VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of Mr J

A report for
NHS East of England

June 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 J stabbed and killed his mother at home on 15 March 2010. Mr J pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order without limit of time.

1.2 At the time of the incident Mr J had been receiving mental health services from Suffolk Mental Health Partnership NHS Trust (the trust). In January 2012 the trust was merged and became Norfolk and Suffolk NHS Foundation Trust.

1.3 The trust commissioned a serious untoward incident review which reported in May 2010. The trust submitted the report to NHS East of England, the responsible strategic health authority (SHA).

1.4 In June 2012 NHS East of England commissioned Verita to carry out this independent investigation into the care and treatment of Mr J. The final draft report was submitted to the SHA in February 2013.

1.5 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. Tariq Hussain, senior consultant, Dr Mostafa Mohanna, consultant psychiatrist and Emily Ewart, community psychiatric nurse did the work. Their biographies appear at the end of this report (appendix A).

1.6 The report was peer reviewed by Derek Mechen, Verita partner.

2. Terms of reference

2.1 To provide an independent report into the care and treatment provided to Mr J from his first contact with the NHS up to the time of the offence.

2.2 This investigation is commissioned in accordance with the Department of Health's guidance and follows the National Patient Safety Agency's *Good practice guidance for independent investigations*.

2.3 Following the review of clinical notes and other documentary evidence:

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the SHA that includes measurable and sustainable recommendations.

2.4 The investigation team will also examine the following areas of practice that have been derived from the trust's investigation and build on the trust's investigation:

- clinical skills of professionals regarding the symptoms and presentations that Mr J exhibited
- the use of the electronic patient record
- team working
- caseload management
- supervision systems.

Approach to the investigation

2.5 We conducted our work in private and took as our starting point the trust's internal review supplemented as necessary by access to source documents (appendix B). A list of the interviews we carried out is attached at appendix C.

2.6 Interviewees were offered the opportunity to be accompanied and to comment on the factual accuracy of the transcript of their evidence.

2.7 Mr J's consultant psychiatrist (consultant psychiatrist 1) and his care coordinator (care coordinator 1) who were the professionals supporting him in late 2009 and early 2010 have both retired. We invited them both to be interviewed and consultant psychiatrist 1 met with us. Care coordinator 1 did not wish to meet with us. We sent both relevant extracts of the draft report for comment.

2.8 We offered Mr J an interview to explain how the investigation was to be conducted and to get his perspective on his care, but he refused to meet with us. We sent him a copy of the draft report for comment.

2.9 We met with Mr J's father (Mr S) and his two sisters to explain how the investigation was to be conducted and to get their perspective on his care and the support the family received. We also sent them a copy of the draft report and met with them to receive their comments.

3. Executive summary and recommendations

3.1 Mr J had been in contact with local mental health services since August 1998. He was first referred to the community mental health team (CMHT) by his GP (GP 1). The referral was made because he had taken an overdose of paracetamol, was using recreational drugs and had a developing alcohol problem. He had a number of unresolved stresses and was thought to be getting depressed after breaking up with his girlfriend in March of that year.

3.2 He was admitted to St Clement's Hospital on 14 October 1998 where he was diagnosed with schizophrenia. The evening before his admission he had been walking around the house he shared with his parents holding a breadknife because he thought people were coming to kill his family. He had asked his mother to join him in committing suicide as this was the only escape.

3.3 On admission, staff noted that there had been three previous suicide attempts. He had twice attempted to kill himself with car exhaust fumes and six weeks earlier he had taken a significant paracetamol overdose. He lacked insight and initially refused an informal admission but later agreed. He became extremely agitated and tried to leave the ward later that afternoon so was assessed under the Mental Health Act 1983 (MHA) and detained under section 2.

3.4 He was started on oral haloperidol, gradually improved and seemed to lose his delusional and suicidal thoughts. A care programme approach (CPA) meeting took place on the ward on 20 November 1998 and he was discharged that same day with community psychiatric nurse (CPN) and outpatient follow-up. He was prescribed haloperidol 7.5 mg[1] daily but it was reduced to 3 mg on 25 May 1999 after an outpatient follow-up appointment. He was due to start college again that September and was seeing his CPN (CPN 1) every few weeks.

3.5 He was admitted to St Clement's Hospital again on 10 September 1999 with a view to changing his oral medication to a depot injection. He was given a test dose of Depixol[2]

[1] An antipsychotic drug.

[2] Depixol is an antipsychotic drug. Its primary use is as a long-acting injection given two to four times weekly to people with schizophrenia who have a poor compliance with medication and suffer frequent relapses of illness.

which was subsequently increased to 40 mg weekly. In August 2001 his mental state had stabilised but he developed side effects with the Depixol so it was stopped and in November 2001 he was put on sulpiride tablets, a different antipsychotic drug.

3.6 In February 2002 CPN 1 noticed he was relapsing and GP 1 was asked to put him on amisulpride 400mg twice a day. He had regular CPN contact and outpatient appointments over the next few years. On 17 July 2006 it was agreed with Mr J to discharge him from the service. It was noted that he had been compliant with medication and had agreed to continue to take it.

3.7 On 22 January 2007 GP 1 wrote to the CMHT to inform it that Mr J had attempted to commit suicide by slashing his wrists and trying to drown himself in the sea. He was admitted to St Clement's Hospital from 22 to 29 January 2007. He told staff that he had reduced his medication over the past month as he did not think he was mentally ill. His medication was reinstated at a reduced dose of 300mg twice a day. Mr J reported feeling brighter and more active.

3.8 Mr J was reviewed by a psychiatrist on 9 September 2008 who found no evidence of depression or overt psychotic symptoms. He was discharged by CPN 1 the following day and agreed to taking his prescribed medication.

3.9 On 5 April 2009 Mr J's family rang the crisis team as Mr J was saying that it would be best if he got rid of his parents. He was assessed by the crisis team the following day and it was noted that he had relapsed after a holiday in Turkey, where he experienced visual hallucinations and believed his drink had been spiked. He recognised that he was ill and came back to the UK. He told staff that he had had constant thoughts over the years about killing his parents as he believed others were trying to harm them. He denied ever having any intent to act on these thoughts.

3.10 Mr J was seen daily by the crisis team and on 14 April 2009 he was allocated a CMHT social worker as his care coordinator (care coordinator 1). On 8 July 2009 a comprehensive carer's assessment was carried out by a carer's assessment team of a local charity called Suffolk Family Carers. During this assessment Mr J's parents expressed their disappointment at the support received from the CMHT since their son's relapse at Easter. Mr J was reviewed in outpatients on 17 July 2009 and it was noted by the psychiatrist that his psychotic thinking was always under the surface but came out when under stress.

3.11 On 25 September 2009 following a CPA review care coordinator 1 wrote to GP 1 advising that Mr J was stable and she was therefore discharging him in her role as care coordinator as *"no further tasks could be identified"*. The plan was for outpatient follow-up every two months.

3.12 Due to a clerical error he was not sent an outpatient appointment until February 2010. The appointment was for 22 March. No further contact took place with Mr J after his CPA review on 25 September 2009. His mother was found fatally injured at home on 15 March 2010.

Overall conclusion

3.13 What emerged from our investigation was a team struggling with operational changes, staff sickness, a pressure to keep patients moving through the system and limited resources given the large geographical area it was expected to cover. The team was also in the process of making changes to care arising from the adoption by the trust of the recovery model of care[1].

3.14 It is clear to us that Mr J should have remained under the CMHT and under CPA. Regular appointments with a care coordinator would have at least provided ongoing support, an up-to-date picture of his presentation and enabled a more robust risk management plan to be in place. Regular CPA meetings would have provided his parents with an opportunity to share their views while the level of support offered could have been reviewed more regularly.

Predictable or preventable

[1] The recovery model aims to help people with mental health problems to move forward, set new goals and do things and develop relationships that give their lives meaning. The recovery model emphasises that, while people may not have full control over their symptoms, they can have full control over their lives.

3.15 Mr J had told the crisis team that he had continuing thoughts of killing his family and therefore this was a risk that staff should have been alert to if he stopped taking his medication and was not under regular review.

3.16 The proposal to discharge Mr J from care coordination should have been discussed and agreed by the CMHT to ensure the care was being appropriately provided to this high-risk individual. The focus appeared to be on engaging him in meaningful activity rather than keeping alert to his risk history and fluctuating mental health.

3.17 Too much responsibility was placed on Mr J and his parents to raise concerns about any relapse. It was clear his delusional thinking never went away entirely and certainly intensified when he was non-compliant with his prescribed medication and during stressful periods.

3.18 We conclude that if Mr J and his family had continued to have regular reviews by the CMHT, including regular appointments with the psychiatrist, this may have prevented him killing his mother, but it may not. The value of regular contact as a maintenance function was not fully appreciated by the mental health professionals working with him. His most stable period was when he was having regular CPN contact that was increased during crisis periods.

