2 noted that Mr G had symptoms of *"depression, anxiousness and a lot of paranoia"*. Mr G was also experiencing auditory and visual hallucinations, depression and sleep deprivation. He admitted to taking amphetamines.

5.40 GP 2 recorded that Mr G had a history of taking cocaine and amphetamines, drank alcohol to excess and had previously used cannabis. Mr G had abused drugs over the Christmas period. This is the first mention of drug abuse. During his preliminary meeting with us, Mr G intimated that he had a history of abusing drugs.

5.41 Mr G told GP 2 that he had thought about cutting himself over the Christmas period, however at the time of assessment he did not have any thoughts of harming himself or others. GP 2 put Mr G on a short course of diazepam, an anxiolytic (anti-anxiety medication). GP 2 asked for the couple to return for a planned appointment the next day to reassess and plan long-term treatment.

5.42 Mr G and Mrs P returned to the GP surgery the next day, 31 December 2010. He was seen again by GP 2 who prescribed an additional antidepressant.

5.43 GP 2 referred Mr G to the CMHT Access Team (formerly the Intake Team) for an urgent assessment within 24 hours. He described Mr G as experiencing various symptoms of depression, anxiety and suicidal thoughts. GP 2 wrote that Mr G had a history of psychosis five years ago after discontinuing illicit drugs. A member of the team telephoned Mr G the same day and arranged an appointment.

5.44 On 4 January 2011, Mr G was sent a letter inviting him to attend an outpatient appointment with the CMHT Access Team on 10 January 2011.

5.45 Mr G and Mrs P saw GP 2 again on 4 January 2011. Mr G reported that he was feeling better with the antidepressant medication and confirmed that he had been given an appointment with the CMHT Access Team. GP 2 discussed Mr G's medication with the couple. A follow-up appointment was made for 16 February.

5.46 Mr G and Mrs P attended the assessment with the CMHT Access Team on 10 January 2011. They were seen by two experienced members of the team, occupational therapist 1 and CPN 1. They did not have access to Mr G's old notes at this time.

5.47 Mr G admitted that he had been in prison for assaulting Mrs P. The couple did not discuss their children other than to say that Mr G was playing with them more. During the interview the couple seemed well presented and relaxed. Mr G told the assessors that his Facebook account had been hacked in October and that he had reported this to police. The couple reported that they had disposed of their computer though it was unclear to the assessors whether this meant it had been put away or disposed of. Mr G and Mrs P told the assessors that they had needed help before Christmas but they felt the crisis was now over.

5.48 Mrs P's presence and her confirmation that Mr G was not using drugs or alcohol reassured the workers that the crisis had passed. The assessment concluded that Mr G did not have a mental health problem, but needed counselling and psychological intervention to address issues about his past. Mr G was not seen by a psychiatrist during this assessment.

5.49 The assessors gave Mr G information on agencies that address drug and alcohol abuse. Mr G told the assessors that he had received counselling in prison and that he had found this helpful.

5.50 Mr G and Mrs P told the assessors that they did not want further engagement with the CMHT. Mr G accepted the assessors' suggestion of attending counselling sessions. An electronic risk assessment (CPA4) and a paper screening form were completed. As a result of Mr G not being offered treatment by the team, a CPA2 needs assessment was not entered on to ePEX.

5.51 The CMHT wrote to GP 1 on 21 January to inform him that Mr G's paranoia had reduced. It was recommended that Mr G be referred to Improving Access to Psychological Therapies services, though it was not clear whether it was GP 1 or the CMHT who were responsible for making this referral.

5.52 Mr G went to his GP surgery on 16 February 2011. He attended the surgery with Mrs P and their children. He was seen by GP 2 who noted that Mr G was better than before but experiencing paranoia and was anxious. GP 2 prescribed Mr G antidepressants. GP 2 planned to refer Mr G to the CMHT again if he had deteriorated by his next appointment.

5.53 Mrs P and her children left the family home to stay with her mother on 23 February. Mr G destroyed electrical equipment and the telephone within the family home.

5.54 In the early hours of 24 February Mr G rang the telephone in Mrs R's home and accused Mrs P of not being at her mother's house, though he was actually speaking to her on her mother's landline. He threatened to kill himself and his brother-in-law. Mrs R reported that Mrs P rang the police at 3.30am but they said that Mr G had not done anything that warranted their attendance. They gave Mrs P the number for the mental health services. Neighbours of Mr G also contacted the police to complain about the loud music he was playing.

5.55 Mr G visited his GP surgery on 24 February 2011. The practice administrator recorded that Mr G *"politely requested to see a GP urgently as he was feeling extremely agitated and anxious"*. He was carrying a large army holdall of clothes. No GPs were immediately available so Mr G rang the CMHT from the surgery. After a short conversation Mr G told the member of staff at the CMHT that they could not help him. There is no record of this call in the CMHT duty log.

5.56 GP 2 saw Mr G as an emergency appointment. It was GP 2's view that Mr G was suffering from depression, anxiety and psychosis and he requested a response from the access team within four hours. He altered Mr G's medication. Mr G told GP 2 that his wife and children had left him, and that he had destroyed the family home as a result. Mr

G admitted to his use of alcohol and drugs, particularly amphetamines. He had cut his wrists.

5.57 GP 2 contacted the CMHT. He explained that he wanted Mr G to be assessed by mental health services as an emergency. A CMHT worker told GP 2 that the CMHT could not see Mr G immediately, but would see him within 24 hours. The CMHT advised GP 2 to send Mr G to A&E for an assessment with the psychiatry liaison team.

5.58 The psychiatric liaison service is managed by Kent and Medway Partnership NHS and Social Care Partnership Trust, but is based within the A&E department at QEQMH. It is not part of the CMHT. The service provides psychiatric assessment, emergency treatments and signposting to other psychiatric services plus advice to general staff. This service includes a dedicated consultant psychiatrist between the hours of nine to five and is covered by nursing staff out of hours. Out of hours, the nursing staff are able to consult, via the phone, with medical and other staff, should the need arise.

5.59 GP 2 paid for a taxi for Mr G to go to A&E at QEQMH to receive treatment for his wrists and to have his mental health assessed. He completed a referral form and faxed it to A&E. At 4.30pm Mr G was referred by a triage nurse in A&E to the liaison psychiatry service.

5.60 Mr G was seen by junior doctor 1 at 4.54pm who conducted an assessment. Junior doctor 1 worked for East Kent Hospitals University NHS Foundation Trust and was not part of the mental health service. Junior doctor 1 recorded in the notes that Mr G was experiencing auditory and visual hallucinations, paranoia and that he had threatened to hurt his wife and children. When commenting on our draft report Mr G stated that he did not threaten to harm his children. It was also recorded that Mr G had abused drugs and alcohol the night before and felt suicidal.

5.61 Junior doctor 1 was of the opinion that symptoms described above warranted an assessment by the liaison service.

5.62 Liaison team secretary 1 recorded that Mr G was experiencing auditory and visual hallucinations, had harmed himself, was expressing suicidal ideation and had threatened to kill his wife and children. Mr G reiterated to us that he did not threaten to harm his children.

5.63 A&E liaison nurse 1 assessed Mr G in an office alone. The office had an escape route. A&E liaison nurse 1 had the notes from triage and junior doctor 1 but later told trust investigators that these were not reviewed prior to the assessment. Mr G had a large army holdall of clothes with him and said that he could not go home. A&E liaison nurse 1 recorded in the assessment records that Mr G was paranoid, felt that his children were 'ganging up' on him and that he had been getting angry with his wife. He admitted that he had previously been violent towards Mrs P.

5.64 When commenting on the draft report Mr G told us that he was angry with Mrs P because he felt she was turning their children against him. He felt increasingly paranoid and believed that she had installed cameras in the family home to spy on him. He added that he had attended A&E believing that he would be sectioned but had been willing to be an informal patient. Mr G told us that he did not relay the extent of his symptoms to A&E liaison nurse 1 as much as he had to other staff in A&E such as junior doctor 1.

