

Independent Investigation
into the
Care and Treatment Provided to Mr. Z
by the
Manchester Mental Health and Social Care NHS Trust

Commissioned by
NHS North West
Strategic Health Authority

Investigation Conducted by: HASCAS the Health and Social Care Advisory Service
Report Authored by: Dr. Androulla Johnstone

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Z was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*.¹ This Investigation was asked to examine a set of circumstances associated with the death of Mr. Y who was found killed on the 21 November 2010.

Mr. Z received care and treatment for his mental health condition from the Manchester Mental Health and Social Care NHS Trust. It is the care and treatment that Mr. Z received from this organisation that is the subject of this Investigation.

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

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

We would like to thank the sister of Mr. Y who offered her full support to this process and who worked with the Independent Investigation Team. We acknowledge the family's distress and we are grateful for the openness and honesty with which Mr. Y's sister engaged with the Investigation. This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

1. Health service Guidance (94) 27

2. Condolences to the Family and Friends of Mr. Y

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. Y.

It is the sincere hope of the Independent Investigation Team that this inquiry process has addressed all of the issues that Mr. Y's family have sought to have examined and explained. We would like to thank the sister of Mr. Y for her assistance to this Investigation.

3. Incident Description and Consequences

The Trust internal investigation report stated the following *“Mr. ... [Mr. Z] was an out-patient of the Trust seeing ... [Consultant Psychiatrist 2] on a regular basis. His last appointment was on the 26.10.10. At this appointment he reported an increase in symptoms. Changes to his medication were recommended and he was referred for further psychotherapy. No concerns about risk to others were identified at this appointment”*.²

On the 23 May 2011 the Manchester Crown Court heard that in the early afternoon of the 21 November 2010 Mr. Z was heard to argue with his ex-partner Mr. Y. This argument took place in the flat in which they both still lived together. Mr. Z then went on to stab Mr. Y 13 times. It was only at midnight when Mr. Z told some friends what had happened that the body of Mr. Y was discovered.³

It was apparent from witnesses who gave evidence in Court that the argument between the two men took place sometime between 13.00 and 14.00 hours. The argument took place for approximately ten minutes and then was reported to have suddenly stopped. At 15.20 hours, and then again at 16.00 hours, Mr. Z was seen going to a local off licence to buy spirits and lager. At midnight Mr. Z telephoned two of his neighbours to say that Mr. Y had died from a *“hypo”*. The neighbours came round to Mr. Z’s flat and were told by Mr. Z that an ambulance had already been to take Mr. Y to hospital and that Mr. Y’s family had been informed. At this juncture the neighbours saw something that they believed to be blood on the floor. They were suspicious and on returning to their flat telephoned the North Manchester General Hospital whereupon it was evident that Mr. Y had not been admitted either to the hospital or the mortuary.⁴ The neighbours returned to Mr. Z’s flat and asked if they could go into the lounge. They found it difficult to open the door as Mr. Y’s body was blocking the entrance. It was evident that he was dead. The neighbours called for the Police at 12 minutes past midnight. Mr. Z was subsequently arrested.⁵

On 25 May 2011 Mr. Z was found guilty of murder at the Manchester Crown Court. He was sentenced to life imprisonment with a minimum tariff of fifteen years.

2. Trust Internal Investigation Report. P. 3

3. Court Transcription P. 2

4. Court Transcription P. 8

5. Court transcription P. 9

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

The HASCAS Health and Social Care Advisory Service was commissioned by NHS North West (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27*, *LASSL(94)4*, issued in 1994 to all commissioners and providers of mental health services. In discussing ‘when things go wrong’ the guidance states:

“In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved”.

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

- i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- ii) When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.
- iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The Manchester Mental Health and Social Care NHS Trust and NHS Manchester, were consulted regarding the Terms of Reference and did not wish to make any additions. The sister of Mr. Y was also consulted. The sister of Mr. Y requested that the appropriateness of her brother's care and treatment was also included as part of this Investigation process. The Terms of Reference were as follows:

1. To examine:

- the care and treatment provided to the service user (Mr. Z), at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- the suitability of that care and treatment in view of the service user's (Mr. Z) history and assessed health and social care needs;
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the adequacy of risk assessments to support care planning and use of the care programme approach in practice;
- the exercise of professional judgement and clinical decision making;
- the interface, communication and joint working between all those involved in providing care to meet the service user's (Mr. Z) mental and physical needs;
- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- the quality of the internal investigation and review conducted by the Trust;

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- the care and treatment received by the victim (Mr. Y) and to assess the appropriateness and effectiveness of this in relation to his potential status as a vulnerable adult.

2. To identify:

- learning points for improving systems and services;
- developments in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To make:

- realistic recommendations for action to address the learning points to improve systems and services.

4. To report:

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Manchester-based Mental Health Services. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in investigation and inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service. Report Author
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Investigation Team Members

Mr. Andrew Skelton	HASCAS Health and Social Care Advisory Service Associate and Nurse Member of the Team
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Dr. Susan O'Connor	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team
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Dr. Alison Conning	HASCAS Health and Social Care Advisory Service Associate and Psychologist Member of the Team
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Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service
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Fiona Shipley	Transcription Services
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Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks
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7. Investigation Methodology

In July 2011 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section six of this report. The investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. Z, his victim, and all witnesses to this Investigation.

Consent and Communications with Mr. Z

On the 20 July 2011 NHS North West wrote to Mr. Z who was residing in HMP Manchester (Strangeways) to seek his consent for the Independent Investigation Team to access his clinical records. On the 12 August 2011 Mr. Z gave consent for his records to be released and on the 23 August 2011 the Strategic Health Authority wrote to the Caldicott Guardians of the Manchester Mental Health and Social Care NHS Trust and NHS Manchester requesting that Mr. Z's records be released to HASCAS. The records were released to HASCAS between September and the end of October 2011.

At the time of writing this report arrangements were in train to meet with Mr. Z in prison.

When the Investigation Terms of Reference were expanded to encompass the care and treatment received by Mr. Z's victim, Mr. Y, (at the end of May 2012) no consent was required prior to accessing the clinical record as Mr. Y was deceased. Mr. Y's GP records were received by this Investigation on 9 July 2012.

Communications with the Victim's Family

In November 2011 NHS North West made contact with one of the sister's of Mr. Y who wished to take an active part in this Investigation. Mr. Y's brother was also written to.

On the 9 January 2012 the Investigation Chair met with Mr. Y's sister at her home. On this occasion she requested that the Investigation Terms of Reference were expanded to include her brother's mental health history as she was concerned that this important aspect would be overlooked. She felt strongly that the insights gained from this inclusion would add significantly to the findings of the Investigation work.

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On the 8 October 2012 the Investigation Chair and a Senior Officer from NHS North of England (the current Strategic Health Authority) visited the sister of Mr. Y at her home. The purpose of this visit was to give her the headline findings from the Investigation and to discuss the ensuing publication process. The Strategic Health Authority made arrangements to continue to maintain contact with the family.

Communications with the Family of Mr. Z

No contact was able to be made with the family of Mr. Z prior to the writing of this report.

Communications with the Manchester Mental Health and Social Care NHS Trust

On the 14 July 2011 NHS North West wrote to the Manchester Mental Health and Social Care NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Z. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust.

On 2 November 2011 a Trust workshop for witnesses and Trust managerial staff was held. A NHS Manchester Senior Officer was also present. Each workshop attendee was given an information pack that described the HSG (94) 27 process, gave witness advice, and set out the draft Terms of Reference. The workshops provided each attendee with the opportunity to learn more about the forthcoming procedure and what would be expected of them.

Between the first meeting stage (2 November 2011) and the formal witness interviews (7-9 December 2011) the Independent Investigation Team Chair worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness would be accompanied by an appropriate support person when interviewed if they so wished.

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On the 20 August 2012 a meeting was held between the Independent Investigation Team Chair and the Trust Top Team. The purpose of this meeting was to inform the Trust of the headline findings of the Investigation and to commence the factual accuracy stage of the process. On this occasion the Trust was invited to comment upon the recommendation section in the report and to contribute further after a period of reflection. The draft report, and all relevant report clinical sections, was given to the Trust and witnesses for factual accuracy checking on the 20 August 2012.

Communication with NHS Manchester (Primary Care Trust)

The Independent Investigation Team Chair made contact with NHS Manchester at the inception of the work and a liaison person was identified. During the Investigation process both the Trust liaison person and the Primary Care Trust liaison person worked closely together to facilitate the workshop events and the witness interview week. This proved to be an effective way of working.

NHS Manchester provided GP Clinical records and performance management data to the Investigation Team. The Primary Care Trust engaged fully with both the workshop and witness interview process.

On the 20 August 2012 a meeting was held between the Independent Investigation Team Chair and the Primary Care Trust. The purpose of this meeting was to share the headline findings of the Investigation. On this occasion NHS Manchester was invited to discuss the required recommendations for the report and to contribute to them after a period of reflection.

Completion of the Process

It was agreed that a formal workshop would be held with the Manchester Mental Health and Social Care NHS Trust and NHS Manchester directly prior to the publication of this report. The purpose of this workshop would be to focus on the lessons learned and the recommendations made.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

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During the five-year period that Mr. Z received his care and treatment from Manchester-based services he was seen by a significant number of health and social care professionals. The Independent Investigation Team took the decision to interview each of the health care professionals that provided care and treatment to Mr. Z during this period and who were responsible for the formulation of his case management. The total number of witnesses interviewed by the Independent Investigation Team was 20. The witnesses who attended for interviews are set out below in table one.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
<p>7 December 2011</p>	<p>Mental Health Trust CEO Mental Health Trust Director of Nursing and Therapies Mental Health Trust Medical Director Mental Health Trust Associate Director of Governance Mental Health Trust Head of Nursing *** Principal Cognitive Behaviour Therapist Psychotherapist *** Internal Investigation Member 1 Internal Investigation Member 2 Internal Investigation Member 3 *** Clinical Director of Psychology Services Rehabilitation and Recovery Manager</p>	<p>Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Psychologist</p> <p>In attendance: Stenographer</p>
<p>8 December 2011</p>	<p>NHS Manchester Associate Director of Joint Commissioning *** Consultant Psychiatrist 2 *** Psychiatric Liaison Nurse 1 Accident and Emergency Liaison Manager</p>	<p>Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse Investigation Team Psychologist</p> <p>In attendance: Stenographer</p>

	Psychiatric Liaison Nurse 2	
9 December 2011	<p>Adult Psychotherapist</p> <p>***</p> <p>Head of Clinical Psychology</p> <p>***</p> <p>Clinical Psychologist</p> <p>***</p> <p>Service Manager/Consultant Psychotherapist</p> <p>***</p> <p>Counsellor Psychotherapist Service</p>	<p>Investigation Team Chair</p> <p>Investigation Team Psychiatrist</p> <p>Investigation Team Nurse</p> <p>Investigation Team Psychologist</p> <p>In attendance:</p> <p>Stenographer</p>

Salmon and Scott Compliant Procedures

The Independent Investigation Team adopted Salmon and Scott compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
 - (a) of the terms of reference and the procedure adopted by the Investigation; and
 - (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

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- (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign; and
 - (h) that they will be given the opportunity to review clinical records prior to and during the interview.
2. Witnesses of fact will be asked to affirm that their evidence is true.
 3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.
 4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
 5. All sittings of the Investigation will be held in private.
 6. The findings of the Investigation and any recommendations will be made public.
 7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
 8. Findings of fact will be made on the basis of evidence received by the Investigation.
 9. These findings will be based on the comments within the narrative of the report.
 10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was made aware in advance of their interview the general questions that they could expect to be asked.

The Team Met on the Following Occasions

4 November 2011. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

7-9 December 2011. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose. On the 9 December 2012, using the Terms of Reference and the timeline as guidance, the Team developed subject headings that required further examination.

Between the 10 December 2011 and the 9 January 2012 each Team Member prepared an analytical synopsis of identified subject headings in order to conduct an in-depth Root Cause Analysis process.

10 January 2012. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety Agency. This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the event and being able to present written, referenced briefings at the meeting.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS North West throughout the process. Communications were maintained in-between meetings by email, letter and telephone.

Root Cause Analysis

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

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

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

- 1. Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed throughout this process.
- 2. Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.

- 3. Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.
- 4. Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

8. Information and Evidence Gathered (Documents)

During the course of this Investigation 1,453 pages of clinical records have been read and some 496 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Z's Manchester Mental Health and Social Care NHS Trust records
2. Mr. Z's Manchester-based GP records
3. Mr. Y's GP records
4. The transcription of the Manchester Crown Court proceedings
5. The Manchester Mental Health and Social Care NHS Trust Internal Investigation Report and action plan
6. The Manchester Mental Health and Social Care NHS Trust Internal Investigation Archive
7. NHS Manchester Assertive Outreach Service review
8. NHS Manchester action plans
9. Secondary literature review of media documentation reporting the death of Mr. Y
10. Independent Investigation Witness Transcriptions.
11. Manchester Mental Health and Social Care NHS Trust Care Programme Approach Policies, past and present
12. Manchester Mental Health and Social Care NHS Trust Clinical Risk Assessment and Management Policies, past and present
13. Manchester Mental Health and Social Care NHS Trust Crisis Resolution Home Treatment Policy
14. Operational Policies (2005-2010)
15. Manchester Mental Health and Social Care NHS Trust Incident Reporting Policies
16. Manchester Mental Health and Social Care NHS Trust Clinical Supervision Policy
17. Manchester Mental Health and Social Care NHS Trust Being Open Policy
18. Healthcare Commission/Care Quality Commission Reports for Manchester Mental Health and Social Care NHS Trust services
19. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm*: a protocol for liaison and effective

communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006

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

21. NICE and ICD 10 guidelines

9. Profile of the Manchester Mental Health and Social Care NHS Trust Services (Past and Present)

The Manchester Mental Health and Social Care NHS Trust was established in 2002. At the time of writing this report it provided a comprehensive range of mental health and social care services and served a population of 484,900. The demography of the City of Manchester population is young and diverse, it is also growing rapidly. A particular challenge is that, in common with many other urban mental health trusts, there are areas of significant deprivation. At the time of writing this report the annual turnover was £104 million and the Trust employed 1,795 staff. The Trust seeks currently to improve the mental health and wellbeing of the City of Manchester through active partnership working with other statutory organisations and authorities, and with voluntary and third sector agencies.

The Trust values are:

- ***“Truthfulness*** *Maintaining an honest and open dialogue with staff and service users to ensure that we provide best advice and integrated care solutions that respond to specific need.*
- ***Respect*** *Valuing people – service users, staff and partners - respecting their dignity and seeking to deliver appropriate care and services tailored to the individual.*
- ***Understanding*** *An ongoing commitment to research and development; to continuously extend our knowledge and skills, so that the latest teaching and practice are at the heart of our service development.*
- ***Standards*** *Setting the highest standards of professionalism, safety, security and confidentiality in all that we do.*
- ***Togetherness*** *A commitment to partnership so that services can be fully integrated to reflect the needs of service users, carers and communities”.*

The Trust Provides the Following Services

- Community Services;
- Recovery Pathways: people through art, people and places;
- Dementia and Memory Services;
- Drug and Alcohol Services;
- Employment Support;

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- Help in a Crisis;
- Inpatient Services;
- Library Services;
- Outpatient Services;
- Prison Healthcare;
- Psychological Services;
- Psychotherapy services
- Dual Diagnosis and alcohol services
- General hospital Accident and Emergency liaison services
- Specialist Services;
- Wellbeing Services
- Start2.

Mr. Z received his care and treatment primarily from Outpatient and Psychotherapy Services whilst a service user with the Trust.

Outpatient Services

The term outpatient services is used to cover all the one-to-one services offered to service users outside the community teams, general hospital liaison, and in-patient settings. Referrals to all these services are generally *via* the Trust's Single Point of Access and are usually accepted from primary care or from general hospital specialists. The Trust provides a variety of outpatient clinics in Manchester covering a wide range of services such as psychiatry, psychology, psychotherapy (described below), the Eating Disorders Service, the Psychosexual Service, perinatal mental health, the Dual Diagnosis service and the Specialist Affective Disorder service. Some of these clinics are aimed at providing specialist assessment, advice and support to GPs, whilst others provide direct one-to-one specialist interventions with people with particular specialist needs. Clinics are offered in a range of hospital, acute trusts and community settings right across the city. The Trust aims to provide a high quality service to meet the individual needs of the people that it supports.

Psychotherapy Services

The Trust's Psychologies Department provides a wide range of services at sites across Manchester. The Psychotherapy Services provide specialist, evidence-based psychological

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therapies to clients with personality and complex chronic emotional adjustment disorders, while Secondary Care Psychology comprises psychological provision to Community Mental Health Teams (CMHTs), Crisis Resolution and Home Treatment Teams (CRHTs), Assertive Outreach (AO) and the Mother and Baby Unit (MBU).

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Z and on his care and treatment from mental health services. The following chronology condenses over 1,453 pages of clinical records.

Background Information

Mr. Z was born on 12 April 1970. His mother remarried when he was five years of age. Following Mr. Z receiving heart surgery at the age of six he was allegedly the victim of abuse. The nature of this abuse cannot be specified in this report, but is pivotal to how Manchester-based services provided care and treatment to Mr. Z between 2005 and 2010. Mr. Z apparently did well at school and left home at the age of sixteen. From this time on he was employed in various kinds of cleaning and factory work. Mr. Z is by orientation a homosexual. He lived with his ex partner, Mr. Y, whom he killed in November 2010.

It was noted by the Independent Investigation Team that Mr. Z appeared to be an inconsistent raconteur of his own history and the accounts he gave to his Manchester-based treating team between 2005 and 2010 regarding his previous mental health problems were frequently of an inconsistent or erroneous nature.

Early Psychiatric History

The extant Clinical information for this period is sparse.

13 June 1996. On this date a Forensic Psychiatrist from Rotherham prepared a Court report (it was not specified for which Court the report was intended or why). The report noted that Mr. Z had received a period of psychotherapy at the age of 16 years; there had been no psychiatric history prior to this point.

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It was recorded that on the 3 May Mr. Z had been admitted to a medical ward after taking an overdose of 25 Paracetamol tablets. Following this event he was admitted to a psychiatric unit. On this occasion Mr. Z was described as displaying a depressive illness. He was “*discharged back to the hostel on 23 May 1996*”.⁶

The Forensic Psychiatrist examined Mr. Z again on the 31 May 1996 when he appeared to be “*a lot better*”. Mr. Z was advised to continue taking his antidepressants and to attend follow up appointments.⁷

The opinion and recommendation was that Mr. Z was fit to appear in Court and that he was currently suffering from a mild depressive disorder. The Psychiatrist offered the view that he did not think that Mr. Z would commit any other kind of similar offence in the future (the nature of which was not specified) and that “*should the Learned Judge see fit to consider a non-custodial sentence in this case, I would recommend a disposal along the lines of a probation order with a condition of out-patient treatment*”.⁸

25 July 1996. Mr. Z moved to a new GP practice in Nottingham. The GP asked for a psychiatric referral for him due to his history of multiple overdoses. It was recorded that Mr. Z had a history of being abused and that he was currently under the care of a Psychiatrist in Rotherham. Mr. Z reported that he had attempted to overdose a week previously. Prior to this he had reported that he had overdosed with more than 100 Paracetamol tablets for which had been an inpatient at Rotherham for “*some time*”.⁹

3 August 1996. The word “*overdose*” was written in Mr. Z’s GP record.¹⁰

2 December 1996. A Probation Officer wrote to Mr. Z’s GP in Nottingham. He explained that Mr. Z was being supervised by his office. Mr. Z had been sentenced at Nottingham Crown Court the previous July and the Court had two copies of a psychiatric report prepared by a Consultant Forensic Psychiatrist from Rotherham General Hospital. The report recommended outpatient treatment. Mr. Z had requested a referral to a local psychiatrist prior

6. GP Record P. 404

7. GP Record P. 404

8. GP Record P. 405

9. GP Record PP. 390-391

10. GP Record. P.78

to leaving Rotherham. The Probation Officer was seeking advice as to the waiting times for such services.¹¹

N.B. the reader is asked to note that Mr. Z had been convicted for wounding in the summer of 1996 when he had stabbed his then male partner with a carving fork repeatedly (22 times). For this offence Mr. Z received a 12-month suspended sentence. At some stage during 1996 Mr. Z began a relationship with Mr. Y.

22 April 1997. The GP made a referral for Mr. Z to have a psychiatric assessment. The referral mentioned that he had previously been admitted to a psychiatric inpatient unit in August 1996. He was then living in Rotherham under the care of a Forensic Psychiatrist. At this time he was on Prozac 40mg a day. Advice and input were sought.¹²

22 February 2001. The word “*overdose*” was written in the GP record. Mr. Z had taken eight 500mg tablets of Paracetamol and may have consumed up to six litres of strong cider. He said that he did not feel depressed unless he was drunk. It was noted that in spite of a “*history of serious assaults*” he had no current plans or intent to harm anyone.¹³

29 June 2001. The word “*overdose*” was written in the GP record.¹⁴

18 June 2003. Mr. Z took 30 Paracetamol, six shots of vodka, six shots of whiskey and half a bottle of wine. His mother returned home early and called an ambulance. The GP said Mr. Z was of no fixed abode and had made some 12-13 previous self-harm attempts. Apparently Mr. Z had been living in Manchester, but had returned to Nottingham to be closer to his family. He was currently living with his mother. Mr. Z said that he had been a heavy drinker but that he had stopped six months ago. Mr. Z also said he had previously stabbed someone because they had been trying to rape him and that he was given 12 months of Probation following this event (see above).¹⁵

11. GP Record. P. 377

12. GP Record. P.369

13. GP Record. PP.78 &353-354

14. GP Record. P.78

15. GP Record. PP.336-338

28 June 2003. The word “*overdose*” was written in the GP record.¹⁶

Clinical History with the Manchester Mental Health and Social Care NHS Trust

21 June 2005. The GP referred Mr. Z to see a Consultant in the Psychiatric Clinic due to his history of depression which had been getting worse over the past two months. The referral also mentioned a history of overdose and anxiety which had been present for some ten years.¹⁷

5 July 2005: 14.00 hours. The GP referred Mr. Z to the Accident and Emergency Department. In a letter the GP said that Mr. Z was living in a flat that he shared with a male friend. He was referred for depression and suicidality.

Mr. Z had said that he had suffered from depression following the prolonged abuse he experienced as a child. Mr. Z had been experiencing thoughts of self harm and had been feeling low for several weeks. He was very irritable and had thoughts of knifing his flatmate. His sleep had been poor and he described visual hallucinations. He described obsessive compulsive behaviour of some two-years standing. Three weeks previously Mr. Z had taken a rock from the garden and a Stanley knife which he placed under his bed. *“His thoughts were to smash his friend’s head in, and afterwards cut his throat”*. He had changed his mind about putting his plan into action. He expressed variable concern about having these thoughts.

Mr. Z’s past psychiatric history was noted as including a period of psychotherapy at the age of sixteen. It was recorded that in 1998 [the wrong date] he attacked a man for no reason, stabbing him with a fork 22 times. The man suffered from a collapsed lung. It was recorded that Mr. Z received a suspended sentence for this offence and that he spent three months in a psychiatric unit in Rotherham, Yorkshire which was not related to the criminal justice proceedings. At this time Mr. Z had been prescribed Fluoxetine; he took it for one to two years and then stopped as he did not think it helped him.

16. GP Record. P.78

17. GP Record. P.155

Mr. Z Investigation Report

Mr. Z said that he had made a number of suicide attempts. He was on Amitriptyline 25mg *nocte* for which he had been treated for one month with no effect. He had a previous history of heavy drinking, which he had reduced, but had reportedly given up when prescribed the Amitriptyline. The issues were described as being psychodynamic and related to unresolved experiences of childhood abuse. He was referred to the Community Mental Health Team (CMHT). The Amitriptyline was stopped and Sodium Valproate 200mg twice daily was commenced for one week, then increased to 400mg twice daily. It was suggested that at a later date Paroxetine should be considered.¹⁸

Hand-written notes recorded that Mr. Z experienced seeing spiders and flies. Mr. Z reported that he had been abused between the ages of six and 16 years.¹⁹

7 July 2005: 13.00 Hours. A CMHT assessment took place by a Community Psychiatric Nurse (CPN). It was noted on the 'Violence Risk Assessment Tool' that Mr. Z had attacked a male partner in 1989 (date given in the clinical record) with a fork stabbing him 20 times and that the victim suffered a collapsed lung. It was noted that this attack was the only one that was known. It was uncertain whether or not a pattern could be ascertained from previous behaviour. It was recorded that Mr. Z had difficulty in forming close relationships with others and that he argued with his current partner often losing control, throwing and smashing things. Mr. Z said during the interview that he had thoughts of throwing the television at his partner but that if he hit him he might not be able to stop "*query fatal consequences*".²⁰

The risk assessment identified that Mr. Z had a depressive illness and that he did not feel that he himself was at risk from others. There were no indications that Mr. Z thought his mind was dominated by forces beyond his control, or that he had thoughts that were not his own. He did not have any paranoid thoughts and claimed not to have any hallucinations. Mr. Z claimed to think about violence "*sometimes*" but that he never carried a weapon.

Observations made over the previous 24 hours were that Mr. Z was evidentially very angry, verbally abusive and had glaring eye contact. It was recorded that Mr. Z did not drink alcohol, but a "?" was placed by illicit substances. It was also recorded that Mr. Z was

18. NM Notes PP.21-22

19. NM Notes PP.88-91

20. NM Notes PP.6-11

Mr. Z Investigation Report

currently living in a house owned by his ex partner. It was noted that healthcare professionals were currently involved in his support and supervision.

The risk summary recorded that Mr. Z was easily aroused leading to arguments. There were issues around impulse control as Mr. Z frequently threw things when he lost his temper. Mr. Z said that he had never had any feelings of guilt or remorse following the assault on his ex partner in 1989. Mr. Z agreed that he ought to inform his current partner about the gravity of his feelings towards him but seemed vague and indecisive about this. The plan was to:

1. monitor by maintaining regular telephone contact;
2. give Mr. Z the telephone numbers of the out of hours services;
3. set up an initial outpatient consultant appointment;
4. discuss areas for service provision and CPN allocation at the next team referral review meeting;
5. consider breaching patient confidentiality on a need to know basis due to the high risk to his partner.

The assessment outcome was that Mr. Z was high risk.²¹

8 July 2005. The CPN identified the risks Mr. Z presented to his partner at a CMHT meeting and arranged for daily contact to be made by telephone. The CMHT Consultant (Consultant Psychiatrist 1) was present at this meeting. The decision to accept the referral onto the CMHT caseload was deferred until the Team referral meeting which was due to be held on the 11 July 2005. In the meantime the CPN raised concerns about interpersonal conflict between Mr. Z and his partner and identified Mr. Z's risk of harm to others from violence as being high. An appointment was made with Consultant Psychiatrist 1 for the 8 August 2005.²²

9 July 2005. A telephone call was made to Mr. Z who reported feeling tired and "groggy" since commencing on the Sodium Valproate. His thoughts of harming others remained although they were less intense than on assessment. It was planned to telephone him again the following day.²³

21. NM Notes PP.70-71

22. NM Notes P.98

23. NM Notes P. 99

12 July 2005. Mr. Z was ‘discharged’ from the CMHT on a ‘Standard’ Care Programme Approach (CPA).²⁴

4 August 2005. Consultant Psychiatrist 1 wrote to the GP to say that Mr. Z had been discussed by the CMHT on this day (there are few extant records that detail what was discussed). The decision was made to trial Mr. Z on antidepressants prior to accepting him into secondary care services. Paroxetine was recommended due its anti-anxiety effects. The GP was advised that the medication could take between two and eight weeks to be effective and Mr. Z could be referred again if it was thought necessary.²⁵

8 August 2005. Mr. Z was assessed by Consultant Psychiatrist 1. The Mental State Examination noted that Mr. Z was clean and had good eye contact. He appeared to have normal mood and levels of anxiety. There was no evidence of any disorder of thought or perception. His cognitive skills appeared to be intact. Mr. Z reported feeling a “*little anxious*” and “*a bit down*”. He was living with his ex partner. He denied having any suicidal ideation or any intrusive thoughts about killing his flatmate. Mr. Z reported that he had felt well for the past two to three weeks and that the Sodium Valproate appeared to suit him. His main concern was his anxiety and bad temper. Mr. Z said that he had been admitted as a psychiatric inpatient in 2000, 2001, 2002 (Salford) and 2004 (Nottingham) following suicide attempts induced by his alcohol intake. Mr. Z also mentioned his admission to Rotherham following the stabbing of a man, he had not been sent to a forensic unit. The opinion was that Mr. Z suffered from a recurrent depressive disorder with obsessive traits, poor anger control and alcohol abuse (until recently). The Sodium Valproate 800mg twice daily appeared to be controlling his anxiety and anger outbursts. Mirtazapine 15mg at night had been prescribed to help with underlying depressive symptoms and insomnia. It was suggested that he stop the Diazepam 20mg at night. Another appointment was arranged for three-months time. Mr. Z was told that in crisis he could contact the CMHT.²⁶

9 August 2005. Consultant Psychiatrist 1 referred Mr. Z to the Psychotherapy Department. He sent to them a copy of the assessment that he recently conducted (it is not clear what exactly was sent). He felt there were good grounds for psychotherapy.²⁷

24. AMIGOS Notes P.1

25. GP Record P.325

26. NM Notes PP.23-25

27. NM Notes P.26

18 August 2005. Mr. Z received a letter from the Psychotherapy Service at McCartney House explaining that he had been referred to them. He was asked to contact them within three weeks to make an appointment.²⁸

22 August 2005. Mr. Z was written to confirming his appointment with an Adult Psychotherapist for the 10 October 2005.²⁹

10 October 2005. Mr. Z met with the Adult Psychotherapist. Mr. Z felt that he was always depressed except for brief periods. He had recently planned to harm his flat mate and explained that he had begun preparing to do this. He had taken a sharp knife from the kitchen and a boulder from the garden. He had hidden these under his bed and had planned to wait until his flat mate was asleep. There were no apparent triggers other than feelings of being angry. Mr. Z mentioned that he had stabbed a friend seven years previously. After drinking a row had broken out and he had stabbed this friend repeatedly with a carving fork. He did not feel bad about this attack and that worried him. Following this attack he had a twelve-month suspended sentence and had a forensic psychiatry assessment which led to a hospital admission for three-four months (the information about the inpatient admission was not correct). Following his discharge he described moving from city to city. In the assessment notes it was recorded that Mr. Z had been abused as a child. The Adult Psychotherapist wrote *“my anxieties were raised in the counter-transference by his description of violence but simultaneously felt optimistic about being open and honest”*. It was recorded that the risks relating to Mr. Z were alcohol and drug misuse, however these risks were considered to be low. The main risk identified was that of violence which would need to be monitored closely throughout the therapy.³⁰

31 October 2005. Mr. Z met with the Adult Psychotherapist. He described feeling *“drained”* following the previous session. He continued to have been *“up and down”* since then. He described himself as always feeling on *“the edge”*.³¹

7 November 2005. Consultant Psychiatrist 1 saw Mr. Z in the Outpatient Clinic. He appeared to be free of psychiatric symptoms. He reported feeling a lot better and with fewer mood

28. NM Notes P.27

29. NM Notes P.28

30. North Psychotherapy Notes PP.152-153

31. North Psychotherapy Notes PP.154-155

swings. He was still living with his flatmate. He had recently attended McCartney House and said it had been very helpful. The care plan was to increase the Mirtazapine from 15mg to 30mg at night. It was arranged to follow him up again in three-months time.³²

23 November 2005. The Adult Psychotherapist wrote to Consultant Psychiatrist 1. The psychotherapy assessment had taken place over three sessions. Mr. Z had been able to detail his history and described experiencing violent feelings towards his flatmate, but so far not having acted on them. She wrote *“this clearly raises a great deal of anxiety in him especially when he found himself organising the implements for an attack although he did not see it through”*. The Adult Psychotherapist also wrote that Mr. Z had been admitted as an inpatient following his stabbing an acquaintance/friend and that he had been assessed by a forensic psychiatrist at this time which led to a three-month hospital stay. It seemed that there had been no follow up on discharge.