Findings

F1 The risk assessment carried out by care coordinator 1, on 20 September 2009 though fully completed failed to properly take account of Mr J's long-standing risk history, including the risks to himself and his enduring belief that his family would be safer dead.

F2 Mr J should not have been discharged by care coordinator 1 in 2009 as there was no evidence that his risk profile had changed and he still needed to be seen on a regular basis by a suitably experienced professional, preferably a CPN.

F3 When it was discovered in February 2010 that Mr J had not been sent an outpatient appointment and had not been seen by a CMHT professional since September 2009 he

should have been given an urgent appointment either with the consultant or another suitable CMHT professional.

F4 Our review of consultant psychiatrist 1's involvement with Mr J shows little evidence of the level of clinical enquiry and communication with GP 1 and others that Mr J's condition required.

F5 The CMHT approach to the recovery model of care now takes account of the needs of individuals like Mr J whose delusional thinking is entrenched and who pose a significant risk if relapse occurs and therefore need care coordination and regular support.

F6 It is likely that a combination of the introduction of the recovery model and the new positive risk management policy played a part in the decision of care coordinator 1 to discharge Mr J from her caseload.

Recommendations

R1 The trust should hold a learning seminar with clinical staff to examine how the principles of the recovery model and the needs of individuals with entrenched risky paranoid thoughts should be supported. In particular the seminar should look at the role of the consultant psychiatrist and psychology in providing clinical enquiry, diagnosis and treatment and the role of community staff in developing appropriate care plans.

R2 The trust should review the level of clinical supervision provided to CMHT professionals and ensure that it complies with the trust's requirements.

4. Chronology of care and treatment

Introduction

4.1 In this section we have purposely provided a detailed chronology going back to the very first contact that Mr J had with mental health services. This level of detail shows that Mr J's paranoid delusions caused him to fear for the life of his family and were firmly fixed in his thinking and emotions. The chronology sets out how the mental health services responded to Mr J's fixed delusions which resulted in suicide attempts and him developing the belief that it would be better to kill his family than have them killed.

First referral from GP

4.2 Mr J had been in contact with local mental health services since August 1998. He was first referred to the community mental health team (CMHT) by GP 1 on 11 August for counselling. The referral was made because he had a lot of unresolved stress, was using recreational drugs and had a developing alcohol problem.

Comment

There is no evidence that Mr J was seen as a result of the referral on the 11 August. Mr J was not assessed until 20 September 1998 after an overdose of paracetamol earlier that morning. On assessment at Norfolk & Norwich Hospital he explained that he took the overdose impulsively due to chronic insomnia. He described feeling **"stressed out"** ***since breaking up with his girlfriend in March.***

4.3 On examination there was no evidence of clinical depression, thoughts of suicide or psychosis. Mr J was prescribed a five-day supply of temazepam,[1] 10 mg at night, and it was suggested to GP 1 that he trial a small dose of dothiepin or amitriptyline (both

[1] Temazepam can be used as a short-term treatment for sleeping problems (insomnia) that are causing severe distress. This includes difficulty falling asleep, waking in the night and waking early in the morning.

antidepressants). GP 1 was advised to refer Mr J to the appropriate sector team if he required psychiatric assessment (GP 1 had already done so five weeks before Mr J took the overdose).

First admission to psychiatric hospital

4.4 Mr J was admitted to St Clement's Hospital on 14 October 1998 and was diagnosed with schizophrenia. The evening before his admission he had been walking around the house he shared with his parents holding a breadknife because he believed that people were coming to kill his family. He had asked his mother to join him in committing suicide as this was the only escape. The staff recorded that Mr J had made three previous suicide attempts. He had twice attempted to kill himself with car exhaust fumes and a month before admission he had taken a significant paracetamol overdose.

4.5 Over the previous two months Mr J's mental health had been getting worse and especially over the past five days. His parents had noticed he was increasingly paranoid and he was physically aggressive towards his father on the morning of admission. At one stage his father found him sitting downstairs with a kitchen knife on the seat beside him. He tried to prevent his sister from leaving the house to go to work, concerned that someone would *"get her"*.

4.6 Mr J had a fixed belief that he had AIDS along with all his family. He was hardly sleeping and appeared unkempt. He lacked insight and initially refused an informal admission but later agreed.

Comment

Suffolk CMHT had not made contact with Mr J before his admission despite being referred by his GP two months earlier. Instead he was assessed by on call SHO 1 on 14 October 1998 at St Clement's Hospital following an urgent GP referral. Mr J agreed to being assessed by a psychiatrist that afternoon.

Allocation of a CPN

4.7 Mr J became extremely agitated and tried to leave the ward later that afternoon so was assessed under the MHA. He was detained under Section 2 and given an Acuphase[1] injection, which caused a dystonic[2] reaction. He was started on oral haloperidol, gradually improved and seemed to lose his delusional thinking and thoughts of suicide. A CPA meeting took place on the ward on 20 November 1998, which was attended by CPN 1 and his parents. He was discharged that same day with CPN and outpatient follow-up. Following an outpatient follow-up appointment he was prescribed 7.5 mg haloperidol a day which was reduced to 3 mg on 25 May 1999. He was due to restart college that September and he was seeing CPN 1 every few weeks.

Comment

During the interview with CPN 1 for the trust's internal investigation he said that he was not aware of Mr J's delusions and thoughts of killing his parents and that **"It was a total surprise."** ***He told the panel that he knew that Mr J was*** **"…very protective of his sister and mother because he was scared that someone was going to harm them".**

He also stated that he was unaware that Mr J had thoughts of a mercy killing of his mother even though GP 1 had identified in his referral letter Mr J's unreasonable beliefs and concluding that Mr J **"is apparently a danger to others".**

Second admission to psychiatric hospital

4.8 Mr J was admitted to St Clement's Hospital again on 10 September 1999 with a view to changing his oral medication to a depot injection. He was given a test dose of Depixol which was subsequently increased to 40 mg weekly. This was changed to fortnightly in February 2000 and increased to 50 mg fortnightly in July 2001. Mr J continued to have monthly contact with CPN 1 and attended outpatient appointments

[1] Acuphase (also known as Clopixol) injection is used in the initial treatment of people with psychotic thoughts or behaviour, and in people with worsening severity of long-term psychotic illness.
[2] Abnormal tonicity of muscle, characterised by prolonged, repetitive muscle contractions that may cause twisting or jerking movements of the body or a body part.

every three to four months. He was considered to be stable in his mental state with no evidence of thought disorder. He was carrying out voluntary work once a week to help people with learning difficulties and undergoing a computer training course.

4.9 Mr J's mental state had stabilised by August 2001 but he developed side effects with the Depixol so it was stopped and he was changed to sulpiride tablets (an antipsychotic drug). In February 2002 CPN 1 noticed Mr J was relapsing and increased his contact during this period. GP 1 was asked to stop the sulpiride tablets and start him on amisulpride 400 mg, a different antipsychotic, twice a day.

Referral to psychologist

4.10 CPN 1 referred him to clinical psychologist 1 on 14 March 2002 and noted that ever since his admission in 1998 his delusional belief system had remained strong. His ideas focused upon the safety of his family and he believed that there was a gang from London exerting pressure for his mother to be admitted to St Clement's Hospital for the rest of her life. Cognitive behavioural therapy (CBT) was requested and Mr J stated that he would be willing to be involved.

4.11 Clinical psychologist 1 wrote a letter on 9 April 2002 stating that it was not possible to see Mr J for CBT for psychosis as it was felt to be a specialist area for which there were limited resources and access. She was also unable to take on new referrals at present.

Comment

Subsequent to the referral to clinical psychologist 1, the National Institute for Health and Clinical excellence (NICE) issued guidelines in December 2002 stating that all patients with schizophrenia should be offered CBT starting in the acute phase.

Even though national guidelines had not been issued at the time of the referral, at the very least, involvement of the psychologist would have been helpful. Clinical psychologist 1's involvement in multidisciplinary discussions about Mr J would have added a different perspective.

Consideration of Mental Health Act assessment

4.12 Mr J was seen by CPN 1 on 27 May 2002 and it was evident he was having delusions of reference[1]. Unusually for him he walked out of the session as he believed CPN 1 thought he was suffering from an illness rather than events being based in reality. CPN 1 wrote to consultant psychiatrist 1, regarding his concerns over this presentation and Mr J was reviewed on 11 June 2002. During this appointment he was agitated and aroused.

4.13 In a letter to GP 1 dated 17 June 2002, consultant psychiatrist 1 wrote that:

> *"His mental state has deteriorated and he is becoming psychotic again. He believes that a man he had met at St Clement's Hospital four years ago is persecuting him."*

4.14 Mr J refused to go back on depot injection and so consultant psychiatrist 1 decided to carry out a MHA assessment. However, Mr S rang consultant psychiatrist 1 the following day to say that his son had been persuaded to increase his dose of amisulpride to 400 mg each morning and 600 mg at night. The MHA assessment was postponed and Mr J was seen again in the clinic in October 2002.