5.65 Mr G told A&E liaison nurse 1 that he had drunk alcohol and taken drugs the previous day. He had destroyed electrical equipment in his home, including his mobile phone that had been causing him concern. Mr G told A&E liaison nurse 1 that he was unemployed, but in receipt of a military pension.

5.66 A&E liaison nurse 1 completed a CPA2 needs assessment and a CPA4 risk assessment. Both were entered onto ePEX. A&E liaison nurse 1 recommended to Mr G that he go home, talk to his wife and help her tidy the home. A&E liaison nurse 1 advised him to see the CMHT Access Team for further assessment of his paranoia. A&E liaison nurse 1 did not record in the assessment notes any concerns about the children or safeguarding needs.

5.67 A&E liaison nurse 1 recommended that Mr G consider self referring to Kent Council on Addiction (KCA) for his drug use. A&E liaison nurse 1 informed the medical team that Mr G could be discharged from A&E at its discretion. We have seen no information about how the A&E staff reacted to this advice. Mr G was discharged.

5.68 Mrs R reported that when Mr G had left home to go to his GP surgery he had posted his front door keys back through the letterbox because he was going to ask to be admitted. After the hospital discharged him, he went home, collected his wedding suit

and slept in the woods near his house until Sunday 27 February. Relatives tried to get hold of him at this time however he had broken his phone and could not be contacted.

5.69 When commenting on the draft report Mr G told us that he had gone to the woods because he wanted to get away. He felt that because he had not been sectioned no one was able to help him.

5.70 The CMHT wrote to GP 1 on 25 February 2011 to inform him that it had been unable to contact Mr G. The CMHT duty team wrote to Mr G on 25 February 2011 requesting that he contact the CMHT by 4 March 2011 to arrange an appointment.

5.71 An unnamed relative contacted the North Crisis Resolution Home Treatment Team on 25 February requesting help for Mr G. This referral was refused on the grounds that it was inappropriate. We have seen no other information in relation to this request, though we assume that it was Mrs P or one of her relatives who contacted the service.

5.72 On 26 February Mrs P contacted the police. She had not been able to get hold of Mr G and was concerned that he might be suicidal.

5.73 Mr G returned home from the woods on 27 February. He did not have his keys so kicked the front door in. Mr G contacted Mrs P and she went to the family home to get the children's school uniforms. Mrs P returned to her mother's house and told her that Mr G seemed fine.

5.74 Mrs R reported that during the week Mr G cleared up the mess he had made in the house the previous week and repainted the wall on which he had scrawled graffiti.

5.75 Mr G telephoned the CMHT requesting a follow up appointment on 2 March 2011. He spoke with an administrator who took his telephone number with the view of asking the duty member of staff to contact him to make an appointment. When asked later by the trust's serious incident lead, duty worker 1 did not remember if she had spoken to Mr G, but assumed that she had. An appointment was recorded on the trust's electronic record system. A letter was sent to Mr G the next day, inviting him to an appointment with the CMHT Access Team on 18 March. The letter stated that if, while waiting for his

appointment, Mr G's situation became intolerable he should contact duty worker 1 for the Intake Team[1]. A copy of this letter was sent to GP 1.

5.76 Mrs P visited Mr G again on Friday 4 March and Mr G asked Mrs P to bring the children to visit the following day.

5.77 On 5 March Mr G attacked his wife with a knife. The youngest child was in the house at the time. Their two other children, aged seven and 12 were in the garden. They ran to their mother when she fled the family home. Mr G contacted the emergency services to inform them that he had killed his wife. He requested the police and an ambulance. Mrs P died later the same day as a result of her injuries.

5.78 When he was assessed after the incident, Mr G presented with florid psychotic symptoms and was not deemed fit to interview. He was assessed under the Mental Health Act 1983 and subsequently detained under Section 2, and admitted to the Willow Suite, a psychiatric intensive care unit within the trust. He was transferred the Trevor Gibbens Unit near Maidstone and then on a medium secure unit at the Cygnet Hospital in Stevenage.

5.79 During an assessment at the Willow Suite Mr G said that he had been on antidepressants but had run out of them five to six days before the incident.

[1] The 'Intake Team' screening function for the CMHT is different to that of the historical 'Intake Team' now referred to as the 'Access Team'.

6. Themes from the chronology, diagnosis and forensic history

6.1 In this section we draw out and analyse the main themes from Mr G's chronology, diagnosis and forensic history.

History of anger/violence

6.2 Mr G had a history of violence and aggression before the incident and had been in trouble with the police many times. He had a history of domestic violence. He attacked his wife Mrs P and was convicted of assault after he broke her cheekbone in October 2008. Before he met Mrs P in 1997 he had attacked a previous girlfriend who said that she was too scared of Mr G to press charges.

6.3 Mr G also had a history of attacking members of the public. He was issued with a warrant for attempted murder in May 1997, given a harassment warning for abusing a former neighbour in 2006, and convicted of ABH after an unprovoked assault on a man in 2007.

6.4 The court transcript and the GP notes detail many other occasions when Mr G had altercations with family members, friends and work colleagues that were not reported to the police.

Substance misuse and deteriorating mental health

6.5 When commenting on the draft report Mr G told us that he had started taking drugs when he was in the army. The chronology describes a number of occasions on which Mr G's unpredictable and irrational behaviour and violence are linked to his use of illegal substances. For example, his mental health severely deteriorated around Christmas 2010 when he admitted to his GP that he had taken amphetamines and was seeing and hearing things. Mrs P's mother reported that Mr G's behaviour altered significantly at this time and he was acting in an odd manner.

6.6 During his trial, both expert witnesses testified that Mr G's psychosis was directly related to his substance abuse.

Mr G's contact with his family doctor

1997 to 2008

6.7 During this period, there seems to have been a cycle of Mr G seeking care when he had what GP 1 described as "*temper tantrums*" and was violent and aggressive, either in the home or other social situations, and then was seeking help from the surgery. Mr G appeared ambivalent about treatment once help was offered and the crisis had died down. Mr G frequently refused treatment and failed to comply with prescribed medication. When Mr G was given an outpatient appointment with mental health services, he did not attend. When he began to attend counselling organised within primary care, he did so sporadically and eventually stopped. We conclude that GP 1's proposed management of Mr G with antidepressant medication and counselling was appropriate.

6.8 GP 1 made four referrals over this period to the CMHT services at CMHT site 1. There also seems to be a cycle for three of these referrals in that GP 1 referred Mr G for anger management, but the CMHT rejected the referral because it did not offer such a service, nor did it see any mental health issues in the referral. It may have been helpful for GP 1 to have considered the stated reasons for refusal. If he was concerned about Mr G's mental health he should have made that clear.

6.9 The referral of January 2006 was different from this in that GP 1 asked for a full psychiatric assessment of Mr G in the initial referral letter. Mr G was subsequently offered an outpatient appointment with senior house officer 1. Mr G told us that he did not receive this appointment. Although Mr G did not attend, subsequent referrals did not ask for a psychiatric assessment and this offer was not repeated. Given subsequent events, this was a missed opportunity to gain a baseline psychiatric assessment of Mr G. It would have been useful to assess subsequent changes in Mr G's mental state, even if it had not resulted in him being taken on by mental health services.

6.10 In a letter responding to our findings GP 1 said everything possible was done to help Mr G however it is almost impossible to manage a patient who does not comply with care and does not attend appointments.

2009 to 2011

6.11 Following his release from prison Mr G returned to the family home and again abused drugs and alcohol. As before, this led to further incidents of aggression. There was a change however in the range of symptoms that Mr G experienced. Where previously Mr G had experienced episodes of aggression and low mood, now there were also psychotic symptoms suggesting delusions of persecution and possibly auditory hallucinations (the messages Mr G claimed he was getting from various sources).