Mr. Z described a history of childhood abuse. Mr. Z experienced *“a lot of emotional and physical pain”* when describing this abuse. Mr. Z was described as feeling curious enough to want to understand his feelings. He was cautioned that if therapy was too distressing he needed to tell his therapist. It was agreed to place him on the waiting list for psychodynamic counselling.³³

6 February 2006. The case was transferred to Consultant Psychiatrist 2 who reviewed Mr. Z in the Outpatient Clinic. The diagnosis was recurrent depressive disorder with obsessive traits. The clinical issues were identified as being a poor control of anger outbursts, and alcohol abuse until recently. Mr. Z said that he had been well and that his mood was stable. He had been attending for psychotherapy. He said that he could better control his feelings of violence against his ex partner. Mr. Z was still reported to avoid crowds, but had a decrease in his checking rituals. He was not sleeping well. The care plan was as follows.

1. To increase the Mirtazapine to 45mg at night. Chlorpromazine 100mg at night was added to assist his sleep. Mr. Z was to continue his psychotherapy.
2. Mr. Z was to be reviewed again in three-months time.³⁴

32. NM Notes P.29

33. NM Notes PP.30-31

34. NM Notes P.32-34

Mr. Z Investigation Report

During this initial contact Mr. Z's thoughts about harming others were explored, but as the picture unfolded the focus moved to examining his risk of harm to self. Mr. Z did not come across as guarded.³⁵

9 March 2006. A Counsellor from the Psychotherapy Service wrote to Mr. Z to offer him a meeting to discuss counselling sessions. An appointment was set for the 5 April 2006.³⁶

6 April 2006. The Counsellor met with Mr. Z for a contracting interview. Mr. Z gave a concise summary of his previous abuse.³⁷

7 April 2006. The Counsellor wrote to a Consultant Psychiatrist (not Consultant Psychiatrist 2) to say that Mr. Z was due to start 15 sessions of weekly counselling on the 27 April 2006 and that he would write to him again when the sessions were complete.³⁸

4 May 2006. The Counsellor met with Mr. Z who was not sure what to talk about. Eventually Mr. Z talked about the close relationship he had with his grandmother. He described a history of alcohol, skunk and cannabis misuse which had increased his feelings of paranoia. Mr. Z described being left with feelings of anxiety about men, despite being gay.³⁹

11 May 2006. Mr. Z telephoned the counselling service to say he could not attend on this day as "*something had cropped up*".⁴⁰

18 May 2006. The Counsellor met with Mr. Z. It was noted that he had missed the previous week's appointment. This was because his flatmate had gone into a diabetic coma. Mr. Z continued to talk about his previous abuse. He said that he was finding it easier to discuss this. Mr. Z said that he had been assaulted by two previous male partners and that he did not want another relationship.⁴¹

23 May 2006. Consultant Psychiatrist 2 wrote to the GP to say that Mr. Z had not attended his Outpatient appointment on the 8 May. Another appointment had been arranged for three-

35. NM Notes P. 81

36. North Psychotherapy Notes P.142.

37. North Psychotherapy Notes P. 157

38. NM Notes P.36

39. North Psychotherapy Notes P.160

40. North Psychotherapy Notes P. 140

41. North Psychotherapy Notes PP.161-162

Mr. Z Investigation Report

months time. It was noted that Mr. Z had appeared improved at the last review and that he continued with psychotherapy.⁴²

25 May 2006. The Counsellor met with Mr. Z who had experienced a difficult week. He had become angry. This anger was a recent phenomenon.⁴³

1 June 2006. The Counsellor met with Mr. Z. He had dreamt about his mother and sister. Mr. Z spoke about the rows he was having with his flatmate, these were described as frightening, but said that they were both each others' "*rocks*".⁴⁴

15 June 2006. The Counsellor met with Mr. Z who was shocked that his mother had written to his flatmate, after not hearing from her for two or three years, to ask where he was. Mr. Z decided that he wanted nothing to do with her, this made him sad. Mr. Z said he felt safe at home in his own room.⁴⁵

22 June 2006. The Counsellor met with Mr. Z. Mr. Z had experienced a disturbing dream and four nights of poor sleep. Mr. Z said that after his counselling sessions he felt unsettled and went straight home.⁴⁶

29 June 2006. Mr. Z telephoned to cancel his counselling appointment due on this day because he had a stomach upset. The Counsellor wrote to Mr. Z saying that he hoped he felt better and to rearrange his appointment for the 27 July 2006.⁴⁷

27 July 2006. The Counsellor met with Mr. Z. Mr. Z had been to the City Centre for the first time, he felt that he wanted "*energy and space*".⁴⁸

3 August 2006. The Counsellor met with Mr. Z, he was tense. Mr. Z continued to talk about his abuse. Mr. Z mentioned getting the all clear for a melanoma from Christies Hospital (it is

42. NM Notes P.37

43. North Psychotherapy Notes PP.162-163

44. North Psychotherapy Notes PP.163-164

45. North Psychotherapy Notes PP.164-165

46. North Psychotherapy Notes PP.165-166

47. North Psychotherapy Notes P.138 & 139

48. North Psychotherapy Notes PP.166-167

not clear when this was). It was noted that Mr. Z was going to talk to his Consultant Psychiatrist about a reduction in his antidepressant medication.⁴⁹

10 August 2006. The Counsellor met with Mr. Z who had experienced a “*terrible week*”. During the week he had repeated arguments with his flatmate about the tidiness of the flat.⁵⁰

17 August 2006. The Counsellor met with Mr. Z. Mr. Z had experienced “*an awful week*”. The previous evening Mr. Z had felt down and drank three quarters of a bottle of whiskey. Drinking made his depression worse. He made a serious suicide plan to cut an artery in his arm with a Stanley knife. He then telephoned the emergency services at Park House and spoke to a psychiatrist. This helped and he put the knife away. Mr. Z had also “*had his first bad argument with his friend for some time*”. These arguments apparently had the potential to result in “*fisticuffs*” and were recorded as having done so in the past. However on this occasion Mr. Z managed to walk away to his room. Mr. Z talked about his anxieties regarding the counselling coming to an end. He knew he could be referred again if so needed.⁵¹

24 August 2006. The Counsellor met with Mr. Z. This was the penultimate session. Mr. Z said that he felt generally better than he did since he started counselling. He still felt suicidal at times, but could sometimes enjoy himself.⁵²

30 August 2006. Mr. Z telephoned to say he had a stomach upset and was going on holiday and that he would have to cancel his appointment with the Counsellor.⁵³

31 August 2006. The Counsellor wrote to Mr. Z saying that he hoped he felt better and had enjoyed his holiday. It was arranged that they would meet on the 21 September 2006.⁵⁴

19 September 2006. Consultant Psychiatrist 2 reviewed Mr. Z in the Outpatient Clinic. The diagnosis was given as being the same as previously with the additional “*revised impression of ? psychosis NOS*”. The medication was listed as being “*Tablets Sodium Valproate 800mg*”

49. North Psychotherapy Notes PP.167-168

50. North Psychotherapy Notes PP.168-169

51. North Psychotherapy Notes PP.169-170

52. North Psychotherapy Notes PP.170-172

53. North Psychotherapy Notes P.137

54. North Psychotherapy Notes P.136

Mr. Z Investigation Report

at night: Tablets Mirtazapine 45mg at night.” Mr. Z described a decrease in his anxiety and obsessions. He did however report nightmares regarding his past abuse. He had been discussing this in psychotherapy. Mr. Z reported that he felt his thoughts were known by other people and that he tended to avoid being in open spaces and with people because of this. He continued to sleep poorly and to live with his ex partner.

The care plan stated:

- *“I have added tablet Risperidone 2mg nocte*
- *I have stopped tablet Chlorpromazine*
- *I confirm Sodium Valproate 800mg at night and Mirtazapine 45mg nocte*
- *He is to be reviewed for psychotherapy or psychology input over next follow up*
- *I have arranged for the next Outpatient review in 3 months time”.*⁵⁵

21 September 2006. The Counsellor met with Mr. Z. Mr. Z had experienced a nightmare whilst on holiday. He still believed that people knew about the abuse when he left his flat and felt safe when in his home. He had talked about this with his Psychiatrist who was due to commence antipsychotic medication. This apart, however, he was feeling better. A CORE assessment was conducted and Mr. Z had a “0” score for risk.⁵⁶

12 October 2006. The Counsellor wrote to Consultant Psychiatrist 2 to say that Mr. Z had completed his 15 sessions of counselling. The childhood abuse that Mr. Z had experienced had been the central issue. Mr. Z had wanted the counselling to replace some of his bad memories with better thoughts. He felt this had been achieved. When the bad memories returned Mr. Z found it difficult to control his feelings of anger and he then found it difficult not to argue with the friend he shared his house with. Counselling had not helped the anger that he felt. Mr. Z had said that he felt “*all talked out*”.

The Counsellor also explained that Mr. Z felt people in crowds somehow knew about his abuse. This at times was a firm belief. This was a longstanding problem and continued to trouble him. It had been decided that a follow up appointment would be offered in the New Year after which the plan was to discharge Mr. Z.⁵⁷

55. NM Notes PP.38-39

56. North Psychotherapy Notes PP.172-173

57. NM Notes PP.40-41

11 November 2006. The Counsellor wrote to Mr. Z to arrange a review of counselling on the 21 December 2006.⁵⁸

5 December 2006. Mr. Z telephoned to say that he could not make his appointment on the 21 December as he was going away on holiday. The Counsellor wrote to rearrange the review of counselling for the 11 January 2007.⁵⁹

11 January 2007. The Counsellor wrote to Mr. Z to arrange a review of counselling for the 31 January 2007.⁶⁰

1 February 2007. The Counsellor wrote to Mr. Z arranging a meeting for the 15 February 2007. Mr. Z telephoned on the 31 January 2007 to cancel his appointment as he had not been feeling very well physically.⁶¹

5 February 2007. The GP wrote on the incapacity benefit form that Mr. Z had a long history of presenting with multiple somatic complaints, which following “*exhaustive*” investigation failed to yield a diagnosis. The GP wrote that he thought Mr. Z was suffering from kind of psychotic illness. This diagnosis had been made by Consultant Psychiatrist 2.⁶²

15 February 2007. Mr. Z had a follow-up session with the Counsellor. It was noted that Mr. Z had missed several appointments. Mr. Z believed that his condition would not change in the future. He still had bad days. However sometimes he was able to replace bad thoughts with good ones. He was rarely arguing with his friend and did not have such “*black and white*” thoughts of suicide. Mr. Z was anxious at only having three-monthly appointments with his psychiatrist. However he believed that he had “*plateaued*” now and would not change in the future.⁶³

21 February 2007. The Counsellor wrote to Consultant Psychiatrist 2. Mr. Z had attended for his follow-up appointment. Mr. Z had maintained his progress and expected that his condition would remain stable in the future. He said he could manage his agoraphobia and

58. North Psychotherapy Notes P. 133

59. North Psychotherapy Notes PP.130 & 132

60. North Psychotherapy Notes P.131

61. North Psychotherapy Notes P.127

62. GP Record. PP.267-269

63. North Psychotherapy Notes PP.173-174

Mr. Z Investigation Report

that although he still had bad days they were only once a week or so. Mr. Z had always had bad dreams, but now they were explicitly about his childhood abuse. He believed that he could replace bad thoughts with good ones and change his mood from bad to good in a few hours. Mr. Z still had suicidal thoughts, but the thought of the consequences stopped him from acting them out. He reported that he had not had an argument with his flatmate for several months. Mr. Z was happy to end counselling and he was discharged from the service.⁶⁴

26 June 2007. Consultant Psychiatrist 2 reviewed Mr. Z in the Outpatient Clinic. His diagnosis and medication remained the same. Mr. Z reported improvement in his ideas of reference both in frequency and intensity. However he reported that his mood had become worse over the past few weeks. He was having nightmares and flashbacks. He had felt suicidal and had thoughts of slashing his wrists or taking an overdose. It was noted that Mr. Z had made suicide attempts in the past. Mr. Z's agoraphobic symptoms persisted. The care plan was to add a small SSRI (antidepressant) to the Mirtazapine to help with residual Post-Traumatic Stress Disorder symptoms. A referral to Psychotherapy Services was discussed and Mr. Z was amenable to this.⁶⁵

3 July 2007. Consultant Psychiatrist 2 wrote to a Consultant Clinical Psychologist (Clinical Psychologist 1) to refer Mr. Z to the service. Mr. Z was referred for an expert opinion and advice.⁶⁶

9 July 2007. Clinical Psychologist 1 wrote to Mr. Z explaining that he had been referred for psychological treatment. Mr. Z was asked to confirm that he wanted to be seen.⁶⁷

16 August 2007. Mr. Z was written to by the Screening Clinic. The letter explained the reasons for the screening process. An appointment was set for the 31 October 2007.⁶⁸

19 August 2007. Mr. Z was admitted into the Pennine Acute Hospital with hematemesis. The diagnosis was "*?Upper GI bleed. Alcohol withdrawal*". He was in hospital until the 23 August.⁶⁹

64. NM Notes P.45

65. NM Notes PP.42-43

66. NM Notes P.4

67. North Psychology Notes P.22

68. North Psychology Notes PP.20-21

25 September 2007. Mr. Z was due to be followed-up in Outpatients by Consultant Psychiatrist 2 but cancelled the appointment. The Consultant wrote to the GP to notify him of this. The appointment was rescheduled.⁷⁰

27 September 2007: 15.15 hours. A Psychiatric Nurse conducted a two-hour long assessment on Mr. Z on a medical ward at North Manchester General Hospital. A full mental state examination was developed on the “*CHORES form*”. Mr. Z was described as being a 37-year old man who had taken an impulsive overdose of mixed medication and a bottle of whiskey in reaction to feelings of stress when acting as a confidante to his neighbour which triggered long-standing issues regarding his own history of abuse. Mr. Z took the overdose to relieve his feelings of stress. He called a friend stating what he had done immediately.

Mr. Z expressed feelings of hope and said that he wanted to access help to address his psychological difficulties stemming from his childhood abuse. He expressed a one-week history of anxiety and low mood. His risk of suicide was considered to be low. His current self harm was considered to be low, but moderate in the long term due to his history of using self harm as a coping mechanism since the age of 16. There were no indicators of psychotic phenomena. Mr. Z was not abusing illegal substances or alcohol at this time although it was noted he had in the past. The nurse telephoned the CMHT Psychiatrist to inform him of Mr. Z’s behaviour. Mr. Z was currently waiting for a Clinical Psychology appointment. A letter was written to his GP and liaison was made with the “*team in crisis*”. The Consultant was informed.⁷¹

31 October 2007. A ‘Screening Clinic Assessment Pro-forma’ was completed by Psychotherapy Services (no signature on form). It was stated that he had been “*sent*” by the Psychiatrist. Mr. Z was not sleeping and was having vivid nightmares from which he would take a day to recover. When experiencing nightmares Mr. Z’s mood would go “*right down*”. It was recorded that Mr. Z had taken an overdose four months previously. It was also recorded that Mr. Z was paranoid about strangers as he believed that they could tell he had been abused. It was noted that he lived with a friend and was currently “*on sick*”. It was recorded that he had attended Accident and Emergency after self harming due to traumatic

69. GP Record. P.255

70. AMIGOS Notes. PP.2-3

71. AMIGOS Notes. P.2 NM Notes P.108

memories. Mr. Z was to be referred for “CAT” (Cognitive Analytic Therapy) at the McCartney Centre.⁷²

1 November 2007. The Principal Cognitive Behaviour Psychotherapist wrote to Consultant Psychiatrist 2. She had seen Mr. Z at the screening Clinic on the 31 October 2007 and described him as a “*very troubled gentleman*”. Mr. Z had described symptoms associated with Post-Traumatic Stress Syndrome. Mr. Z had said that he was extremely depressed and had difficulties sleeping due to nightmares and flashbacks about his abuse as a child. Mr. Z said that in the past he had dealt with his resulting feelings of anxiety by drinking alcohol and taking illicit drugs, however this was a past behaviour and he was now ready to begin psychological intervention for these problems.

It was thought that Mr. Z should receive Cognitive Analytical Therapy (CAT). A referral had been sent to McCartney House to expedite the treatment. The Principal Cognitive Behaviour Psychotherapist was happy to meet with Mr. Z again once his treatment had been completed. To this effect she wrote to Mr. Z to say that she had referred his case on to McCartney House.

The Principal Cognitive Behaviour Psychotherapist wrote to a Consultant Psychotherapist to ask for an assessment for Mr. Z. She referred to Mr. Z as “*a troubled gentleman.*” She wrote that she had seen him on the 31 October 2007 and that Mr. Z had presented with symptoms associated with Post-Traumatic Stress Disorder. He had told her that he had difficulties sleeping with vivid nightmares and was experiencing flashbacks during the day. It had been suggested that he would benefit from Cognitive Analytic Therapy (CAT). Because there was a risk for Mr. Z regarding suicide she requested an early appointment.

13 November 2007. Consultant Psychiatrist 2 wrote to the GP to say that Mr. Z had been seen at Outpatients on the 13 November. The diagnosis was recurrent “*depressive disorder with obsessive traits Psychosis NOS alcohol abuse in the past*”. The medication was listed as being:

“Tab Sodium Valproate 88mg nocte

Tab Mirtazapine 45mg nocte

Tab Escitalopram 5mg mane

72. North Psychotherapy Notes PP.146-149

Tab Risperidone 2mg nocte"

Mr. Z had reported overdoses with painkillers in September 2007, coupled with alcohol and precipitated by the worsening of his "PTSA" symptoms. He had subsequently improved and reported that he now felt better; consequently he had been referred to Psychological Services. He currently reported no persistent mood features. The Post-Traumatic Stress Disorder had persisted with ideas of reference and persecution; however these feelings were only prominent in crowded places. Mr. Z denied any ideas of self harm or suicide. Mr. Z had been referred to McCartney House for Cognitive Behaviour Therapy and was looking forward to it. The GP was asked to raise the Risperidone to 3mg *nocte* (at night). The plan was to review Mr. Z again in three-months time.⁷³

31 January 2008. Mr. Z met with the Consultant Psychotherapist. Mr. Z repeated his history of abuse. He was still experiencing nightmares and flashbacks. Mr. Z was staying in bed until midday watching television. He was not exercising. He had found counselling helpful as it had been good to talk and not be judged. It was noted that he had taken an overdose in September 2007 which had resulted in three days in hospital. It was also noted that Mr. Z usually did not drink, but that this had precipitated his overdose. Mr. Z said that he had only had two or three rows with his ex-partner in seven years and was good friends with his ex-partner's two sisters. He mentioned that he had stabbed a friend ten years ago.

The psychotherapy assessment notes recorded that Mr. Z had been referred for CAT. Mr. Z had been referred to a psychologist between the ages of six and seven after writing a story of burning his sister alive because she was a witch. It was noted that he had received counselling from a Counsellor within the service in 2006.

It was recorded that Mr. Z had experienced abuse between the ages of six and 16 perpetrated by a family member. He said that he had always felt angry and helpless as a child. Mr. Z had a history of moving from city to city until four years previously when he moved to Manchester with his then partner. He continued to live in a flat with his ex partner. He felt safe in his flat but this meant he lived a very restricted life.⁷⁴

73. AMIGOS Notes. PP.4-5

74. North Psychotherapy Notes PP.175-178

11 February 2008. Mr. Z cancelled his appointment with the Consultant Psychotherapist because of a broken boiler.⁷⁵

19 February 2008. Mr. Z did not attend his Outpatient appointment with Consultant Psychiatrist 2. The next follow up was planned for three-months time. Mr. Z did however attend his appointment with the Consultant Psychotherapist. Mr. Z said that he had been “*drained*” following the previous session. He said that this had also occurred after counselling, but that this was harder. Mr. Z said that he had not been drinking for four years except for the time leading up to his recent overdose. Mr. Z described spending a lot of time in his bed. His mood seemed to vary and he wanted to be able to understand himself better. Mr. Z also went back into his history of abuse and poor family relationships. He said that he had always been angry when young but had “*kept it in*”. He described himself as having acquaintances but not friends and that he did not feel safe outside of his flat.⁷⁶

4 March 2008. A risk assessment was partially completed by the Consultant Psychotherapist (documentation incomplete). It was noted that Mr. Z had been convicted of violence in the past and that he had experienced suicidal ideation and had conducted acts of self harm in the past. Most of the form was left blank.

The risk assessment included the information that he had cut his arms some ten years ago for which he was admitted to a psychiatric unit for three-four months. His medication was listed. It was also mentioned that he had stabbed someone repeatedly some ten years ago for which he received a three-month hospital admission. Mr. Z said he could not remember what he did, but that there had been no violence since then. It was noted that he used to drink heavily, but did not do so now. No formulation was made regarding his risk to others.⁷⁷

13 March 2008. The Consultant Psychotherapist wrote to the Principal Cognitive Behaviour Therapist and copied Consultant Psychiatrist 2 and the GP into the correspondence. She had met with Mr. Z for two assessments. It was noted that Mr. Z was seeking therapy to understand himself better, to stabilise his moods, and to reduce his symptoms of anxiety and intrusive imagery associated with Post-Traumatic Stress Disorder.

75. North Psychotherapy Notes P.179

76. NM Notes P.48 and North Psychotherapy Notes PP.179-182

77. North Psychotherapy Notes PP.73-74 and 87

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It was also noted that Mr. Z had strong feelings of hurt and anger due to his abuse as a child and of his reports of this abuse being ignored. He had flashbacks and nightmares. Mr. Z also withdrew from others to the safety of his own home. It appeared that Mr. Z's symptoms had grown worse over recent years. He felt this was triggered by talking to his mother four years ago which had led to family conflict and recrimination. He found medication useful in controlling his mood swings. Facing his feelings was painful for Mr. Z; however he had found counselling useful. Consequently Mr. Z was placed on the waiting list for Cognitive Analytic Therapy (CAT).⁷⁸

24 March 2008. Mr. Z was assessed on a medical ward at North Manchester General Hospital by a Specialist Nurse Practitioner. Mr. Z had been admitted the previous day following an overdose of Tramadol tablets. Mr. Z could not really explain his actions. He had felt low the previous day and decided to get drunk. Whilst intoxicated he had impulsive thoughts about taking an overdose.

Mr. Z thought that a friend had called the ambulance. Mr. Z regretted his actions and said he had no further thoughts of self harm. There was no evidence of mental illness; however psychological difficulties were noted for which he was said to be receiving treatment. There was no plan for further psychiatric intervention or follow up resulting from this incident. The GP was written to. A Mental State Examination and assessment were entered in the general case notes.⁷⁹

20 April 2008. Prior to CAT commencing a screening process took place. The person conducting the screen attempted to contact Consultant Psychiatrist 2 but was unsuccessful. She had read in the clinical record that Mr. Z had previously stabbed a person and wanted further information.⁸⁰

1 May 2008. The person conducting the screen tried to contact Consultant Psychiatrist 2 again. She left a message and recorded that no one returned her call. She discussed Mr. Z with the Adult Psychotherapist who recalled that Mr. Z had mentioned a previous stabbing incident. However she had felt safe when in the counselling room with him and recalled that

78. NM Notes PP.51-52

79. AMIGOS Notes. PP.5-6

80. North Psychotherapy Notes P.183

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he had required coping skills, nothing more. Consequently the subject was dropped and Mr. Z was referred for CAT.⁸¹

7 May 2008. Following his referral for CAT Mr. Z met with Clinical Psychologist 2. The meeting lasted for 50 minutes during which time they discussed confidentiality and risk, particularly regarding his previous overdose. The aims of the CAT therapy were that he would have a better understanding of himself and to reduce the impact of the past upon his present. At this time he discussed experiencing flashbacks and nightmares. He wanted to be able to make friends and engage in a meaningful activity, e.g. work. It was recorded that he lived with his ex partner and that he saw Consultant Psychiatrist 2 every three months. He appeared motivated to start therapy.⁸²

14 May 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z had experienced a good week. The session focused on Mr. Z talking about his childhood.⁸³

21 May 2008. Clinical Psychologist 2 recorded that Mr. Z was thinking about his grandmother and that he had written to an aunt requesting a photograph which she duly sent to him.⁸⁴

25 May 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z had completed the Psychotherapy File documentation.⁸⁵

4 June 2008. It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z was able to talk about his past abuse.⁸⁶

10 June 2008. Consultant Psychiatrist 2 saw Mr. Z in the Outpatient Clinic. The diagnosis remained largely unaltered; however Post-Traumatic Stress Disorder was added. Mr. Z's medication was:

“Tab Sodium Valproate 800mg nocte

81. North Psychotherapy Notes P.183

82. North Psychotherapy Notes PP.70-71

83. North Psychotherapy Notes PP.61-63

84. North Psychotherapy Notes P.60

85. North Psychotherapy Notes PP.40-50

86. North Psychotherapy Notes PP.57-59

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Tab Mirtazapine 45mg nocte

Tab Escitalopram 5mg mane

Tab Risperidone 3mg nocte”

Mr. Z informed his Consultant that he had been admitted with an overdose in March. He stated it had been an impulsive act. Mr. Z had been overwhelmed with flashbacks about his former abuse. However Mr. Z had changed his mind about killing himself and called an ambulance. Mr. Z thought people could read his thoughts but denied any further thoughts of wanting to commit suicide. He was under the care of Psychotherapy Services and had only had three sessions so far. The care plan was:

- to increase the Risperidone to 4mg at night;
- to increase the Escitalopram to 10mg in the morning;
- to decrease the Mirtazapine to 30mg after a week of Escitalopram;
- to take Mr. Z's blood for Valproate levels;
- to review Mr. Z in Outpatients in two-months time.⁸⁷

11 June 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z was experiencing flashbacks which were overwhelming. In the past he had gone cottaging in order to meet people and had also experienced violence when drinking which had resulted in a broken nose and cheek bones (it is not clear whether the violence was to Mr. Z or perpetrated by him). There were issues regarding separating violence from sex. Mr. Z stated that there had never been violence between him and his ex partner, Mr. Y with whom he was currently living.⁸⁸

17 June 2008. Mr. Z telephoned to cancel his appointment with Clinical Psychologist 2 due to feeling unwell.⁸⁹

25 June 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z was “*feeling good today*”.⁹⁰

87. NM Notes PP.53-54

88. North Psychotherapy Notes PP.54-56

89. North Psychotherapy Notes P.51

90. North Psychotherapy Notes P.38

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28 June 2008. Clinical Psychologist 2 wrote to Mr. Z as part of his therapy. The letter detailed Mr. Z's history and what he had hoped to achieved from his psychotherapy sessions. The letter also set out what Mr. Z could do to cope better.⁹¹

2 July 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z had experienced nightmares for three nights.⁹²

9 July 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z was angry and sad.⁹³

16 July 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z was sleeping better but still experiencing flashbacks.⁹⁴

23 July 2008. It was recorded in the psychotherapy session with Clinical Psychologist 2 that Mr. Z said he had "*nearly committed suicide*" the previous Thursday. He felt he had "*Had enough*" and described an overwhelming sadness which he wanted to stop.⁹⁵

6 August 2008. Mr. Z was described in his psychotherapy session as being "*still not well*". However he was noted to be sleeping well, his flashbacks were decreasing and his mood was "*pretty good*".⁹⁶

19 August 2008. Mr. Z cancelled his psychotherapy session because he had a hospital appointment.⁹⁷

27 August 2008. Mr. Z cancelled his psychotherapy appointment because he had not been well. He stated he was not cancelling because of any issues he had with the sessions.⁹⁸

7 October 2008. Mr. Z attended the Outpatient Clinic. In the letter written to the GP following this event Consultant Psychiatrist 2 wrote that the diagnosis was "*recurrent*

91. North Psychotherapy Notes PP.35-37

92. North Psychotherapy Notes P.39

93. North Psychotherapy Notes P.34

94. North Psychotherapy Notes P.32

95. North Psychotherapy Notes P.29

96. North Psychotherapy Notes P.28

97. North Psychotherapy Notes P. 26

98. North Psychotherapy Notes P. 25

Mr. Z Investigation Report

*depressive disorder with obsessive traits and possible psychosis NOS. Alcohol abuse in the past. Post-Traumatic Stress Disorder”.*⁹⁹

The medication was listed as being:

“Risperidone 4mg nocte

Escitalopram 10 mg mane

Mirtazapine 30mg nocte

Sodium Valproate 800mg nocte”

Mr. Z had reported flashbacks and nightmares along with poor sleep. This occurred every two or three days and were primarily about being abused. However Mr. Z did say that his anxiety had lessened following cognitive therapy. Mr. Z reported improvement in psychotic phenomena; ideas of reference remained but his conviction was decreased. He still said that people could read his mind but that these beliefs were less intense; it was thought that his insight was increasing. However he was still finding it difficult to apply the strategies for managing his flashbacks. Mr. Z reported that his mood was more or less stable most of the time. His self care remained poor. Mr. Z still had occasional thoughts of suicide but had no intent.