4.15 Mr J was not reviewed in outpatients until four months after the MHA assessment was considered. Despite Mr J experiencing a couple of clear relapses in his psychotic illness over the course of 2002 consultant psychiatrist 1's correspondence to GP 1 does not reflect this. In a brief letter summarising an outpatient review in October 2002 he wrote:

> *"His mental state seems to be stable at the moment. There is no cause for concern. He says he takes his amisulpiride medication regularly. He has started on a computer course two days a week arranged by The Shaw Trust, which he is enjoying. He lives with his parents and everyone seems to be happy with this arrangement."*

[1] Delusions of reference refers to the strongly held belief that random events, objects, behaviours of others, etc. have a particular and unusual significance to oneself.

Comment

The outpatient appointment should have been sooner. Consultant psychiatrist 1's letter to GP 1 was inadequate. It fails to provide evidence of a thorough mental state assessment or reflect the ongoing struggles around Mr J's insight.

4.16 During the trust's internal investigation interview with consultant psychiatrist 1 he admitted not asking Mr J about his family or the thoughts of killing his parents as *"it would have made him angry. In hindsight he should have been more closely monitored"*.

4.17 CPN 1[1] stated during his trust investigation interview that Mr J had walked out on one occasion *"because he felt I was pushing too hard into his thoughts. So that shows you what we were trying to avoid. We didn't want to put him off."*

4.18 CPN 1 commented to us that:

> *"On each occasion that I met Mr J for support I would check on his persecutory beliefs which we referred to as* "illness beliefs" *which he gradually became able to discuss and appear to accept as illness with the aim to help him to see the need to continue his oral medication."*

4.19 He also commented to us that:

> *"Throughout all my contacts in the time that I gave support for Mr J he never referred to harming his parents or family, or anyone, because of his persistent persecutory beliefs."*

4.20 During our interview with Mr S, he spoke about how strongly his son's paranoid beliefs were fixed in his mind:

> *"He so strongly believed that he was trying to protect the family. He had really strong beliefs and he was very, very headstrong. He will not change and he will actually start getting angry if you try to tell him he is wrong."*

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[1] CPN 1 retired from nursing in March 2009 after 45 years of continuous service. He was not involved with Mr J from the end of February 2009. We did not interview him but he was sent and reviewed relevant extracts of the draft report.

4.21 We asked about the role of his long-term CPN in probing Mr J's thought processes. Mr S told us:

> *"In some ways, he fooled the CPN. CPN 1 was quite a nice chap, quite laid back - he was a nice chap and we had no problems with CPN 1 but he would not force the issue."*

4.22 CPN 1 commented to us:

> *"My approach was friendly and non-threatening in order to have access to Mr J to be able to assess and discuss the level of his current illness. I did not feel* "fooled" *by Mr J."*

Comment

According to our expert advisor, it is undoubtedly the case here that little effort was made to understand Mr J's thought processes and content. This is in spite of the long-term involvement of the services and numerous outpatient sessions over many years.

Concerns raised by GP

4.23 A letter from GP 1 on 7 January 2003 noted that Mr J was possibly a bit *"high"* and CPN 1 was asked to see him. On 25 March CPN 1 noted that he was having persecutory delusions and it was agreed that if he found it difficult to cope with them he could contact consultant psychiatrist 1. He was happy with this as he did not want to go into hospital again.

4.24 Consultant psychiatrist 1 noted on 15 April 2003 that Mr J had seen a man who he thought was against him and perceived it as a deliberate act of intimidation. As a result, Mr J stopped going to a computer course as he felt that he was being spied upon by him and his accomplices. Consultant psychiatrist 1 felt that a risk assessment was required and this was completed by CPN 1 on 23 April 2003.

4.25 The summary section of the risk assessment identified that:

> *"His persecutory delusions fluctuate in intensity, causing him to be protective to his family and himself. Confronting Mr J with the fears being illness causes him to be upset at being 'called a liar' as his belief is strong. Urgent review is necessary if Mr J takes active steps to protect the family i.e. stop his sister going to work etc. If Mr J has sufficiently high anxiety levels about persecution he may take action to prevent this."*

Comment

No reference was made to this risk assessment at the next CPA meeting on 24 June 2003 and the focus was instead on **'normalisation'** ***and promoting independence.***

4.26 Mr J was having respite care in Westfield Hostel in Bury St Edmunds on 16 September 2003 where he was thought to be mentally stable with normal mood and affect. There was no evidence of thought disorder and he was taking amisulpride 400 mg in the morning and 800 mg at night.

Discharge from outpatient clinic

4.27 Mr J had regular CPN contact and outpatient appointments over the next few years. During this period he was relatively more settled. He was also having input from support worker 1 around engaging in activities in the community. According to CPA documentation in 2004/2005 this was *"to promote coping with basic reality boundaries and grounding and also to promote the maintenance of movement in local geographical boundaries for normalisation."*

Comment

This is unnecessary jargon and was unlikely to help in planning his care.

4.28 During contact with CPN 1 on 20 December 2004, Mr J admitted that he still felt suspicious but explained that he didn't feel as restricted as he did previously. In January 2005 it was decided not to have routine outpatient appointments but he continued to see CPN 1 on a monthly basis.

4.29 Consultant psychiatrist 1 reviewed Mr J in January 2005 and discharged him from the outpatient clinic. The letter relating to this review is very brief: there is no looking back or reflecting on the case and no summary. There is no mention of the diagnosis or any clarifying of the condition. The fact that Mr J is discharged implies that he is well but there is no clarification regarding this: there is no indication of what was wrong in the past and whether this was in any way remedied. There is no mention of how Mr J was functioning at that time and nothing regarding the family dynamics.

Comment

This was poor practice on behalf of consultant psychiatrist 1. If a patient is being discharged from consultant oversight (or from secondary mental health services) this should be accompanied with a discharge summary that deals with the issues we have identified in the paragraph above. This enables a GP and others to be alert to the signs and symptoms that might lead to a re-referral or some other intervention if the patient's mental health appears to be deteriorating.

Concerns raised by CPN 1

4.30 CPN 1 reported on 15 February 2005 that Mr J appeared more stressed. Mr J told CPN 1 that this was due to his persecutory beliefs in the lead up to Easter. He said that this particular Easter was the 33rd reference to Jesus being 33 and was linked with the gang that were after him from London. Mr J spoke of taking on the concept of his '*illness reality*' and felt he could still cope with his '*normal life*' as this has never completely gone away.

Comment

***CPN 1 commented to us that he understood Mr J's statements as meaning that though he felt his delusional thought appeared real he accepted it was part of his illness and that he could continue his* "normal life".**

4.31 Mr J told CPN 1 on 28 February 2005 that he was coping by pushing his paranoid thoughts out of his mind. In his written summary of that visit CPN 1 wrote:

> *"(Mr J) appeared to benefit from the empathy of his 'double reality' problem as we discussed and unlike previously he was freer to discuss this and stated that he found the support helpful."*

4.32 Mr J spoke to CPN 1 on 21 March 2005 and reported that he was feeling safer. He also spoke about the *'illness beliefs'* versus *'reality'*, saying that he felt both perceptions were real.

First discharge from allocated care coordinator and discharge from CMHT

4.33 At a CPA review on 22 August 2005 it was agreed with Mr J to reduce CPN contact to monthly and then two monthly *"to see if he may choose discharge with further help on request if needed"*. Mr J said he had been grateful for the support worker input but felt he no longer needed it. It appears from the written CPN records that Mr J asked subsequently to continue with monthly support *"that he feels is enabling"*.

4.34 CPN 1 wrote to the GP on 19 July 2006 to say that Mr J agreed to be discharged from the service *"having considered this an option for many months now"*. It was noted he had been compliant with prescribed medication and appeared to understand the need to take it in future. CPN 1 added that:

> *"…no serious effect to his security has been experienced for over a year and when small occasions have unsettled him he has been able to discuss this to gain objectivity successfully."*

Comment

Despite clear historical evidence of paranoia and limited insight the decision was made to discharge Mr J from mental health services. The very fact that Mr J benefitted from CPN input, stating that he found the support **"helpful"** ***and*** **"enabling",** ***was a reason for it to continue as it helped maintain a relative stability in his mental state. In the CPN's own words, when unsettled*** **"he has been able to discuss this to obtain objectivity successfully".**

We comment later in this report on the need for some patients to be seen regularly, despite what appears on the surface to be progress in their mental state and risk profile.

Second referral by GP following suicide attempt

4.35 GP 1 wrote to the CMHT on 22 January 2007 to inform them that Mr J had attempted to commit suicide by slashing his wrists and trying to drown himself in the sea. He was initially taken to Ipswich Hospital A&E and then his father was asked to come and collect him. Mr S felt he was getting worse and sought advice from GP 1.