6.12 When Mr G was seen by GP 2 on 30 and 31 December he was in crisis. GP 2 was sufficiently concerned to begin Mr G on antidepressant medication and ask for an immediate appointment with the CMHT. GP 2 was correct to prescribe an antidepressant to treat the anxiety that Mr G was experiencing as a result of his psychotic experiences. GP 2 did not address Mr G's psychotic symptoms with antipsychotic medication, but referred him to the CMHT for an urgent appointment.

6.13 GP 2 was incorrect to assess that Mr G had experienced psychosis five years ago. Although Mr G had received care for low mood at the surgery, the psychotic symptoms were new.

6.14 Following the letter from the CMHT on 21 January 2011, it would have been appropriate for GP 2 to follow-up with the service to explore the option of prescribing antipsychotic medication to Mr G.

6.15 GP 2 was aware that Mr G had children. He had seen Mr G accompany his children when they visited the surgery. Like GP 1, GP 2 had no concerns for the couple's children. Mr G and Mrs P presented as a supportive couple. At this time Mrs P was acting as a carer and was described as happy to be included in the planning, monitoring and administration of medication to Mr G.

6.16 The care provided to Mr G by his GP surgery was generally of a good standard. Both GPs took steps to help Mr G. GP 1 referred Mr G on more than one occasion to the CMHT and arranged counselling and a psychiatric assessment for him.

6.17 GP 2 managed Mr G with medication and requested an emergency review from mental health services. GP 2 provided a good level of care in that he managed the presenting problem as best he could and sought specialist advice from secondary mental health services.

6.18 In a letter responding to our report findings GP 2 said that there was no certainty that Mr G would have been compliant with antipsychotic medication when taking into account Mr G's "*chaotic*" drug use and limited insight when using drugs.

Finding

F1 Both of Mr G's GPs generally delivered a good level of care in their treatment of Mr G and referral to the CMHT for assessment when required. However, there were two areas where Mr G's care could have been improved. GP 1 should have considered the reasons why the CMHT repeatedly refused his referral. If he was concerned about Mr G's mental health he should have made it clearer. GP 2 might usefully have explored with the CMHT the option of prescribing Mr G with antipsychotic medication after he had been referred to the psychological services. We do not suggest that there is a link between these two points and the death of Mrs P.

The CMHT

6.19 In keeping with other service models in the trust, the CMHT has been divided into teams: one team dealing with screening and short term interventions, another dealing with longer term or more complex serious mental health problems.

6.20 The screening and short term intervention team was initially called the Intake Team, but changed its name to First Response and Intervention Services (FRIS) in 2008 and to the Access Team in early 2011.

6.21 We were told during interviews with trust staff that historically the CMHT did not function well. All cases were allocated to the team manager or a senior practitioner as opposed to individual staff members. This resulted in both individuals having a caseload in excess of 300. There was very little care coordination. Staff reported that morale was low, sickness was high and there was a lack of supervision and managerial support.

6.22 The assistant director of the CMHT for the Community Recovery Service Line 1 told us that there were no systems and processes in place within the Access Team. We were told that supervision was only taking place sporadically and that staff were not aware of their responsibilities.

6.23 At the time of Mr G's referral, the duty system of the CMHT was staffed by non-medical staff (nurses, occupational therapists, social workers etc) and was busy. The current acting service manager stated that:

> *"Duty was pretty awful when I started – the poor staff had to work on it, I don't know how they did it for so long, to be honest, but they managed a system. But they were overwhelmed – everything went to Duty, so we'd begun to look at ways to separate that out, to stop the bombardment onto the team, because they weren't able to achieve everything that they needed to do"*

6.24 Senior practitioner 1 and Access Team service manager 2 told us that they also had concerns in relation to the way the duty service was operating at the time. In particular, access to consultants was described as *"awful"*.

6.25 Further changes to the way the CMHT was managed and its operational procedures were being introduced in 2010/11. These changes were taking place at the same time that Mr G's mental health deteriorated.

Finding

F2 The CMHT did not function well. It had experienced a number of problems historically and was undergoing significant managerial and structural change during the period when Mr G's mental health was deteriorating. If Mr G has been accepted into the service he would have joined the caseload of a poorly functioning team.

Mr G's referral and assessment within the CMHT

6.26 The duty system screening of the three referrals for anger management was appropriate. At the time of these referrals, Mr G was recorded as not having mental health problems that would have benefitted from mental health treatment. Mr G was effectively care-seeking after incidents where he had lost control and become aggressive. The advice given to GP 1 by the CMHT about seeking counselling from other services for Mr G was also appropriate. GP 1 took this advice and referred Mr G to counselling within primary care, though Mr G failed to engage.

6.27 Mr G's referral in January 2006 was also dealt with appropriately. GP 1's concerns regarding Mr G's symptoms of depression resulted in him being offered an assessment. It is regrettable that Mr G did not take up this offer because it would have provided a point of reference for future contact.

6.28 The multiple referrals should have led to further enquiry from the CMHT. However the duty service was dealing with a large volume of work from multiple sources and managed by different workers on a daily basis. The CMHT provided GP 1 with information about counselling services for Mr G.

6.29 Even if the CMHT had made a further enquiry, it is unlikely that Mr G would have received any more care than that GP 1 was able to provide. At this time, Mr G's presenting problems were aggression and low mood. There was no recorded evidence of the psychotic symptoms that would manifest later.

6.30 A member of the CMHT spoke to Mr G on 31 December 2010. An appointment was arranged for ten days later. This was a significant delay in light of GP 2 requesting an urgent appointment on 31 December 2010 and may have been a missed opportunity to identify Mr G's deteriorating mental health.

6.31 During this time Mr G controlled his drug and alcohol abuse and was assisted in taking medication by Mrs P. By the time Mr G saw the Access Team workers on 10 January 2011, the crisis had abated.

6.32 The CMHT workers had not met Mr G before and based their assessment on the GP's referral and the interview they had with the couple.

6.33 They concluded that Mr G was no longer in crisis and that he did not need immediate care, although he would benefit from counselling. They were reassured in this by the presence and contribution of Mrs P during the interview. CPN 1 told us:

> *"At the time X and I saw him, he was not taking drugs, he wasn't using alcohol and they both said everything was fine; their relationship had improved because of him not doing drink and drugs. They seemed quite happy. They were, on the surface, it appeared that there was a very good relationship."*

6.34 The workers' assessment was understandable given the nature of the interview, and that it would seem that Mr G's psychotic symptoms were resolved because his drug and alcohol use were under control. CPN 1 told trust serious incident lead investigator 1:

> *"They were not asking for anything. They said 'we're fine', but they just felt they should keep the appointment."*

6.35 It appears that the true nature of Mr G's psychotic symptoms experienced during his crisis were not fully recounted during the assessment interview. When interviewed later by the trust investigators, those who assessed Mr G gave no indication that he had mentioned the voices he had told GP 2 about, or the extent to which he felt he was being monitored by electronic equipment.

6.36 Despite this, it would have been appropriate for Mr G to have been assessed by a psychiatrist based on the nature of the referral sent by GP 2. Though GP 2 had not ticked risk factors within the referral, he had outlined that Mr G was paranoid, had a history of psychosis and violence and needed to be seen within 24 hours. A psychiatrist would have been able to carry out a psychiatric assessment and consider whether antipsychotic drugs were appropriate.

6.37 At this point Mr G's long-term care would have benefited from some monitoring and crisis planning including a further review of his medication. This was not considered because the workers assumed that the crisis was a relapse, rather than the first presentation of psychotic symptoms. The assessors were also unaware of the true nature and seriousness of Mr G's recent psychotic symptoms over the Christmas period. Despite this, based on Mr G's history and the nature of the referral from GP 2, a follow up

appointment to monitor his symptoms should have been considered plus a review of medication with advice to Mr G and his GP.