The risk assessment stated that Mr. Z was reported to have shown an improvement in his symptomology. The risk of self harm remained but it was low. Although Mr. Z *“reported abstinence”* his gamma-glytanyl transpeptidase (GGT) had been elevated. It was also noted that his serum Valproate levels were low, less than the therapeutic range. The plan was to ask the GP to raise the Escitalopram to 15mg *mane* (in the morning) and to decrease the Mirtazapine to 15mg *nocte* (at night). The Sodium Valproate was to be increased to 1000mg *nocte*. The Risperidone was to remain the same. Mr. Z was to be reviewed again in three-months time.

Hand-written medical notes recorded that the flashbacks lasted between two and three minutes and would leave Mr. Z scared and frightened for a couple of hours. Mr. Z stated that he felt guilt about not staying in contact with his family. It was noted that there was an

99. AMIGOS Notes. PP.7-8 and NM Notes PP.55-56

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improvement in psychotic symptoms although Mr. Z retained the belief that people could read his mind. Mr. Z was still experiencing some suicidal ideation.¹⁰⁰

22 October 2008. A ‘Clinical Outcomes in Routine Evaluation’ outcome measure was completed. There were no present indications of violence or self harm. The CORE outcome measures indicated an improvement since January 2008.¹⁰¹

29 October 2008. Mr. Z attended an appointment with Clinical Psychologist 2.¹⁰²

4 November 2008. A status update recorded that Mr. Z was not on CPA but was receiving care.¹⁰³

13 January 2009. Mr. Z had flu and could not attend his psychology appointment with Clinical Psychologist 2.¹⁰⁴

11 February 2009. A follow-up session with Clinical Psychologist 2 took place. It was recorded that things were “*pretty much the same*”. Mr. Z was still experiencing flashbacks and was not sleeping. He was going to visit his GP for this.¹⁰⁵

12 May 2009. Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained unaltered. It was decided to increase the Escitalopram to 20mg once daily and to reduce the Mirtazapine to 7.5mg *nocte*. Mr. Z reported that he was stable overall; however he still experienced some periods of low mood. His flashbacks persisted and had become more frequent, some 4 to 5 times each day. These flashbacks only lasted a minute or so. Mr. Z’s psychotherapy at McCartney House had been completed in January. He found it difficult on occasion to apply the coping strategies. He was still living with his ex partner. Mr. Z was reported to have ideas of persecution, his self care was “*erratic*” and he remained socially isolated. It was noted that he had gained 2.5 stones in weight. The plan was to review

100. NM Notes P. 79

101. North Psychotherapy Notes PP.6-7

102. North Psychotherapy Notes P.12

103. AMIGOS Notes. P.8

104. North Psychotherapy Notes P. 8

105. North Psychotherapy Notes PP.9-10

Mr. Z Investigation Report

him in three-months time. The GP was written to. Mr. Z was given Zopiclone 7.5mg for two weeks to help him sleep.¹⁰⁶

17 August 2009. Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis and medication remained unaltered. Mr. Z reported that his mood was “*maintaining well*” and he was not drinking alcohol. There was an improvement in the ideas of reference that he experienced. He was still having nightmares about what had happened in the past “*suggestive of first residual symptoms of Post-Traumatic stress disorder*”. Otherwise Mr. Z’s social activities had increased and he denied depressive symptoms. His personal hygiene was still noted to be poor as he only took a bath every few weeks. On mental state examination his affect was euthymic and ideas of reference were reported. His insight was preserved and he was compliant with his medication. The plan was to continue with the same treatment and to increase the Risperidone if the ideas of reference persisted. Mr. Z was to be reviewed again in three-months time.¹⁰⁷

23 September 2009. Clinical Psychologist 2 wrote to Consultant Psychiatrist 2. Mr. Z had been offered 16 sessions of Cognitive Analytic Therapy between June 2008 and December 2008. He had been seen for follow up earlier in 2009. Mr. Z had engaged well, however he had cancelled a number of appointments due to poor physical health. He acknowledged that at times he was overwhelmed by the sessions. Mr. Z’s flashbacks were reduced but did not disappear. He was able to use the methods of distraction that he was learning. He had now been discharged from the service.¹⁰⁸

4 December 2009. Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained unaltered; however it was decided to stop the Mirtazapine. Mr. Z reported that he had been doing well since the last follow up. He still found it difficult to sleep and was still experiencing flashbacks, but was coping with this better. The medication was listed as being:

Escitalopram 20mg in the morning;

Mirtazapine 7.5mg at night;

Sodium Valproate 1000mg at night.

106. AMIGOS Notes. PP.8-10 and NM Notes PP.57-58

107. AMIGOS Notes. PP.10-11 and NM Notes PP.59-60

108. NM Notes PP.61-62

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When Mr. Z went out on his own he still experienced ideas of reference, but he had insight into this. He was not drinking alcohol. Mr. Z was active and was enjoying gardening. He was living with his ex-partner who was now his friend. His self care remained poor. The mental state examination recorded that his mood was euthymic, speech relevant and coherent with no formal thought disorder. There were no ideas of reference or persecution noted in general. No significant risks were identified. The care plan was to cease the Mirtazapine. Follow up was arranged for four-months time.¹⁰⁹

10 June 2010. Mr. Z was reviewed in the Accident and Emergency Department by a Locum Senior House Officer on call. The previous day Mr. Z had taken an overdose. Mr. Z had experienced a good day, but suddenly had thoughts of taking an overdose. He denied any further thoughts of self harm or suicide or of wanting to harm others. It was noted that Mr. Z saw Consultant Psychiatrist 2 as an outpatient. The mental state examination reported that Mr. Z had paranoid ideation but also had good insight. It was thought that Mr. Z presented a low risk of both self harm and harm to others. Mr. Z was discharged home and advised to keep his appointment with Consultant Psychiatrist 2 on the 28 June 2010. Mr. Z was advised to attend Accident and Emergency in the future when in a state of crisis.¹¹⁰

28 June 2010. Mr. Z cancelled his appointment with Consultant Psychiatrist 2. The Psychiatrist wrote to the GP to inform him of this and that Mr. Z had been booked into the next available clinic.¹¹¹

26 October 2010. Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained the same. The changes to the medication were to increase the Risperidone to 5mg *nocte*, and to prescribe Zopiclone 7.5mg at night for a couple of weeks. Procyldine was also to be given PRN (as required) if needed.

It was noted that Mr. Z was not on CPA. Mr. Z had reported feeling “*up and down*” since the last follow up. Since June his flashbacks had increased to some three or four times a day. He also thought people could read his mind and reported persecutory ideas. The mental state examination noted that Mr. Z was well dressed and well kempt. He had good eye contact and

109. AMIGOS Notes, PP.11-13 and NM Notes PP.63-64 and NM Notes P.107 and 109

110. AMIGOS Notes, PP.13-15 and NM Notes P.67

111. AMIGOS Notes, PP.15-16

a rapport was established easily. The plan was to refer Mr. Z to the Cognitive Therapy Team for booster sessions with regards to his PTSD.

The Consultant was informed by Mr. Z that he went to the Accident and Emergency Department in June after an increase in flashbacks and suicidality.¹¹²

19 November 2010. Consultant Psychiatrist 2 referred Mr. Z back to the Counsellor. It was explained that Mr. Z had an exacerbation of his PTSD symptomology following a seemingly innocuous remark made by a person at a pub in June about Mr. Z's family. It was also explained that Mr. Z had been using the strategies formally taught but that he could benefit from some booster sessions. The referral was for both advice and opinion.¹¹³

22 November 2010. It was reported that Mr. Z had been arrested the preceding evening on suspicion of the murder of the person with whom he lived. The Police had been called after Mr. Z had told a neighbour that he had stabbed and killed his ex-partner. Mr. Z had reported hearing voices before the act. A Police Surgeon asked Consultant Psychiatrist 2 if an assessment would be required (under the Mental Health Act). He was told that it would. A duty Approved Mental Health Professional received a call from the Police Surgeon requesting a Mental Health Act assessment. Mr. Z had been in Police custody since the preceding day. A discussion took place with Consultant Psychiatrist 2 regarding the referral of Mr. Z to Edenfield for forensic support. Mr. Z was described as calm and relaxed in manner. The Forensic Psychiatrist from Edenfield made the assessment with Consultant Psychiatrist 2 and it was thought that Mr. Z was fit to be interviewed.¹¹⁴

112. AMIGOS Notes, PP.16-18 and NM Notes PP.65-66

113. AMIGOS Notes, PP.18-19 and NM Notes P.69

114. AMIGOS Notes, PP.19-21

11. Timeline and Identification of the Thematic Issues

Root Cause Analysis (RCA) Second Stage

11.1. Timeline

The Independent Investigation Team formulated a timeline and a chronology in a narrative format in order to chart significant data and identify thematic issues and their relationships with each other. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

11.2. Thematic Issues Arising from the Timeline

On examining the timeline, care pathway and chronology the Independent Investigation Team identified 13 thematic issues that rose directly from analysing the care and treatment that Mr. Z received from the Manchester Mental Health and Social Care NHS Trust. These thematic issues are set out below.

1. Diagnosis. Mr. Z's principle diagnosis was that of depression. He was also identified as having Post-Traumatic Stress Disorder (PTSD) symptoms. During the period of time in which Mr. Z received care and treatment from Manchester mental health services it was also noted that he had anger control problems, obsessive traits, a history of alcohol misuse and self-reported psychotic symptoms. The diagnoses made were reasonable based upon the evidence available. However further diagnostic formulation was indicated with particular reference to:

- the presence of alcohol abuse and the potential influence this would have regarding prognosis, recovery and risk management;
- the presence of a psychosis and the potential influence that this would have regarding risk and Mr. Z's long-term care and treatment management strategy;
- the impact alcohol and psychosis may have had on Post-Traumatic Disorder symptoms and any consequent behaviour.

2. Medication and Treatment. The Independent Investigation Team found that the medication Mr. Z was prescribed was in keeping with his diagnoses and within recommended therapeutic ranges. Four issues were found in relation to the psychological

therapy that Mr. Z received. First: Mr. Z received Cognitive Analytic Therapy as opposed to trauma-based Cognitive Behaviour Therapy as indicated by the National Institute of Health and Clinical Excellence (NICE) best practice guidelines for people with Post-Traumatic Stress Disorder (PTSD). Second: Mr. Z presented with several high risk factors that should have been taken into consideration prior to and during therapy taking place. This did not occur. Third: significant risk information was accessed during therapy sessions which was not appropriately disclosed. Fourth: psychological therapy professionals may not have accessed sufficient specialist training in the management of either abuse or Post-Traumatic Stress Disorder. Whilst these four issues were identified it was recognised by the Independent Investigation Team that Mr. Z appeared to benefit from therapy and that no causal link could be made in relation to the medication and therapy regimen that Mr. Z received and the killing of Mr. Y. However it was recognised that the management of Mr. Z during therapy did not address the relationship between risk, PTSD and therapeutic intervention sufficiently to ensure that a clinically effective and safe approach was taken.

- 3. Mental Health Act (1983 and 2007).** The Independent Investigation found no issues relating to the implementation of the Mental Health Act and the care and treatment Mr. Z received.

- 4. Care Programme Approach (CPA).** Mr. Z was not in receipt of the Care Programme Approach and consequently he did not have access to robust Care Coordination. At the point of his referral to Manchester mental health services in June 2005 he met the criteria for referral to the Community Mental Health Team and for ‘Enhanced’ CPA. Mr. Z had a complex presentation and the decision to place him in an Outpatient context on ‘Standard’ CPA meant that his Care Coordinator was in effect his Consultant Psychiatrist. The Independent Investigation Team concluded that it is difficult for a Consultant Psychiatrist to successfully accomplish the role of Care Coordinator as it requires a time commitment not readily achievable by this kind of clinician. Mr. Z required a consistent level of Care Coordination in order to ensure that risk assessment, care planning and inter-professional communication and liaison took place in a manner commensurate to his needs. Without Care Coordination significant information about Mr. Z was not shared between members of his disparate treating team and long-term care and treatment

planning remained reactive rather than proactive to the ultimate detriment of his continued wellbeing.

5. Risk Assessment. Mr. Z did not receive a consistent approach to clinical risk assessment. The Independent Investigation Team could find only one fully completed risk assessment form and one risk management plan, both developed at the point of Mr. Z's first contact with the Trust. Mr. Z had a history of suicide and self-harm events. He also had a conviction for stabbing a former partner which had resulted in serious injury. Mr. Z had a history of significant alcohol abuse and depression. Between 2005 and 2010 he was also diagnosed as having a psychotic condition and Post-Traumatic Stress Disorder for which he received treatment. It was known that Mr. Z acted impulsively, especially when drinking, and had significant anger control problems. It was also frequently recorded in the clinical record that Mr. Z was unkempt and malodorous implying that he was neglecting himself. However it was not thought that Mr. Z had a severe or enduring mental illness and this appeared to minimise the perception of the risk that he presented with.

Over the five-year period that Mr. Z received his care and treatment the Trust improved both its risk assessment and record keeping processes. It was evident that in June 2005 the Trust did not use the CHORES risk assessment tool comprehensively and that the use of an electronic record was embryonic. As improvements were made to Trust systems over time, Mr. Z's case, which predated some of the new assessment processes, did not receive a retrospective review of his risk in keeping with the new processes. This situation was exacerbated by Mr. Z receiving the management of his case from the Outpatient Clinic which operated within a traditional model and did not lend itself to detailed holistic assessment, monitoring and review.

All of the individuals who were involved with Mr. Z's care understood certain aspects of his risk profile. However no single person understood all of the risks at the times when they emerged. This meant that Mr. Z was not understood in the context of his full risk profile in a consistent and timely manner.

- 6. Referral, Discharge and Handover Processes.** At the point Mr. Z first entered mental health services in July 2005 referral decisions were made, in the face of the evidence, to divert him to an Outpatient Clinic instead of to the CMHT. This decision precluded his access to ‘Enhanced’ CPA or its equivalent under the new guidance. This decision prevented an in-depth and holistic assessment being undertaken at his point of entry to the service. Over the course of the next five years Mr. Z was provided with therapy and Outpatient assessments and monitoring, but it is evident from reading through his case notes that there were large gaps of time when during crisis, and following periods of crisis, no review of his case was undertaken and no additional support provided.

In 2009 Consultant Psychiatrist 2 considered referring Mr. Z to a CMHT in order for him to receive more structured support. However in the end this avenue was not pursued. This was a missed opportunity which would have ensured Mr. Z’s home situation was understood better and a more robust support network put into place.

- 7. Carer Communication and Involvement.** Mr. Z had a supportive, but turbulent, relationship with Mr. Y with whom he shared a flat. Both Mr. Z and Mr. Y had a range of physical and mental health problems which prevented them living their lives to the full. This caused an increase of tension between the two men on an ongoing basis. At times each was required to be the carer for the other. This dynamic was not understood by secondary care mental health services.

The Independent Investigation Team concluded that Mr. Y should have been informed at the point Mr. Z’s first contact with services about the thoughts of violence that he harboured against him. At the point of this initial contact a more in-depth assessment of Mr. Z was indicated prior to the decision to place him on ‘Standard’ or NonCPA. This was not achieved and consequently the relationship between the men and their significant health needs were not understood; this was to the ultimate detriment of their long-term wellbeing.

- 8. Service User Involvement in Care Planning and Treatment.** Mr. Z was involved in an entirely appropriate manner regarding the treatment programme that he was offered. The Independent Investigation Team found evidence of sensitive and person-centered practice. However Mr. Z was not understood well in the full context of either his past

psychiatric history or current health and social care problems. It was evident that Mr. Z denied key behaviours and at times gave incorrect and misleading information to members of his treating team. Mr. Z's self-reported history was neither challenged nor corroborated. The Independent Investigation Team concluded that this was due to the fact that Mr. Z was never in receipt of full and comprehensive assessment at the point of entry into the service and that this omission was never corrected over the ensuing five years. Had the disparate members of the treating team been in possession of a more robust and accurate assessment then the approach to Mr. Z's care and treatment plan may well have been managed differently.

9. Documentation and Professional Communication. Documentation was of a generally good standard although the AMIGOS Trust electronic system was used in a variable manner. The effectiveness of professional communication was compromised by disparate members of the treating team placing an over reliance upon Mr. Z's own accounts of his psychiatric history and crisis events. The ongoing and timely communication of clinical information between health care professionals did not flow and this meant that risk information was not always shared, and Mr. Z's continued alcohol consumption was not understood. The decision was made to divert Mr. Z's case from the Community Mental Health Team in July 2005 to the Outpatient Clinic prior to a full assessment having been undertaken. As a consequence important and relevant information about Mr. Z was never collected, corroborated or examined in depth.

10. Adherence to Local and National Policy and Procedure. The care and treatment that Mr. Z received fell broadly into local and national best practice guidance. However there were some inconsistencies in regard to the adherence to NICE guidelines and local risk management and record keeping policies.

11. Clinical Management of the Case. The care and treatment that Mr. Z received had many positive aspects. He had an established therapeutic relationship with Consultant Psychiatrist 2 and access to psychological therapy which was of benefit to him. Whilst every effort was made to address Mr. Z's clinical needs it would appear that he was not truly understood in the context of his social and emotional needs, which were considerable. Mr. Z's social, emotional and clinical needs impacted one upon the other

and it was evident when examining his case that a more holistic approach was indicated in order to effect a break in a somewhat vicious cycle of circumstance.

12. Clinical Governance and Performance. During the latter years that Mr. Z received his care and treatment from the Mental Health Trust many problems were apparent with regard to both governance and performance. The Trust struggled to manage its activity, finances and service quality. There had been a lack of sustained leadership which had subsequently resulted in the formulation of limited strategic direction. This had led to poor relationships with strategic partners and with staff. This provided a backdrop against which difficulties within services could not be challenged and non-adherence to Trust policy and procedure could neither be detected nor managed.

In recent years the Trust has modernised both its governance and assurance processes. The Independent Investigation Team was given a substantial amount of evidence to validate the fact that this transformation work has been implemented successfully.

13. Care and Treatment of Mr. Y. Mr. Y is documented as having three separate episodes of mental illness. The first took place when Mr. Y was a teenager between 1975 and 1977. The second took place in 1996 for which he saw a Community Psychiatric Nurse for a limited period of time. The third took place following Mr. Y's move to Manchester in 2004 and continued until the time of his death in 2010.

Whilst living in Manchester Mr. Y received care and treatment from primary care services for diabetes, hypertension and mild to moderate depression. A GP referral was made for a secondary care mental health assessment in July 2006 however following assessment it was not thought that Mr. Y's mental health problems were of either the severity or complexity to require input from a Community Mental Health Team. Consequently a referral was made for Mr. Y to be seen by the primary care team. Whilst it is not certain what happened to this referral it is documented within the GP record that Mr. Y continued to report stress but that his depressive symptoms were abated. It would appear that Mr. Y suffered from a mild to moderate depressive illness for which he was treated with antidepressant medication. It was the conclusion of the Independent Investigation Team that Mr. Y could not be considered a vulnerable adult by virtue of any

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illness, either physical or psychiatric, and that neither these conditions, nor the manner in which they were treated, could be identified as making a contribution to death.

However the Independent investigation Team did conclude that Mr. Y and Mr. Z both had health and social care problems which created an increased tension between them. The dynamic and mutual co-dependence between the two men was understood poorly and this was to the ultimate detriment of the wellbeing of them both. A more holistic approach could have identified support and practical assistance to Mr. Z and Mr. Y.

12. Further Exploration and Identification of Contributory Factors and Service Issues

In its simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the ‘five whys’ could look like this:

- Serious incident reported = serious injury to limb
- Immediate cause = wrong limb operated upon (ask why?)
- Wrong limb marked (ask why?)
- Notes had an error in them (ask why?)
- Clinical notes were temporary and incomplete (ask why?)
- Original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for Clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. Z it would look like this:

- Mr. Z killed Mr. Y (ask why?)
- Mr. Z and Mr. Y had an argument during which Mr. Z lost his temper and became violent stabbing his friend multiple times with a knife = root cause

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. Y. In order for causality to be attributed to a service it has to be shown that the service had either complete control, or a high degree of control, over the outcome of the events in question.

The purpose of using root cause analysis is to seek out lessons that can be learned from the examination of a single case to try to establish how incidents of this kind can be prevented from occurring in the future. No Investigation Team should endeavour beyond a sensible limit to make connections where they cannot reasonably be made.

This Investigation has developed a detailed narrative which chronicles the events that occurred during Mr. Z’s time with Manchester-based services. It has assessed whether services worked in accordance with extant national and local best practice guidance and detailed where interventions could have been improved.

RCA Third Stage

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

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

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

Contributory factors can either be identified as either being ‘influencing’ or ‘causal’.

Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them. The term ‘causal factor’ is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage Mr. Z effectively and that this as a consequence impacted directly upon the death of Mr. Y.

Influencing Factors. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. Z’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a mental health service and the act of homicide perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr. Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1. Manchester Mental Health and Social Care NHS Trust Findings

The findings set out under this subsection analyse the care and treatment given to Mr. Z by the Manchester Mental Health and Social Care NHS Trust between the 21 June 2005 and the 21 November 2010.

Subsections 12.1.1. and 12.1.2. address diagnostic, medication and treatment issues. These are key headings from the Terms of Reference and are addressed first in order to provide a context for the rest of the findings. Subsections 12.1.3. – 12.1.12. address all other Terms of Reference issues. Subsection 12.2. examines the care and treatment of Mr. Y who was the victim of Mr. Z.

12.1.1. Diagnosis

12.1.1.1. Context

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

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

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues. Diagnosis should be part of a formulation of the client's problems which draws together information from all the sources, defines the client's needs and develops an appropriate plan of intervention.

Throughout most of the time Mr. Z received care and treatment from Manchester mental health services he had a consistent diagnosis of depressive disorder with obsessive traits combined with Post-Traumatic Stress Disorder (PTSD). The International Classification of Mental and Behavioural Disorders (ICD-10) World Health Organisation 1992 Post-Traumatic Stress Disorder is defined below.

“F43.1 Post-Traumatic Stress Disorder

This arises as a delayed and/or protracted response to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime).

Predisposing factors such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence.

Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.

There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. Excessive use of alcohol or drugs may be a complicating factor.

The onset follows the trauma with a latency period which may range from a few weeks to months (but rarely exceeds 6 months). The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of patients the condition may show a chronic course over many years and a transition to an enduring personality change.

Diagnostic Guidelines

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A "probable" diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities all contribute to the diagnosis but are not of prime importance".

12.1.1.2. Findings

It is not the function of an Investigation of this kind to attempt to offer an alternative diagnosis to that of the treating team who worked with Mr. Z. This report subsection sets out what diagnosis/diagnoses the treating team formulated and to consider whether or not the formulation was complete based upon what was known, or thought to be known, at the time.

The Independent Investigation Team, and those who gave expert witness evidence to Manchester Crown Court during Mr. Z's trial, found that Mr. Z was an unreliable raconteur of his own history. It was evident that he gave contradictory accounts of his psychiatric history to Manchester-based mental health professionals prior to the killing of Mr. Y and to forensic psychiatrists prior to his trial. Why this was the case is not known, however it illustrates the difficulties that clinicians face when making diagnostic assessments. In the case of Mr. Z his previous psychiatric history was never corroborated and his own accounts were accepted as factually accurate.

Internal Investigation Findings

The internal investigation identified that Mr. Z was a regular attendee at his GP surgery with physical health problems and sought frequent engagement with secondary care mental health services. It was also identified that Mr. Z had a significant history of both drug and alcohol usage which appeared to have grown less problematic following his move to Manchester in 1996. The Internal Investigation recognised that Mr. Z's alcohol consumption may have been underestimated by the treating team between June 2005 and the time of the incident in November 2010.

It was noted that Mr. Z's diagnosis was not clear but that during his early contact with the Trust his problems were considered to be those of depression with Post-Traumatic Stress Disorder symptoms arising from his experience of previous abuse. It was also noted that the therapy he received between 2005 and 2010 was directed towards treating these symptoms.¹¹⁵

The internal investigation found that Mr. Z had begun to report symptoms associated with psychosis in 2006 and that he was treated with antipsychotic medication for this. At the time of writing the internal investigation report the conclusions from pending forensic psychiatric

115. Trust Internal Investigation Report P.15

assessments were not known and the investigation panel did not know whether or not Mr. Z had experienced an emerging psychosis which had resulted in unexpected and serious violence leading to the death of Mr. Y.

Diagnoses

Mr. Z was given a number of diagnoses during his period of contact with Manchester mental health services. These diagnoses were based upon his history and self presentation. There was no information available or sought from relatives or friends and limited information from Mr. Z's previous contact with psychiatric services. The notes and reports from the psychiatric contact in 1996 were not available to the clinical teams who saw Mr. Z in Manchester from 21 June 2005 until the time of the killing of Mr. Y on the 21 November 2010.

The diagnoses provided between 21 June 2005 and 21 November 2010 included:

- recurrent depressive disorder with obsessive traits was made on the 8 August 2005 by Consultant Psychiatrist 1 and on the 6 February 2006 by Consultant Psychiatrist 2;
- at an early stage Mr. Z was diagnosed as having anger control problems;
- to this was added a possible diagnosis of psychosis, not otherwise specified, on the 19 September 2006 and the 13 November 2007 by Consultant Psychiatrist 2;
- residual Post-Traumatic Stress Disorder symptoms were noted on the 26 June 2007 by Consultant Psychiatrist 2;
- a diagnosis of Post-Traumatic Stress Disorder was made on the 10 June 2008 by Consultant Psychiatrist 2;
- previous significant alcohol abuse was noted on the 26 June 2007 and 7 October 2008 by Consultant Psychiatrist 2.

Post-Traumatic Stress Disorder

The diagnoses of depression and Post-Traumatic Stress Disorder appear to be well founded given the information available. There were suggestions of psychotic symptomatology being present at times such as persecutory ideas and ideas of reference on the 13 November 2007. The diagnosis of Post-Traumatic Stress Disorder was based on recurrent nightmares of previous abuse, intrusive thoughts and low mood and anxiety. This is consistent with the ICD 10 diagnostic guidelines. A diagnosis of personality disorder does not appear to have been

considered. This is a little surprising as Mr. Z had a history of self-harming, alcohol abuse, difficult relationships and emotional lability.

Alcohol Abuse

Mr. Z's alcohol abuse was described in the medical notes as being in the past, albeit there was some evidence in the GP record that Mr. Z continued to drink heavily at least on some occasions e.g. haematemesis in 2007 and abnormal liver function tests in October 2008. It was evident that Consultant Psychiatrist 2 was aware of the raised Gamma-Glutamyl Transpeptidase (GGT) levels which indicated an abnormal liver function test indicative of heavy drinking. Mr. Z had been identified as having significant anger management control issues and, as can be seen from the chronology, he was prone to acting impulsively when drinking. He had been known previously to make attempts on his life when intoxicated and he had also been known to get into fights and altercations.

It would appear that the healthcare professionals Mr. Z saw between 21 June 2005 and 21 November 2010 took his claims to have stopped drinking at face value even though there was significant evidence to the contrary to some members of the treating team that he had not. Members of the treating team were told by Mr. Z that he acted impulsively when under the influence of alcohol. Closer questioning and bringing together of all of the information known about Mr. Z during Outpatient appointments may have identified the ongoing problem.

The likelihood that Mr. Z probably continued to drink alcohol should have been taken into consideration prior to the commencement of psychological therapy inputs as the alcohol consumption may have affected adversely his ability to undertake work of this kind.

Psychosis

A possible diagnosis of psychosis, not otherwise specified, was made on the 19 September 2006 and the 13 November 2007 by Consultant Psychiatrist 2. The nature of Mr. Z's possible psychosis was not explored in any depth. Mr. Z had mentioned that he thought people could tell that he had been abused as a child when he went out into crowded places and that these thoughts led him to seclude himself in his flat. It was recorded in 2006 by Consultant Psychiatrist 2 that Mr. Z was experiencing thought broadcasting when he left his home (thought broadcasting is the belief that the people around you can read your thoughts). No

other psychotic symptoms were elicited or recorded throughout the period that Mr Z was seen. A formal diagnosis of psychotic illness was not therefore made and there was insufficient evidence to support this. Isolated psychotic symptoms can be features of other conditions. A forensic psychiatric assessment conducted after the killing of Mr. Y suggested that these thoughts may not have been signs of psychosis *per se* but were the result of Mr. Z's extreme sensitivity and self consciousness around other people.¹¹⁶

Depression

Mr. Z had a significant history of depression. He reported low mood on several occasions and was treated with antidepressants throughout the last few years. At other times he presented as having normal mood. Mr Z also presented with self harming behaviour. The GP record provides evidence of several suicide attempts having been made between February 2001 and June 2003. Each of these events appeared to have been triggered by the consumption of alcohol and underlying issues relating to his previous abuse as a child.