Comment

Six months after discharge from CPA and from the service altogether the patient presents dramatically again: on the beach, hypothermic and having cut his wrists. It was left to his family to collect him from Ipswich Hospital A&E and in the words of his father:

> **"We went and parked in the car park and he was standing in the foyer with a white sweatshirt on....It was absolutely covered in blood, all over his sweatshirt and everything. Nobody was there and he was standing in the doorway on his own. There was nobody there and he was there, waiting for us to collect him."**

It is a concern that Mr J does not appear to have been psychiatrically assessed at A&E despite him having an eight year history of paranoid schizophrenia and still

taking amisulpride. We have not pursued this apparent poor practice further given that it took place more than three years before Mr J killed his mother.

4.36 Following this GP 1 referred Mr J to the crisis services with the following message:

> *"This man attempted suicide today by slashing his wrists and trying to drown himself in the sea - he was seen at Ipswich Hospital and discharged to the care of his family. No attempt was made, as far as I can see, to involve the psychiatrists. He is requesting to be seen at St Clement's tonight of his own volition". The GP letter went on to describe Mr J as "an extremely vulnerable individual … it is worth noting that his initial presentation involved an attempt at suicide."*

Comment

This note, brief as it is, reflects several aspects of the case: the vulnerability, the risk, and the dramatic nature of Mr J's presentation. It is this kind of understanding of the nature of the case and of the risks involved that is missing in the outpatient letters written by consultant psychiatrist 1. It is our view that GP 1 had a better "feel" for the case than the psychiatric team.

It also appears that crisis services requested Mr J visit GP 1 before agreeing to see him at St Clement's. This is in spite of the contingency plan agreed at the last CPA meeting that Mr J should contact the crisis team outside of office hours in an emergency and not to leave it too long before making contact. Too much responsibility was again placed on the patient and his family to access help in an emergency.

Third admission to psychiatric hospital

4.37 GP 1 insisted Mr J was seen at St Clement's Hospital that day. He was admitted from 22 to 29 January 2007. Mr J said that he had reduced his medication over the previous month as he didn't think he was mentally ill and became increasingly suspicious, believing that the television was specifically speaking to him. He was discharged to the

care of the home treatment team which planned to visit daily until the end of the week and then hand over to the central recovery team when he was stable.

Second discharge from allocated care coordinator

4.38 Mr J was seen on 7 February 2007 by consultant psychiatrist 1 who found him not to be actively psychotic, although he reported feeling that his brain was floating. Mr J had a vacant look in his eyes and complained of reduced motivation. On review two weeks later he was noted to be depressed and was prescribed antidepressant mirtazapine 30 mg at night. On 3 April 2007 it was noted that his sleep had improved and his mood had lifted. Mr J had reduced his amisulpride to 600 mg at night and he said that he felt brighter and more active. He was not depressed and consultant psychiatrist 1 changed the medication to 300 mg twice a day.

4.39 Mr J told CPN 1 on 11 February 2008 that consultants had complete power over his life and that one word out of place would lead to his admission. He was reassured by CPN 1 that this was not the case.

4.40 He was reviewed by a psychiatrist on 9 September 2008 who found no evidence of depression and no overt psychotic symptoms. He was discharged by CPN 1 on 10 November 2008 and reviewed by a staff grade psychiatrist on 14 January 2009 who formed the impression that Mr J's presentation was *"stable"*. The plan was to continue with Mr J's medication and review him in June 2009.

Comment

This patient had a diagnosis of paranoid schizophrenia, a history of suicide attempts and had demonstrated ambivalence when it came to taking prescribed oral medication. Despite this latest dramatic attempt to take his life leading to another hospital admission, he was again discharged by his CPN the following year.

Concerns raised by family

4.41 On 5 April 2009 his family rang the crisis team as Mr J was saying that it would be best if he got rid of his parents. His family were advised to take him to A&E and when we interviewed him Mr S told us:

> *"We got to Ipswich Hospital and sat there for two hours, bearing in mind that we had to travel for 45 minutes to get there....We had a two hour wait, sitting in A&E, in reception - a public place - with a person who is clearly not well at all. He needed help."*

4.42 Mr S told us that they eventually spoke to the crisis team at 2.45 am:

> *"We told them what the problem was, what had happened, and that he had threatened that the only way he could see out was to do away with his family."*

Crisis team assessment in A&E

4.43 The crisis team assessment form dated 6 April 2009 records that Mr J had returned home early from holiday the previous day as he felt uneasy and believed his drink (water) had been spiked. It states he *"thought people were coming round to hurt his family"* and *"he felt it would be better if he killed the family rather than allowing these people to do it."*

4.44 On assessing his mental state, the assessor records that Mr J was *"not expressing any suicidal ideation or homicidal ideation at time of contact. Would never harm his family"*. The plan was to discharge him from A&E and refer him to the crisis team for further review later that day. He was also prescribed and given temazepam 10 mg to help him sleep.

4.45 According to his father the crisis team told him that Mr J would be okay if he just had some sleep. Mr S disagreed and told us:

> *"I asked them to section him. I distinctly asked them: that was how strongly I felt about this."*

4.46 Mr S said he spoke to the lead clinician and told him:

"If anything happens I will be holding you responsible'. I stood in front of him and told him that, because I felt so strongly about this. If there was one point in my life where I might let people say, 'well, if you do this and you do that, they'll probably be alright' - I will put trust in people but, at that point, I was very, very disappointed".

4.47 Mr S made it clear during our interview with him that he considered this relapse to be a significant one, saying:

"This is where it really started to go downhill. There was nothing that went right from then on. It was more or less as if Ipswich Mental Health had actually all completely given up."

4.48 He emphasised throughout the interview that the main thing which he and his wife needed to be done was to speak to and have a meeting with a psychiatric doctor. Mr S explained:

"It was because of the outcome of the night when we took him to see the crisis team. The crisis team didn't do anything really significant to nip the problem or deal with the problem. It was that severe and we needed him to be sectioned at that time, under whatever you call it. Under the surface, his problems were still there they don't just suddenly disappear overnight and with some sleeping tablets and calming tablets."

Crisis team assessment at home

4.49 Mr J was assessed at home by the crisis team later that day and denied having current thoughts that his family would be killed but said the idea was always at the back of his mind, even when well. He told crisis team staff grade psychiatrist 1 that he had thoughts of harming his family to prevent others harming them but denied ever having any intent to act on these thoughts. Mr J also admitted that before going on holiday he had

sometimes missed his morning dose of amisulpride. His amisulpride was increased to 400 mg twice a day, and he continued on mirtazapine 30 mg at night.

Comment

The notes had already indicated from early on Mr J's preoccupation with the belief that his parents were in danger and that he might have to take their lives before the danger befalls them, reflecting his love of them and his wish to protect them. These beliefs were clearly documented during the first episode of illness back in 1998 whilst an inpatient and significantly on this occasion when staff grade psychiatrist 1 visited Mr J at his home. At this time Mr J admitted that his belief that his parents are in some danger and that he needed to act on this had always been there, if only at the back of his mind at times.

Referral to CMHT by crisis team

4.50 An internal transfer request was made by the crisis team to the central recovery team on 7 April 2009 outlining Mr J's thoughts about harming his parents to prevent others targeting them and stating *"anxiety has calmed although thought disorder remains in situ."*

Allocation of a social worker

4.51 On 14 April 2009 Mr J was allocated to a CMHT social worker (care coordinator 1) as a care coordinator and a risk assessment and care plan was agreed the following week. A handover was given to care coordinator 1 by CPN 1 (who had been Mr J's CPN for over ten years).

4.52 During the trust's interview with care coordinator 1 for the internal investigation, she was asked what CPN 1 told her about Mr J. She said they:

> *"...mainly talked about his lack of motivation. The discussion was not very specific to his mental health but to the broader recovery model."*

Comment

The handover information from CPN 1 to care coordinator 1 appears to have been inadequate. We invited care coordinator 1 to meet with us but as she had retired she declined our invitation. Our assessment of the handover of Mr J has therefore been based on records and CPN 1 and care coordinator 1's interviews with the trust.

4.53 Mr S told us that the home visits carried out by care coordinator 1 following this significant relapse were brief and there was no indepth assessment of Mr J's mental state and delusional belief system.

4.54 During our interview with Mr J's father he expressed reservations about the level of support offered by care coordinator 1. He told us:

> *"Again, they were people you put your trust into, so you believe and trust that they are carrying on and keeping an eye on the situation. However, when you ask this person if you can have an appointment to see a psychiatric doctor on three separate occasions and it takes from April until July before you actually get an appointment, you lose confidence in that person."*

Comment

Mr J had been visited on a regular basis by CPN 1 for over ten years. He was known to have fluctuating psychotic and paranoid symptoms and that his presentations were often dramatic including a number of attempts at suicide. On this basis it may have been more appropriate for Mr J to be allocated to a CPN instead of a social worker. Someone coming from a psychiatric nursing background might have had a better understanding of a psychotic disorder as well as medication management.