6.38 At the time of the incident, the new management staff in post at the CMHT were concerned that the system of referring and assessing patients was not appropriate to deal with presentations such as Mr G. Although it would have been difficult for CMHT workers to have picked up the risk inherent in the Mr G case, it seems clear that even if they had, the structure of the service would not have facilitated the care needed. It is likely that if his referral had been accepted, it would not have been addressed in a timely manner, nor would there have been any continuity of care. Access Team service manager 2 told us:

> *"... It became apparent also that they* [the Access Team] *structured their working life in terms of assessment clinics, routine follow up clinics and duty. Very few people were getting specific care co-ordination... clients were coming in, being assessed urgently or routinely by one person, and being seen several weeks later by another."*

Findings

F3 The assessment conducted by CMHT staff on 10 January 2011 was reasonable based on the information available to them at the time. However in this case based on Mr G's history and the nature of the referral by GP 2, best practice would have been for Mr G to have been assessed by a psychiatrist, and the use of antipsychotic medication explored.

F4 The CMHT staff assumed that the crisis Mr G had experienced over Christmas was a relapse as opposed to the first presentation of psychotic symptoms. The assessors were unaware of the true nature and seriousness of Mr G's recent psychotic symptoms.

F5 Mr G did not wish to engage further with mental health services. Despite this, the CMHT should have arranged close liaison and support to GP 2 in order to monitor Mr G after his assessment on 10 January 2011.

Mr G's presentation in late February and early March 2011

6.39 Mr G's alcohol and drug misuse led to a further crisis in February 2011. This was in keeping with the previous crisis in December 2010. Mr G reported this to GP 2 who responded with an appropriate and immediate referral to mental health services via the A&E liaison team in QEQMH A&E.

6.40 Psychiatry liaison teams work within acute general hospital A&E departments. The service is provided by the mental health trust, but is a separate service to the CMHT.

6.41 A&E liaison nurse 1 failed to respond appropriately to Mr G's presentation. Mr G should have received a full mental health assessment. This should have led to consideration of either an admission or a referral to the crisis and home treatment team for monitoring. Discharge and self referral to the CMHT was not an appropriate response to the information that A&E liaison nurse 1 had access to and not what would be expected.

6.42 A&E liaison nurse 1's response to the report's findings said that at no point during the assessment did Mr G act in a threatening manner. A&E liaison nurse 1 believed that Mr G had been risk assessed and that all actions taken were in good faith. We think that this was a missed opportunity to fully assess Mr G. This led to a lack of appropriate concern from mental health services. The trust subsequently carried out an investigation into the conduct of A&E liaison nurse 1 that concluded that the actions constituted gross misconduct. Further details about this are discussed later in our report.

6.43 In her closing statement at Mr G's trial, the judge was critical of the decision not to admit Mr G on 24 February 2011. We agree with this criticism.

6.44 The phone call Mr G made on 2 March for an appointment with the CMHT and the earlier call to the crisis resolution home treatment team by an unnamed relative on 25 February could have prompted a further review of Mr G. However a further review would have been unlikely because these services would have been aware that he had been seen by A&E liaison nurse 1 shortly before and assessed as well enough for discharge. It is unclear as to what response was made to these phone calls, other than routine processing. The phone call on 5 March was logged in the duty log and an appointment letter sent.

Finding

F6 The assessments conducted by A&E liaison nurse 1 on 24 February 2011 were inadequate. The nurse did not carry out a full psychiatric assessment and the risk and needs assessments were not in keeping with trust policy.

Safeguarding

6.45 Neither of Mr G's GPs had concerns in relation to his family. Mr G attended appointments alone or with Mrs P. When the couple attended together, they presented as a supportive, loving couple who gave neither GP cause for concern.

6.46 The trust and the police were both aware of Mr G's violent behaviour, his attacks on his wife and threats to hurt her.

6.47 During his assessment by the CMHT Access Team in January 2011 Mr G admitted that he had taken illegal drugs, had problems with alcohol and had been in trouble with the police. Staff did not make the link between Mr G's drug and alcohol use which was known to exacerbate his aggressive and violent behaviour. Staff recorded that there were no issues of risk or protection of the children. The assessors subsequently told the trust lead investigator 1 that Mrs P and Mr G presented as a happy couple.

6.48 When Mr G was assessed in A&E in February 2011, junior doctor 1 recorded in the notes that Mr G had threatened to hurt Mrs P. However when Mr G was later assessed by A&E liaison nurse 1, no adult or child safeguarding issues were identified, or the need for a children's service assessment.

Finding

F7 Despite evidence of Mr G's drug and alcohol abuse and violent behaviour, the healthcare professionals involved in Mr G's care were not given cause for concern in relation to the safeguarding of his children.

Interagency working

6.49 The trust did not contact either the police or Kent County Council about Mr G because they were not concerned. No safeguarding issues were identified during his assessments. If safeguarding issues had been identified these would have been the catalyst to prompt the trust to contact the police.

6.50 Other agencies were working with Mr G and his family. The police were aware of Mr G because of his criminal history. Kent County Council Specialist Children's Services visited the family on two occasions, in October 2008 and April 2009. We were informed that they had worked with the health visitor and also worked with the police. They said that this included the child abuse investigation unit and subsequently a domestic abuse officer. We have not investigated this interagency working.

6.51 The trust informed us that they have strong involvement with Multi Agency Public Protection Arrangements (MAPPA[1]) and that they are part of the Margate Taskforce. The Margate Taskforce is a pilot project that involves the police, social services and health services. The Taskforce is focused on a small deprived area in Margate, looking to improve and develop the area.

6.52 Despite this the trust said that further work is needed in relation to strengthening the CMHT's sub-MAPPA links.

Finding

F8 Mr G had a forensic history which included assaults against his wife and destruction of family property. He was a concern to his GP and had been referred to the mental health services. On this basis there should have been shared intelligence between the police, the children's services and the mental health service about Mr G. The police and children's services had worked together but not with mental health services.

[1] MAPPA refers to the arrangements in England and Wales for the 'responsible authorities' tasked with the management of offenders who pose a serious risk to the public. Emphasis is placed on the role of the police, probation service and prison service, but agencies such as social services and health services are also involved.

Predictability vs preventability

6.53 Based on the evidence we have reviewed, we have assessed whether the incident on 5 March 2011 was either predictable or preventable.

Was there any known history of violence or threats of violence?	**Yes.** The Access Team and the GP surgery were aware that Mr G had assaulted a man in 2007. The Access Team was aware that Mr G had assaulted Mrs P in the past. A&E liaison nurse1 was aware that A&E staff had reported that Mr G had threatened to harm his wife.
Was there a history of actual violence?	**Yes**. Mr G had a number of criminal convictions and had assaulted Mrs P.
Was the history recent?	**No.** Mr G's paranoia had escalated from October 2010 onwards and he had destroyed items in the family home, however he is not known to have been violent toward Mrs P at this time. However in February 2011, such was her concern, Mrs P and her children moved to her mother's home.
Was the potential violence risk assessed?	**No effective risk assessments took place.** The Access Team did not believe a full risk assessment was required in January 2011. A&E liaison nurse 1 failed to conduct an effective psychiatric assessment on 24 February 2011. It is at this time that Mr G should have been admitted to the hospital or referred to the crisis home treatment team.

Finding

F9 It would have been reasonable to predict that Mr G would be violent again in light of his escalating drug and alcohol use, and behaviour. However, it could not have been foreseen that his violence would escalate to the extent that he would kill his wife.

7. Trust internal review

7.1 The trust conducted three reviews after the incident on 5 March 2011:

- 72-hour management review
- 'management clinical serious untoward incident learning review' (serious incident review)
- review of A&E liaison psychiatry service.

72-hour management review

7.2 The trust conducted a 72-hour review[1] after the incident on 5 March 2011. It was completed on 7 March 2011. The review identified a number of concerns that included a lack of:

- robust systems within the CMHT
- available leadership due to senior staff having to 'act down'
- appropriate treatment resource and support for clients which may lead to referrals to psychological services.