Between June 2005 and November 2010 Mr. Z's diagnosis was predominantly one of a recurrent depressive disorder. It was also identified that that he had obsessive traits, poor anger control and a history of alcohol abuse. During this period Mr. Z made three further suicide attempts (27 September 2007, 23 March 2008 and 10 June 2010). On each occasion Mr. Z had presented himself at the local Accident and Emergency Department in a timely manner and sought help.

12.1.1.3. Conclusion

The diagnoses made were reasonable based upon the evidence available. However a further diagnostic formulation was indicated with particular reference to:

- the presence of alcohol abuse and the potential influence this would have regarding prognosis, recovery and risk management;
- the presence of a psychosis, or psychotic symptomatology, and the potential influence that this would have regarding risk and Mr. Z's long-term care and treatment management strategy;
- Mr. Z's personality and the possibility of personality disorder; Mr. Z had a history of self-harming, alcohol abuse, difficult relationships and emotional lability;

116.Evidence for the Prosecution Manchester Crown Court 20 May 2011

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- the social context; Mr. Z was long-term unemployed and living with an ex partner with whom he appeared at times to have a difficult relationship. The impact of the social situation on his presentation and in turn the impact of his mental health on his social situation was not explored.

It was evident that Mr. Z suffered from recurrent depression; however the diagnostic formulation failed to take into account the full clinical picture and symptomatology and the significance of existing co-morbidities. This meant that Mr. Z was not understood in the full context of his psychiatric problems and that the potential successes of planned treatment and management strategies were limited and at times, potentially, contra-indicated.

Members of the treating team understood that Mr. Z had a significant history of alcohol misuse and that the suicide attempts he made, between 2005 and 2010 whilst a service user with the Trust, were impulsive acts triggered by alcohol consumption. Clinicians from secondary mental health care were not aware of Mr. Z's haematemesis in 2007 diagnosed as being due to alcohol abuse, but Consultant Psychiatrist 2 was aware of the liver function test conducted in 2008 that indicated that Mr. Z was probably still consuming large amounts of alcohol. This went unchallenged. A Forensic Psychiatrist giving evidence at Mr. Z's trial at Manchester Crown Court stated that *"those who misuse drugs and alcohol come under significant pressure to hide the levels of their misuse and this too will often involve giving false accounts"*.¹¹⁷ Research undertaken with individuals suffering from PTSD has shown that up to 40% of them have a problematic alcohol consumption habit. Knowing Mr. Z as they did, and also being mental healthcare professionals, each member of the treating team should have explored Mr. Z's ongoing relationship with alcohol in a more extensive manner. Accessing his early notes and the sharing of information between professionals involved in his care is likely to have resulted in a clearer formulation of his problems.

The lack of understanding about Mr. Z's ongoing relationship with alcohol in conjunction with the lack of clarity around the nature of his self-reported psychotic symptoms was unsatisfactory. Whilst it was thought by Consultant Psychiatrist 2 that Mr. Z did not have a severe and enduring mental illness he was nonetheless being treated with Risperidone for a non specified psychosis. Although Mr. Z had a significant and long history of lability of mood, a history of self harm and

117.Evidence for the Prosecution Manchester Crown Court 20 May 2011

alcohol abuse and a history of poor relationships with fleeting psychotic symptoms a diagnosis of personality disorder was not considered. Personality factors were also not mentioned. Further diagnostic formulation may have yielded a clearer picture of Mr. Z and may also have led to the consideration of a treatment strategy that addressed his problems more effectively.

During the course of Mr. Z's trial at Manchester Crown Court it could not be established with any degree of confidence that he had a severe or enduring mental illness and the notion that he may have suffered from a psychotic illness at the time of Mr. Y's murder was discounted. It was also noted during the trial that Mr. Z was a fantasist whose general accounts of his mental illness and past psychiatric history could not be accepted as either wholly authentic or reliable.

This Investigation has been party to information that would suggest that Mr. Z's account of the history of his abuse may not have been how he described it to be.¹¹⁸ It is not the function of this Investigation to make a judgement about the validity of Mr. Z's claims. However Manchester mental health services provided care and treatment to Mr. Z based upon this premise and it may have been that further work could have elicited a clearer picture of both Mr. Z's presentation and his underlying needs. It has to be said that services provided care and treatment to Mr. Z in good faith and that it is an ongoing challenge to ensure the veracity of what is told to a treating team by a service user in confidence.

- *Contributory Factor 1. The limited diagnostic formulation meant that Mr. Z was not understood in the full context of his mental health issues and his continued reliance upon alcohol.*

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho

118. GP Records

education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Medication

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

When prescribing medication there are a number of factors that must be borne in mind. They include consent to treatment, compliance, monitoring, and side effects.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly/monthly.

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

Psychological Treatment

Mr. Z received psychotherapy inputs from Manchester mental health services primarily to treat his Post-Traumatic Stress Disorder (PTSD) symptoms. The National Institute for Health and Clinical Excellence (NICE) quick reference guide recommends the following actions be taken:

- *“Assessment should be comprehensive and should include a risk assessment, assessment of physical, psychological and social needs*
- *Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment*
- *Provide practical advice to enable people with PTSD to access appropriate information and services for the range of emotional response that may develop*
- *Identify the need for social support and advocate for the meeting of this need*
- *Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers*
- *Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions”*.¹¹⁹

Additional recommendations include the following to be considered:

- ensure sufferers understand the emotional reactions and symptoms that may occur;
- respond appropriately if a PTSD sufferer avoids treatment;
- keep technical language to a minimum;
- only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed;
- ensure treatment is delivered by competent individuals;
- where depression is present consider treating the PTSD first, unless the depression is severe;
- prioritise any high risk of suicide or risk of harming others.

Other recommendations from the NICE guidance suggest avoiding single sessions that focus on the traumatic incident. Psychological therapy is the treatment of choice, delivered once a week by the same person. Several sessions may be required in order to build up a therapeutic relationship based on trust prior to traumatic events being discussed. Drugs should not be offered as a routine first-line treatment for adult PTSD sufferers unless the patient prefers not to engage in trauma-focused psychological therapy.

119. National Institute for Clinical Excellence, Quick reference Guide, *Post-Traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care*. (2005) PP. 8-10

Comorbidities and Post-Traumatic Stress Disorder (PTSD)

The National Institute of Health and Clinical Excellence (NICE) PTSD quick reference guide had the following to say about the treatment of individuals suffering from PTSD who also had depression and/or alcohol misuse problems:

“Depression

- *Consider treating the PTSD first unless the depression is so severe that it makes psychological treatment very difficult, in which case treat the depression first.*

High Risk of Suicide or at Risk of Harming Others

- *Concentrate first on the management of this risk in PTSD sufferers.*

Drug or Alcohol Problem

- *Treat any significant drug or alcohol problems before treating the PTSD”.*¹²⁰

12.1.2.2. Findings

Medication

Mr. Z was seen in outpatients 13 times between 2005 and 2010; approximately once every six months. Apart from the first two appointments Mr. Z was seen by Consultant Psychiatrist 2. Mr. Z missed appointments on several occasions so there were periods longer than six months between outpatient appointments at times. For example he was seen on the 4 December 2009 and then not seen again until the 26 of October 2010 (Mr. Z cancelled an appointment in June 2010).

Both Consultant Psychiatrist 1 initially, and Consultant Psychiatrist 2 subsequently, prescribed consistently with the diagnoses that had been made. The prescribed medication is set out below.

- Initially, in August 2005, Paroxetine was prescribed due to its anti-anxiety effects. Sodium Valproate 800mg twice daily was prescribed to manage anxiety, mood disorder and angry outbursts (2005). It should be noted that Sodium Valproate is not recommended for those who drink alcohol.
- Mirtazapine 15mg increasing to 30mg, and then 45mg, was given for depression.

120. National Institute for Clinical Excellence, Quick reference Guide, *Post-Traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* (2005) P. 11

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- Chlorpromazine (an older type of antipsychotic) 100mg was prescribed to help with sleep in 2006.
- The Chlorpromazine was stopped and replaced by Risperidone 2mg (a newer antipsychotic) later in 2006. This was in response to the emergence of some psychotic symptoms.
- Escitalopram 5mg was prescribed as an additional antidepressant in November 2007. The plan was to increase this and decrease the Mirtazapine. This was in response to continuing depressive symptoms. This plan continued over the next several months. The Mirtazapine was finally stopped in December 2009.
- In October 2008 the Sodium Valproate was increased to 1000mg daily after a blood test had shown that the level was below the therapeutic range.
- The Risperidone was increased to 4mg daily in response to some persistent psychotic symptoms.
- On 26 October 2010 the Risperidone was increased further to 6mg to treat the persistence of persecutory ideas and the increasing occurrence of flashbacks.

All the medication was prescribed within recommended therapeutic ranges.

In addition to the medication, Consultant Psychiatrist 1, and then Consultant Psychiatrist 2, referred Mr. Z for psychological therapy on three occasions to treat his anxiety, depression, and Post-Traumatic Stress Disorder. The therapeutic plan was to use medication and appropriate psychological approaches to work through Mr. Z's problems.

Psychological Treatment

The Independent Investigation found that Mr. Z had been in receipt of psychological intervention prior to receiving services from the Manchester Mental Health and Social Care NHS Trust. Extant Clinical records indicate that Mr. Z had a period of psychotherapy at the age of sixteen years *circa* 1986.¹²¹ The GP Medical Records also note that in June 1992 Mr. Z had been under psychological treatment to resolve outstanding issues caused by abuse as a child.¹²² It is reported that he was half way through the treatment when he moved and his GP sought a new referral so that the treatment could continue. The GP Medical Records state that

121. North Manchester notes pages 21-22

122. GP Record page 416

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in 1994 Mr. Z was referred by his GP for counselling but he failed to attend his appointments.¹²³

Mr. Z was assessed within the Manchester Mental Health and Social Care NHS Trust psychological services department three times between October 2005 and February 2009 and subsequently received two periods of intervention from these services. At the time of the incident he had been referred again for counselling. The interventions he received were psychodynamic counselling between 27 April and 21 September 2006 with a follow up appointment on 15 February 2007, and Cognitive Analytic Therapy (CAT) between 7 May 2008 and 29 October 2008, with a follow-up appointment on 11 February 2009.

Psychodynamic Counselling (2006)

The Independent Investigation found that no rationale was given for Mr. Z receiving psychodynamic counselling, rather than other psychological interventions, other than that Mr. Z “*was curious enough in his wish to understand these feelings to motivate him in therapy*”.¹²⁴

Cognitive Analytic Therapy (CAT) (2008)

The Independent Investigation found that at the time of Mr. Z’s assessment in February 2009, and the consequent referral for CAT, he was considered to be suffering from Post-Traumatic Stress Disorder.¹²⁵ The Independent Investigation was informed that the reason for selecting CAT was that it was felt that this was the more appropriate treatment for somebody whose trauma had not happened in the immediate past. The Independent Investigation noted that the NICE Guidelines for Post-Traumatic Stress Disorder (PTSD) are that regardless of the time that has elapsed since the trauma all PTSD sufferers should be offered twelve or more sessions of trauma focussed Cognitive Behaviour Therapy (CBT) or eye movement desensitisation and reprocessing (EMDR).¹²⁶ The Independent Investigation found that this treatment of choice was not offered to Mr. Z despite cognitive behaviour therapy being one of the treatments available within the Trust’s psychological services and the NICE Guidelines on PTSD being available from 2005.

123. GP Record pp411-412

124. North Manchester notes page 31

125. North Manchester notes page 51

126 .National Institute for Clinical Excellence, 2005, National Clinical Practice Guideline Number 26, page 129

The Independent Investigation found that Mr. Z's history of violence and his recent thoughts of harming his flatmate were known to staff within psychological services. In October 2005, following the first pre-therapy assessment, an Adult Psychotherapist documented both Mr. Z's recent plans to harm his flatmate and his previous history of stabbing a friend repeatedly with a carving fork.¹²⁷ In January 2008 Mr. Z told a Consultant Psychotherapist during his second pre-therapy assessment that he had been convicted of violence in the past.¹²⁸ Concern about his violent history was raised by the Principal Adult Psychotherapist, who attempted to discuss this concern with Consultant Psychiatrist 2, prior to Mr. Z's commencement of CAT. The Principal Adult Psychotherapist was able to discuss the concern with the Adult Psychotherapist who said that Mr. Z "*does have memory of stabbing incident*" but nevertheless she had "*Felt safe in the room with him at that time [that she conducted his pre-therapy assessment in 2005]*".¹²⁹ This discussion appeared to provide reassurance that it was safe for CAT to proceed. The Independent Investigation found that the Psychological Service staff who assessed and treated Mr. Z did not consider that his violent history or his thoughts about harming his flatmate required any response from themselves other than to document these findings and to continue with his referrals and therapy. It is possible that the therapists felt that primary responsibility for Mr. Z's safety and the safety of his flatmate lay with Consultant Psychiatrist 2 whom he saw in the Outpatient Clinic, or that the presentation of Mr. Z was such that the therapists did not consider him to be a potential risk to himself or others. The Independent Investigation found that exploration of his current relationships did not receive priority in his therapy, despite the knowledge of his history of violence and more recent thoughts towards his flatmate. This is of particular concern as by 2008 Mr. Z was being referred to Psychological Services for the treatment of his PTSD and NICE guidance is quite clear that violence to either self or to others should be explored in depth prior to any kind of therapy commencing and that these risks of violence should be managed as a priority. It must also be noted that Psychological Therapy Services knew about Mr. Z's recent suicide attempts but these did not seem to be factored either into his pre-therapy assessment or his risk management strategy once CAT had commenced.

Internal Investigation Findings

The Independent Investigation is in agreement with the internal investigation that Mr. Z formed good relationships with the therapists he saw from Psychological Services. It appears

127. North Psychotherapy Notes pages 152-3

128. North Psychotherapy Notes page 179

129. North Psychotherapy notes page 183

that he was motivated well to engage in psychological therapy as he completed the assessment forms he was given, attended in total six assessment sessions by three different therapists and engaged in therapy despite the time he had to wait between referral and assessment and between assessment and therapy. During his period of fifteen psychodynamic counselling sessions Mr. Z cancelled three of the appointments, twice due to a stomach upset and once due to his flatmate being taken ill.¹³⁰ During his period of CAT he was offered sixteen sessions and cancelled four appointments due to ill health. He always telephoned to cancel the appointments he was going to miss.

The internal investigation found that the psychological therapy Mr. Z received was of clear benefit to him. Given that Mr. Z cooperated with the referral process and in the main attended his appointments it would be reasonable to conclude that he considered the appointments to be of benefit to him. At the conclusion of his counselling sessions with Mr. Z in February 2007, the Counsellor wrote to Consultant Psychiatrist 2 reporting that Mr. Z had achieved his goal of replacing some of his bad memories with better thoughts. He still however found it difficult to control his anger when bad memories returned which led to arguments with his flatmate.¹³¹ It was also reported that Mr. Z believed that people in crowds knew of his abuse. The Counsellor wrote to Consultant Psychiatrist 2 again after his follow-up session with Mr. Z saying that he had maintained his progress and expected that his condition would remain stable in the future.¹³² Although Mr. Z was noted to still have suicidal thoughts the consequences stopped him from taking action.

Independent Investigation Findings Summary

The Independent Investigation found that although Mr. Z reported some improvement, his bad dreams had become more explicitly about his abuse and when he was reviewed by Consultant Psychiatrist 2 four months later in June 2007 his mood had worsened, he was experiencing nightmares and flashbacks and he felt suicidal. This deterioration resulted in re-referral to the Psychological Services and treatment with Cognitive Analytic Therapy during 2008/2009. At the conclusion of the CAT sessions with Mr. Z in February 2009, the Clinical Psychologist who had provided the therapy wrote to Consultant Psychiatrist 2.¹³³ She concluded that Mr. Z had engaged well even though at times he had said that he was

130. North Psychotherapy Notes

131. North Manchester Notes pages 40-41

132. North Manchester notes page 45

133. North Manchester notes pages 61-62

overwhelmed by the sessions. Mr. Z had reported that his flashbacks were reduced but had not disappeared, however he said that was able to use distraction techniques to manage them.

Whilst Mr. Z was engaging with the Cognitive Analytic Therapy, in October 2008, when it appears that Mr. Z had not been seen for two months due to his cancellation of the appointments, he was reviewed by Consultant Psychiatrist 2 who found him to be experiencing flashbacks and nightmares with poor sleep. At this stage Mr. Z was having difficulty applying the strategies for managing the flashbacks. Consultant Psychiatrist 2's handwritten medical notes recorded that the flashbacks left Mr. Z feeling scared and frightened. However his psychotic symptoms had improved, although he still believed people could read his mind, and his mood was relatively stable.¹³⁴ The Independent Investigation concluded that the difference between Mr. Z's report of his mental state during his CAT sessions and to Consultant Psychiatrist 2 could either be because at the time of seeing his Psychiatrist in October 2008 he had not received therapy for two months and had deteriorated during this period, or because he reported his mental state differently according to whom he was speaking. The Independent Investigation concluded that although Mr. Z engaged well in therapy, indicating that he felt it was of benefit, it is unclear whether the gains made during therapy, such as learning distraction techniques to help him cope with flashbacks, remained once therapy had ended. No psychometric measures were used to measure therapeutic change in an objective manner.

The internal investigation found that in general Mr. Z's care was documented well, with appropriate correspondence sent in a timely fashion.¹³⁵ The Independent Investigation however found that there were some significant exceptions to correspondence being sent in a timely fashion. Whilst the Counsellor wrote to Consultant Psychiatrist 2 at the start and end of therapy, and after the follow up session no letters were sent during the course of the fifteen sessions of psychodynamic counselling. The Clinical Psychologist who conducted the CAT sessions with Mr. Z completed her follow-up session with him on 11 February 2009 and wrote to Consultant Psychiatrist 2 for the first time on 23 September 2009. Of more concern is the fact that no information relating Mr. Z's ongoing suicide attempts, ongoing alcohol abuse, and thoughts of harming his partner were communicated to Consultant Psychiatrist 2 during the course of the therapy. These issues were raised and discussed in therapy and were of a serious and significant nature. At no stage was corroboration or professional liaison

134. AMIGOS notes pages 7-8 and North Manchester notes pages 55-56

135. Serious Untoward Incident Final Report, page 16

considered with Consultant psychiatrist 2. Neither did Consultant Psychiatrist 2 liaise with the therapists during the treatment of Mr Z, other than by sending copies of his Outpatient letters.

12.1.2.3. Conclusion

There are five main issues that need to be considered as points of learning with specific regard to the psychological treatments offered to Mr. Z.

First: selected therapies. The Independent Investigation found that the treatment of choice for Post-Traumatic Stress Disorder, namely trauma focussed cognitive behaviour therapy, was not offered to Mr. Z despite:

- cognitive behaviour therapy being one of the treatments available within the Trust's psychological services and the NICE Guidelines on PTSD being available from 2005;
- Consultant Psychiatrist 2 making the referral on 30 November 2007 for Cognitive Behaviour Therapy.

Second: risk factors. The NICE guidance identifies several risk factors that require in-depth consideration when treating a person with PTSD. They are:

- risk of harm to self;
- risk of harm to others and a propensity towards violence;
- alcohol or substance misuse.

It is advised strongly by the NICE guidance that these issues are not only assessed but addressed prior to psychological intervention taking place as the susceptibility of those with PTSD to act impulsively can be raised. When a person is placed in an intense therapeutic situation memory can be re-awakened and the hyperarousal and tendency towards acting impulsively can be increased. This needs to be avoided and managed in a robust manner. There is no evidence to suggest that a treatment management strategy was put into place for Mr. Z in conjunction with Consultant Psychiatrist 2 as would be expected especially once the diagnosis of Post-Traumatic Stress Disorder had been made. Mr. Z informed his therapists on several occasions that:

- he had made recent attempts on his life leading to Accident and Emergency intervention;

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- he continued to have thoughts of violence towards his partner;
- he had been drinking alcohol which had led to impulsive self-harming behaviour;
- he continued to have feelings of intense anger;
- he was experiencing frequent flashbacks and nightmares relating to his previous abuse.

These factors were indicative of the requirement for a more coordinated and planned approach to have been taken in the best interests of Mr. Z's safety.

Third: communication. The unmanaged risks set out above were compounded further by the Psychological Service staff who assessed and treated Mr. Z neither corroborating nor sharing the information with Consultant Psychiatrist 2. No response was forthcoming other than to document these findings and to continue with Mr. Z's referrals and therapy. At interview the witnesses from the Psychological Therapy Services consistently expressed the view that confidentiality to the service user was paramount. Whilst this view is laudable, the Independent Investigation Team found that the inability of witnesses to identify appropriate and necessary instances when exceptions have to be made regarding information sharing in the best interests of the patient, or those around him, of concern.

The Independent Investigation found that exploration of Mr. Z's current relationships did not receive priority in his therapy, despite the knowledge of his history of violence and more recent thoughts towards his ex partner and flatmate, Mr. Y. The Independent Investigation concluded that this was a serious omission as it resulted in Mr. Y not being alerted to the risks of continuing to live with Mr. Z.

Fourth: training. The Independent Investigation Team found it difficult to ascertain exactly what kinds of specialist training Trust psychological therapy professionals had received in relation to either abuse or Post-Traumatic Stress Disorder. Witnesses stated that training was either part of their core pre-registration education or based upon articles read and in-house training opportunities. It is possible that a more in-depth and targeted training and up-dating programme should have been put into place for professionals working in such a potentially high risk and complex area.

Five: Social Intervention. Social factors can both contribute to the onset of, and recovery from, mental health problems. For example unemployment is related to poor mental health. Mr. Z had been unemployed for many years and lived with Mr. Y with whom he had at times a difficult relationship. He appeared to be quite socially isolated with little meaningful activity.

Social interventions are known to be helpful in supporting recovery from mental illness and preventing relapse. The social context in which Mr. Z was living was not explored by the mental health services and no interventions were therefore offered.

Summary

The Independent Investigation Team found that the medication Mr. Z was prescribed was generally in keeping with his diagnoses and within recommended therapeutic ranges.

The Independent Investigation is in agreement with the internal investigation in that Mr. Z formed good relationships with the therapists he saw from the Psychological Services. However the Independent Investigation concluded that although Mr. Z engaged well in therapy, indicating that he felt it was of benefit, it is unclear whether the gains made during therapy, such as learning distraction techniques to help him cope with flashbacks, remained once therapy had ended. At the time of the incident Mr. Z was not receiving therapy.

Once the diagnosis of Post-Traumatic Stress Disorder had been made the therapy programme should have adhered to an evidence-based methodology. The approach taken by the Psychological Treatment Services was not best practice in relation to the treatment of PTSD and could have potentially placed both Mr. Z and those around him at risk.

Whilst the Independent Investigation found four key points of learning no direct causal link could be made between the medication and treatment regimen that Mr. Z received and the killing of Mr. Y. It is a fact that Mr. Y had not been in therapy for a significant period of time prior to the killing of Mr. Y and that therapy-induced hyperarousal was not a factor. However the management of the therapy process represents a series of missed opportunities which had they been acted upon could have ensured Mr. Z was understood better and managed more appropriately. It is unfortunate that the information known by the Therapists was not shared with either Consultant Psychiatrist 2 or with Mr. Y and that some information known by

Consultant Psychiatrist 2 was not shared with the Therapists. It cannot be known what the outcome of such information sharing would have been however it is the conclusion of this Investigation that it was of a nature and significance that required disclosure.

- *Contributory Factor 2. The approach taken to the psychological therapy that Mr. Z received did not run in accordance with national best practice guidance relating to PTSD treatment management. This potentially placed Mr. Z and those around him at risk.*
- *Contributory Factor 3. The failure to achieve the necessary levels of professional communication and disclosure of information placed Mr. Y in an unacceptable position of risk. This failure also prevented Consultant Psychiatrist 2 accessing significant facts that could have led to a more in-depth formulation of Mr. Z's case.*

12.1.3. Use of the Mental Health Act (1983 & 2007)

12.1.3.1. Context

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

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.

12.1.3.2. Findings

From the documentation made available to the Independent Investigation Team it was evident that Mr. Z had never been subject to detention under the Mental Health Act (1983 & 2007).

Previous Forensic History

Following the serious, but non-fatal, stabbing of his then male partner in May/June 1996 Mr. Z was sentenced to a twelve-month suspended sentence. He underwent a short period of time in an inpatient psychiatric unit as an informal patient following an overdose in July 1996 but this was not as a consequence of the stabbing. The Consultant Forensic Psychiatrist who assessed him at this time diagnosed him as an individual suffering from a mild depressive episode with a history of abuse who had acted impulsively.¹³⁶

The Forensic Consultant Psychiatrist recommended that Mr. Z be followed up with psychiatric outpatient treatment. The Probation Officer tried to follow this up but the outcome of his effort is no longer part of any extant record.

Risk to Self

There are multiple mentions in Mr. Z's mental health and GP Clinical records of "numerous" suicide attempts having been made between 1996 and 2010. It was difficult for the Independent Investigation Team to trace the dates of the attempts made prior to 2005 or to verify either what actually took place or the severity of the attempts. The reader is asked to refer to subsection 12.1.5. for more details.

Between 1996 and November 2010 Mr. Z was not diagnosed as suffering from a severe or enduring mental illness. Between June 2005 and November 2010 Mr. Z reported frequent suicidal thoughts to both Consultant psychiatrist 2 and also to his therapists. However at no time was Mr. Z thought to be at risk and at no time did Mr. Z meet the criteria for either assessment or detention under the Mental Health Act (1983 & 2007).

Risk to Others

In 1996 Mr. Z received a 12-Month suspended sentence for the non-fatal stabbing of his partner. Upon examination by a Forensic Consultant Psychiatrist no severe mental illness was

136. GP Record PP.400-405

detected. Between 1996 and June 2005 when Mr. Z first came to the attention of Manchester mental health services the GP record makes reference to impulsive behaviour and a “*history of serious assaults*”.¹³⁷ No other information was available.

At the point of Mr. Z’s referral to Manchester mental health services in June 2005 it was noted that three weeks previously he had collected a rock from the garden and a Stanley knife with the intention of causing harm to his ex-partner with whom he still lived. “*His thoughts were to smash his friend’s head in, and afterwards cut his throat*”.¹³⁸ At this stage it was thought that Mr. Z was suffering from a depressive illness. At this stage and from this time onwards Mr. Z was not thought to require either assessment or detention under the Mental Health Act (1983 & 2007).

12. 1.3.3. Conclusions

The Independent Investigation Team concluded that at no time did Mr. Z meet the criteria for either assessment or detention under the Act. Mr. Z did not appear to be suffering from a severe or enduring mental illness and he retained capacity throughout his episode of treatment with Manchester-based services. The issues relating to the management of Mr. Z’s risk profile are addressed in subsection 12.1.5. below.

12.1.4. The Care Programme Approach

12.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.¹³⁹ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*.¹⁴⁰

137. GP Record PP. 78 & 353-354

138. NM Notes PP. 21-22

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

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

“The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services.” (Building Bridges: DoH 1995).¹⁴¹ This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

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

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

The essential elements of any care programme include:

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

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their

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

carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Manchester Mental Health and Social Care NHS Trust CPA Policy

At the time Mr. Z received his care and treatment from the Mental Health Trust a robust series of CPA policies were in place that were in keeping with national guidance. Policies stated that the Care Programme Approach applied to all people accepted by specialist mental health services. When Mr. Z was first referred to secondary care services the terms ‘Standard’ and ‘Enhanced’ CPA were still in use. The main requirements of CPA were described as follows:

- *“an assessment of the service user’s health and social care needs, including an assessment of any risks posed by them or to them;*
- *a multi-disciplinary care plan stating how the assessed needs are going to be met, including crisis and contingency plans;*
- *the appointment of a Care Coordinator to oversee the implementation of the care plan and to link the client to appropriate services;*
- *regular reviews to ensure the appropriateness of the care plan”*.¹⁴²

The criteria for a person to be accepted onto Enhanced CPA were as follows;

- *“multiple care needs, which could include housing, employment etc. requiring inter-agency co-ordination;*
- *contact with a number of agencies;*
- *likely to require more frequent and/or intensive interventions;*
- *have mental health problems co-existing with other problems such as substance abuse;*
- *at risk of harming themselves or others;*
- *likely to disengage with services;*
- *entitled to Section 117 aftercare;*
- *people who are admitted to an in-patient facility, informally or under Section 2 of the Mental Health Act (although they may be discharged under the provisions of standard CPA)”*.¹⁴³

142. Manchester MHT Revised 2006 policy. Policy for 2007-2008. P. 4

143. Manchester MHT Revised 2006 policy. Policy for 2007-2008. PP.5-6

The criteria for a person to be accepted onto Standard CPA were as follows:

- *“people who are eligible to receive help from the Mental Health Services but do not meet the requirements for Enhanced CPA will be dealt with under the Standard CPA;*
- *if the user has eligible needs, but only requires the intervention of a single professional then Standard CPA applies. An appropriate worker will be allocated to offer a simple service and provide a simple care plan”*.¹⁴⁴

Trust policies also outlined the importance of:

- *“one point of entry into services;*
- *one assessment of needs and risks;*
- *one care plan to include contingency and crisis care plans;*
- *the appointment of a lead officer, with the power to work across agencies, to allocate resources and develop the integrated CPA”*.¹⁴⁵

12.1.4.2. Findings

On 21 June 2005 Mr. Z was referred for a psychiatric assessment to Manchester mental health services by his GP due to his history of depression which had been growing worse. The referral also mentioned a history of overdoses and anxiety.¹⁴⁶ It is not clear what happened to this referral, but on the 5 July 2005 the GP referred Mr. Z to the Accident and Emergency Department where he received a psychiatric assessment. On this occasion it was noted that Mr. Z:

- had been a victim of previous abuse;
- had suffered from depression from an early age;
- had been experiencing thoughts of self-harm;
- had been prescribed Amitriptyline 25mg for the past month with no effect;
- had a history of previous heavy drinking;
- had been experiencing thoughts of extreme violence towards his friend with whom he lived;
- was describing both auditory and visual hallucinations;
- described obsessive compulsive behaviour;

144. Manchester MHT Revised 2006 policy. Policy for 2007-2008. PP. 6 & 8

145. Manchester MHT Revised 2006 policy. Policy for 2007-2008. P.5

146. GP Record P.155

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- had a previous history of actual bodily harm due to his having stabbed a man with a carving fork 22 times.¹⁴⁷

As a consequence of this assessment Mr. Z was referred as an “*urgent*” case to the Community Mental Health Team (CMHT). At this stage the Amitriptyline was ceased and Sodium Valproate was introduced 200mg twice daily for one week, increasing to 400mg twice daily.