Carer's assessment

4.55 On 8 July 2009 a comprehensive carer's assessment was carried out by a local charity, Suffolk Family Carers. His parents expressed their disappointment with the support received from the CMHT since Mr J's relapse at Easter. His father commented that

Mr J had not yet been referred to consultant psychiatrist 1 despite them being told on three separate occasions that this would be done. According to the carer's assessment:

> *"They feel that given the nature of their son's illness and the likelihood of a relapse (usually at Easter time), that he should be assessed by consultant psychiatrist 1."*

4.56 The carer's assessment also highlighted the considerable stress Mr J's parents were under in caring for their son, particularly when he had a relapse. They explained that they *"balance their life around Mr J's illness and do the best they can"*. His mother left her job of 21 years in 2008 as she could no longer cope with work and the demands of her caring responsibilities. They felt he could not be left on his own when he was experiencing *"paranoid episodes"*.

4.57 Mr J was reviewed in outpatients by consultant psychiatrist 1 on 17 July 2009 who noted that his psychotic thinking was always under the surface but came out when under stress. No reference to Mr J's ideas about harming his family were made in the notes or communicated to GP 1. Consultant psychiatrist 1 indicated in the letter to GP 1 that he would be making another appointment for Mr J to see him in two weeks time *"to see if his mental state is stable or not"*. In actual fact, consultant psychiatrist 1 wrote to Mr J on 20 July 2009 to offer him another outpatient appointment in three months' time.

Comment

The carer's assessment was detailed and gave Mr J's parents an opportunity to talk about how they felt about their caring role and the impact this had on their lives. It was not carried out by a member of the CMHT but by a local charity. This meant that the staff responsible for Mr J's care did not hear the concerns raised by the family first hand.

The CMHT received the carer's assessment on 20 July but this assessment does not appear to have been taken into consideration at the CPA review. There is no clear understanding in Mr J's care plan of the trigger points or concerns that should prompt the parents to contact the service.

Risk assessment

4.58 A full risk assessment and management plan was carried out by care coordinator 1 (dated 20 September 2009). This identified historical risks around travelling abroad, non-compliance with medication and Easter being a difficult time for him. Current risk was considered to be low, saying Mr J *"understands his medication is very important"*.

4.59 This risk assessment did not seem to take account of the original GP referral letter to the assessing psychiatrist outlining Mr J's unreasonable beliefs and concluding that Mr J *"is apparently a danger to others"*. It also lost sight of the 1998 discharge summary which described him as carrying a knife and asking his mother to join him in committing suicide as he considered this the only form of escape.

Comment

The risk screening information lists the history of Mr J's risk events but does not detail the content of his delusional thoughts. The risk action plan is poor and appears to be one written by CPN 1 on 7 February 2007 but signed by the new social worker care coordinator 1. It just says **"discuss with consultant psychiatrist 1, Mr J, parents and GP".**

Emphasis was on 'risk to self' despite Mr J's consistent and long-held belief that his parents would be better off if he killed them. In her interview with the trust care coordinator 1 denied being aware that he had a history of carrying a knife and asking his mother to commit suicide.

The risk management plan was for Mr J and his parents to ensure that he took his medication and for Mr J **"to verbalise any worrying thoughts/feelings and communicate any problems to CMHT".** ***This is in spite of the risk screening identifying problems around expressing his paranoid ideas about others and denying he has an illness.***

4.60 Care coordinator 1 said to the trust internal investigation that:

> *"When he came back from the crisis team he was still quite unwell."*

4.61 She was asked whether she saw a long-term role for the mental health service in Mr J's care. She replied:

> *"No, because Mr J becomes quite well and I felt that this was how he was normally in terms of not wanting to do things."*

4.62 She saw the CMHT involvement ending when Mr J became stable.

Third discharge from allocated care coordinator

4.63 On 25 September 2009 following a CPA review, care coordinator 1 wrote to GP 1 advising that Mr J was stable and she was therefore discharging him in her role as care coordinator as no further tasks could be identified. The plan was for outpatient follow up every two months. This essentially left the professional responsibility of monitoring Mr J's mental state to consultant psychiatrist 1 and GP 1. Due to a clerical error Mr J was not sent an outpatient appointment until 24 February 2010. The appointment was for 22 March. His mother was found fatally injured on 15 March 2010.

4.64 We asked Mr J's father whether he had deteriorated in the period between the 25 September and the 15 March 2010. He told us *"There was nothing too much unusual."* He also told us that if his son was relapsing he would have done something about that.

4.65 Mr J clearly lacked capacity when he killed his mother and was convinced he was protecting her from an outside threat. The risk of harm to others was first identified in 1998 and remained a feature of his thinking and emotions. Mr S admitted to us that what happened was not a complete shock to him, saying:

> *"It was as though something had happened which had always been a possibility."*

Chronology summary comment

Mr J's most stable period was when he was having regular CPN contact which increased during crisis periods. This had a containing effect on Mr J and provided an opportunity for regular reviews of his mental state and compliance with medication.

Mr J had been supported for over ten years by the same CPN. When his care was handed over to a new care coordinator the quality of handover was poor and as a consequence the need for continuing support was lost. The focus of care coordinator 1's work with Mr J appeared to be on engaging him in meaningful activity rather than being alert to his risk history and fluctuating mental health.

Mr J's delusional thinking never went away entirely and certainly intensified when he was non-compliant with prescribed medication and during stressful periods. Easter was identified in the risk assessment as a difficult time for him and he killed his mother around this period. Too much responsibility was placed on Mr J and his parents to raise concerns about relapse.

The clerical error that delayed the outpatient appointment was significant but the important failure was that Mr J had been discharged from the CMHT by care coordinator 1 and was therefore not seen again after September 2009. There is no evidence that his paranoia and risk were substantially reduced.

When it was discovered in February that he had not been sent an outpatient appointment, he was still not offered an appointment until 22 March 2010. This meant that he would not have been seen for six months.

The CMHT did not have Mr J's risk history in mind, in spite of his long history of involvement with mental health services.

Findings

F1 The risk assessment carried out by care coordinator 1, on 20 September 2009 though fully completed failed to properly take account of Mr J's long-standing risk history, including the risks to himself and his enduring belief that his family would be safer dead.

F2 Mr J should not have been discharged by care coordinator 1 in 2009 as there was no evidence that his risk profile had changed and he still needed to be seen on a regular basis by a suitably experienced professional, preferably a CPN.

F3 When it was discovered in February 2010 that Mr J had not been sent an outpatient appointment and had not been seen by a CMHT professional since September 2009 he should have been given an urgent appointment either with the consultant or another suitable CMHT professional.

5. Expert advice

5.1 The consultant psychiatrist member of our team provided us with expert medical advice. He reviewed the clinical notes, letters and also led the interview we held with consultant psychiatrist 1. We include here a summary of his expert review in particular additional insights from some aspects from the chronology in section 4. The advice is endorsed by the rest of the investigation team.

5.2 Mr J suffered from a delusional, persecutory illness, probably of a schizophrenic type over the ten or so years from the first diagnosis being made in 1998 to the killing of 2010. What is not at all clear is the course of the illness in particular, whether it was episodic, fluctuating or deteriorating.

5.3 How likely was Mr J to act on this fixed delusion? To some extent action depended on whether the schizophrenic illness had eroded the underlying personality and, for example, produced such features as lack of motivation or poverty of thought or speech. Evidence is that there were no 'negative' features of this kind, at least not to any significant extent. This means that, with the personality relatively intact, Mr J was capable of acting on his persecutory delusions, which involved not only the family but Mr J himself (hence the attempts at suicide).

5.4 It is clear that Mr J was suffering greatly as a result of the various delusions he held, as evidenced by the attempts to kill himself (cutting his wrists, for example, and trying to drown himself in 2007). It is possible that the case would have ended in suicide rather than matricide. There is little evidence that the team was sufficiently aware of either risk. Whilst such delusions persisted, Mr J should have been kept under the care of the services.

5.5 Attempts should have been made to understand better Mr J's thinking, including any delusions he might hold. It is unlikely that the family was able to speak openly or freely in Mr J's presence, given how deeply they were involved in his delusional system. The family should have been given the opportunity to express their thoughts and fears without Mr J being present. Though it is unlikely that Mr J would have agreed to his family being interviewed in his absence, it is irrelevant as confidentiality would not have

been breached if the professionals adopted the role of listening and not divulging information.

5.6 Furthermore, assessment by psychology should have been arranged. This would have offered another route into Mr J's thinking and delusions. Better understanding of these delusions might have been gained, irrespective of whether any therapy was possible.

5.7 Could the killing have been averted through different actions by the services? Delusional disorders, and schizophrenia of the paranoid type, are notoriously difficult to treat, the more so the more chronic the delusions. Furthermore, patients with delusions of a persecutory nature, as in this case, are often secretive, reluctant to reveal their thoughts, sometimes because the professionals are incorporated into the delusional system (though it is not clear if this was the case). For all these reasons, it is often difficult to gain influence over the patient's delusions, whether through medication or by psychological means.