7.3 Two immediate actions were identified:

1. Carry out a complete review of the CMHT, evaluating the systems, processes and cultural issues of the service.

2. The service manager was to carry out a debrief and systems analysis with the CMHT Access Team, regarding Mr G and his management in view of identifying, and where possibly remedying 'fail and pinch' points subject to the outcomes of action 1.

[1] A 72-hour review must be carried by a trust in accordance with guidance published by the Department of Health in circular HSG (94) 27 (updated in June 2005).

Serious incident review

7.4 The trust conducted a serious incident review. It was completed on 29 April 2011. The terms of reference for the review were to examine:

> *"The care and treatment of Mr G with specific reference to be made to the assessment process"*

7.5 The work was undertaken by trust serious incident lead investigator 1 and service manager for the west locality 1. The serious incident review was set out in two reports. The first report examined the assessments of Mr G; the second, the wider management of processes within the CMHT.

7.6 Four members of staff were interviewed for the review and a document review was carried out. The review did not involve Mr G because criminal proceedings were underway. The trust did not contact the police for the same reason. All interviews were recorded and transcribed. The trust did not meet with the families of either Mr G or Mrs P.

7.7 The serious incident review gave a brief chronology of events and Mr G's engagement with the trust and described what happened on the three dates that Mr G engaged with services, 10 January 2011, 24 February 2011 and 2 March 2011.

7.8 The serious incident review identified three ways in which Mr G's care could have been improved:

- A comprehensive needs assessment should have been recorded on ePEX on 10 January 2011.

- A&E liaison nurse 1 should have made a referral to the Crisis Home Treatment Team on 24 February 2011.

- A comprehensive assessment of risk on 2 March 2011 might have led to an earlier appointment or referral to acute services.

7.9 The review identified further issues that were relevant to the incident, gave recommendations, outlined what support was offered to staff, and reported on changes implemented after the incident.

7.10 The serious incident review made six recommendations:

1) *"The present system of recording only a contact and CPA4 is contrary to policy and this should change immediately to ensure that CPA2 is completed as fully as possible [relating to the assessment on 10.01.11].*

2) *The individual concerned should receive manager support in exploring the reasoning behind the lack of adherence to process and policy. Should this result in any issues regarding capability, this should be dealt with in the most appropriate manner [relating to the phone call 02.03.11].*

3) *It must be clearly emphasised that full records should be kept and recorded in the electronic system and care should be taken to ensure that such recordings identify exactly whether telephone calls are received or made.*

4) *The service manager should consider whether or not it is efficient and safe for all calls to be received by administrative staff, particularly with a duty system.*

5) *The existing duty system at the CMHT site 1 should be arranged to ensure that there is a time or resource allocated for full record keeping to be made.*

6) *Consideration to be given to make arrangements to ensure that all staff are supported to achieve the highest standards of patient safety."*

7.11 At the time of completion, the trust's reviewers were yet to formulate a fully informed view on the A&E liaison assessment. The review concluded that the assessments on 10 January 2011 and 24 February 2011 were missed opportunities to ensure the safety of Mr G and his family. The Root Cause Analysis Action Group recommended that the staff involved in the 10 January 2011 assessment be subject to a competency review.

7.12 The second part of the review examining the management of processes identified a number of problematic areas within the CHMT. Those interviewed as part of the trust

internal review reported the CMHT suffered from low team morale and that there was a lack of managerial support. They said the caseload was 'hectic' and that there were an increasing number of referrals to the team. The Access Team acting service manager 1 reported that caseloads were only being allocated to two individuals; Access Team service manager 1 and senior practitioner 1. As a result each had over 300 cases on their caseload. The review concluded that this would not support safe practice.

7.13 Staff interviewed as part of the trust internal review said there had been a historical lack of management and support. Staff did not receive regular supervision and there was no consultation with staff. The review found that the directorate risk registers did not accurately reflect the difficulties that the CMHT had been experiencing.

Review of A&E liaison psychiatry service

7.14 In parallel with the serious incident review, liaison psychiatry service manager 1 investigated the events that occurred on 24 February 2011 at QEQMH A&E. The liaison psychiatry service manager 1's preliminary investigation examined record keeping, risk assessment and management and information sharing within the liaison service. The report concluded that there were failings in all of the areas it examined.

7.15 Following this preliminary investigation, liaison psychiatry service manager 1 further submitted an action plan to the Root Cause Analysis Group. There were six actions (refer to section 8 for further information):

1) *"Spot check of records on ePEX to establish adherence to safeguarding policy and protocol taking necessary actions as a matter of urgency.*

2) *All supervisions to include scrutiny of all CPA assessments for adherence to safeguarding with immediate effect and until further notice.*

3) *All staff advised of SUI and expectations of them regarding safeguarding restated.*

4) *Safeguarding assessment checklist to be developed with support of the named nurse and tested by A&E liaison.*

5) *Training for A&E liaison staff in MSE (Mental State Examination) and drug and alcohol history taking in order to determine dual diagnosis.*

6) *Review of the A&E liaison assessment records for Mr G to establish adherence to safeguarding procedures."*

7.16 Liaison psychiatry service manager 1 produced a management statement about the Mr G case on 16 May 2011. The report outlined that A&E liaison nurse 1 had received clinical and managerial supervision with the A&E liaison service. A&E liaison nurse 1's last appraisal had been in March 2010. The appraisal indicated that A&E liaison nurse 1 was aware of the clinical actions needed to promote safety and protection. Prior to this, A&E liaison nurse 1 had received training in 2009 on the clinical management of risk from a liaison perspective, and the assessment of patients and their use of alcohol.

7.17 As part of the investigation leading to this statement A&E liaison nurse 1 was interviewed on 12 April 2011. The report said that A&E liaison nurse 1 did not follow the appropriate safeguarding protocols and policy and that the risk assessment was not undertaken in accordance with the risk assessment and management protocol. A full psychiatric assessment of Mr G was not carried out. The report concluded that the assessment conducted on 24 February 2011 was not in keeping with the relevant trust policies and liaison psychiatry protocols.

7.18 A&E liaison nurse 1 was on leave when the department became aware of the incident on 5 March 2011. On returning from leave A&E liaison nurse 1 was removed from the liaison service and placed in an office-based role. A&E liaison nurse 1 subsequently went on sick leave and later resigned.

7.19 Liaison psychiatry service manager 1 wrote to A&E liaison nurse 1 on 20 April 2011. The letter advised that as a result of the investigation findings, a disciplinary hearing was to be held.

7.20 The hearing was held on 15 June 2011. A&E liaison nurse 1 declined to attend the hearing. The disciplinary hearing concluded that the practice of the nurse constituted gross misconduct. A&E liaison nurse 1 had left the trust but was informed in writing of the hearing outcome. The written notification confirmed that, if still in post, A&E liaison

nurse 1 would have been dismissed. The trust wrote to the Nursing and Midwifery Council to report its findings.

7.21 A further action plan dated 14 October 2011 had 3 actions in addition to those listed above:

- repeat a spot check of the ePEX records
- undertake the disciplinary hearing
- undertake an independent audit of notes in relation to safeguarding children.

Comment

Following a serious incident or homicide, a trust will typically produce one report and one action plan. In the case of Mr G, the trust produced four reports and a combined action plan. The trust acted in a timely manner in light of the incident on 5 March 2011, and took a number of steps to address the problems that had been identified.

The trust recognised that the service was struggling, therefore undertook a general review. The two actions that came out of the 72-hour review were trust-wide as opposed to being focused on Mr G e.g. "a whole system review of the ... CHMT".

The trust's serious incident review was shorter than internal reviews that have previously been carried out by the trust because the trust anticipated an independent review of Mr G's care and treatment would be carried out promptly. The trust serious incident review examined both the events specific to Mr G and wider issues relating to the CMHT.

As a patient, Mr G only engaged with the trust minimally. The trust could only review the three engagements that Mr G had with the service and the outcomes of these events. The recommendations outlined by the serious incident review were reasonable and could mostly be implemented within a short timeframe. They were specific to the Mr G case.