On the 7 July 2005 a Community Psychiatric Nurse (CPN) undertook a CMHT assessment. On this occasion a risk assessment was conducted and it was understood that Mr. Z had a previous history of violence and that he was currently experiencing violent thoughts focused upon the friend with whom he lived. Mr. Z reported that he often lost his temper and would throw things around the flat when he lost control. The risk assessment noted that Mr. Z was easily aroused and had poor impulse control. He was described as angry and verbally abusive with glaring eye contact. The assessment concluded that Mr. Z was a high risk.¹⁴⁸

On the 8 July 2005 a discussion was held within the CMHT. The CPN provided feedback about the case. It was decided that decisions about the referral would be made on the 11 July and that Mr. Z was due to be seen by Consultant Psychiatrist 1 on the 8 August 2005. It is unclear what discussions ensued but it was recorded on the 12 July 2005 that Mr. Z was discharged from the CMHT on ‘Standard’ CPA.¹⁴⁹

On the 4 August 2005 Consultant Psychiatrist 1 wrote to the GP to say that it had been decided to treat Mr. Z with antidepressants prior to accepting him into secondary care services. Paroxetine was advised and the GP was warned that the medication could take between two and eight weeks to be effective.¹⁵⁰

Consultant Psychiatrist 1 saw Mr. Z on the 8 August 2005 and concluded that he was suffering from a recurrent depressive disorder with obsessive traits, poor anger control, and alcohol abuse until recently. It was noted that the Sodium Valproate 800mg twice daily appeared to be controlling his anxiety and that Mirtazapine 15mg at night had been

147. NM Notes PP. 88-91

148. AMIGOS Notes. P.1 & NM Notes PP.6-11 & NM Notes PP.70-71

149. AMIGOS Notes. P.1

150. GP Record. P.325

prescribed to help with underlying depressive symptoms and insomnia. Mr. Z was to be referred to the Psychotherapy Department and another appointment was arranged at the Outpatient Clinic for three-months time. Mr. Z was advised to contact the CMHT if in crisis.¹⁵¹

For the next five years Mr. Z continued to be seen in the Outpatient Clinic and by the Psychotherapy Department. During this time he was placed on 'Standard' or NonCPA and Consultant Psychiatrist 2 was in effect his Care Coordinator. In 2009 Consultant Psychiatrist 2 considered referring Mr. Z to the CMHT in order to access further support for him but this was not done.

12.1.4.3. Conclusions

Findings and Conclusions taken from the Trust Internal Investigation Report

The Trust Internal Investigation Panel was told that Mr. Z was not considered for Enhanced CPA because:

- Mr. Z did not initially appear to be suffering from a severe and enduring mental illness;
- Mr. Z had not had any recent admissions to a mental health unit;
- Mr. Z engaged well with Outpatient services;
- whilst Mr. Z had a history of violence and contact with the Criminal Justice system, this was some years previously and his life was now much more stable;
- Mr. Z did not report any social problems which he would like help with;
- Mr. Z's problems were mainly of an emotional nature linked to his history of previous abuse and these needs were appropriately met through the therapy he was offered.

The Internal Investigation Panel considered that this was a reasonable decision in light of the factors identified above. However all patients on 'Standard' CPA should have been in receipt of a care plan which should have included what to do when in crisis. This practice did not appear to have been in widespread operation in Outpatient settings at the time Mr. Z was receiving his care and treatment.

151. NM Notes PP.23-25

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Mr. Z was not considered to meet the criteria for 'Enhanced' or full CPA. As a result he did not receive a full assessment of his needs and was never visited at his home. The Internal Investigation Panel found that Consultant Psychiatrist 2 did consider referring Mr. Z on to the Community Mental Health Team in 2009 in order for a more comprehensive approach to be taken but that this did not occur. The Panel felt that this was a missed opportunity which could have ensured a more holistic approach was taken to Mr. Z's needs. The Independent Investigation Team concurs broadly with the findings and conclusions of the internal investigation.

Conclusions of the Independent Investigation Team

The Independent Investigation Team considered that at the point of referral in June 2005 Mr. Z met the criteria for 'Enhanced' CPA as set out in the Trust policy documentation in operation at that time. The guidance suggests a number of criteria that should have been taken into consideration when deciding whether care should be delivered under CPA or not. These included complexity; diagnosis; risk; service delivery; neglect; and disengagement. These are all pertinent issues in relation to Mr. Z's initial and ongoing presentation. Over time Mr. Z's presentation became more complex and on frequent occasions during his five-year period with the Trust would have met the threshold for both CPA and CMHT-led care.

- Mr. Z had a forensic history of violence.
- Mr. Z was presenting initially, and then periodically, with intrusive thoughts of wanting to kill or seriously harm his friend and flatmate. It was also noted that he had anger control issues.
- Mr. Z had a history of significant alcohol abuse, poor impulse control, and self-harm.
- The diagnosis was complex. There were a number of concurrent medications and treatments. At the least, there was consideration given to anxiety, depression, PTSD, and psychosis.
- There were clear risk issues that had been assessed as being both high and current.
- The service delivery to Mr. Z was complex. During the course of five years the patient was referred to the CMHT, received Outpatient appointments, counselling, Cognitive Analytic Therapy, and psychiatric liaison input following suicide attempts and acts of self harm.
- There were clear signs of self-neglect which persisted throughout the five-year period.

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- Mr. Z made reference to the poor physical health of his friend and flatmate whilst at the same time expressing thoughts of wishing him serious harm. This should have warranted a vulnerable adult assessment/alert/consideration.

The Trust CPA policy extant during the time Mr. Z was referred to services gave guidance on when CPA should be applied. It identified (amongst others) the following as areas for consideration:

- self harm;
- a high degree of Clinical complexity;
- self neglect;
- adult/child protection issues;
- co-morbidity including alcohol misuse;
- multiple-service provision

All of the above were present in Mr. Z's case. The Trust policy gives a helpful list of what CPA and NonCPA clients can expect. It is clear from this that many of the things missing from the care and treatment Mr. Z received may have been addressed through the provision of CPA. These include support from a Care Coordinator; full risk assessment; carer assessment; contingency/crisis plans; and an assessment of social care needs. Mr. Z had a complex presentation and the decision to place him in an Outpatient context on 'Standard' CPA meant that his Care Coordinator was in effect his Consultant Psychiatrist. The Independent Investigation Team concluded that it is difficult for a Consultant Psychiatrist to successfully accomplish the role of Care Coordinator as it requires a time commitment not readily achievable by this kind of Clinician. Mr. Z required a consistent level of Care Coordination in order to ensure that risk assessment, care planning and inter-professional communication and liaison took place in a manner commensurate to his needs.

It would appear from a close examination of Mr. Z's clinical record that he did not receive an ongoing risk assessment or care planning process. The Outpatient appointments, which were at times sporadic and irregular, focused upon the assessment of his mental state. The subsequent care plans that were developed focused upon medicines management only. When Mr. Z appeared to be experiencing difficulties referrals were made to Psychological Services.

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This in itself was a reasonable approach, but in the absence of a structured long-term care plan may have been both counter productive and unsafe (please refer to subsection 12.1.2.).

It was evident that the GP, Consultant Psychiatrist 2, the Therapists and Liaison Psychiatry all knew different things about Mr. Z at different times and that this information did not come together in a coordinated and timely manner. As a result many things of significance were neither known nor understood about Mr. Z by members of the treating team. This is of most concern when considering his ongoing alcohol abuse, poor impulse control and anger management problems, none of which were sufficiently understood by members of the treating team. These factors should have been taken into account especially with regard to Mr. Z's ongoing risk assessment and management. It is a fact that individuals undertaking therapy for PTSD are often more prone to depression, impulsive acts and aggressive behaviour. This is of course exacerbated by alcohol consumption and is for this reason a strong contra indication to this kind of therapy taking place without a robust risk assessment and management strategy being first put into place.

Had Mr. Z had access to Care Coordination and the Care Programme Approach it is more likely that a sustained therapeutic relationship could have been built up and more structured approach taken to the care and treatment that Mr. Z received over a five-year period with seemingly variable and unsustainable results.

The Independent Investigation Team was told that Mr. Z was not thought to be eligible for CPA. However it was the conclusion of this Investigation that the lack of CPA and Care Coordination impacted negatively upon the overall management of Mr. Z's case. Without the oversight that CPA could have provided, there were gaps in risk assessment, information sharing and carer involvement.

Had a different view been taken, and the patient placed on CPA within the CMHT, then the following aspects of his care would have been tighter:

- there would have been regular Multidisciplinary Team reviews;
- risk assessment would have been reviewed at least six monthly;

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- Mr. Z would have had a plan in place to support him in crisis which could have diverted him away from inappropriate Accident and Emergency admissions and presentations;
- carer assessment and involvement would have been initiated;
- a more holistic overview would have been taken to Mr. Z's needs and long-term care and treatment goals;
- a Care Coordinator would have overseen the different aspects of care ensuring that liaison between all members of the treating team took place;
- potential safeguarding issues may have been considered.

This Investigation did not reach the conclusion that the decision to place Mr. Z on 'Standard' CPA made a causal contribution to the killing of Mr. Y. However without CPA Mr. Z's care and treatment moved forward in an unstructured manner which was not subject to either review or progress monitoring. Significant information about Mr. Z was not shared and this was to the ultimate detriment of his well-being. Mr. Z's presentation was both complex and inconsistent. The failure to provide the Care Programme Approach and Care Coordination represents a missed opportunity. It is the conclusion of this Investigation that had it been in place Mr. Z would have received a more robust care and treatment management strategy which may have been able to address many of the problems which continued to cause him difficulties and which were not effectively addressed over a five-year period.

- ***Contributory Factor 4. Mr. Z met the criteria for 'Enhanced' CPA at the point of his referral to secondary care mental health services in June 2005, and at certain other stages during his five-year period with the Trust. Mr. Z did not receive a Care Programme Approach and consequently had no overarching Care Coordination to ensure that he received holistic assessment and that his care and treatment was managed effectively.***

12.1.5. Risk Assessment

12.1.5.1. Context

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

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

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

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

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

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

- *it conforms with relevant guidelines;*

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- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed”.*¹⁵²

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

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

Manchester Mental Health and Social Care NHS Trust Policy

During the period that Mr. Z received his care and treatment from the Trust robust risk policies were in place. These policies very sensibly made the connection between risk management processes and other Trust policies and procedures such as the:

- Care Programme Approach;
- Mental Health Act (1983 & 2007) procedures;
- Medicines Management;
- Child Protection Policy;
- Vulnerable Adults Policy;
- Incident Reporting Policy.

The Policies stated that it was the responsibility of the Clinicians making the first contact with the service user to commence the risk assessment process. The Care Coordinator, Responsible Clinician or Named Nurse should continue the process and that all clinicians working with the service user should keep risk profiles updated as required.

¹⁵². Best Practice in Managing Risk; DoH; 2007

The policies also stated that risk assessment should be conducted on the following occasions:

- at the beginning of each major episode of care;
- when a person presents in an emergency situation where there are no previous notes available;
- every time a mental state examination is carried out;
- as clinically required, e.g. at CPA reviews and ward rounds;
- prior to discharge;
- prior to leave and return from leave;
- after a Serious Untoward Incident or period of seclusion;
- updated as clinically required.

The Trust established that there were two main approaches to risk assessment. The formulation approach and the measurement approach. The formulation approach was described as *“the application of clinical knowledge in predicting risks, identifying cues and using expert interviewing and care planning to bring together a formulation of risk that deals with the origins, development, maintenance and recent changes in risk level”*.¹⁵³ The measurement approach was described as being a method that provides an objective measurement tool in order to facilitate an accurate prediction of the likelihood of a risk event occurring. The Trust policies advocated the two approaches being combined together in order to effectively assess and manage risk.

Psychotherapy Services

During the times Mr. Z received treatment from Macartney House Psychotherapy Service a robust risk protocol document was in place which detailed how risk assessment should be conducted in a therapy context. This policy outlined the need for:

- an initial risk assessment to take place prior to therapy commencing;
- ongoing risk assessment to continue throughout therapy;
- an awareness that patients may mask their risk as part of their defensive style;
- an awareness that therapy can increase risk;
- (where relevant) a contract for avoiding self harm;
- therapists to record risk on the required proforma documentation/system.

153.Trust Clinical Risk Management and Assessment Policy and Procedure. Nov. 2007. P.9

12.1.5.2. Findings

Events History

Self Harm and Risk to Self

Mr. Z had a history of self-harm and suicide attempts pre-dating his referral to Manchester mental health services in June 2005. It is difficult to ascertain the number or severity of the suicide attempts that he made as Mr. Z's full historic psychiatric archive could not be accessed. Mr. Z is reported to have attempted suicide on the following occasions:

- **July 1996.** Mr. Z was reported to have overdosed with 100 Paracetamol tablets. This led to an inpatient admission.¹⁵⁴
- **3 August 1996.** The word “*overdose*” was recorded in the GP record.¹⁵⁵
- **22 February 2001.** Mr. Z was reported to have overdosed on eight 500mg tablets of Paracetamol. He had taken the overdose whilst “*drunk*”.¹⁵⁶
- **29 June 2001.** The word “*overdose*” was recorded in the GP record.¹⁵⁷
- **18 June 2003.** Mr. Z was reported to have taken 30 Paracetamol, six shots of vodka, six shots of whiskey and half a bottle of wine.¹⁵⁸
- **28 June 2003.** The word “*overdose*” was recorded in the GP record.¹⁵⁹
- **27 September 2007.** Mr. Z had taken an impulsive overdose of mixed medication and a bottle of whiskey in reaction to feelings of stress.¹⁶⁰
- **24 March 2008.** Mr. Z was admitted to the North Manchester General Hospital overnight following an overdose of Tramadol tablets. He had decided to get drunk and whilst intoxicated had impulsive thoughts of taking an overdose.¹⁶¹
- **10 June 2010.** Mr. Z was reviewed at the Accident and Emergency Department following taking an overdose.¹⁶²

A key feature of Mr. Z's suicide attempts is that he often acted impulsively, usually when intoxicated. Throughout the time that Mr. Z received his care and treatment from Manchester mental health services he was adamant that he no longer drank alcohol. This would appear to have been a false assertion in that he experienced a severe haematemesis in August 2007 as a direct result of heavy drinking. Mr. Z also had a liver function test in October 2008 the results

154. GP Record PP.390-391

155. GP Record P.78

156. GP Record PP. 78 7 353-354

157. GP Record P.78

158. GP Record PP.336-338

159. GP Record P.78

160. AMIGOS Notes. P2

161. AMIGOS Notes. PP.5 -6

162. AMIGOS Notes PP. 13-15

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of which were highly suggestive that he continued to drink heavily. Whilst the only member of his treating team to know about the haematemesis was his GP, Consultant Psychiatrist 2 knew about the liver function test, and over time all clinicians involved in Mr. Z's care knew about his suicide attempts which had in part been exacerbated by heavy drinking.

The reason for Mr. Z's GP initial referral to secondary care mental health services in June 2005 was because Mr. Z was depressed and anxious and had a history of overdoses. It is unclear what happened to this referral, but following Mr. Z's presentation at Accident and Emergency on the 5 July 2005 he was seen by a Community Psychiatric Nurse from the CMHT and a risk assessment was commenced. However on this occasion Mr. Z's risk to himself was not explored.

On the 22 August 2005 Mr. Z was assessed by an Adult Psychotherapist following a referral made by Consultant Psychiatrist 1. During the assessment it was noted that there were concerns about past risk but that Mr. Z's current living arrangements would provide a protective factor (it is unclear what this assertion was based upon especially since Mr. Z's living arrangements appeared to be causing him stress). These risks were not specified. No formal risk assessment was undertaken.¹⁶³

On the 10 October 2005 Mr. Z met once again with the Adult Psychotherapist to continue pre-therapy assessment. On this occasion it was recorded that the risks Mr. Z presented to himself related to alcohol, which he said he no longer drank, and these risks were deemed to be low. No formal risk assessment was undertaken.¹⁶⁴ On the 31 October 2005 the final assessment took place and Mr. Z subsequently commenced a counselling programme.

On the 26 June 2007 Mr. Z was seen in the Outpatient Clinic by Consultant Psychiatrist 2. Mr. Z said that he was having nightmares and had thoughts of slashing his wrists or taking an overdose. A referral to Psychotherapy Services was decided upon. No risk assessment was conducted.

The next mention of risk in Mr. Z's clinical record is on the 27 September 2007. On this occasion Mr. Z had been assessed on a medical ward at the North Manchester General

163. Witness Transcription.

164. North Psychotherapy Notes PP. 110-112

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Hospital following an impulsive overdose of mixed medication and a bottle of whiskey. It was recorded that a full mental state examination and risk assessment was conducted on the “*CHORES form*”.¹⁶⁵ This form is no longer within Mr. Z’s Clinical record. However the remaining extant record states that Mr. Z was considered to be a current low risk of self harm. It was also noted that Mr. Z was not abusing alcohol even though the overdose had included a bottle of whiskey (it had also been recorded in the GP record that Mr. Z had been admitted to the Pennine Acute Hospital on the 19 August 2007 with a severe upper gastro intestinal bleed indicative of high alcohol consumption). Consultant Psychiatrist 2 was informed. No further risk assessment was undertaken.

On the 31 October 2007 Mr. Z was assessed once again by the Psychotherapy Service following the June 2007 referral from Consultant Psychiatrist 2. A Screening Clinic Proforma was completed. It was recorded on this form that Mr. Z had taken an overdose four months previously and that he had attended the Accident and Emergency Department after self harming due to traumatic memories. When Clinical Witnesses were interviewed by this Investigation it became apparent that at this stage Mr. Z’s forensic history was not known to the person undertaking the assessment. Mr. Z’s main risks were thought to be those of harm to self and under the proforma heading ‘Assessment of Risk’ it was recorded “*Not presently has in past*”.¹⁶⁶ However because Mr. Z was thought to be a “*moderate*” risk of suicide he was referred on for an assessment with another therapist to see whether Cognitive Analytic Therapy (CAT) could be expedited. No formal risk assessment was conducted at this stage and when Consultant Psychiatrist 2 was written to no mention was made regarding the concerns relating to Mr. Z’s moderate risk of suicide.¹⁶⁷

Despite the referral being expedited due Mr. Z’s moderate risk of suicide he was not seen for assessment for CAT until 31 January 2008. Due to Mr. Z not being available further assessment for CAT was postponed until the 4 March 2008. On this date a risk assessment screen was conducted although the documentation was not completed and many of the assessment fields were left blank. It would appear that no risk management strategy resulted from this exercise.¹⁶⁸

165.AMIGOS Notes P.2

166.North Psychotherapy Notes PP.146-149

167.North Psychotherapy Notes P. 18

168.North Psychotherapy Notes PP. 73-74

Psychiatric Liaison Services conducted risk assessments following Mr. Z's overdoses in 2007, 2008 and 2010; however no CHORES documentation has been retained in the clinical record. There are no other risk assessment activities recorded within Mr. Z's clinical notes in relation to his acts of self harm and the risk that he may have presented to himself.

Clinical Witnesses to this Investigation described Mr. Z as being unkempt and as having a strong body odour. It was evident that he was neglecting himself. It was also evident that he frequently described thoughts of harming himself and that on three occasions between June 2005 and November 2010 he had resorted to self harming. Whilst these things are noted in the clinical record it is evident that no risk management plan was formulated and pertinent risk information was not shared in a consistent manner between members of the disparate treating team.

Risk to Mr. Y

At the point of his first presentation to Manchester mental health services on 5 July 2005 it was known that Mr. Z had a previous forensic history which had involved the stabbing of a person he knew well some 22 times. It was also known at this time that Mr. Z had thoughts of harming Mr. Y and had taken a Stanley knife and a rock from the garden with the intention of hitting him over the head and attacking him whilst he lay sleeping. Mr. Z was also noted to be experiencing visual hallucinations of some kind. Consequently Mr. Z was referred to the CMHT for assessment.

Mr. Z was assessed by a Community Psychiatric Nurse (CPN) from the CMHT on the 7 July 2005. A 'Violence Risk Assessment Tool' form recorded that Mr. Z:

- had stabbed a male partner 20 times with a carving fork in 1989 (incorrect date but this is what was recorded in the Clinical record);
- had thoughts of and plans to seriously harm Mr. Y;
- had been arguing with Mr. Y whereupon he had lost control and started to smash things in the flat that they both shared;
- had anger control issues;
- had difficulties forming and maintaining close relationships;
- was observed to be angry and verbally abusive during the assessment and maintained a glaring eye contact.

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The plan was to:

- monitor wellbeing by maintaining regular telephone contact;
- give Mr. Z the telephone numbers of the out of hours services;
- set up initial outpatient consultant appointment;
- discuss areas for service provision and CPN allocation at next team referral review meeting;
- consider breaching patient confidentiality on a need to know basis due to the high risk to his partner.

The assessment concluded that Mr. Z was high risk. As well as the points set out above the plan included to “*raise anger management awareness*”.¹⁶⁹

On the 8 July 2005 the CPN discussed the case with the CMHT and the risks to Mr. Y were identified. It was arranged that daily contact would be made by telephone with Mr. Z. The CPN was concerned that Mr. Z’s risk to others was high. However on the 12 July 2005 it was decided that Mr. Z would not be retained by the CMHT and he was discharged. This effectively marked the end of all formal risk assessment and management processes. It would appear that at no stage was Mr. Y notified that Mr. Z had expressed both thoughts and plans to cause him serious harm.

Consultant Psychiatrist 1 referred Mr. Z to Psychotherapy Services on the 9 August 2005. He had conducted an assessment which accompanied his referral letter. Whilst the letter is retained in the clinical record the assessment does not appear to be. However the Consultant did send a copy of his assessment to the GP. It is important to note that whilst Mr. Z’s past offending history and violence was recorded his recent thoughts of wanting to harm Mr. Y were not mentioned. In effect neither the GP nor the Psychotherapy Services understood Mr. Z’s current presentation and thought processes.¹⁷⁰

On the 10 October 2005 during assessment with Psychotherapy Services Mr. Z told the Adult Psychotherapist that he recently planned to seriously harm Mr. Y whilst he slept. Mr. Z gave the Psychotherapist very specific details of his plans. It was recorded that the main risks were those of violence towards other people and that this would need to be monitored throughout

169. AMIGOS Notes, P.1 & NM Notes PP.6-11 & NM Notes PP.70-71

170. NM Notes PP. 23-26

therapy. It appears that no attempt was made to contact Consultant Psychiatrist 1 at this stage to discuss these risks and to plan a risk management strategy. At this stage both Consultant Psychiatrist 1 and the Adult Psychotherapist knew about Mr. Z's risk profile but only because he self-reported to them individually. The Psychotherapy assessment information was not shared with the Consultant Psychiatrist until the end of November 2005.

During 2006 Mr. Z received counselling. On the 21 September 2006 it was recorded by the Counsellor that *"I showed him the Core form (he asked for a copy) and he was surprised and pleased that in the relevant week he had a risk score of 0"*.¹⁷¹ It is not evident how the Counsellor was able to conduct an accurate risk assessment based upon what he knew of Mr. Z which was largely self-reported. It was noted towards the end of Mr. Z's counselling sessions that he still had difficulty controlling his feelings of anger but that on the whole he was feeling better and was able to use some of the techniques with positive effect that he had learned during therapy.

On the 19 August 2007 Mr. Z was admitted to the Pennine Acute Care Trust as a result of haematemesis connected with his drinking alcohol. He was in hospital for four days. Two months later Mr. Z presented at the North Manchester General Hospital with a drug and alcohol overdose. Consultant Psychiatrist 2 considered that Mr. Z would benefit from another course of psychotherapy. At this stage concerns were focusing on a potential Post-Traumatic Strass Disorder (PTSD). In October and November 2007 Mr. Z was duly assessed by Psychotherapy Services and the presence of PTSD confirmed. However at this time Psychotherapy Services were not aware of Mr. Z's forensic or diagnostic history. Relationship difficulties from the past were identified as part of the assessment process and for that reason Cognitive Analytic Therapy (CAT) was thought to be a good therapeutic avenue. When interviewed clinical witnesses from Psychotherapy Services explained that:

- CAT would not normally be considered for someone with active alcohol problems;
- partners/family members would not be considered as part of the assessment formulation if they did not attend the assessment session with the service user;
- the Trust CHORES risk assessment tool was not used routinely by Psychotherapy Services at the time;
- clinical information was not shared widely on the AMIGOS system at this time;

171. North Psychotherapy Notes PP.172-173

- carer considerations were perceived as being the responsibility of the CMHT.

It would appear that no detailed risk assessment was conducted prior to Mr. Z commencing therapy for PTSD despite this being a clear national best practice guideline from the National Institute of Health and Clinical Excellence (NICE) “*Assessment should be comprehensive and should include a risk assessment, assessment of physical, psychological and social needs*”. The guidance states clearly that any past or current risk of harm to self or others should be robustly assessed prior to treatment commencing.¹⁷²

In March 2008 a risk assessment was undertaken by the Psychotherapy Services however the form was incomplete and no formulation was developed with regard to Mr. Z’s potential risk to others although his past forensic risk was recorded.

The Independent Investigation noted that Mr. Z did not discuss or report any ideas that would indicate he planned to harm Mr. Y or anyone else that he knew following his initial entry into secondary care mental health services, although he did report arguments with Mr. Y that could result in “*fisticuffs*”.¹⁷³

Safeguarding Vulnerable Adults and the Safety of Mr. Y

Mr. Y is a ‘shadowy’ figure mentioned throughout Mr. Z’s Clinical records as being his ex-partner, flatmate and friend. It is evident that Mr. Z had difficulties with relationships and that he had a relationship with Mr. Y that was often of an argumentative nature. During the initial contact that Mr. Z had with the Trust in June 2005 it was evident that not only did he harbour thoughts of killing his friend but that these thoughts had actually been formulated into a plan which involved a Stanley knife and rock from the garden which he kept in readiness under his bed. This information was given feely by Mr. Z together with the fact that he had previously stabbed a former partner 22 times with a carving fork. At this stage Mr. Z’s risk to others was considered to be high and care plan was put into place. It is evident from reading the Clinical records that the Community Psychiatric Nurse who undertook Mr. Z’s assessment on behalf of the Community Mental Health Team considered breaching patient confidentiality in order to inform Mr. Y about the risk presented to him which was considered to be real. It is not recorded in the clinical record why no further action was taken but it would appear that Mr. Z

172. National Institute for Clinical Excellence, Quick reference Guide, *Post-Traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care*. (2005) PP. 8-11

173. North Psychotherapy Notes PP.169-170

was not thought to be suffering from a severe and enduring mental illness and was duly discharged from the CMHT after a period of some five days, presumably the risk to Mr. Y was still present but had not been communicated to him at this stage.

During 2006 Mr. Z discussed his life with his Counsellor. He described having difficulty controlling his anger and that it was hard not to argue with Mr. Y. Mr. Z said that the relationship could be difficult and the arguments could at times be “*frightening*”.¹⁷⁴ Mr. Z also mentioned to the Counsellor that he had missed a counselling session on the 11 May 2006 because Mr. Y had slipped into a diabetic coma.¹⁷⁵ The Independent Investigation Team understands how this information could be interpreted with a hindsight bias, however when taken into a risk context the following was known:

- Mr. Z had a previous conviction for stabbing;
- Mr. Z had previously told clinicians that he was planning to kill Mr. Y;
- Mr. Z described an argumentative, and at times, physically violent relationship with Mr. Y;
- Mr. Z mentioned that Mr. Y had lapsed into a diabetic coma.

It would appear from the evidence presented to this Investigation that Psychotherapy Services would not normally see a role for itself as a working intermediary between ongoing social and relationship issues. This Investigation was told that this would normally fall under the *aegis* of the CMHT. As has been already identified in subsection 12.1.4., had a CMHT been involved then a more holistic approach may have been taken and the potential for future risk identified. By 2006 not only was it known to the service that Mr. Z had anger control problems, a history of assault, and occasional thoughts of harming either himself or others, it was also known that Mr. Y suffered from a physical condition that at times could render him both helpless and vulnerable.

12.1.5.3. Conclusions

Findings and Conclusions of the Trust Internal Investigation

The Trust internal investigation report identified the following points relating to the management of Mr. Z’s clinical risk.

174. North Psychotherapy Notes PP.163-164

175. North Psychotherapy Notes PP.161-162

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1. At the time of Mr. Z's first contact with the Outpatient Clinic in 2005 risk assessment processes did not include a separate risk assessment schedule and the CHORES form was not completed. This meant that Mr. Z's recorded risk assessments between 2005 and November 2010 took the sole form of letters written to the GP. This was identified as being standard Outpatient practice.
2. Mr. Z's historic risk was not corroborated and relied upon self-reporting.
3. Mr. Z's first contact with the service predated the introduction of the Trust's standardised risk assessment tool. This may have influenced poor risk assessment and documentation practice, with particular reference to the communication of historic risk.
4. Mr. Z was not considered by those involved in his care to pose an ongoing risk to others. This is because his circumstances between June 2005 and November 2010 appeared to be different from the time of his first and only known conviction for assault and because he was accepting of services. The Internal Investigation Panel concluded that Mr. Z's violence to Mr. Y was unexpected and could not have been predicted.
5. The Internal Investigation Panel remained uncertain whether or not Mr. Z knew how to access mental health services in an emergency and saw no evidence that anyone had discussed this with him despite several presentations to Accident and Emergency Departments over the years.

The Independent Investigation Team concurred in general with the findings of the Internal Investigation Panel. However additional considerations have been identified which are set out below.