5.8 However, it is undoubtedly the case here that little effort was made to understand Mr J's thought processes and content. This is in spite of the long-term involvement of the services and of the numerous outpatient sessions over the years. The evidence available shows that very little attempt was made to probe into Mr J's thinking. In his interview with the trust in 2010, only a few months after the killing, consultant psychiatrist 1 said that when Mr J was asked directly about his ideas he would get angry. There is however nothing in consultant psychiatrist 1's numerous outpatient letters regarding this: there is no mention that this has ever been Mr J's reaction when his thinking is probed nor reference to any plan or strategy to get round this reluctance on the part of Mr J by, for example, talking separately to the parents or siblings. Nor is there the thought of re-referring Mr J to a psychologist who might have been able to drill deeper into Mr J's thinking (there was a referral made to psychology early in the course of the illness).

5.9 In 2007 Mr J was visited by a staff grade doctor at his home. Mr J said that this belief that his parents are in some danger and that he needed to act on this, had always been there, if only at the back of his mind at times.

5.10 This should have been not only recognised but put at the centre of a care plan. Nothing of the kind was done. In fact, there is not even a mention of this belief in any of

consultant psychiatrist 1's letters to GP 1, either before the 2007 episode or after. This is remiss.

5.11 Furthermore, without some understanding of the thought processes and contents, including any delusions, and without any sense of the intensity of any such beliefs, it is not possible to establish some 'baseline' by which the effects of medication can be assessed. It would not have been possible to know whether any particular medication was working or what dose of the drug is needed. And this was indeed the case here.

5.12 Could the killing have been averted? Possibly. A better understanding of the thought content might have identified the risks and would have established a baseline upon which to judge the efficacy or otherwise of medication and a better judgment as to whether Mr J was taking his medication. Treatment with medication is likely to have been more intensive and guided and might have at least alleviated the intensity of any delusions.

Consultant psychiatrist care

5.13 Consultant psychiatrist 1 had been Mr J's consultant for almost eleven years, which spanned almost the entire course of Mr J's illness.

5.14 The clinical notes contain 23 letters sent by consultant psychiatrist 1 to GP 1, each letter written after Mr J had been seen in the outpatient clinic. All the letters are brief, mostly no more than one side of an A4 page.

5.15 Consultant psychiatrist 1's letters give no indication of what the course of the illness might have been, and it is clear from our interview with consultant psychiatrist 1 that he himself did not know. In none of the numerous letters to GP 1 did consultant psychiatrist 1 summarise the illness or reflect back on the related events. Nor is there in the letters any description of psychopathology. There is no summarising of the situation at those points when Mr J was discharged from the clinic. Nor is there any restatement of the facts of the case when the patient is picked up again and seen in the clinic.

5.16 Consultant psychiatrist 1 reviewed Mr J in October 2005 and discharged him from the clinic. Again, the letter relating to this review is very brief: there is no looking back

or reflecting on the case and no summary of the case. There is no mention of the diagnosis or any clarifying of the condition. The fact that the Mr J is discharged implies that he is well but there is no clarification regarding this: there is no indication of what was wrong in the past and whether this was in any way remedied. There is no mention of how Mr J was functioning at that time and nothing regarding the family dynamics.

5.17 In January 2007 Mr J presents dramatically again: on the beach, hypothermic and having cut his wrists. At that time GP 1 referred Mr J to the crisis services with the following message: *"an extremely vulnerable individual … it is worth noting that his initial presentation involved an attempt at suicide"*. This note, brief as it is, reflects several aspects of the case: the vulnerability, the risk, and the dramatic nature of the presentation (the word 'extremely'). It is this kind of understanding of the nature of the case and of the risks involved that is missing in the outpatient letters by consultant psychiatrist 1.

5.18 It appears from the notes available, that GP 1 had a better 'feel' for the case than the psychiatric team.

5.19 Consultant psychiatrist 1 reviewed Mr J two weeks after his crisis visit to hospital on 6 April 2009 and the assessment at home when he told the assessors that killing his family had always been slightly at the back of his mind. He did not see Mr J himself but discussed him with CPN 1. Consultant psychiatrist 1 wrote to GP 1 on the same day as the review. No description is given of the relapse nor is there any discussion around it or what its significance might be. There is no reference of any kind to the kind of thoughts Mr J shared with staff grade psychiatrist 1 regarding his family or the risk to them from Mr J that this might reflect. There is no bringing together of the three fairly dramatic presentations over the years. There is no reflecting on how, regarding this episode and the previous one, the patient had been discharged from care shortly before. The letter merely makes mention of changes in medication.

5.20 We were told by consultant psychiatrist 1 that in later years he had become demoralised and as a result took retirement one year early.

Finding

F4 Our review of consultant psychiatrist 1's involvement with Mr J shows little evidence of the level of clinical enquiry and communication with GP 1 and others that Mr J's condition required.

Summary

5.21 Mr J had a complex psychotic illness with a well embedded paranoia. His level of risk of acting upon this paranoia remained high through most of the time that he was cared for by the trust. Consultant psychiatrist 1's role was to oversee and lead the clinical management of Mr J's illness. The evidence from a review of the clinical records and letters and our interview with him indicates that consultant psychiatrist 1 did not carry out this role very effectively.

Recommendation

R1 The trust should hold a learning seminar with clinical staff to examine how the principles of the recovery model and the needs of individuals with entrenched risky paranoid thoughts should be supported. In particular the seminar should look at the role of the consultant psychiatrist and psychology in providing clinical enquiry, diagnosis and treatment and the role of community staff in developing appropriate care plans.

6. Team service design and operational issues

Structures

6.1 The mental health service in Suffolk comprises several services of which the community mental health service is one. Suffolk developed its community mental health services in line with the national service framework from 2000 onwards.

6.2 This service is linked to other services, particularly the inpatient wards and crisis team. The service provides diagnosis and treatment for those people experiencing mental health problems which cannot be treated by the primary care team (GPs, improving access to psychological therapies [IAPT]). The CMHTs cover specific geographical catchment areas based on GP practices.

6.3 Recovery team manager 1 in April 2010 told us he had flagged up to his service manager his concerns that the staffing establishment at the central recovery CMHT was too small given the geographical area it had to cover, which includes the Essex and Norfolk borders. He explained:

> *"That meant that quite a small staff team who had a high level of sickness was being stretched. That large geographical location means that people had to travel large distances and there is less face-to-face time as a result."*

Workload

6.4 The pressure on the team increased in the year before the incident due to the introduction of Face Tools (a computer assessment and clinical recording system), meaning significantly more administrative work for clinicians. Also, triage work and an assessment function had been brought back into the team but not the resources to go with it.

Leadership

6.5 The management of the team had changed several times over the previous two years, with the resultant impact that this sort of change can have on team effectiveness.

Team working

6.6 At the time of the incident, changes to the way the CMHT team worked were being introduced but had not been fully embedded. The changes related to the daily team meeting and the use of a whiteboard to record all clients and allocate them a 'RAG' rating (red for concern, amber needing to be alert, green for no known problems). This approach allows the whole team to share information about case loads not just individuals working in isolation.

6.7 The current recovery team manager, recovery team manager 2 told us:

> *"We have a morning meeting every day, which everybody is expected to attend. … we use our whiteboard, which is part of our recovery model, and each person within our service has a named tie or magnet. Not only are they recorded at that time on to the computer.*
>
> *...We then look at what is called seven-day follow-up, so targets that we have for people that are being discharged. We then look at what we call 'Red' issues as part of our recovery model, and those are things that we need to highlight, either that the team need to know about or that there has been a change. It would be in that instance that we would bring that case up, and it would be recorded."*

6.8 We also spoke with senior social work practitioner 1 who came into post just after care coordinator 1 had discharged Mr J from her case load. He also told us about the role of the morning team meeting:

> *"… when people are discharged it is in the morning meeting, they say 'This person is discharged', and we will pick up on that. Nobody is just discharged, especially if they are high-risk, especially if they are complicated or complex.*

We look at referrals, allocations, we look at assessments of people who have come in, have a quick discussion, then we have a slot for the link workers to discuss new referrals or referrals that have been sent back to them, step-up/step-down care."

Comment

This process was not well established at the time when care coordinator 1 discharged Mr J. If it had been in place and working effectively then the decision to discharge Mr J from care coordination might have been challenged but there is no certainty of this.

Our interviews and our group meeting with staff assures us that the current processes for team management of assessment, discharge and allocation of clients to individual practitioners is more robust than it was in late 2009 and early 2010.

Model of care

6.9 In the lead up to this incident, there had been a change in the way the team was working. Towards the end of 2008/2009 staff were being taught to work with the principles of recovery.

6.10 The east and west community adult mental health teams' operational protocol dated 11 January 2010 gave the following definition of recovery:

"Recovery involves a process of changing orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life."