The review undertaken by the A&E psychiatry liaison service was timely and decisive. The actions and recommendations outlined in the review were clear and subsequently implemented. In particular, the actions of liaison psychiatry service manager 1 to investigate and address the practice of A&E liaison nurse 1 were both proactive and timely. The management statement of case concluded that A&E liaison nurse 1 had received clinical and managerial supervision. A&E liaison nurse 1 was deemed capable of fulfilling the role. The assessment undertaken on 24 February 2011 was not completed to the level expected, nor was it in keeping with agreed trust protocols.

The trust felt it was inappropriate to meet the family of Mrs P at the time of the internal review because it was carried out very soon after her death. Court proceedings against Mr G further delayed the trust contacting the family. We feel that the trust should have contacted Kent Police to discuss this and make arrangements to meet the family of Mrs P. By meeting with Mrs P's family, the trust would have provided them with information and support during a very difficult time.

8. Implementation of trust recommendations

Serious incident review

8.1 In light of the findings of the serious incident review and other ongoing concerns about the service the trust commissioned a service review of the CMHT. The review resulted in the creation of the Thanet 'task and finish' group to address the performance of the CMHT.

8.2 This group was chaired by a non-executive and reported to the risk committee. Three trust executives were involved in the work. The purpose of the group was to support those implementing the recommendations of the serious incident review and to hold the CMHT to account for its practice.

8.3 The six recommendations of the serious incident review were finalised in April 2011. The first draft of the action plan to address these recommendations was completed on 3 June 2011. The action plan was combined with six actions drawn from the psychiatry A&E liaison review. The action plans were submitted to the Root Cause Analysis Action Group.

8.4 The assistant director of the CMHT for the Community Recovery Service Line 1 was responsible for completing the action plan. Access Team service manager 2, was responsible for monitoring the implementation of actions.

8.5 The trust provided us with documents in relation to its progress against the action plan. We also spoke with trust staff to assess progress made.

8.6 The serious incident review made six recommendations. We explore these in detail below. We asked the trust, when necessary to provide us with further evidence to test whether the recommendations had been implemented.

Recommendation 1

The present system of recording only a contact and CPA4 is contrary to policy and this should change immediately to ensure that CPA2 is completed as fully as possible [10.01.11].

8.7 A reflective practice session took place on 24 May 2011. It was attended by the CMHT Access Team. Minutes of the meeting recorded that any contact regarding patient care must be recorded on ePEX/RiO. Staff were advised that the log book could be used as a secondary source alongside the electronic records, but not as the sole record. It was further recorded in the minutes that CPA2 and 4 must be completed for each assessment.

8.8 Access Team service manager 2, sent an email to the Access Team on 23 June 2011 reminding staff to adhere to staff policy about the electronic recording of patient assessments. It was stated that this action needed to be implemented immediately. The trust action plan recorded that the recommendation was achieved in June 2011.

8.9 The trust provided us with two examples of case note audits conducted in June and July 2011.

Recommendation 2

The individual concerned should receive manager support in exploring the reasoning behind the lack of adherence to process and policy. Should this result in any issues regarding capability, this should be dealt with in the most appropriate manner [02.03.11].

8.10 This recommendation relates to the CMHT's handing of Mr G's phone call to them on 2 March 2011. When interviewed as part of the trust's internal review, the individual concerned had been unable to recall the details of the exchange. The trust supplied us with records of supervision sessions held with the member of staff. On 22 June 2011, the member of staff outlined the process to manage a referral to the access service manager and Kent County Council senior practitioner/practice supervisor. Subsequently three observations were carried out to monitor her assessment skills. The trust provided an example of direct observation that was undertaken on 5 May 2011.

8.11 The trust reported that the member of staff was found to be competent through supervision and observation processes. The trust action plan recorded that the recommendation was achieved in June 2011.

Recommendation 3

It must be clearly emphasised that full records should be kept and recorded in the electronic system and care should be taken to ensure that such recordings identify exactly whether telephone calls are received or made.

8.12 The trust developed an electronic file audit tool to monitor progress against this recommendation.

8.13 We asked the trust in November 2012 and January 2013 to provide us with details of any relevant audits and the monitoring of telephone record management. It gave us a copy of a template for auditing that they had introduced in 2012. We were told by senior practitioner 1 that all telephone calls should be recorded in RiO (or ePEX) and an entry is added to the duty log book. In February 2013 the trust informed us that it is difficult to audit telephone contact however they were able to demonstrate that telephone contacts were being recorded. The trust provided us with reports which demonstrated that the number of contacts made to the CMHT had increased between 2011 and 2012 and that telephone contact had also risen proportionally.

8.14 The trust moved its electronic records from ePEX to RiO in June 2011. Access Team acting service manager 1 told us that though RiO was a good recording system, the migration was taking time and that RiO required more work than ePEX. Members of the Access Team reported that RiO was not fully functioning and that the transition was not complete. Access Team acting service manager 1 told us that RiO feeds in to the trust's business intelligence system which is monitored by the performance team, which in turn send reports to Access Team acting service manager 1 about its use.

Recommendation 4

The service manager should consider whether or not it is efficient and safe for all calls to be received by administrative staff, particularly with a duty system.

8.15 Access Team service manager 2 wrote a protocol for handling duty phone calls. The protocol, dated 24 June 2011, states that receptionists for the Dover, Deal and CMHT Access Team must transfer callers wishing to speak to the access duty worker. It states that callers must be advised that their call may not be answered immediately and that if they wish to leave a message it will be passed to the duty worker immediately. In turn, the duty worker must return the call at the first opportunity.

8.16 The trust action plan recorded that this recommendation was to be achieved by June 2011.

8.17 We were told by members of the Access Team that the duty system is now more organised. Duty is now overseen by the team senior practitioner. Dedicated consultants are available to the team and involved in the screening process. The team will screen a referral and then contact the patient. If there is no immediate concern the referral goes to the senior practitioner and consultants who assess it within two days. If it is an emergency they will ask the patient to attend the CMHT site 1 to be seen by the duty doctor and another member of staff. Consultants are aligned to GP surgeries making it easier for them to have an overview of referrals from each surgery.

Recommendation 5

The existing duty system at the CMHT site 1 should be arranged to ensure that there is a time or resource allocated for full record keeping to be made.

8.18 The service managers for both the access and recovery teams were responsible for this recommendation, which was to be in place by September 2011. Access Team service manager 2 provided an update on 24 June 2011. Access Team service manager 2 reported in the update that this recommendation was not being achieved because of the demands on the depleted Access Team. Access Team service manager 2 reported:

"*the demand on staff is at times so intense and complex that they are unable to keep their electronic records contemporaneously up to date.*"

8.19 We were told in interviews with members of the Access Team, that timely record keeping continued to be a problem. Staff said that letters for clinics that had taken place four weeks previously were just being sent out. This delay was attributed to the high demands on the administrative staff. We were told that a review of the administrative function was ongoing at the time of our interview.

Recommendation 6

Consideration to be given to make arrangements to ensure that all staff are supported to achieve the highest standards of patient safety.

8.20 The management of the CMHT has changed a number of times. Access Team service manager 2 was in post as Access Team manager from February 2011 for just over a year. Access Team service manager 2 then moved to another post within the trust. As a result, Access Team acting service manager 1 was seconded to the team as the acting service manager. Access Team acting service manager 1 has been in post since May/June 2012. Access Team acting service manager 1 had previously been a senior practitioner in the Access Team between March 2011 and March 2012. We were told that since the arrival of Access Team acting service manager 1, the management of the team has improved and that staff felt more supported. It was unclear to both the team and Access Team acting service manager 1 when the secondment would end.

8.21 The assistant director of the CMHT for the Community Recovery Service Line 1 told us:

"*they* [Access Team staff] *now have regular supervision and they are now clear about what's expected of them.*"

8.22 As part of recommendation 6, two further recommendations were:

6a) A whole system review of the CMHT to evaluate systems, process and cultural issues has been agreed with the Service Director and will commence immediately.