Risk and PTSD

It was acknowledged by all members of the treating team from 2007 onwards that Mr. Z had Post-Traumatic Stress Disorder (PTSD). It was evident that this was an unusual presentation in that it was both persistent and of long duration. NICE offers specific guidance as to the care and treatment that should be offered to individuals with PTSD. Individuals with PTSD often experience:

- flashbacks;
- impulsive behaviour;

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- hyperarousal;
- anger control problems.

Individuals with PTSD can often be at raised risk of self harm and of harming others, this risk can be increased when entering therapy which can reawakened and heighten levels of distress. Before therapy is offered it is essential that an extensive risk assessment is conducted and a management plan formulated. This was not achieved in the case of Mr. Z. When clinical witnesses were interviewed it was evident that although individuals thought they were familiar with the treatment of PTSD and the NICE guidance no evidence was brought forward to suggest that they understood the raised risk that intensive therapy can bring to this vulnerable service user group. Whilst Mr. Z appeared to benefit from therapy, and come to no harm from it, this was a significant omission on the part of the treating team.

Risk of Self Harm

Mr. Z's risk of self harm was the initial reason for his referral to secondary care mental health services in 2005. Whilst assessments took place in Accident and Emergency contexts there is no evidence that this particular aspect of his risk profile was assessed and managed by other members of his treating team.

Risk to Mr. Y

It is a fact that Mr. Z had previously stabbed a former partner with a carving fork 22 times and that in 2005 he had harboured thoughts of killing Mr. Y. The fact that Mr. Z had extreme violence as part of his behavioural repertoire should have alerted members of the treating team to the potential of this occurring again in the future. In June 2005 Mr. Z's thoughts of harming Mr. Y had escalated to a serious stage of planning in that Mr. Z had both a Stanley knife and rock under his bed in preparation of an attack upon his friend. At this time a comprehensive assessment was conducted in relation to Mr. Z's risk of harming others and an appropriate plan was put into place. However this plan was not achieved in full and it was not recorded why no action was taken to alert Mr. Y of the risks posed to his safety when they had been identified as being significant. The Independent Investigation Team concluded that this was a serious error of judgement on behalf of the CMHT. Mr. Y should have been alerted at this juncture. The fact that the CMHT decided that Mr. Z was not suffering from a severe and enduring mental illness was irrelevant. The CMHT knew Mr. Z had plans to kill Mr. Y

and it had a clear duty of care to inform him of this. The extant clinical record is incomplete and it has not been possible to piece together exactly why Mr. Z's case was not taken on by the CMHT or why no further action was taken.

During the course of this Investigation it has become evident that Mr. Y suffered from poor physical health and that he also suffered from depression and anxiety (please see subsection 12.2.). Whilst this Investigation did not conclude that Mr. Y could formally be described as a vulnerable adult, both Mr. Z and Mr. Y struggled to maintain their health, safety and wellbeing at times. It was also evident to this Investigation that both men argued and fought on a regular basis and that sometimes this could escalate into physical violence. There were several issues identified by this Investigation which may have contributed to Mr. Y's potential needs and safety issues being neither known nor understood.

1. Mr. Z and Mr. Y were registered at the same GP practice but were not routinely seen by the same GP. Neither man discussed relationship issues with their GP. It was not possible for the Practice to be aware of the social circumstances that both men were living in together.
2. Whilst Mr. Z received treatment from Manchester mental health services Mr. Y's mental health problems were not considered severe enough to require a secondary care input, therefore Mr. Y and his particular needs and vulnerabilities were not known to services.
3. Mr. Z did not receive care and treatment from a CMHT and was not considered to be eligible for CPA. This meant that a holistic approach to his care and treatment was not taken. Had this approach been taken then it is possible that help and support could have been given to both men in relation to their mental health problems and the difficulties this presented for them on a daily basis.
4. Had Mr. Z been subject to CPA he would have been in receipt of regular assessment and would have had a care plan that would have addressed his issues in a consistent manner which may have relieved the pressure that built up on a regular basis between the two men. CMHT input could also have provided support to Mr. Y in a carer capacity.

Summary

Mr. Z did not receive either comprehensive or regular risk assessment over a five-year period. Whilst it could not be predicted that Mr. Z would kill Mr. Y a serious untoward event of some kind was foreseeable. The Independent Investigation Team ascertained that Mr. Z had:

- a conviction for stabbing a former partner;
- a history of overdosing and self-harm events;
- intrusive thoughts of self harm and of harming Mr. Y;
- a turbulent relationship with Mr. Y that often resulted in “*frightening*” arguments and “*fisticuffs*”;
- a depressive illness with obsessive compulsive traits, psychoses, and PTSD;
- a history of significant alcohol abuse which was probably still ongoing;
- anger control problems;
- a tendency to act on impulse, exacerbated by his drinking alcohol.

At regular times between June 2005 and November 2010 individual clinical staff from various treating teams knew about significant information pertinent to Mr. Z’s risk profile. This information was not shared in either a systematic or timely manner. This was exacerbated by Mr. Z having been deemed not eligible for CPA and CMHT input. There was enough information known about Mr. Z to have merited a regular risk assessment and risk management plan with a consistent degree of monitoring and support. However, despite this concern, the Independent Investigation Team did not make a causal link between the murder of Mr. Y and the poor standard of risk assessment provided to Mr. Z. This is due in part to the fact that no link could be made between Mr. Z’s mental health problems and the murder of Mr. Y by the Manchester Crown Court where Mr. Z’s trial took place.

Mr. Z had a complex presentation and was clearly an unhappy and troubled individual. He received treatment from the Trust which he undoubtedly found to be of benefit. However in order for care and treatment to be delivered in an optimal manner it has to be provided in a systematic manner which takes into full consideration the risk profile of each individual service user. Had a more coherent approach been taken to Mr. Z’s risk profile it is probable that both he, and Mr. Y, would have received more effective support in the form of a care and treatment package in keeping with the actual difficulties that he had which encompassed a wide-ranging series of problems. The seeming ‘blind spot’ that members of Mr. Z’s treating

team had in the face of significant risk indicators is a point of learning. In the case of Mr. Z the fact that he was not deemed to have a severe and enduring mental illness appeared to have minimised the clinical appreciation of the risk that he may have presented with. However he had a latent risk for both self harm and violence to others which appeared to have been prone to exacerbation by alcohol and Post-Traumatic Stress Disorder symptoms and this dynamic was understood poorly. Based upon what was known, and what should have been known about Mr. Z, his case merited a more structured approach. Whilst this approach may not have prevented Mr. Z's fatal attack upon Mr. Y it constitutes an omission which contributed to the lack of review and structure that his case received.

- *Contributory Factor 5. Mr. Z's risk profile was understood poorly despite opportunities existing for a more accurate understanding to be gained. Mr. Z's needs were complex in nature and he retained a latent potential for both self harm and violence to others. This potential was exacerbated by alcohol and Post-Traumatic Stress Disorder symptoms. A more structured approach may have ensured that the problems he had were acknowledged and identified and could have been managed more effectively.*
- *Service Issue 1. The clinicians involved in Mr. Z's care and treatment did not appear to understand the risks associated with the concurrent presence of alcohol usage, depression, Post-Traumatic Stress Disorder and intensive therapy. No appropriate level of risk assessment was conducted prior to therapeutic interventions counter to extant NICE guidance.*

12.1.6. Referral, Transfer and Discharge

12.1.7.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies

communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

12.1.6.2. Findings

Initial Referral to Secondary Care Services

On the 21 June 2005 Mr. Z was referred for a psychiatric assessment by his GP due to his history of depression which had been growing worse over the past two months. It is not clear what happened to this referral, however on the 5 June 2005 the GP referred Mr. Z to the Accident and Emergency Department. On this occasion Mr. Z presented with a letter from his GP which stated that he was being referred for suicidality and depression. It remains unclear why Mr. Z was referred *via* this route.

Mr. Z was seen at the Accident and Emergency Department and following a psychiatric assessment was referred to the Community Mental Health Team (CMHT) on the 6 July 2005 with the words “*medical urgent*” recorded in his clinical record.¹⁷⁶ Mr. Z was seen by a Community Psychiatric Nurse from the CMHT on the 7 July 2005 and a detailed assessment was undertaken.

Discharge from the CMHT on 12 July 2005

On the 12 July 2005 Mr. Z was discharged from the CMHT caseload and the arrangement was made to follow him up in the Outpatient Clinic. This arrangement was to continue for a period of five years. The extant clinical record does not detail the rationale given for the discharge of Mr. Z from the CMHT caseload on 12 July 2005. A letter was sent to the GP from Consultant Psychiatrist 1 that stated the plan was to treat Mr. Z for depression prior to accepting him on the CMHT caseload. Consultant Psychiatrist 1 followed Mr. Z up in the Outpatient Clinic on the 8 August 2005 when the decision was made to refer Mr. Z to the Psychotherapy Department.

Psychological Therapy Referral and Discharge Processes

First Referral 2005

Following the referral to Psychotherapy Services being made on the 8 August 2005 a period of assessment ensued to decide whether or not Mr. Z could benefit from therapy. During the

176. AMIGOS Notes. P.1 & NM Notes PP.6-11 & NM Notes PP.70-71

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assessment period it became evident that Mr. Z had a history of previous violence towards a former partner and current thoughts of violence towards Mr. Y. At no stage during the assessment was additional information sought from Consultant Psychiatrist 1.

It was not until the 6 April 2006 that Mr. Z commenced counselling. It must be noted that when Consultant Psychiatrist 2 took over the responsibility for Mr. Z's case in February 2006 he understood that Mr. Z was already in receipt of psychological therapy even though it had not yet commenced.

On the 12 October the Counsellor wrote to Consultant Psychiatrist 2 to say that the planned 15 sessions of counselling had come to an end. He also wrote again on the 21 February 2007 after Mr. Z had received his follow up appointment. The communication in these letters was both clear and detailed.

Second Referral 2007

When Mr. Z's mood began to worsen in June 2007 he was referred by Consultant Psychiatrist 2 to Psychotherapy Services again. On the 31 October 2007 Mr. Z was assessed and it was decided that he may be eligible for Cognitive Analytical Therapy (CAT). Consultant Psychiatrist 2 was written to and informed that Mr. Z would be assessed for CAT and that the process would be expedited due to Mr. Z's depression and suicidal thoughts. The assessment process continued on until April 2008. Concerns were raised regarding the referral because of Mr. Z's history of violence; however these concerns were not pursued with Consultant Psychiatrist 2 apart from a message left on an answer-machine service. Mr. Z commenced CAT on the 7 May 2008 almost a year after the initial referral took place. Mr. Z attended his final meeting with the CAT Therapist on the 9 February 2009. Consultant Psychiatrist 2 was not written to with a summary of the therapy until the 23 September 2009.

Third Referral 2010

On the 19 November 2010 Consultant Psychiatrist 2 made a referral for Mr. Z to receive some "booster" sessions for his Post-Traumatic Stress Disorder symptoms. This referral was not processed due to Mr. Z killing Mr. Y on the 21 November 2010.

12.1.6.3. Conclusion

Initial Referral to Secondary Care Services

The Independent Investigation Team considered the delay of two working days between Mr. Z presenting at the Accident and Emergency Department on the 5 July 2005 and his assessment by the CMHT on the 7 July 2005 to be potentially problematic. This is because Mr. Z:

- presented in a complex manner with depression and psychotic symptoms;
- described his thoughts and plans to knife his flatmate;
- disclosed a history of having committed a serious stabbing in the past;
- was irritable, abusive and presented in a menacing manner;
- had thoughts of self harm.

Taking all of these factors into account a same day assessment was probably indicated. The Independent Investigation Team concluded that Mr. Z's initial referral to secondary care mental health services in the summer of 2005 could have been managed in a more timely manner considering his presentation and that an assessment by the CMHT should have been requested with immediate effect rather than incurring a delay of some 48 hours.

Discharge from the CMHT on 12 July 2005

Once the CMHT became involved a robust initial risk assessment and care plan was developed. It is difficult to understand why Mr. Z was discharged from the CMHT on the 12 July before his assessment had been completed and his initial care plan implemented. There is no extant record available to clarify this matter and no witnesses were available to this investigation who worked with Mr. Z during this period.

The Independent Investigation Team concluded that Mr. Z may have benefitted from a longer period of time with the CMHT and that discharge at this stage represented a missed opportunity as it brought to a close his chance to have an 'Enhanced' CPA package which would have ensured a comprehensive risk assessment and risk management plan, which at the time were clearly indicated as being required. According to the evidence available to this Investigation at this particular stage Mr. Z met the Trust criteria for acceptance onto the CMHT caseload.

Psychological Therapy Referral and Discharge Processes

The Independent Investigation Team thought that the decision to refer Mr. Z to Psychotherapy Services was clearly indicated and in accordance with national policy guidance. It was noted that there were significant periods of time between Mr. Z being referred and actually commencing his therapy programmes. Witnesses to this Investigation explained that when individuals were/are referred to the Psychotherapy Service unless the referral letter specifies the need for urgency they are put onto a waiting list to be screened. The aim is to screen people within three months of the referral being made. This is what occurred in the case of Mr. Z as he was referred to the department with no indication of any urgency or great priority. This Investigation heard that for non urgent cases the normal time between referral and screening would be three months, and between screening and the commencement of therapy some nine to twelve months.

Mr. Z's three referrals to the Psychological Service were prompted by his reaching a state of crisis and presenting himself at Accident and Emergency. Due to the long periods between referral and commencement of therapy that could reasonably be expected it may have been a good practice to have ensured that Mr. Z received some additional support in the intervening period in order to ensure a more timely response to his needs. The Psychiatrist did not seem to be aware of the process of assessment and then waiting for treatment as at times he seemed to think Mr Z was being treated when he was being assessed or waiting after being assessed.

The Independent Investigation Team also noted that there were no communication processes in place following either the referral process or during the assessment period between the Therapists and Consultant Psychiatrists 1 and 2. This is of particular note as assessment raised many significant risk issues. This Investigation was told that this is not such an issue at the current time as the AMIGOS electronic record system is now used widely and key service user information is available at stage of the patient care pathway. Communication processes were also delayed following Mr. Z's discharge from Psychotherapy Services in 2009 when it took seven months for the discharge letter to be sent to Consultant Psychiatrist 2.

Summary

The issues relating to Mr. Z's initial referral to secondary care mental health services in June 2005 and his rapid discharge from the CMHT in July 2005 have already been explored in subsections 12.1.4. and 12.1.5. Whilst Mr. Z may have benefitted from being placed on the

CMHT caseload this single decision alone at this stage cannot be seen as being a significant factor in the killing of Mr. Y. This Investigation heard that Consultant Psychiatrist 2 considered referring Mr. Z to the CMHT in 2009 to ensure that he had a better level of support. Had this referral taken place, once again, it is not possible to determine whether the course of events that led to Mr. Y's death could have been altered. The Independent Investigation did however conclude that Mr. Z would have been best placed with a CMHT so that he received appropriate Care Coordination and that referral decisions in both 2005 and 2009 contributed to a less than optimal approach being taken to the assessment and ongoing management of Mr. Z's needs. At the very least a period of time with the CMHT would have ensured a comprehensive level of assessment which may have yielded information about Mr. Z which was only understood after the death of Mr. Y, such as his probable continued heavy drinking.

No issues of significance were found regarding Psychotherapy Service referrals, but it was noted that an over reliance was perhaps placed on the ability of these services to alleviate Mr. Z's needs once he had reached a point of crisis and that other support mechanisms needed to have been identified as well in order to ensure a more timely response was made. This brings the conclusion summary back full circle to the point that CMHT intervention should have been considered.

- *Contributory Factor 6. Referral decisions about Mr. Z served to divert him away from services which may have been able to provide a holistic range of support. The referral decisions regarding Psychotherapy input were clinically indicated but could not provide a timely response to Mr. Z's needs following episodes of crisis.*

12.1.7. Carer Communication and Involvement

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that *“the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at*

meeting their wishes". In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. Also that it will *"deliver continuity of care for a long as this is needed"*, *"offer choices which promote independence"* and *"be accessible so that help can be obtained when and where it is needed"*.

Carer Involvement

The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required.

Further to this, The Carers and Disabled Children Act (2000) gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act (2004) placed a duty on Local Authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- have their own written care plan which is given to them and implemented in discussion with them.

12.1.7.2. Findings

Mr. Z was not perceived by members of his treating team to have a carer in the literal meaning of the sense as he was not thought to have a mental illness that required the acknowledgement of a person in this kind of relationship. However Mr. Z lived with Mr. Y who was his ex-partner and closest friend. At the time Mr. Z received his care and treatment from the Trust he was estranged from his family and Mr. Y, and Mr. Y's family, were the people closest to him.

As has been mentioned in subsection 12.1.5., Mr. Y was a 'shadowy' figure to members of Mr. Z's treating team. However it was known that Mr. Z and Mr. Y had a difficult relationship together. It is a fact that at the point of Mr. Z's first presentation to the Trust in the summer of 2005 he described both thoughts of, and fully formulated plans to, cause serious harm to Mr. Y. It is also a fact that Mr. Z continued to describe a relationship with Mr. Y that could, and did, escalate into physical violence on occasion.

It was recorded during the psychological therapy assessment in October 2005 that concerns had been identified. Mr. Z had been abused as a child and the assessing Therapist wrote "*my anxieties were raised in the counter-transference by his description of violence but simultaneously felt optimistic about being open and honest*".¹⁷⁷ It was noted that Mr. Z's past relationships where violence had been a factor, both as a victim and a perpetrator, had featured those close to him.

Based upon this knowledge and understanding of Mr. Z's relationship with Mr. Y, and his thoughts and feelings about his past, a better understanding of Mr. Y was clearly indicated. As has been examined above, it was not, and is not, usual practice for clinicians operating from an Outpatient Clinic, or within a Psychotherapy Service, to meet with family members and work with family relationship issues unless that person/or persons routinely accompanies the service user to appointments. This kind of intervention and involvement is usually provided by a CMHT *via* a Care Coordinator. Had this kind of service been available to Mr. Z then issues pertinent to Mr. Y may have been identified and managed. It may have been possible to:

177. North Psychotherapy Notes PP.110-112

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- have undertaken a home visit which would have helped assess Mr. Z's social context and provided an opportunity to meet with Mr. Y;
- understand better the relationship between the two men, especially the violence between them and the potential risk of harm to Mr. Y;
- provide an opportunity to obtain some collateral information about Mr. Z and to understand whether Mr. Y had any particular support needs in relation to coping with Mr. Z's mental health;
- provide an opportunity to understand whether or not Mr. Z required support in relation to Mr. Y's care needs.

One important factor which is only hinted at in Mr. Z's clinical record is the fact that Mr. Y also had health issues. Mr. Y suffered with mental health problems; he was agoraphobic and suffered from some kind of obsessive compulsive disorder. Mr. Y also had physical health problems and was a diabetic. Mr. Z disclosed to his Counsellor in 2006 that Mr. Y had experienced a diabetic coma with which he had had to deal. It would appear that both men had health problems which impacted upon their ability to live their lives to the full and that both in effect provided a caring and supportive role one to the other. However this relationship which was mutually co-dependent could also erupt into violence and rows of "*frightening*" intensity.

12.1.7.3. Conclusions

Trust Internal Investigation

The Trust Internal Investigation Panel noted that Mr. Z's next of kin details were never recorded during the five-year period that he received services from the Trust. In an Outpatient context this information would normally be sought at the point of registration. For some reason this information did not appear to have been captured for Mr. Z and there was no process for "*chasing the missing data*".¹⁷⁸ The Panel considered that the lack of data may have reflected a lack of awareness of Mr. Z's home situation and indicated the need for a wider appreciation of social issues. The Independent Investigation concurs with this conclusion.

178. Internal Investigation Report P.16

Summary of Independent Investigation

National policy best practice guidance would suggest that carer assessments are offered in 100% of cases for individuals in receipt of CPA. As this report has already identified, Mr. Z was not considered to have been eligible for CPA. The Trust CPA policy does not define who exactly would constitute a carer and this in itself may create confusion as it does not recognise that carers can come in many forms and provide many functions. The policy does however state that *“Carers (including young carers) should be identified during the assessment process. If someone is providing care on a regular and substantial basis, they must be informed of their right to an assessment of their caring, physical and mental health needs”*.

It is perhaps a moot point to discuss whether either man was a carer to the other or not. This Investigation concluded that both men had a complex range of needs which they struggled to meet. Each man appeared to undertake a carer role when the situation arose. For example Mr. Z looked after Mr. Y when in a diabetic coma, and Mr. Y called an ambulance for Mr. Z following his overdose in March 2008. Mr. Z described their relationship as being difficult but they remained each others’ *“rocks”*.¹⁷⁹

The Independent Investigation Team concluded that CPA is an essential tool when providing care and treatment to complex service users. CPA not only provides in-depth, ongoing risk assessment and care planning, but also ensures that a holistic approach is taken to encompass all aspects of a person’s life. The relationship that Mr. Z and Mr. Y had together was problematic. Enough was known at the point of first contact to merit an immediate visit to Mr. Y to ensure his safety and to seek collateral information. As Mr. Z’s care continued through time it was evident to the Independent Investigation Team, based upon the content of Mr. Z’s case notes alone, that there were significant issues relating to Mr. Y and his role in Mr. Z’s continued wellbeing. Because Mr. Z’s case was diverted through the Outpatient Clinic route at such an early stage he rapidly became ‘typecast’ as not requiring any social care or wider holistic assessment. Regardless of the evidence that accrued over time to suggest otherwise, there was no single clinician who could take an overview of the case and ensure that Mr. Z’s home situation was understood.

179. North Psychotherapy Notes PP.163-164

- *Contributory Factor 7. Mr. Z had a turbulent relationship with Mr. Y which was both supportive and problematic at the same time. Both men, by virtue of a mix of physical and mental health problems, found it difficult to live their lives to the full and this created tension within the home that both shared. The kind of secondary care service that Mr. Z received precluded home visits and a holistic assessment approach and this was ultimately to the detriment of the wellbeing of both Mr. Z and his friend Mr. Y.*

12.1.8. Service User Involvement in Care Planning

12.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

“... the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes”.

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *“... people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care”*. It also stated that it will *“... deliver continuity of care for as long as this is needed”, “... offer choices which promote independence”* and *“... be accessible so that help can be obtained when and where it is needed”*.

12.1.8.2. Findings

Mr. Z was provided with regular support for his mental health issues. It was evident from an examination of the Clinical record that Mr. Z was consulted about the treatment options open to him and that he was able to determine a treatment pathway that was acceptable to him. Mental healthcare professionals were respectful of Mr. Z and sensitive to his needs and situation.

The Independent Investigation Team however found a significant amount of information about Mr. Z which members of his treating team did not know. It was evident to this Investigation that Mr. Z was a poor raconteur of his own history and he often gave information which was potentially misleading to clinicians providing care and treatment to him. An example is that Mr. Z gave an account of having agoraphobia and an obsessive compulsive disorder. This may have been the case, but if accurate would have been of short duration as it is not mentioned in any of his previous clinical records. It is a fact however that Mr. Y suffered from these conditions and it is possible that for whatever reason Mr. Z had somehow 'adopted' them.

Another key issue is that of Mr. Z's alcohol dependence and chaotic lifestyle. The Psychological Service risk assessment policy notes that individuals may often mask and deny key destructive behaviours when in therapy as they may wish to present themselves in a positive manner to their therapist. In the case of Mr. Z this was problematic as his alcohol consumption coupled with Post-Traumatic Stress Disorder and impulsive behaviour made for a potentially high risk combination, the dynamic of which was never understood properly. This was compounded by members of Mr. Z's treating team demonstrating a very limited professional curiosity into his past psychiatric history, an exploration of which would have given them a more accurate picture upon which to build a case management strategy.

12.1.8.3. Conclusions

The Independent Investigation Team concluded that every effort was made to ensure that Mr. Z received a treatment programme that was person-centred and planned in accordance with his presenting needs and wishes. However Mr. Z had a complex presentation and problematic forensic history. At the point of his entry into mental health services the decision was made to divert him away from Community Mental Health Team Services and this meant that the initial assessment phase was short lived and embryonic. Mr. Z's case management never recovered from this initial referral decision and made a significant contribution to Mr. Z's ongoing care being delivered in a reactive manner which did not take into account his wider needs and could not be expected to make an impact upon factors which remained unknown and unexplored.

- *Contributory Factor 8. Mr. Z received sensitive and person-centred care. However he was not understood in the full context of either his psychiatric history or his*

current alcohol consumption and social care needs. This meant that the care plan put into place for Mr. Z could not provide the range and depth of service that Mr. Z needed in order to be able to affect the problems that he had.

13.1.9. Documentation and Professional Communication

12.1.9.1. Context

'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion'.¹⁸⁰

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone.¹⁸¹ The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.¹⁸² The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.9.2. Findings

The Trust Internal Investigation Panel found that overall the standard of communication between services was good. Following each Outpatient Clinic appointment a detailed letter was sent to the GP and it was found that the GP was satisfied with the information he received. There is evidence to demonstrate that letters were sent to the GP from Liaison Psychiatry following each of Mr. Z's emergency presentations. It was also noted that following each period of therapy a summary letter was sent to Consultant Psychiatrist 2 and

180. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P.121

181. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). P.144.

182. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

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the GP. The delay in sending the summary letter from Psychotherapy Services (between therapy ceasing in February 2009 and the letter being sent to Consultant Psychiatrist 2 in September 2009) was identified but the Panel did not consider that this had a negative impact upon Mr. Z's care. Some inconsistencies in the way in which Mr. Z's management plan was communicated were also identified following Mr. Z's emergency presentations. The Independent Investigation Team concurred broadly with the findings of the Internal Investigation Panel, but found some additional points of learning.

Documentation

This Investigation found that the general standard of record keeping was good. This was however compromised by incomplete assessment documentation and the variation in usage of AMIGOS, the Trust electronic record. It was evident that Mr. Z's clinical record was at times incomplete and fragmented which meant that not everything that was known about Mr. Z was either recorded or placed onto a system that could be shared by each member of the disparate treating team.

Professional Communication

The Independent Investigation Team found that the issue fell under the heading of professional communication. There were seven issues of note.

First. Mr. Z's Psychiatric history was self reported at the point of his entry into mental health services. This information was of a significant nature especially so since he presented at this stage with violent thoughts and plans of stabbing Mr. Y. At no stage did it appear that corroboration of this psychiatric history was sought. At the time Mr. Z entered Manchester-based services in 2005 it is probable that his previous clinical record was still extant and would have been easy to obtain.

Second. Communication with Mr. Y should have taken place with immediate effect at the point of Mr. Z's first contact with secondary care mental health services. Based upon what the treating team knew about Mr. Z at the time this kind of action was clearly indicated. The factors known at this stage were:

- Mr. Z's previous forensic history of committing a stabbing;
- Mr. Z's current thoughts and plans of causing serious harm to Mr. Y;

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- Mr. Z's anger control issues, suicidal thoughts and psychotic symptoms which became evident during assessment.

The risks to Mr. Y and to others at this stage were deemed to be high and would have been good practice for Mr. Y to have been informed of the situation.

Third. Consideration should have been given to communicating with the Police. This would have been entirely reasonable at the point of Mr. Z's first contact with secondary care mental health services. It would have been good practice to have checked with the Police whether or not Mr. Z's previous forensic history was correct and to ascertain whether or not he had been in any other kind of trouble since. It is a fact that evidence was brought forth at Mr. Z's trial to suggest that he had been involved in other violent incidents in the past, usually when intoxicated with alcohol. At this early stage a great deal of additional information could have been sought and Mr. Z's immediate risk to others assessed more comprehensively. Consideration should also have been given to report the threats made about Mr. Y to the Police as part of protection strategy for him.

Fourth. Communication between mental health services regarding risk and assessment processes were weak, both in regards to the regularity and content of what was provided. The detail of information passed between the Outpatient Clinic and Psychotherapy Services did not include a full history of Mr. Z or a detailed analysis of his risk. Communication was considered by this Investigation to be weak on both sides. An example of this is at the point Mr. Z's first referral to Psychotherapy Services when details of his forensic history were not given by Consultant Psychiatrist 1, and subsequently information gleaned from the psychotherapy assessment regarding Mr. Z's potential risk was not shared in return in a timely manner. This meant that two separate Trust departments delivering care to Mr. Z did not share relevant risk information.

Fifth. Communication between primary and secondary care was good from the Outpatient Clinic to the GP, but as is usually the accepted norm nationally, communication from the GP surgery to the Outpatient Clinic was largely non-existent. It was evident from an examination of the GP-held record that a great deal of information pertinent to the ongoing care and treatment of Mr. Z by secondary care mental health services was held by the GP but not shared. This kind of situation is common. Had Consultant Psychiatrist 1 and 2 been in receipt

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of Mr. Z's psychiatric and social history which was held by the GP then a more in depth understanding of him would have been gained from an early stage. Had Consultant Psychiatrist 2 been informed by the GP of Mr. Z's haematemesis in 2007 then he may have realised that Mr. Z had probably continued to drink heavily. It is not possible for a busy GP to provide a thorough psychiatric history for all of the referrals made to secondary care mental health services. This illustrates once again the importance of CPA and the role of a Care Coordinator whose job it is to conduct a full psychiatric history.

Six. Consultant Psychiatrist 2 took over Mr. Z's case in February 2006. Consultant Psychiatrist 1 left the organisation the same day that Consultant Psychiatrist 2 inherited his caseload. This had a negative impact upon the quality of the clinical handover that he received. In effect the only handover Consultant Psychiatrist 2 had to rely upon was a solitary read through of each patient's clinical records prior to meeting them for the first time in the Outpatient Clinic.

Seventh. The AMIGOS system was not widely available to all members of Mr. Z's treating team at his point of entry to the service. Over the five-year period that ensued, although AMIGOS was adopted throughout the Trust services, such as the Psychotherapy Service and Liaison Psychiatry, did not always enter case notes upon it.