6.11 The recovery discharge guidelines continued:

"To ensure the Recovery Teams maintain capacity for new users being referred for services, there is a need to be proactive in discharging service users back to the Primary Care Trust".

6.12 Consultant psychiatrist 1 made an important point during the trust internal investigation when he asked:

"What do we do with people who are only partially recovered?"

6.13 Recovery team manager 1, recovery team manager in April 2010, told us that the recovery model was being sold to staff as a very person-centred type of approach where service users were defining their own criteria for recovery. He added:

"Therefore, when we look at the context which is the recovery model, we should see care coordinator 1's decisions and the way in which she is working with Mr J at that point as very much in keeping with the principles of the recovery model. She was trying to listen to his views about the way he wanted support and the terms on which he wanted to engage."

6.14 The introduction of the recovery model of care throughout mental health trusts in England has had varying impacts on the way some community staff work with clients. We spoke to the current manager of the recovery team, recovery team manager 2, about the introduction of recovery. We asked her about how the recovery model works for clients like Mr J who have delusions that are sometimes below the surface and who are guarded in their disclosures. She told us:

"What has changed even over the last couple of years is that when the recovery model came in we followed it to a 'T'. The recovery model means that as soon as someone is stable you discharge them back to primary care, but we have learned that actually there are cases where even if you are not doing very much necessarily, and it might look like that, there is a bit on the recovery model called the 'White bit' on the whiteboard. It might be that for those people, like Mr J, you might feel 'Actually we will hang on to them', just to keep a monitoring role."

6.15 She told us that during supervision she used to say to staff:

"'You need to discharge them', or 'Have you thought about discharging them', whereas now when we talk about them we think 'Maybe we need to keep them'."

6.16 Consultant psychiatrist 1 told us:

> *"The team are under pressure to discharge. If the team identifies that there is nothing more they can do then we discharge. The thing that was not in our mind at the time of Mr J's discharge was the need for close monitoring."*

Comment

This incident occurred at a time when the recovery model was being introduced into the trust. For care coordinator 1 to discharge Mr J because there were no other tasks to carry out is a distortion of the recovery model. The current refinement of the approach to using a recovery model is to be welcomed.

Finding

F5 The CMHT approach to the recovery model of care now takes account of the needs of individuals like Mr J whose delusional thinking is entrenched and who pose a significant risk if relapse occurs and therefore need care coordination and regular support.

Managing risk

6.17 The trust positive clinical risk management policy was implemented in the same month as this tragic incident. This was based on the principle in the Mental Capacity Act 2005 that every adult has the capacity to make *all* decisions affecting their own life unless (in particular circumstances) there is evidence that this capacity is lacking.

6.18 The policy states that positive risk management is based on the same fundamental principles of individual rights and responsibilities:

> *"It is disempowering to assume that just because someone has a mental health problem they are unable to exercise choice, or have responsibility in decision making."*

6.19 The purpose was not to eliminate risk, but to assess it and bring it down to an acceptable level.

6.20 We interviewed current consultant team psychiatrist 1 who told us about his approach to risk by illustrating it with a recent case he was involved in. He told us:

> *"I think I can quote an example about a patient who I saw after the discharge from the ward. There was a bit of debate. A care coordinator came and mentioned that there was a debate about the diagnosis, whether the patient had a major risk of psychosis, we don't know. I decided to see the patient. As I mentioned, I offer two appointments. So I saw the patient. She was quite tearful and was not talking much. There was an acute lack of insight. So regarding the risk of suicide, when I asked, she mentioned that she does not have any plan or intent but she was in tears and vaguely mentioned committing suicide, probably fleeting thoughts, in a garage, by hanging."*

> *"So if we go for a classic risk assessment, there is no intent, there is no plan, definitely. But the fleeting thought is about a specific method, which made me worried. I thought that I can't probe much because the patient is not talking. So I thought that this is a high risk scenario and I thought that the patient was probably discharged a bit early and I immediately referred the patient to the crisis team with the help of the care coordinator and she was re-admitted. ECTs were given and she responded in a slightly better way and even the crisis team doctor was communicating with me. This happened in June, very recently, and she communicated with me about the medication change, sort of thing."*

Comment

The approach taken by current consultant team psychiatrist 1 shows sensitivity to ensuring that risk is properly assessed and if serious doubts are present to err on the side of caution.

Mr J was assessed by care coordinator 1 in September 2009 as low risk and consequently discharged from the CMHT and referred for outpatient follow up. The

risk assessment did not take sufficient account of the historical risk that Mr J faced or his ongoing suicidal and homicidal delusions.

Finding

F6 It is likely that a combination of the introduction of the recovery model and the new positive risk management policy played a part in the decision of care coordinator 1 to discharge Mr J from her caseload.

Care Programme Approach (CPA)

6.21 The care programme approach is a statutory requirement in England and Wales. It is an individualised care programme to be delivered by health and social care services. It applies to anyone who is in contact with secondary mental health services.

6.22 Generally the CPA process appears to have been followed with the involvement of family and psychiatrist. GP 1 was invited to CPA reviews but was unable to attend. A crisis and contingency plan was written into the CPA, covering what action needs to be taken when the person's mental health deteriorates.

Skills/access to specialist advice

6.23 The team philosophy was to allocate service users to the most appropriate member of staff based on their clinical skills. In reality this was not always possible and it often came down to which team member had capacity to take on new service users. In this case a social worker with a less than desirable skill set was allocated to work with Mr J who had a complex delusional network and required regular monitoring of his mental state.

Consultant psychiatrist involvement

6.24 Current consultant team psychiatrist 1 told us at interview that he sought to keep his outpatient list as small as necessary so that he was available to the team and to GPs

for advice and support. He attends the daily team meeting and the fortnightly multidisciplinary team meeting.

6.25 Current consultant team psychiatrist 1 gave the following reasons for keeping his outpatient appointments small:

> *"The problem with that [large outpatient lists] is that it gives a bit of peace of mind to the consultant, that we are seeing the clients every day. But the limitation is that if the link worker or if the GP comes with a certain risky scenario, which cannot be passed over to the crisis team but there is a greater level of risk, you can't fit them in. You tell the doctor, 'I'll see them in two months' time'. What's the use of that? Here, I can tell them, 'Okay, I'll see them in a week's time'."*

Comment

The approach of the new consultant contrasts with the approach taken with Mr J in February 2010 when it was realised that he had not been sent an outpatient appointment. He was subsequently sent an appointment for 22 March 2010, six months after his CPA review.

Supervision

6.26 There were three types of formal supervision and the profession of the individual dictated the one used.

- Managerial: for all. This is to look at issues regarding conduct, workload and training.
- Clinical: this is for health professionals to look at clinical management of all cases.
- Professional: this is for social workers. This is focused on professional development but may bring in some discussion of cases.

6.27 The care coordinator in this case was a social worker and therefore did not necessarily receive formal 'clinical' supervision.

6.28 Mr J's consultant psychiatrist 1 observed that since the adult mental health service had been reconfigured into specialist inpatient and specialist community services, he had lost his office in St Clement's and was now based in the CMHT. This had led to professional isolation. He attended one weekly meeting with colleagues which was business orientated and there was only one peer review meeting every three months.

6.29 The current consultant team psychiatrist 1 told us that he attended a weekly consultant peer group supervision session which he found very helpful.

Geography

6.30 The central recovery team covered a large rural area extending into Essex and Norfolk. This therefore meant travelling time was increased, thus reducing available face-to-face contact with clients.

7. Trust's internal investigation

7.1 The trust carried out an internal investigation into the care of Mr J. The report is dated 24 May 2010.

7.2 The report was carried out by a consultant psychiatrist and a 'bank' (a person temporarily employed) investigator. The report was quality assured by the trust's chief executive.

7.3 The report had terms of reference that covered the care that Mr J received from the trust. The investigation team interviewed seven people. These interviews included CPN 1, care coordinator 1 and consultant psychiatrist 1 who were mostly involved in Mr J's care. Notes of these interviews were made available to us so we were able to know what CPN 1 and care coordinator 1 had said to the trust investigators.

7.4 The report reviewed Mr J's care and provided a seven-page chronology. It analysed the following contributory factors: structures; allocation of work; geography; workload; leadership; task factors such as guidelines, procedures and policies; communication; education and training; environmental factors; organisational factors - safety culture, managing risk; service-user factors - mental state, relationships, social factors.

7.5 The report identified five recommendations. We set out below the themes identified from the recommendations and the actions that have been taken by the trust.

Structures

7.6 The report recommended clustering caseloads around GP practices to reduce travel and improve capacity.

Update

7.7 The trust has appointed link workers who are the first level of assessment and communication with primary care. We were told that more people with mental illness had

been engaged with services due to link workers. Link workers are not supposed to carry caseloads but provide a conduit between the GP and services. We were told by the CMHT that the link workers were not adequately resourced initially. There were five link workers across east Suffolk but now there are 12. They now have a presence in secondary mental health care by attending morning meetings and taking referrals from the CMHT.