6b) Recommendation from the Clinical SI [serious incident] *learning review group that the assessment competencies of the staff who made the January assessment should be assured to the Clinical SI learning review group.*

8.23 Recommendation 6a formed part of the original 72-hour review. The resulting service-wide action plan identified six actions.

i. Recruitment (two band 6 nurses and one occupational therapist).

ii. Rotation and short-term secondment of Crisis Recovery Service Line staff from other east Kent localities into Thanet service.

iii. Data 'clean up' (provide dedicated administrative staff and extra support to achieve optimum data accuracy.

iv. Management focus (dedicate management time to CMHT Access Team).

v. Risk management (identify key risk areas, ensure that the risk register is used effectively, implement risk management training).

vi. Governance (establish a Thanet specific governance group).

8.24 Within the action plan it is recorded that actions i, ii and iv were achieved by 14 March 2011. Despite this, an update on 11 May 2011 describes recruitment as continuing. In relation to action iii, it is recorded that on 11 May 2011, no administrative support had been provided to facilitate the data clean up.

8.25 In relation to action v, it was recorded on 11 May 2011 that the Datix[1] system is updated with all current risks for Thanet. An update for action vi reports that plans were established to set up a Thanet Governance Group as a 'sub group' of the Thanet/Dover/Deal LOMT (Locality Operational Management Team).

8.26 In relation to recommendation 6b, we have seen evidence that one of the individuals involved in the January assessment of Mr G was assessed and found to be competent. We have not seen evidence of any assessments of the other member of staff.

Psychiatry A&E liaison review

8.27 The actions derived from this review are examined below.

1) Spot check of records on ePEX to establish adherence to safeguarding policy and protocol taking necessary actions as a matter of urgency.

8.28 Liaison psychiatry service manager 1 and senior practitioner 2 conducted a spot check of all A&E referrals between 1 and 8 March 2011. During this period 27 patients were referred to the liaison service, of which 19 were assessed. The records of six of these patients had not been completed or evidenced correctly. Liaison psychiatry service manager 1 undertook a clinical review of these six records which identified further actions.

8.29 Liaison psychiatry service manager 1 sent a letter to all A&E liaison nurses on 16 March 2011 reminding them of best practice and what the trust expected in relation to safeguarding.

2) All supervisions to include scrutiny of all CPA assessments for adherence to safeguarding with immediate effect and until further notice

8.30 Liaison psychiatry service manager 1 sent an email on 10 March 2011 to liaison service personnel responsible for supervising staff. The email raised concerns identified

[1] Datix is an electronic system used by the trust to record risk management and patient safety data

by the spot check of records. As a result, senior personnel responsible for supervising staff were asked to give particular attention to the nurse liaison assessments in relation to child safeguarding and adherence to policy. A liaison psychiatry supervision template was circulated with the email.

3) All supervisions to include scrutiny for CPA2 assessments for adherence to safeguarding with immediate effect and until further notice.

8.31 We have seen evidence that safeguarding was added to the liaison psychiatry service supervision records. We have seen evidence that ePEX records were reviewed to check that safeguarding was being addressed with the correct information.

4) Safeguarding assessment checklist to be developed with support of the named nurse and tested by A&E liaison.

8.32 We have seen a copy of the safeguarding assessment checklist, and evidence that it was circulated to liaison service staff.

5) Training for A&E liaison staff in Mental State Examination and drug and alcohol history taking in order to determine dual diagnosis.

8.33 A&E liaison nurses were given training on mental state examinations, and drug and alcohol history taking on 16 March 2011. Further training was given during a clinical practice development day on 1 June 2011.

6) Review of the A&E liaison assessment records for Mr G to establish adherence to safeguarding procedures.

8.34 Two reviews were conducted by liaison psychiatry service manager 1. Both reviews explored the events of 24 February 2011. The first looked at the completed documentation; the second looked at the overall assessment. Both reviews were completed in March 2011.

8.35 Three further actions were recorded in the psychiatry SUI management action plan dated 14 October 2011.

7) Repeat spot check of records on Epex to establish adherence to safeguarding and policy and protocol

8.36 A spot check of A&E liaison assessment records was carried out on 22 July 2011. It showed a significant improvement in adherence to Safeguarding protocol.

8) Disciplinary hearing to be held

8.37 A disciplinary hearing was held on 15 June 2011. A&E liaison nurse 1 chose not to attend. The hearing found that A&E liaison nurse 1 had failed to follow liaison safeguarding protocol and safeguarding policy, and that the risk assessment was not undertaken in line with risk assessment and management protocol. Had the nurse still been employed by the trust, A&E liaison nurse 1 would have been dismissed for gross misconduct.

9) Support an independent audit of notes in relation to safeguarding children.

8.38 An independent audit of the notes was completed in September 2011 by the safeguarding children auditor. It was reported that staff had a real grasp of safeguarding children.

Comment

We have seen evidence that the trust has implemented changes following the three reviews undertaken by the trust in March and April 2011.

The CMHT has undergone change both in terms of management and structure. Staff we interviewed told us that improvements had been made following the trust's internal review. They attributed this largely to the dedicated work of the team and

its management in recent months. In their opinion the duty service is managed better and the team has access to consultants. Team members reported that they felt more supported. We were told that the current service manager was occupying the post temporarily, and it was unclear when a substantive appointment would be made.

Staff reported that their caseloads remained too high, were complex and there continued to be a lack of resources within the service. Senior practitioner 1 for the Access Team told us that the team had received over 1000 new referrals between January and August 2012. As a result, service users may wait a number of months to be referred to a service which ultimately may not accept them for treatment.

We were given the impression that staff within the CMHT were unclear as to the future plans for the service, and that to a certain extent they felt isolated from the trust.

The psychiatry A&E liaison review was carried out promptly and efficiently. Action was taken by liaison psychiatry service manager 1 to address problems identified by the review. We are confident that liaison psychiatry service manager 1 has taken action to prevent a similar incident occurring. The recommendations of the review were implemented promptly.

The action plan produced as part of the Community Recovery Service Line service wide review did not specifically relate to Mr G. The trust had experienced a couple of incidents prior to that of Mr G, therefore had undertaken a service-wide review. The trust has implemented changes in the CMHT however there are still ongoing problems with the service.

Findings

F10 The trust has implemented a number of changes as a result of the reviews undertaken in March and April 2011.

F11 Staff at the CMHT report that there continue to be problems within the service. They reported that their caseloads remained too high given their complexity and that there continued to be a lack of resources within the service.

9. Findings and recommendations

9.1 During the course of our investigation, we found that there was one item within the terms of reference that we could not address. We found no evidence that Mr G had suffered from post traumatic conflict stress, despite this being raised as part of his defence during his trial. Both expert witnesses at the trial, a professor of forensic mental health and forensic psychiatrist, were in agreement that Mr G experienced a psychotic disorder due to substance abuse.

Findings

F1 Both of Mr G's GPs generally delivered a good level of care in their treatment of Mr G and referral to the CMHT for assessment when required. However, there were two areas where Mr G's care could have been improved. GP 1 should have considered the reasons why the CMHT repeatedly refused the referral. If GP 1 was concerned about Mr G's mental health GP 1 should have made it clearer. GP 2 might usefully have explored with the CMHT the option of prescribing Mr G with antipsychotic medication after he had been referred to the psychological services. We do not suggest that there is a link between these two points and the death of Mrs P.

F2 The CMHT did not function well. It had experienced a number of problems historically and was undergoing significant managerial and structural change during the period when Mr G's mental health was deteriorating. If Mr G has been accepted into the service he would have joined the caseload of a poorly functioning team.

F3 The assessment conducted by CMHT staff on 10 January 2011 was reasonable based on the information available to them at the time. However in this case based on Mr G's history and the nature of the referral by GP 2, best practice would have been for Mr G to have been assessed by a psychiatrist, and the use of antipsychotic medication explored.