12.1.9.3. Conclusions

It is a fact that Manchester-based health services (primary and secondary care combined) held most of the clinical information that was extant about Mr. Z. However this knowledge was not communicated between services. Based upon what was known about Mr. Z, and what was thought to have been known about him at his point of entry to the service, his case merited a high degree of corroboration as part of the initial assessment process which would have benefitted from being extended beyond the five days that he was held by the Community Mental Health Team.

The Independent Investigation Team heard from several psychotherapy-based witnesses that relevant risk pertinent information would always be shared with other members of the treating team outside of the therapeutic relationship. However no clear boundaries appeared to exist to provide guidance about when such information sharing should take place. Psychotherapy witnesses described the service user/therapist relationship as being bound by a

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level of confidentiality over and beyond that of a usual therapeutic relationship. The prevailing concern of the psychotherapy witnesses was that service users would not feel safe if they thought that sensitive and personal information could be shared more widely to other members of their treating team, and that this would impact negatively upon therapeutic effectiveness. Whilst this is laudable and good practice, the Independent Investigation Team felt concern that in the case of Mr. Z the boundary had become too rigid and that therapists may no longer have been alert to the fact that some of the risk pertinent information should have been shared with Consultant Psychiatrist 2. At the very least Mr. Z's permission should have been sought for such an intervention to have taken place.

In the case of Mr. Z the notion of confidentiality prevented information about Mr. Z flowing in a timely manner. Mr. Y was not informed by mental health services in July 2005 about the potential risk posed to him, and Consultant Psychiatrist 2 was not informed in full by Psychotherapy Services exactly how volatile the relationship was that Mr. Z shared with Mr. Y. In the face of such a pertinent forensic history coupled with intrusive thoughts of causing further harm to Mr. Y, Mr. Z's risk assessment and risk management strategy should have afforded a high degree of clarity as to monitoring and communication processes. It also has to be noted that both Consultant Psychiatrist 1 and Consultant Psychiatrist 2 provided information at the point of referral to Psychotherapy Services which was not comprehensive and did not provide all the information that needed to be known.

In February 2006 Consultant Psychiatrist 2 took over Mr. Z's case. At this time he did not receive a handover of the case when Consultant Psychiatrist 1 left the Trust. A comprehensive assessment of Mr. Z had never taken place and Consultant Psychiatrist 2 inherited a case which had been diverted away from the Community Mental Health Team and into the Outpatient Clinic. By this stage the case had been 'de-escalated' and Consultant Psychiatrist 2 worked on the pre-recorded diagnosis that depression was the primary process at play.

The Independent Investigation Team concluded that the standard of general record keeping was good, with the exception of the use of the AMIGOS system which was not always used to best effect. The main issue identified by the Independent Investigation Team was the quality and timeliness of professional communication. It would appear that Mr. Z's case could have been both understood and managed more effectively had:

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- increased efforts been made when he entered the service to gain collateral information about him;
- risk information been communicated to Mr. Y;
- collateral information been sought from the GP;
- more information been sent at the point of referral to, and discharge from, Psychotherapy Services;
- risk pertinent information flowed between services during the time Mr. Z was receiving his psychotherapy.

It was evident to the Independent Investigation Team that most of the information known, or thought to be known, by members of Mr. Z's treating team, had in fact been communicated by Mr. Z himself. Mr. Z shared a great deal of information about himself, and the Independent Investigation Team speculated as to how effective the communication systems described to this Investigation would be in regard to a service user who masked feelings and emotions and did not disclose information as readily as Mr. Z did. This Investigation concluded that whilst the communication between Consultant Psychiatrist 2 and Mr. Z's GP was good, an over reliance was placed upon the communication flow instigated by Mr. Z himself.

It is not possible to make either a direct or reliable causal link between the failure to inform Mr. Y about Mr. Z's thoughts and plans to cause him harm in June 2005 and his eventual death in November 2010. However this was a serious omission as Mr. Y had a right to know about any possible risk to him which outweighed any duty of confidentiality owed to Mr. Z.

Had professional communication been more proactive it is probable that a more accurate and coherent clinical picture of Mr. Z would have emerged and this would have ensured that his care and treatment was managed in a more effective manner.

- ***Contributory Factor 9. Professional communication practice was poor. An over reliance was placed upon the information that Mr. Z gave about himself and corroboration was seldom sought. Consequently the clinical picture was not based upon all of the information that was held by disparate members of the treating team***

and this meant that the care and treatment approach taken was not based upon the best evidence available.

12.1.10. Adherence to Local and National Policy and Procedure

12.1.10.1. Context

Evidence-based practice has been defined as “... *the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients*”.¹⁸³

National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in Clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding Clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 13.1.12 below.

Team Responsibility. Clinical team leaders/managers have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders/managers also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to

183. Callaghan and Waldoock, *Oxford handbook of Mental Health Nursing*, (2006) p. 328

report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.10.2. Findings

At the time Mr. Z was receiving his care and treatment from the Trust sound clinical policies pertinent to his case were in place. Between June 2005 and November 2010 several policy changes took place in relation to the Care Programme Approach, clinical risk assessment, and the use of the electronic clinical record system which brought into alignment risk assessment and recording processes.

The decision not to place Mr. Z on 'Enhanced' CPA in July 2005 could be interpreted as running counter to the extant Trust CPA policy guidance in place at the time. It was difficult for the Independent Investigation Team to understand the rationale for this decision as no clinical record was made.

It was evident that the clinical risk assessment policy was used in a variable manner and that recording processes were also variable. This Investigation found it difficult to chart how clinical risk assessment was undertaken as key risk documentation is missing from Mr. Z's extant record. It would appear that a comprehensive and documented risk assessment was not conducted in line with policy guidance at the following junctures:

- prior to psychological therapy commencing;
- following Mr. Z's crisis presentations at Accident and Emergency Departments;
- following changes to Mr. Z's mental state.

Whilst there is evidence that risk assessment did take place in a dynamic manner it was not conducted in the true spirit of the policy guidance and did not result in a coherent set of risk management plans.

The Independent Investigation Team heard that clinical staff received regular training in adult safeguarding and risk assessment training. Clinical Witnesses also explained that regular supervision and in house training was available to them on a regular basis. These processes were described as the main vehicles through which professional updating took place. This Investigation observed that there was a potential disconnect between the therapeutic route

taken by Psychological Therapy Services in relation to Mr. Z's Post-Traumatic Stress Disorder and that recommended by the National Institute for Health and Clinical Excellence (NICE).

12.1.10.3. Conclusions

The Independent Investigation Team concluded that whilst Mr. Z's care and treatment delivery fell broadly into local and national best policy guidance, there were several departures that may have served to contribute to a less than optimal approach being taken to case management and service provision.

This Investigation was told that most training in the areas of child abuse, trauma and Post-Traumatic Stress Disorder therapy was part of each Psychologists'/Psychotherapists' core training prior to professional registration. This Investigation noted that a significant majority of professional updating was self directed and that this may not always have ensured that either local or national best policy guidance was targeted as part of ongoing professional updating in a structured manner. This may have led to the understanding in some areas such as child abuse, trauma and Post-Traumatic Stress Disorder being out dated and no longer in accordance with best practice guidance.

Whilst these omissions did not in themselves lead to the death of Mr. Y, the lack of consistency in the following of both local and national best policy guidance contributed to the overall lack of coordinated case management that Mr. Z received.

- *Contributory Factor 10. The care and treatment delivered to Mr. Z fell broadly into local and national policy best practice guidance. However there were examples of clinical practice not adhering to NICE guidelines coupled with local policy adherence inconsistencies.*

12.1.11. Management of the Clinical Care and Treatment of Mr. Z

This subsection acts as a summary subsection and draws heavily from the findings set out above.

12.1.11.1. Context

The delivery of patient care and treatment in secondary mental health services is usually provided within a team context. People with mental health problems often require a high degree of case management in order to ensure that effective liaison between agencies takes place and that long-term treatment strategies are effective.

People with mental health problems can transition between services on a frequent basis. Continuity of care and robust management is essential in order to ensure that professional communication occurs in a timely manner. This is essential in providing a safe and effective level of intervention.

Key findings from other Independent Homicide Investigations (HSG 94 (27)) over the years have highlighted consistent practice shortcomings across the country in regard to:

- risk assessment and risk management;
- professional communication;
- Care Programme Approach.

12.1.11.2. Findings

The Independent Investigation Team did not find a causal link between any act or omission on the part of individual members of Mr. Z's disparate treating team and the killing of Mr. Y. At Mr. Z's trial a substantial amount of evidence was heard relating to Mr. Z's psychiatric diagnosis and mental state at the time he killed Mr. Y. The jury found Mr. Z guilty of murder and Mr. Z's plea of manslaughter was rejected. During the trial at Manchester Crown Court in the spring of 2011 whilst it was acknowledged that Mr. Z suffered periodically from depression, and that Post-Traumatic Stress Disorder symptoms probably formed part of his diagnosis, he was not thought to be suffering from a psychotic disorder or that his mental health problems played a part in the killing of Mr. Y. However regardless of the findings of the Court there are several points of learning identified by this Investigation regarding the way in which Mr. Z's care and treatment was managed.

Mr. Z presented in a complex manner to Manchester-based mental health services in July 2005. The nature of this presentation was considered by the Independent Investigation Team to have merited a more intensive period of assessment by the Community Mental Health

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Team (CMHT) in July 2005 prior to the decision being made to divert the case to the Outpatient Clinic. The Independent Investigation Team considered that the decision made to discharge Mr. Z from the CMHT after a period of five days was not indicated at this stage and that further work was required prior to this decision being made. Mr. Z's case was initially compromised by this decision in that:

- no full psychiatric history was ever formulated for him and no corroborative evidence was received;
- the initial risk assessment was not developed further despite clear indications that his risk was high;
- care plans were formulated but not implemented fully due to his rapid discharge from the CMHT;
- a holistic assessment of needs was not made.

Once Mr. Z had been diverted to the Outpatient Clinic all of the assessment processes were seemingly 'frozen in time' in that no further evaluation took place apart from mental state examinations during appointments with Consultant Psychiatrist 2. Examination of Mr. Z's case led the Independent Investigation Team to conclude that whilst Mr. Z did not appear to have a severe and enduring mental illness of the kind usually thought to merit admission to a CMHT caseload he did have a complex presentation. During the five years that he received care from Manchester-based services he received services from:

- his GP;
- the Outpatient Clinic;
- Psychotherapy Services;
- Accident and Emergency Departments (on five occasions).

It was evident that whilst Mr. Z appeared to receive benefit from Psychotherapy Services his depression and Post-Traumatic Stress Disorder symptoms remained and the resultant associated difficulties that he had went largely unabated. Mr. Z's social and relationship difficulties remained constant features. It is likely that he self medicated at times with alcohol which in turn made his relationship difficulties worse. This Investigation concurred with the findings of the Trust Internal Investigation Panel in that a re-referral to the CMHT was indicated so that a more holistic approach could have been taken and a more supportive care plan put into place. The presence of a Care Coordinator would have made certain that the

practical aspects of Mr. Z's care and treatment strategy, such as a crisis plan, were both considered and provided. It would also have ensured that an ongoing therapeutic relationship was built and maintained in a manner which could have understood his home circumstances and social context better.

12.1.11.3. Conclusions

The care and treatment that Mr. Z received had many positive aspects. He had an established therapeutic relationship with Consultant Psychiatrist 2 and access to psychological therapy which was of benefit to him. Whilst every effort was made to address Mr. Z's clinical needs it would appear that he was not truly understood in the context of his social and emotional needs, which were considerable. Mr. Z's social, emotional and clinical needs impacted one upon the other and it was evident when examining his case that a more holistic approach was indicated in order to affect a break in a somewhat vicious cycle of circumstance.

Whilst some patients thrive with Outpatient provision alone, others require a more wide-ranging approach. Mr. Z had recurrent difficulties that required a moderate to high degree of Care Coordination. This is something that a consultant psychiatrist cannot always provide in an Outpatient Clinic due to the time constraints inherent in the role. When considering all of the points which have been made in the subsections above it is evident that all of the omissions in Mr. Z's case management could have been addressed by the presence of Care Coordinator and that this individual would have benefitted from this kind of approach. It is not possible to know how Mr. Z would have fared had a Care Coordination and a CMHT placement been provided. However it is probable that a more in-depth assessment, care plan and level of engagement would have ensued which would have made a positive impact on Mr. Z's wellbeing and would have ensured that his high risk behaviours were both monitored and managed better.

12.1.12. Clinical Governance and Performance

12.1.12.1. Context

“Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which Clinical excellence will flourish”.¹⁸⁴

NHS Trusts implement Clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Z was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

During the time that Mr. Z was receiving his care and treatment the Trust should also have been subject to robust performance monitoring and review from local statutory authorities charged with the commissioning of Manchester-based mental health services.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. Y. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Z received.

12.1.12.2. Findings

A revised Governance Framework for the organisation was introduced in April 2010 and in the process of embedding at the time of the homicide of Mr. Y. This framework has a Quality Board, which is a subcommittee of the Trust Board, and is chaired by a Non-Executive Director. The Quality Board is supported by three other committees comprising the Risk

184. Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

Committee, the Clinical Governance Committee and the Patient Experience Committee, each of which is chaired by an Executive Director.

The key committees each have representatives from the Trust's Care Groups and the Care Groups in turn have developed their own governance meetings. These governance meetings include learning from serious incidents, complaints and claims. They also provide a Care-Group based opportunity to review information on best practice, policy development and clinical audit and monitoring checks.

In September 2010 the Trust Board commissioned an independent review of the efficacy of the organisation's quality governance arrangements to ensure that any necessary improvements were made in preparation for the Trust's application to become a Foundation Trust. The framework for the review was pursuant to the standards of Quality Governance set by Monitor. The review comprised of interviews with a range of staff at all levels of the organisation, attendance and observation of the Trust Board and key sub committees to analyse and test the governance structure, observation and quality walks to a range of services, mainly unannounced and a review of over 200 policies, procedures, minutes, papers, investigation reports and electronic systems.

In November 2010 the Trust received a full report of the Quality and Governance review. The review found that the Trust had many characteristics of a high performing organisation and that the quality governance infrastructure was capable of delivering continual improvement. The Trust was rated with an overall Quality Governance score of 1.5 rating out of 4.0 (with lower scores indicating higher levels of assurance), using Monitor scoring criteria.

The report proposed a number of recommendations and to ensure that the required improvements were made a Governance action plan was developed and monitored on a monthly basis through the Trust Quality Board. Delivery of the action plan was completed in July 2011. During the early part of 2011, the Trust commissioned a detailed review of its key areas of clinical service and developed a wide-ranging clinical strategy for the organisation.

There are seven key themes to the strategy:

1. a new emphasis on community health and wellbeing throughout the city;

2. services focused on recovery and on connecting with people with the life of their communities;
3. a stepped care model for community mental health services, with care pathways for primary care, intake and treatment, and longer-term care services;
4. clear and seamless relationships between primary and secondary care mental health services, based on a new structure of community teams;
5. improved arrangements for urgent care, with a focused home treatment service, and an integrated acute liaison service;
6. improvements to the quality of inpatient services, provided from two sites, including clearer care pathways and a dedicated rehabilitation ward;
7. better links between research and practice *via* a new network of clinical academic groups.

The second and third of these themes involve a review of community services, particularly at the interface between primary and secondary care. Part of this work has been to review the role and function of Trust Outpatient Clinics and the development of a more formalised care pathway into and out of Trust services.

The work programme covered by the clinical strategy was overseen by the Trust Management Board which included a senior professional and operational managers as well as members of the Executive Team. Following a review of progress a Programme Board has been established, which consists of Directors and reports regularly to the full Trust Board.

How the Trust has responded to the incident and how the learning has been disseminated

The incident was subject to a Serious Incident Review which followed the Trust procedure for reporting and investigating the incident. When completed the report was agreed and signed off by Executive Directors. The Trust procedure is for all reports and subsequent action plan to be discussed at the Trust Risk Committee and the Care Group Governance meetings. In this case the report was revised according to the agreed process and the action plan that reflected the seven recommendations of the Panel was approved.

On completion of the Serious Untoward Incident (SUI) report, feedback was given to the Consultant Psychiatrist who was the Responsible Medical Officer for Mr. Z. Feedback was

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also given to staff involved from Psychological Services. The report was reviewed and approved at the Risk Committee and taken to the local governance meetings by the Care Groups for discussion and leaning. The action plan was developed by the Associate Medical Director who was the Panel Chair in collaboration with the Associate Director of Governance.

The action plan has seven recommendations (please see Section 15) The action plan has also been considered by NHS Manchester as part of the commissioning quality monitoring process and signed off by them.

The Commissioners have received a copy of the SUI report and the action plan, which they have assigned off and closed. They are satisfied with the assurances received from the Trust that the identified actions have been completed. The actions are all relevant to Trust services and do not require additional service development by the Commissioners.

The Trust has worked with Commissioners to ensure that it has regular opportunities to review service development and quality. With changes in the commissioning of health services the Trust has contributed a number of commissioning forums. In the spring of 2011 the Trust worked with the Manchester Primary Care Trust Joint Commissioning Team to establish a Mental Health Clinical Board (MHCB). This comprises members from each of Manchester's three Clinical Commissioning Groups, the three acute Trusts and Local Authority managers for adults and children. The MHCB has established a number of work streams and now provides a focus for reviews and presentations relating to the implementation of the Trust's clinical strategy and also significant event reviews. The Trust has engaged with each of the Clinical Commissioning Groups (CCGs) and the Trust Chief Executive and Medical Director have met with the CCG GP leads. Since the summer of 2010 the Trust has been a member of the Central Manchester Clinical Board and has actively contributed to working groups in relation to acute care, intermediate care and a King's Fund project on service integration.

In relation to service quality the 2011/12 CQUIN has been jointly developed with service commissioners and reflects shared goals. Progress has been jointly monitored through regular meetings with commissioners.

These mechanisms together with *ad hoc* meetings ensure that actions arising from SUIs can be addressed jointly where that is required. There is an established process whereby the commissioners receive a copy of the SUI report and the action plan. In the present case although actions are all relevant to Trust services and so do not require additional service development by the commissioners, quality and implementation monitoring occurs through regular meetings with relevant members of the commissioning team.

Clinical Supervision

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations which stress the importance of supervision for Clinical governance, quality improvement, staff development and maintaining standards.¹⁸⁵

The NHS Management Executive defined clinical supervision in 1993 as:

“...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations”.¹⁸⁶

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

Professional and clinical supervision has a high profile within the Trust. The Trust has a range of Professional Heads who offer professional leadership and advice to staff.

Medical leadership is through the Medical Director. Medical leaders meet monthly with the Medical Director, the Chief Operating Officer, and finance and Human Resources representatives. There are Associate Medical Directors and Directors of Research and Development and Medical Education in place who report directly to the Trust Medical

185. Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses.

186. Nursing and Midwifery Council, Advice Sheet C. (2006)

Director. There are also a number of lead consultants and clinical tutors throughout the organisation. The permanent medical staff participate in an annual appraisal process and all consultants are members of Professional Development groups that meet regularly. Trainees are employed by a lead employer, the Greater Manchester West NHS Foundation Trust, on behalf of the North West Deanery. Each trainee has a designated consultant trainer who meets the trainees weekly to support professional development and to supervise clinical practice. The trainers provide appraisals to the Head of School at the Deanery and also ensure that the trainees PDP is agreed and appropriate work-based assessments are undertaken.

The current structure for Psychological Services within the Manchester Mental Health and Social Care NHS Trust reflects the recommendations laid out in *Organising and Delivering Psychological Therapies (DH July 2004)*. Within this structure effective leadership and management is provided through the Psychological Services Management Group (PSMG) which oversees a wide range of psychological therapies and services and undertakes to identify and resolve significant gaps in psychological service provision and provide advice on the implementation of psychological therapies outlined in NICE guidelines. PSMG includes representation from managers of all the key specialist areas within Psychological Services managed by the Clinical Director of Psychological Services and is accountable to the Chief Operating Officer of the Trust. In addition the Psychological Therapies Quality Group has responsibility for advising the Trust on all quality and governance issues relating to psychological therapy.

All members of Psychological Therapy Services participate in regular agreed Specialism/Trust meetings as appropriate. Operational and strategic matters relating to Psychological Services and wider Trust issues are discussed at these meetings and all members of the services are encouraged to participate in these discussions and to present their views.

Supervision is considered essential to ensure a high quality service and a valuable way of maintaining morale and commitment. Each staff member has regular line management supervision and in addition all psychological therapists receive regular clinical supervision. Supervision is structured and recorded in accordance with the Trust Supervision Policies and related professional guidance which have been deemed National Health Service Litigation Authority compliant.

Formal appraisal of individual members of staff within Psychological Services, nursing and occupational therapy is undertaken by their line managers *via* the Knowledge and Skills Framework (KSF) review process. The purpose of these reviews is to assess the post holder against the knowledge and skills required for their post and ensure their progression through the gateways; to promote the development of the staff member, the quality of service he/she provides, and the meeting of care group and Trust objectives. A key outcome of the annual review is the identification of individual service objectives, training needs and continuing Professional Development requirements and this is documented as a Personal Development Plan. All staff are required to participate in regular training and professional development, as appropriate to their needs, to meet Trust mandatory requirements and to maintain professional registration and accreditation with the relevant professional bodies.

12.1.12.3. Conclusions

The Independent Investigation Team recognised that the Trust operated differently in 2005, when Mr. Z first entered the service, to its current way of working in 2012. This Investigation was given a significant amount of information about Trust governance and assurance systems and could validate the Trust's claims that significant improvements and innovations have been made. This Investigation concluded that the systems currently in place have been rigorously externally audited by the Trust commissioned review and are fit for purpose and ensure that the governance issues raised by this Investigation have already been addressed in full.

12.2. Care and Treatment of Mr. Y

The sister of Mr. Y requested that his care and treatment was also considered as part of this Investigation. The chronology below sets out Mr. Y's contact with health services primarily in relation to his mental health needs. Mr. Y was followed up by his GP practice in a diligent fashion for his physical ailments in accordance with national best practice guidance.

Mr. Y was born in February 1960 and was 50 years of age at the time of his death. As a child Mr. Y was severely school phobic between 1974 and 1977 and was understood to be

suffering from depression.¹⁸⁷ During the time that Mr. Y lived in the Manchester area he did not work and received incapacity benefit.

Chronology of Healthcare

12 January 1977. A letter was sent from an Area Social Worker to his GP stating that Mr. Y had been school phobic for a period of two and a half years and that he had been attending a Special Education Unit. It was noted that Mr. Y suffered from a severe phobic condition and that behaviour modification techniques were being considered.¹⁸⁸

11-21 March 1996. Mr. Y was noted to be depressed by his GP following a failed relationship. Mr. Y was also noted as suffering from compulsive behaviour. A Community Psychiatric Nurse referral was made. At this stage Mr. Y was prescribed Lofepramine.¹⁸⁹

April-May 1996. It was recorded in the GP record that Mr. Y's mental health improved gradually and that he was able to return to work. It was thought psychological therapy could help. A referral was sent on the 28 May.¹⁹⁰

September 2002. Hypertensive Disease was diagnosed. Mr. Y was also prescribed Fluoxetine Hydrochloride for depression and anxiety during this period as he found leaving his flat stressful.¹⁹¹

Summer 2003. Diabetes and asthma were diagnosed.¹⁹²

6 January 2004. "*Obsessive Compulsive Disorder*" was recorded within the GP record.¹⁹³

22 March 2004. Mr. Y did not attend his Primary Care Mental Health Clinic appointment.¹⁹⁴

23 May 2006. Endogenous depression was recorded in the GP record.¹⁹⁵

187. Mr. Y GP Records PP. 2-3

188. Mr. Y GP Records P. 9

189. Mr. Y GP Records P. 5

190. Mr. Y GP Records PP. 5 & 8

191. Mr. Y GP Records P. 15

192. Mr. Y GP Records P. 12

193. Mr. Y GP Records P. 33

194. Mr. Y GP Records P. 111

195. Mr. Y GP Records P. 49

7 June 2006. Endogenous depression was recorded in the GP record.¹⁹⁶

4 & 14 July 2006. A psychiatric referral was made by the GP. It was noted that Mr. Y was at moderate risk of suicide and that he lived alone with no help available. On the 14 July a depression rating scale was used.¹⁹⁷

26 July 2006. “*Seen in psychiatry Clinic*” was written in the GP record. The Community Mental Health Team had assessed Mr. Y and concluded that he would be best referred to the primary care team.¹⁹⁸

29 September 2006. An assessment was carried out by the Primary Mental Health Care Team. It was noted that “*patient very low in mood, has no motivation to do things, feels hopeless. Worries about health and poor quality of life. Gets irritable easily since health deteriorated. Symptoms of ocd present, ie repetitive checking. Disturbed sleep pattern, lack of energy and difficulty concentrating. Discussed treatment options, patient will consider which problem areas to tackle first and will discuss in follow up sessions*”.¹⁹⁹

14 September 2006. Mr. Y was reviewed at the GP surgery. He had a personal mental health plan. His other physical conditions were also discussed.²⁰⁰

10 September 2007. A depression rating scale was used. It was recorded in the GP record that “*ocd controlled*”.²⁰¹

26 August 2008. A depression rating scale was used. It was recorded in the GP record that “*ocd controlled*”.²⁰²

5 September 2008. “*Panic Attack*” was recorded within the GP record.²⁰³

24 June 2010. Diazepam 1 x 2mg tablets prescribed “*up to 1 every two hours for stress*”.²⁰⁴

196. Mr. Y GP Records P. 51
197. Mr. Y GP Records P. 39
198. Mr. Y GP Records P. 93
199. Mr. Y GP Records P. 53
200. Mr. Y GP Records P. 53
201. Mr. Y GP Records P. 38
202. Mr. Y GP Records P. 40
203. Mr. Y GP Records P. 33
204. Mr. Y GP Records P. 35

11 November 2010. A depression rating scale was used. It was recorded in the GP record that Mr. Y was well.²⁰⁵ This was the last entry made in the GP record whilst Mr. Y was alive.

Findings and Conclusions

It was evident to the Independent Investigation Team that Mr. Y suffered from both physical and mental health problems. However this Investigation concluded that the nature of these problems, whilst they affected Mr. Y's quality of life, were not of a severity to merit him being classified as a vulnerable adult. It would appear that based upon the evidence available to this Investigation that the decision not to place him with secondary care mental health services was reasonable and that mental health primary-care based provision, which was offered to him, was appropriate.

205. Mr. Y GP Records P.41

14. Findings and Conclusions Regarding the Care and Treatment Mr. Z Received

On examining the timeline, care pathway and chronology the Independent Investigation Team identified 13 thematic issues that rose directly from analysing the care and treatment that Mr. Z received from the Manchester Mental Health and Social Care NHS Trust. These thematic issues are set out below.

1. Diagnosis. Mr. Z's principle diagnosis was that of depression. He was also identified as having Post-Traumatic Stress Disorder (PTSD) symptoms. During the period of time in which Mr. Z received care and treatment from Manchester mental health services it was also noted that he had anger control problems, obsessive traits, a history of alcohol misuse and self-reported psychotic symptoms. The diagnoses made were reasonable based upon the evidence available. However further diagnostic formulation was indicated with particular reference to:

- the presence of alcohol abuse and the potential influence this would have regarding prognosis, recovery and risk management;
 - the presence of a psychosis and the potential influence that this would have regarding risk and Mr. Z's long-term care and treatment management strategy;
 - the impact alcohol and psychosis may have had on Post-Traumatic Disorder symptoms and any consequent behaviour.
- *Contributory Factor 1. The limited diagnostic formulation meant that Mr. Z was not understood in the full context of his mental health issues and his continued reliance upon alcohol.*

2. Medication and Treatment. The Independent Investigation Team found that the medication Mr. Z was prescribed was in keeping with his diagnoses and within recommended therapeutic ranges. Four issues were found in relation to the psychological therapy that Mr. Z received. First: Mr. Z received Cognitive Analytic Therapy as opposed to trauma-based Cognitive Behaviour Therapy as indicated by the National Institute of Health and Clinical Excellence (NICE) best practice guidelines for people with Post-Traumatic Stress Disorder (PTSD). Second: Mr. Z presented with several high risk factors that should have been taken into consideration prior to and during therapy taking place.

This did not occur. Third: significant risk information was accessed during therapy sessions which was not appropriately disclosed. Fourth: psychological therapy professionals may not have accessed sufficient specialist training in the management of either abuse or Post-Traumatic Stress Disorder. Whilst these four issues were identified it was recognised by the Independent Investigation Team that Mr. Z appeared to benefit from therapy and that no causal link could be made in relation to the medication and therapy regimen that Mr. Z received and the killing of Mr. Y. However it was recognised that the management of Mr. Z during therapy did not address the relationship between risk, PTSD and therapeutic intervention sufficiently to ensure that a clinically effective and safe approach was taken.

- *Contributory Factor 2. The approach taken to the psychological therapy that Mr. Z received did not run in accordance with national best practice guidance relating to PTSD treatment management. This potentially placed Mr. Z and those around him at risk.*
- *Contributory Factor 3. The failure to achieve the necessary levels of professional communication and disclosure of information placed Mr. Y in an unacceptable position of risk. This failure also prevented Consultant Psychiatrist 2 accessing significant facts that could have led to a more in-depth formulation of Mr. Z's case.*

3. Mental Health Act (1983 and 2007). The Independent Investigation found no issues relating to the implementation of the Mental Health Act and the care and treatment Mr. Z received.

4. Care Programme Approach (CPA). Mr. Z was not in receipt of the Care Programme Approach and consequently he did not have access to robust Care Coordination. At the point of his referral to Manchester mental health services in June 2005 he met the criteria for referral to the Community Mental Health Team and for 'Enhanced' CPA. Mr. Z had a complex presentation and the decision to place him in an Outpatient context on 'Standard' CPA meant that his Care Coordinator was in effect his Consultant Psychiatrist. The Independent Investigation Team concluded that it is difficult for a Consultant Psychiatrist to successfully accomplish the role of Care Coordinator as it requires a time

commitment not readily achievable by this kind of Clinician. Mr. Z required a consistent level of Care Coordination in order to ensure that risk assessment, care planning and inter-professional communication and liaison took place in a manner commensurate to his needs. Without Care Coordination significant information about Mr. Z was not shared between members of his disparate treating team and long-term care and treatment planning remained reactive rather than proactive to the ultimate detriment of his continued wellbeing.