Model of care

7.8 The report recommended that service users who are guarded and show reluctance to discuss their inner world should have a higher threshold of discharge, and should only be discharged after review by the multidisciplinary team.

Update

7.9 It appears from interviewing staff that there is now more flexibility when dealing with individuals who have a need for continued CMHT involvement. CMHTs historically kept people on their caseloads for a very long time. When the recovery model was first introduced, if clients were stable and the risk low, CMHTs would discharge them back to primary care. Capacity issues were a problem. Now, if people's mental health is stable but there is some historical risk, teams are more cautious about discharging them.

7.10 During our group meeting with a range of staff from different disciplines we discussed how the trust was implementing the principles of the recovery model. We were told that there is more discussion and consideration of recovery principles and how they relate to individual cases. We were told that staff members feel they can assert their professional autonomy and raise concerns if they consider that a risk of relapse remains and that this is taken into account before agreeing to discharge a patient.

Managing risk

7.11 The trust's report recommended improving compliance with the FACE[1] risk assessment tool and reviewing the documentation of previous service users whenever a case is allocated to a new care coordinator.

Update

7.12 Suffolk has been using FACE tools but clinicians have fed back that they are not comfortable with the rigour of the approach. The trust is rolling out DICES[2] training (which is well established in Norfolk and Waveney) to Suffolk later this year in response to this feedback and to standardise a trust-wide risk management system.

7.13 During our group discussion there was a consensus that positive risk taking was all about communication with the client and relevant agencies and was not an individual decision. There is training in illness indicators as well as risk management.

Skills/access to specialist advice

7.14 The trust report recommended that cases should be allocated on the basis of the skills of the team member and also said that clinical staff must have a basic knowledge of the psychiatric conditions which prevail in the area in which they work including specific training for risk factors in psychosis, especially dangerousness. It also recommended that a referral to a forensic psychiatrist should be considered where threats of violence are present.

Update

7.15 The staff we interviewed strongly disagreed with the assertion in the trust's report that there was a need for training in psychosis. All of the staff who were directly

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[1] FACE (Functional Assessment of the Care Environment) system results in an integrated approach to assessing and documenting clinical risk.

[2] DICES Risk Assessment and Management System shows how to assess and manage risk.

responsible for Mr J have now retired. Our interviews of current staff did not identify any deficit in basic knowledge of psychosis and the skills needed to support staff with these problems.

7.16 Cases are allocated to generic care coordinators within the CMHT and it is the exception to the rule that core skills (such as nursing and social work) are drawn upon. Due to demands on the service and capacity problems it was not always possible to choose the most appropriate professional skills.

7.17 Factors such as the geographical area of the client came into play, with clients being allocated to a particular care coordinator if they lived near to other clients on their caseload. During our group discussion it was felt that professional skills have been 'diluted' and most care coordinators are in a generic role.

7.18 However, it was mentioned that clinicians utilise the skills of other team members as a resource and that this exposure to broader mental health skills.

7.19 Staff are supported in their work through the multidisciplinary team. An important aspect of this support is the team's morning meeting using the whiteboard. This has proved effective in identifying service users where there are concerns, pooling of multidisciplinary knowledge and skills as well as reviewing 'green' cases that might otherwise be overlooked.

7.20 The morning meeting approach also addresses recommendations that all high-risk cases should be reviewed by the multidisciplinary team and it would be at this point that a forensic referral might be considered. The forensic consultant has developed a protocol for referral which makes it easier for CMHT staff to seek advice and make referrals.

Supervision

7.21 The report recommended that consultant psychiatrists should re-assess their peer review and supervision systems. There was also an action plan to improve knowledge and competency of all clinical staff in dealing with the range of psychiatric conditions that prevail in their area of work.

Update

7.22 There is now weekly peer support for consultants and allocated time is put aside for this.

7.23 The new clinical supervision policy implemented in June 2011 *"aims to ensure that Suffolk Mental Health Partnership NHS Trust staff are properly supervised and supported to provide care and treatment to people who use services."*

7.24 The new supervision model is very much about group supervision and is structured and organised. The focus is on clinical peer supervision, where supervisees benefit from each others' expertise and experiences. According to the trust policy, *"the content of supervisory sessions should focus on issues relating to, or impacting on, clinical practice and the delivery of patient care."*

7.25 Group supervision does not take place at present within the CMHTs and due to capacity issues and resources it is not compulsory. Clinical supervision does not happen routinely due to demands on the service. Management supervision takes place on a monthly basis in line with trust policy and is performance-led. It looks at any HR issues, caseload size and activity levels.

7.26 Informal supervision, when staff could seek out colleagues for support and advice, was recognised as valuable. There is more of a culture of team work within the CMHTs, making it less likely that poor practice can remain hidden. Within CMHT multidisciplinary meetings cases are routinely discussed, even those in the 'green zone' who are not considered cases of concern.

Recommendation

R2 The trust should review the level of clinical supervision provided to CMHT professionals and ensure that it complies with the trust's requirements.

Learning/best practice

7.27 The report also highlighted a need for a more systematic approach to sharing learning from incidents.

Update

7.28 There were two trust learning events in 2010/11 and dissemination of learning now takes place via service governance. All serious incident reports across the trust get forwarded to team managers and outcomes are to be shared within the weekly business meeting.

7.29 However, the trust recognises that this is an area where there is scope for further improvement and plans are being developed in service governance to address this. There are no learning events organised for themes arising from serious incidents. No specific feedback has been given in relation to the Mr J report.

7.30 We were told by staff that systems often change but staff do not always know the rationale for making these changes. This was partly put down to senior managers engaging with teams via the team manager rather than directly with staff.

7.31 We were told by staff in our group meeting that the dissemination of information was better now as the cascading process is more robust. For example, the Rae report[1] was cascaded to trust staff via the intranet, linked to a summary of the findings. This cascade process was led by team managers and staff all knew the outcomes of the report.

[1] This was a report dated 12 January 2011. It was a review of patient safety and safety reporting following a number of serious incidents that had occurred over the previous two years.

Appendix A

Team biographies

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Emily Ewart

Emily is a registered mental health nurse and a cognitive behavioural therapist. She is currently employed in Central London as a CPN and also carries a CBT caseload. During her career she has worked in a range of acute wards and community based positions including work as a Care Coordinator. Emily has gained considerable experience in the identification of patient risks and has been involved in the creation of programs for trainee therapists. In her roles she has taken a proactive involvement in the development of procedures to ensure patients conditions are meet with the correct levels of care and experience. Emily has gained a number of Graduate and Postgraduate professional qualifications.

Dr Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation.

Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position since. Mostafa, during his consultant tenure, became the clinical tutor organising the junior doctor rotation and from there went on to become the clinical director for the mental health services. He then became the medical director for the newly formed Lincolnshire Partnership Trust in 2001 but has recently vacated that post. He currently continues to practice as a consultant psychiatrist within the same trust. His role as medical director involved, amongst other things, investigating untoward incidents and complaints and liaising with external bodies coming into the trust to investigate incidents. As medical director, Mostafa was joint lead, with the director of nursing, on clinical governance and quality, and had the lead on research and clinical effectiveness. Mostafa is a Fellow of the Royal College of Psychiatrists (FRCPsych).

Appendix B

Documents reviewed

Internal reports

- Internal investigation into the care and treatment of Mr J
- Transcripts of internal interviews
- Mr J action plan updated 29 October 2012

Medical records

- Mr J's clinical records

Policies

- Suffolk Mental Health Partnership care programme approach policy, 2010
- Norfolk and Suffolk care programme approach (CPA) and non-CPA, 2012
- Suffolk Mental Health Partnership risk assessment policy, 2009
- Norfolk and Suffolk clinical risk assessment and management policy, 2012
- Suffolk Mental Health Partnership incident report policy and procedures, 2009
- Norfolk and Suffolk serious incidents requiring investigation policy, 2012
- Suffolk Mental Health Partnership crisis resolution home treatment team operational policy, 2010
- East and West Suffolk Community Adult Mental Health Teams operational protocol, 2010
- East Suffolk Outreach Team operational guidelines, in place in 2010
- Suffolk Mental Health Partnership positive clinical risk management policy, 2010
- Crisis Resolution/Home Treatment Team operational policy, 2010

Other documents

- Background information regarding trust electronic patient records (as at March 2010)
- Description of the configuration of Suffolk mental health services

Appendix C

Interviewee list

- CRHTT worker
- Recovery team manager 1
- Assertive outreach team leader
- Current consultant team psychiatrist 1
- Senior social work practitioner 1
- Medical secretary
- Team administrator
- Community nurse
- Consultant psychiatrist 1
- CRHTT representative
- Director of operations, Suffolk
- Trust secretary
- Group interview:
    - Current consultant team psychiatrist 1
    - Senior social work practitioner
    - Community nurse
    - AO representative
    - Medical secretary
    - Team administrator
    - CRHTT representative

Meetings with

- Mr J's family