F4 The CMHT staff assumed that the crisis Mr G had experienced over Christmas was a relapse as opposed to the first presentation of psychotic symptoms. The assessors were unaware of the true nature and seriousness of Mr G's recent psychotic symptoms.

F5 Mr G did not wish to engage further with mental health services. Despite this, the CMHT should have arranged close liaison and support to GP 2 in order to monitor Mr G after his assessment on 10 January 2011.

F6 The assessments conducted by A&E liaison nurse 1 on 24 February 2011 were inadequate. The nurse did not carry out a full psychiatric assessment and the risk and needs assessments were not in keeping with trust policy.

F7 Despite evidence of Mr G's drug and alcohol abuse and violent behaviour, the healthcare professionals involved in Mr G's care were not given cause for concern in relation to the safeguarding of his children.

F8 Mr G had a forensic history which included assaults against his wife and destruction of family property. He was a concern to his GP and had been referred to the mental health services. On this basis there should have been shared intelligence between the police, the children's services and the mental health service about Mr G. The police and children's services had worked together but not with mental health services.

F9 It would have been reasonable to predict that Mr G would be violent again in light of his escalating drug and alcohol use, and behaviour. However, it could not have been foreseen that his violence would escalate to the extent that he would kill his wife.

F10 The trust has implemented a number of changes as a result of their reviews undertaken in March and April 2011.

F11 Staff at the CMHT report that there continue to be problems within the service. They reported that their caseloads remained too high given their complexity and that there continued to be a lack of resources within the service.

Recommendations

9.2 The trust has made a number of changes to the service in recent years, some of which continue. We have therefore discussed with the trust how recommendations arising from our findings can be made without impeding this work.

9.3 We identified four issues for further exploration.

- How can the trust mitigate risk around patient safety during change?
- How can the trust continue to provide support to the CMHT now that the 'task and finish' group has completed its work?
- How can the trust maintain safe practice during periods of service change?
- What steps has the trust taken to strengthen the CMHT's interagency links and particularly sub MAPPA communication?

9.4 We recommend that these issues should be part of a short independent review commissioned by the trust. The review should take place within 12 months and be used to examine the extent to which changes have become effectively embedded within the trust's structure and services.

Appendix A

Terms of reference

NHS South of England

Independent Mental Health Investigation into the care and treatment provided to Mr G

Commissioner

This independent investigation is commissioned by NHS South in accordance with guidance published by the Department of Health in circular HSG (94) 27 (updated in June 2005), *The discharge of mentally disordered people and their continuing care in the community*

Terms of reference

The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr G to include:

- a review of the trust's internal investigation to assess its rigour, objectivity and completeness against the investigation's terms of reference including an assessment of the adequacy of its findings, recommendations and action plans;
- reviewing the progress made by the trust in implementing the action plan from the internal investigations;
- involving Mr G and his wife's family;
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident;
- an examination of the mental health services provided to Mr G and a review of the relevant documents;
- the extent to which Mr G's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies;
- the appropriateness and quality of assessments and care planning;
- a review of his care from an expert in post conflict stress disorders;
- consideration of the effectiveness of interagency working;
- consideration of other such matters as the public interest may require;

As well as the matters above the investigation team will review the following themes:

- The effective team working of the Thanet Intake Team and the North CMHT in the light of the trust service review changes.
- The robustness of referral and assessment processes.
- The effectiveness of management systems to identify poor team working and provide support and assistance to improve practice.
- The trust's processes for accessing specialist assessments in particular assessments for post conflict stress disorders for ex armed forces personnel.

The investigation team will produce a report for presentation to NHS South within 26 weeks of receiving the clinical notes and commencing the investigation. The investigation team will, if required, assist in the preparation of the report for publication.

Approach

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

The investigation team will follow established good practice in the conduct of interviews ensuring that the interviewees are offered the opportunity to be accompanied and given the opportunity to comment on the factual accuracy of the transcript of evidence.

If the investigation team identifies a serious cause for concern then this will immediately be notified to NHS South of England.

Appendix B

Documents reviewed

Medical records

- Mr G's medical and nursing records

Policies and procedures

- The trust liaison psychiatry service safeguarding protocol

Internal report

- SUI review report, April 2011
- Action plan, 3 June 2011
- Notes of internal investigation interviews
- Updated action plan, 14 October 2011

Kent Police

- Individual management review, 14 April 2011

Kent County Council

- Letters sent from the director of specialist children's service, on 1 October 2012 and 1 November 2012, providing details of the family engagement with children's services

Other

- Selection of emails and documents from the trust SI lead
- Minutes from the Directorate of mental health formal directorate and LOMT meetings
- Review of A&E Liaison Psychiatry documentation

Appendix C

Interviewee list

- The trust serious incident lead
- The trust liaison psychiatry service manager
- Assistant director of the CMHT, Community Recovery Services (East and Medway)
- Community psychiatric nurse, CMHT Access Team
- Senior practitioner, CMHT Access Team
- Former service manager, the CMHT
- Former assistant director of the CMHT, Community Recovery Services (East and Medway)
- Former service manager, CMHT Access Team
- The trust medical director
- Service manager, CMHT Access Team
- Former recovery service manager, Community Recovery Services (East and Medway)
- Group interview with the CMHT Access Team:
    - Social worker
    - Community psychiatric nurse
    - Social worker
    - Consultant psychiatrist
    - Social worker
    - Member of the administration team
- GP 1, Mr G's GP
- GP 2, Mr G's GP

Meetings with

- Mr G
- Mrs P's family

Appendix D

Team biographies

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's managing partner with an active role in leading complex investigations and advising clients on the political repercussions of high-profile investigations. He is an expert in investigative techniques and procedures, and facilitated the introduction of a joint protocol for investigating serious patient safety incidents by the police, Health and Safety Executive and the NHS. Ed co-wrote with Derek Mechen the review of the board leadership of Maidstone and Tunbridge Wells NHS Trust after the Healthcare Commission (now the Care Quality Commission) reported on the deaths of 90 patients as a result of *Clostridium difficile* infection. He is currently advising the States of Jersey Council of Ministers on the commissioning of a public inquiry into historical child abuse. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

Kathryn Hyde-Bales

Kathryn joined Verita as a senior consultant in 2012. She previously worked at the Care Quality Commission (CQC), and its predecessor organisation, the Healthcare Commission. During this time she primarily held roles in Investigations, working and leading on a number of investigations. Her last role at CQC focused on managing the provision of analytical support to standalone projects and regional teams within CQC, covering the NHS, independent sector and social services.

Geoff Brennan

Geoff Brennan is a registered nurse for the mentally handicapped and a registered mental nurse. Geoff has worked in a variety of clinical and academic posts, mainly in London and the south east of England. Geoff has practised and taught psychosocial interventions for psychosis since the early 1990's. Geoff was chair of the standing nursing conference mental health group for London for five years.

Throughout his career Geoff has maintained an active involvement with acute care including carrying out the benchmark of London Inpatient Services for the London Development Centre and for three years was one of two city nurses working in east London to improve acute inpatient wards. Since 2006 Geoff has worked as a nurse consultant in acute care both in Berkshire and now in Camden and Islington Mental Health Trust. Geoff has published numerous articles and research papers on acute mental health and also co-edited a major text book for nurses. For two years Geoff has also been the national chair of the Consultant Nurse Association.

Dr Mostafa Mohanna

Mostafa Mohanna gained his basic training in psychiatry in Leicester after graduating with an MB Bch. He subsequently became a member of the Royal College of Psychiatrists and lecturer with the Leicester Medical School. He took up his first consultant post in Lincoln in 1990. He combined this role with various management positions. In 2001 he became the medical director for the newly formed Lincolnshire Partnership Trust. As medical director, Mostafa is joint lead, with the director of nursing, on clinical governance and quality, and has the lead on research and clinical effectiveness. Mostafa was recently made a Fellow of the Royal College of Psychiatrists (FRCPsych).