- ***Contributory Factor 4. Mr. Z met the criteria for 'Enhanced' CPA at the point of his referral to secondary care mental health services in June 2005, and at certain other stages during his five-year period with the Trust. Mr. Z did not receive a Care Programme Approach and consequently had no overarching Care Coordination to ensure that he received holistic assessment and that his care and treatment was managed effectively.***

5. Risk Assessment. Mr. Z did not receive a consistent approach to clinical risk assessment. The Independent Investigation Team could find only one fully completed risk assessment form and one risk management plan, both developed at the point of Mr. Z's first contact with the Trust. Mr. Z had a history of suicide and self harm events. He also had a conviction for stabbing a former partner which had resulted in serious injury. Mr. Z had a history of significant alcohol abuse and depression. Between 2005 and 2010 he was also diagnosed as having a psychotic condition and Post Traumatic Stress Disorder for which he received treatment. It was known that Mr. Z acted impulsively, especially when drinking, and had significant anger control problems. It was also frequently recorded in the clinical record that Mr. Z was unkempt and malodorous implying that he was neglecting himself. However it was not thought that Mr. Z had a severe or enduring mental illness and this appeared to minimise the perception of the risk that he presented with.

Over the five-year period that Mr. Z received his care and treatment the Trust improved both its risk assessment and record keeping processes. It was evident that in June 2005 the Trust did not use the CHORES risk assessment tool comprehensively and that the use of an electronic record was embryonic. As improvements were made to Trust systems over

time, Mr. Z's case, which predated some of the new assessment processes, did not receive a retrospective review of his risk in keeping with the new processes. This situation was exacerbated by Mr. Z receiving the management of his case from the Outpatient Clinic which operated within a traditional model and did not lend itself to detailed holistic assessment, monitoring and review.

All of the individuals who were involved with Mr. Z's care understood certain aspects of his risk profile. However no single person understood all of the risks at the times when they emerged. This meant that Mr. Z was not understood in the context of his full risk profile in a consistent and timely manner.

- *Contributory Factor 5. Mr. Z's risk profile was understood poorly despite opportunities existing for a more accurate understanding to be gained. Mr. Z's needs were complex in nature and he retained a latent potential for both self harm and violence to others. This potential was exacerbated by alcohol and Post-Traumatic Stress Disorder symptoms. A more structured approach may have ensured that the problems he had were acknowledged and identified and could have been managed more effectively.*
- *Service Issue 1. The clinicians involved in Mr. Z's care and treatment did not appear to understand the risks associated with the concurrent presence of alcohol usage, depression, Post-Traumatic Stress Disorder and intensive therapy. No appropriate level of risk assessment was conducted prior to therapeutic interventions counter to extant NICE guidance.*

6. Referral, Discharge and Handover Processes. At the point Mr. Z first entered mental health services in July 2005 referral decisions were made, in the face of the evidence, to divert him to an Outpatient Clinic instead of to the CMHT. This decision precluded his access to 'Enhanced' CPA or its equivalent under the new guidance. This decision prevented an in-depth and holistic assessment being undertaken at his point of entry to the service. Over the course of the next five years Mr. Z was provided with therapy and Outpatient assessments and monitoring, but it is evident from reading through his case

notes that there were large gaps of time when during crisis, and following periods of crisis, no review of his case was undertaken and no additional support provided.

In 2009 Consultant Psychiatrist 2 considered referring Mr. Z to a CMHT in order for him to receive more structured support. However in the end this avenue was not pursued. And this was a missed opportunity which would have ensured Mr. Z's home situation was understood better and a more robust support network put into place.

- *Contributory Factor 6. Referral decisions about Mr. Z served to divert him away from services which may have been able to provide a holistic range of support. The referral decisions regarding Psychotherapy input were clinically indicated but could not provide a timely response to Mr. Z's needs following episodes of crisis.*

7. Carer Communication and Involvement. Mr. Z had a supportive, but turbulent, relationship with Mr. Y with whom he shared a flat. Both Mr. Z and Mr. Y had a range of physical and mental health problems which prevented them living their lives to the full. This caused an increase of tension between the two men on an ongoing basis. At times each was required to be the carer for the other. This dynamic was not understood by secondary care mental health services.

The Independent Investigation Team concluded that Mr. Y should have been informed at the point Mr. Z's first contact with services about the thoughts of violence that he harboured against him. At the point of this initial contact a more in-depth assessment of Mr. Z was indicated prior to the decision to place him on 'Standard' or NonCPA. This was not achieved and consequently the relationship between the men and their significant health needs were not understood; this was to the ultimate detriment of their long-term wellbeing.

- *Contributory Factor 7. Mr. Z had a turbulent relationship with Mr. Y which was both supportive and problematic at the same time. Both men, by virtue of a mix of physical and mental health problems, found it difficult to live their lives to the full and this created tension within the home that both shared. The kind of secondary care service that Mr. Z received precluded home visits and a holistic assessment*

approach and this was ultimately to the detriment of the wellbeing of both Mr. Z and his friend Mr. Y.

8. Service User Involvement in Care Planning and Treatment. Mr. Z was involved in an entirely appropriate manner regarding the treatment programme that he was offered. The Independent Investigation Team found evidence of sensitive and person-centered practice. However Mr. Z was not understood well in the full context of either his past psychiatric history or current health and social care problems. It was evident that Mr. Z denied key behaviours and at times gave incorrect and misleading information to members of his treating team. Mr. Z's self-reported history was neither challenged nor corroborated. The Independent Investigation Team concluded that this was due to the fact that Mr. Z was never in receipt of full and comprehensive assessment at the point of entry into the service and that this omission was never corrected over the ensuing five years. Had the disparate members of the treating team been in possession of a more robust and accurate assessment then the approach to Mr. Z's care and treatment plan may well have been managed differently.

- *Contributory Factor 8. Mr. Z received sensitive and person-centered care. However he was not understood in the full context of either his psychiatric history or his current alcohol consumption and social care needs. This meant that the care plan put into place for Mr. Z could not provide the range and depth of service that Mr. Z needed in order to be able to affect the problems that he had.*

9. Documentation and Professional Communication. Documentation was of a generally good standard although the AMIGOS Trust electronic system was used in a variable manner. The effectiveness of professional communication was compromised by disparate members of the treating team placing an over reliance upon Mr. Z's own accounts his psychiatric history and crisis events. The ongoing and timely communication of clinical information between health care professionals did not flow and this meant that risk information was not always shared, and Mr. Z's continued alcohol consumption was not understood. The decision was made to divert Mr. Z's case from the Community Mental Health Team in July 2005 to the Outpatient Clinic prior to a full assessment having been undertaken. As a consequence important and relevant information about Mr. Z was never collected, corroborated or examined in depth.

- *Contributory Factor 9. Professional communication practice was poor. An over reliance was placed upon the information that Mr. Z gave about himself and corroboration was seldom sought. Consequently the clinical picture was not based upon all of the information that was held by disparate members of the treating team and this meant that the care and treatment approach taken was not based upon the best evidence available.*

10. Adherence to Local and National Policy and Procedure. The care and treatment that Mr. Z received fell broadly into local and national best practice guidance. However there were some inconsistencies in regard to the adherence to NICE guidelines and local risk management and record keeping policies.

- *Contributory Factor 10. The care and treatment delivered to Mr. Z fell broadly into local and national policy best practice guidance. However there were examples of clinical practice not adhering to NICE guidelines coupled with local policy adherence inconsistencies.*

11. Clinical Management of the Case. The care and treatment that Mr. Z received had many positive aspects. He had an established therapeutic relationship with Consultant Psychiatrist 2 and access to psychological therapy which was of benefit to him. Whilst every effort was made to address Mr. Z's clinical needs it would appear that he was not truly understood in the context of his social and emotional needs, which were considerable. Mr. Z's social, emotional and clinical needs impacted one upon the other and it was evident when examining his case that a more holistic approach was indicated in order to effect a break in a somewhat vicious cycle of circumstance.

12. Clinical Governance and Performance. During the latter years that Mr. Z received his care and treatment from the Mental Health Trust many problems were apparent with regards to both governance and performance. The Trust struggled to manage its activity, finances and service quality. There had been a lack of sustained leadership which had subsequently resulted in the formulation of limited strategic direction. This had led to poor relationships with strategic partners and with staff. This provided a backdrop against which difficulties within services could not be challenged and non-adherence to Trust policy and procedure could neither be detected nor managed.

In recent years the Trust has modernised both its governance and assurance processes. The Independent Investigation Team was given a substantial amount of evidence to validate the fact that this transformation work has been implemented successfully.

13. Care and Treatment of Mr. Y. Mr. Y is documented as having three separate episodes of mental illness. The first took place when Mr. Y was a teenager between 1975 and 1977. The second took place in 1996 for which he saw a Community Psychiatric Nurse for a limited period of time. The third took place following Mr. Y's move to Manchester in 2004 and continued until the time of his death in 2010.

Whilst living in Manchester Mr. Y received care and treatment from primary care services for diabetes, hypertension and mild to moderate depression. A GP referral was made for a secondary care mental health assessment in July 2006 however following assessment it was not thought that Mr. Y's mental health problems were of either the severity or complexity to require input from a Community Mental Health Team. Consequently a referral was made for Mr. Y to be seen by the primary care team. Whilst it is not certain what happened to this referral it is documented within the GP record that Mr. Y continued to report stress but that his depressive symptoms were abated. It would appear that Mr. Y suffered from a mild to moderate depressive illness for which he was treated with antidepressant medication. It was the conclusion of the Independent Investigation Team that Mr. Y could not be considered a vulnerable adult by virtue of any illness, either physical or psychiatric, and that neither these conditions, nor the manner in which they were treated, could be identified as making a contribution to death.

However the Independent investigation Team did conclude that Mr. Y and Mr. Z both had health and social care problems which created an increased tension between them. The dynamic and mutual co-dependence between the two was understood poorly and this was to the ultimate detriment of the wellbeing of both men. A more holistic approach could have identified both support and practical assistance to both Mr. Z and Mr. Y.

Conclusions

It remains unclear exactly what kind of mental health problems Mr. Z actually had. At his trial at Manchester Crown Court this was examined at length. Ultimately it was decided that Mr. Z did not kill Mr. Y as a direct result of any mental health issues that he may have had.

This Investigation concluded that no causal link could be made between any act or omission on the part of the Manchester Mental Health Care NHS Trust and the killing of Mr. Y. Mr. Z retained full capacity and was found to have no abnormality of mind sufficient to have influenced either his thoughts or his actions. However this Investigation has identified four main points of learning.

First: Care Coordination and CPA. This Investigation concluded that at the point of Mr. Z's first presentation to secondary care mental health services, and at several stages between July 2005 and November 2010, he met the criteria for Community Mental Health Team referral and 'Enhanced' CPA. This would have ensured the allocation of a Care Coordinator and also the undertaking of an in-depth period of clinical assessment. Mr. Z was a complex individual who was found to be a 'fantasist' during his trial. It is probable that Mr. Z presented in a less than authentic manner at times to the disparate members of his treating team. This is not to discount in any way Mr. Z's underlying mental health problems, but had a consistent therapeutic relationship been maintained with a Care Coordinator Mr. Z's complex personality and presentation may have been understood better within his full social context.

Second: Professional Communication. Since the inception of the HSG (94) 27 professional communication issues have been identified as a key underlying factor when things go wrong in secondary care mental health service provision. Levels of professional communication were variable in this case. It was evident that information was not shared in either a comprehensive or timely manner.

Third: Risk Assessment and Management. Risk was occasionally assessed but no management strategy was prepared, it is fair to say that Trust risk management policies were not adhered to in the full spirit of the documentation. Mr. Z presented with a significant level of risk to both himself and to others. It would appear that the levels of personal safety felt by

health care professionals when in Mr. Z's presence was a key determining factor in deciding whether or not he was truly a risk to other people. This was not good practice.

Fourth: Evidence-based Practice. The Independent Investigation Team concluded that whilst the services provided to Mr. Z were of benefit to him practice was not always evidence-based and this could have placed the integrity of what was provided in jeopardy.

Summary

Activity does not always equate to meaningful engagement. All interventions have to take place based upon a period of clinical assessment and should be part of an overarching care and treatment strategy. All interventions should be monitored and reviewed against predetermined clinical outcomes. This is essential if the efficacy of treatment approaches are to be evaluated appropriately and the true benefit to a service user ascertained. Over a five-year period Mr. Z was in receipt of secondary care mental health services but at no stage was his case the subject of full and comprehensive assessment or review.

Whether a person is on CPA or NonCPA a structured approach should be taken to the care and treatment provided. In the case of Mr. Z there appeared to have been an open-ended episode of care which was not goal orientated and perhaps fostered Mr. Z's ongoing dependence. Over time Mr. Z's presentation and medication regimen appeared to grow more complex, rather than less, and it is difficult to see how the interventions provided contributed to his recovery.

In effect Consultant Psychiatrist 2 acted as Mr. Z's Care Coordinator. This is a difficult role for a Consultant Psychiatrist to fulfil due to the time commitment required. It was the conclusion of this Investigation that Mr. Z should have been considered for 'Enhanced' CPA and that robust Care Coordination would have ensured assessment, care planning and review. Had this been provided Mr. Z's case would have been managed in a more coherent manner which would have been subject to an overarching care and treatment plan. However whilst this may have been of benefit to Mr. Z the events of the 21 November would probably not have been prevented by it.

It was the conclusion of this Investigation that a serious untoward incident of some kind was foreseeable based upon Mr. Z's past history and behaviour between July 2005 and November

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2010. It was evident that his behaviour was impulsive and that he had anger control issues. He was still experiencing flashbacks relating to his Post Traumatic Stress Disorder symptoms which were not controlled by the therapeutic interventions that he received. This Investigation concluded that all known risks regarding Mr. Z's thoughts and plans in relation to causing Mr. Y harm should have been made known to Mr. Y and that the Trust had a clear duty of care to have ensured this took place. This was a serious omission. However it was not possible to establish a causal link between Mr. Z's mental illness and his decision to kill Mr. Y. Therefore it was not possible to establish a casual link between any act or omission on the part of the Trust.

15. Manchester Mental Health Services Response to the Incident and Internal Investigation

The following section sets out the Manchester mental health services response to the events of 21 November 2010. It also sets out the view of the Independent Investigation Team with regards to how effective the Internal Investigation Panel was in conducting its work. The following comments are intended to provide helpful feedback whilst offering a contextual background to assess the progress the Trust has made against the action plan developed from the findings of its own internal investigation.

15.1. The Trust Serious Untoward Incident Process

The National Patient Safety Agency issued a fresh set of guidance for the investigation of serious untoward incidents *Independent Investigation of Serious Patient Safety Incidents in Mental Health Services Good Practice Guidance (February 2008)*. This guidance provided instruction for the management of both the internal and the independent investigation processes. The Trust made the decision to implement this guidance and it was used as a policy framework throughout the process.²⁰⁶

15.2. The Trust Internal Investigation

The Internal Investigation Panel comprised the following personnel:

- Chair: Associate Medical Director;
- Panel Member 1: Clinical Director Psychological Services;
- Panel Member 2: Rehabilitation and Recovery Manager.

Methodology

The Terms of Reference were:

- “To review the care and treatment of Mr. Z

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- *To identify any process/procedural failures or causal factors which may have impacted on the incident;*
- *To establish if the care provided was of good quality and identify any issues that fell below agreed standards;*
- *To make appropriate recommendations for any part of the organisational system”.*²⁰⁷

The Investigation Panel reviewed the following documents:

- Clinical Risk Management and Assessment Policies: First edition 2006, updated in 2007 and 2009;
- Integrated Care Programme Approach and Care Management Policy & Procedures 2005: Updated 2007;
- Assessment and Care Management Policy & Procedures Guidance: The Care Programme Approach (CPA): September 2010.

The Investigation Panel also accessed Mr. Z’s Manchester-based clinical records, with the exception of the GP record. Efforts were made to access Mr. Z’s earlier clinical records with no success.

The Investigation Panel had access to statements from the following people:

- Mr. Z’s GP;
- The Counsellor;
- The Clinical Psychologist;
- The Consultant Psychotherapist;
- The Adult Psychotherapist.

The Internal Investigation Panel interviewed a single witness, Consultant Psychiatrist 2. A timeline was developed and root cause analysis was deployed.

Key Findings

Patient Factors

Mr. Z was noted to have engaged well with services, however despite this little was known about him. When Mr. Z was distressed he appeared to have utilised the Accident and

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Emergency Department instead of Consultant Psychiatrist 2 or his GP. It was not clear whether he knew about other sources of help such as the Crisis Team.

The Internal Investigation Panel speculated that Mr. Z may have had a more serious problem with alcohol than staff realised based upon his past history and the fact that he had been drinking at the time of the incident.

It was noted that Mr. Z's diagnosis was not clear and that latterly he had been describing symptoms more associated with psychosis. At the time of writing the internal investigation report the Panel did not know what the outcome of the forensic assessment process would be and whether or not Mr. Z had killed Mr. Y because of an emerging psychosis resulting in unexpected violence.

Staff Factors

It was noted that Mr. Z appeared to have a good relationship with Consultant Psychiatrist 2 and the Therapists that he saw. It was also noted that his care was well documented with documentation sent out appropriately. It was deemed that the therapy he received was considered by the Panel to be of a high standard, appropriate to his needs and of clear benefit to Mr. Z.

Recording of Next of Kin

None of the Trust records had any details of next of kin. It was thought that this lack of next of kin data may reflect a lack of awareness of Mr. Z's home situation and indicate a need for a wider appreciation of social issues. The Panel considered that this absence of data did not contribute directly to Mr. Y's death but that it was important information when dealing with a range of situations and that this was an area that the Trust needed to consider a review of policy and procedure.

Care Planning

The Internal Investigation Panel was told that Mr. Z was not considered for Enhanced CPA because:

- Mr. Z did not initially appear to be suffering from a severe and enduring mental illness;

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- Mr. Z had not had any recent admissions to a mental health unit;
- Mr. Z engaged well with Outpatient services;
- whilst Mr. Z had a history of violence and contact with the Criminal Justice system, this was some years previously and his life was now much more stable;
- Mr. Z did not report any social problems which he would like help with;
- Mr. Z's problems were mainly of an emotional nature linked to his history of abuse and these needs were appropriately met through the therapy he was offered.

The Internal Investigation Panel considered that this was a reasonable decision in light of the factors identified above. However all patients on Standard CPA should have been in receipt of a care plan which should have included what to when in crisis. This practice did not appear to have been in widespread practice in Outpatient settings at the time Mr. Z was receiving his care and treatment.

Mr. Z was not considered to meet the criteria for Enhanced or full CPA. As a result he did not receive a full assessment of his needs and was never visited at his home. Following national changes to the CPA process service users who were no longer eligible for CPA, but who were still receiving care, should have expected to receive a full assessment of their needs, the development of a simple care plan and a regular review of care by a lead professional. At the time Mr. Z was receiving his care and treatment from the Trust it would appear that there was no standardised documentation for recording care given in Outpatient contexts. This may have compromised Mr. Z's ability to understand how to access care when in crisis. The Internal Investigation Panel was told that Consultant Psychiatrist 2 was considering referring Mr. Z to the CMHT for additional support in May 2009 but there was no record of this occurring. The Internal Investigation Panel felt that this was a missed opportunity. The Panel concluded that with hindsight a more thorough assessment of Mr. Z's needs, including a visit to his home, may have identified a need for greater community support. However it appeared that Mr. Z did not think this was necessary and neither did the GP.

Assessment and Recording of Risk Information

The account given to the Trust by Mr. Z indicated that he had a past history of violence. Members of the treating team were unable to access his original records relating to his past psychiatric history. Mr. Z's first presentation to services predated the introduction of the

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Trust's standardised risk assessment tool in the autumn of 2006. An initial risk assessment was conducted in the summer of 2005 when Mr. Z's risk to others was deemed to be high. However it is not known whether his risk reduced from this point as contact with the CMHT appeared to cease abruptly.

From the summer of 2007 the Trust's electronic system contained a section for recording past incidents of risk known as CHORES, however it would appear that Mr. Z's past offending was not recorded and it would have been good practice for this to have been. It was noted that following Mr. Z's presentation to emergency services in 2007 and 2008 a paper version of CHORES was filled in but that this was not completed electronically and the records could be traced by the Internal Investigation Panel.

Recording Risk in Outpatient Settings

The Outpatient risk assessment and recording processes for all new patients are covered by the Trust's overarching Clinical Risk Assessment Policy. Mr. Z's contact with the Trust predated the policy introduction. Consequently Mr. Z's Outpatient record did not contain a separate risk assessment schedule and the CHORES was not complete.

The Internal Investigation Panel heard that risk issues were recorded in letters to the GP and that there was good evidence to support this. The Panel accepted that Consultant Psychiatrist 2's practice was in accordance with extant Trust policy but that the Trust needed to review the use of risk assessment tools for those service users seen only in Clinics and to review the historical risk for those patients whose care pre-dated current systems.

Recording Risk Following Urgent Presentations

Mr. Z was assessed on medical wards on two occasions, 27 September 2007 and 24 March 2008, following overdoses, and also on the 10 June 2010 with suicidal ideas. The first two assessments were recorded in brief on the AMIGOS electronic record, both assessments state that the Trust risk assessment schedule was completed and letters sent to Mr. Z's GP. This documentation was not available to the Internal Investigation Panel. It was noted that this kind of information was not routinely added onto the AMIGOS system at the time, but that in the present assessments were routinely put onto the AMIGOS system even though GP letters were still being stored in separate liaison records. The third assessment was documented in

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detail in a letter to Mr. Z's GP. There were detailed hand-written notes but no contemporaneous record of the contact on AMIGOS.

On all three occasions the clinical assessments appear to have been thorough and Mr. Z was considered to be a low risk to both himself and to others. The GP was communicated with appropriately. Following the first assessment Consultant Psychiatric 2 was informed about the overdose and an Outpatient review was arranged for Mr. Z one week later. Following the second assessment there is no record that Consultant Psychiatrist 2 was informed and he may not have been aware of the overdose. Following the third assessment it was noted that Mr. Z made an Outpatient appointment a few days later.

The Internal Investigation Panel found that there was no standard procedure for recording the overall management plan following a presentation to emergency mental health services.

Assessment and Recording of Risk in Psychological Therapy Services

Mr. Z had extensive contact with Trust Psychological Therapy Services between 2005 and 2008. The Internal Investigation Panel found that the contacts were thorough and well recorded. It was also found that Mr. Z benefitted from therapy. During these contacts therapists used an assessment and outcome measure known as the CORE. This was accepted as a routine risk assessment measure in the Trust's risk management policy. The CORE includes a systematic assessment of risk and this was completed on several occasions during Mr. Z's contact with psychological therapies. On all occasions Mr. Z's risk was considered to be low.

Communication

Overall the Internal Investigation Panel found the standard of communication between services to be good. Following each clinical appointment a detailed letter was sent to Mr. Z's GP and Mr. Z's GP was satisfied with the level of information that he received. There was also evidence to suggest that the GP was written to after each emergency presentation. Following each period of therapy a summary letter was sent to Consultant Psychiatrist 2 and Mr. Z's GP. There was a delay in sending the summary letter from psychotherapy in 2009 but the Internal Investigation Panel did not consider this had any negative impact on Mr. Z's care. The Panel did note that there were some inconsistencies in the way the management

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plan was communicated to Consultant Psychiatrist 2 and the GP following emergency presentations.

Organisational Factors

Mr. Z was seen for a long period of time in one of the Trust's Outpatient Clinics. His appointments were always with Consultant Psychiatrist 2. Mr. Z attended 12 appointments (of approximately 30 minutes duration) between 2005 and 2010. The appointments were planned to be every three-to-six months but Mr. Z sometimes cancelled them. The longest gap between appointments was ten months. The Internal Investigation Panel found that the care Mr. Z received in Outpatients was of a good standard. Changes to his medication were made in response to his symptoms and these were communicated clearly to the GP.

Mr. Z was referred for psychological therapy. The Panel noted the contrast between the focused approach provided by therapy services in contrast to the relatively unstructured care provided in the Outpatient Clinic. Therapy services offered comprehensive assessment processes and an agreed plan of care including the number of sessions to be offered with the routine use of outcome measures. In contrast it was found that the Outpatient Clinic was more open-ended with no markers for progress utilised. The Panel found that the Outpatient care offered to Mr. Z was in keeping with normal Consultant Psychiatrist practice, but that "*less traditional models of care may have offered a more holistic or focused approach*".²⁰⁸

Education and Training

The Internal Investigation Panel did not identify any major gaps in Mr. Z's care and treatment resulting from training issues.

Internal Investigation Panel Analysis and Conclusions

Overall the Internal Investigation Panel considered that the care provided to Mr. Z was of "*a reasonable standard*".²⁰⁹ The Panel found some concerns relating to the documentation of historical risk. Mr. Z was not considered to pose an ongoing risk by those involved in his care. This was identified as being because his circumstances were very different to those at the time of his earlier violence. The Panel concluded that Mr. Z's extreme violence towards his friend was unexpected and could not be predicated.

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The Panel remained uncertain as to whether or not Mr. Z knew how to access help from services in an emergency and saw no evidence that this had ever been discussed with him despite several presentations at Accident and Emergency Departments.

The Panel was concerned that little was known about Mr. Z's home circumstances and that a more holistic approach should have been taken. The Panel accepted there was a missed opportunity in 2009 when Consultant Psychiatrist 2 planned to refer Mr. Z on to community services, but did not do so. It was thought that a more holistic approach may have been helpful.

The Panel identified three areas of good practice:

- regular and consistent contact with a Consultant Psychiatrist over a five-year period;
- two separate course of psychotherapy which appear to have been of a high standard and which were clearly found to have been of benefit;
- Mr. Z's GP reported that he was satisfied with the care that Mr. Z received.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

The Independent Investigation Team found that the Internal Review was managed well and identified relevant and useful findings. The Independent Team did not concur in full with the findings of the Internal Review but acknowledges that this Investigation had access to more clinical information about Mr. Z than was available to the Internal Investigation Panel.

The Independent Investigation noted that the Trust utilised Root Cause Analysis methodology appropriately and that all due process was observed.

15.3. Being Open

The Trust took proactive measures to communicate with the family of Mr. Y as soon as the incident occurred. Once again the *Independent Investigation of Serious Patient safety Incidents in Mental Health Services Good Practice Guidance (February 2008)* was utilised.

Victim's Family

Mr. Z was arrested for the murder of Mr. Y on 21 November 2010. As part of the learning from a previous homicide the Trust followed some simple principles in terms of making and maintaining contact with the victim's family. In the early stages of the management of this incident the Trust focused on assembling the information that was available and establishing contact with the Senior Investigating Police Officer (SIO) to gain more detail of the incident. The SIO through the Police Family Liaison Officer approached the family to seek their views on whether they would like contact from the Trust and how they might receive that contact.

The Trust received details of the victim's family from the Police and a message that the family would like contact *via* one of Mr. Y's sisters. The Associate Director of Governance contacted the Family Liaison Officer who said that Mr. Y's two sisters would like to meet with her. Arrangements were made to meet with the family on the 9 December 2010. The purpose of the meeting was to enable the family to ask questions and for the Trust to explain the internal processes that would be taking place and agree how the family would like to be involved. At this meeting the family were able to identify key issues that they would like the Internal Investigation to address. The meeting was followed up with a letter on the 14 December 2010 confirming the discussions and the agreement that had been made. On the 16 December 2010 the Chief Executive sent a letter of condolence on behalf of the Trust.

Between December 2010 and May 2011 the Associate Director of Governance maintained telephone and email contact with one of Mr. Y's sister to provide an update on progress with the Internal Investigation. A copy of the investigation report was sent to the family on the 4 March 2011. The copy that the family received was the full report; however specific clinical information was omitted due to patient confidentiality reasons. That this kind of information would be omitted had been explained previously to the family. Family members were offered another meeting to provide an opportunity for further discussion about the report but they decided to wait until after the trial took place, the hearing was due in May 2011.

The Associate Director of Governance continued to maintain contact with the family. During the trial it became evident that the family was to have a full clinical record disclosure which contained difficult and upsetting information. The family was devastated when they received this information and consequently felt that the Trust had not been completely open with them and wished to have no further contact with the organisation.

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After the trial was concluded the family wished to resume communications with the Trust in order to discuss the Internal Investigation report which they thought was flawed. Mr. Z was contacted to elicit his consent for the disclosure of the full report which he duly gave. The full report was sent to the family in July 2011. The Trust maintained contact with the family up until the commissioning of the Independent Investigation commissioned by the Strategic Health Authority.

The Independent Investigation concluded that the Trust acted in full accordance with the national *Being Open* guidance and provided an exemplary level of communication and contact with the family. The Independent Investigation notes that it is extremely challenging for NHS Trusts to disclose confidential patient information to third parties such as victim's families as they are bound by the Data Protection Act. NHS Trusts are not permitted under legislative frameworks to make certain disclosures and this places them in challenging situations at times. Despite the anxiety and distress that this ultimately caused the family of Mr. Y the Trust acted in an appropriate manner and within the confines of the legislature. The Trust is to be commended in its decision to seek consent from Mr. Z prior to the full disclosure of the Trust Internal Investigation.

Perpetrator's Family

The Trust's contact with the Perpetrator's family was less successful. It was understood that Mr. Z was estranged from his mother and no details could be found within the Clinical Record for family contacts. No formal contact was able to be made by the Trust.

15.4. Staff Support

During and Following the Internal Investigation

Few members of staff were interviewed during the Internal Investigation process. However staff were offered support and feedback during this period of time. Members of staff were offered both individual and team support and feedback was given regarding the findings of the Internal Investigation report.

Support continued to be provided by the Trust during the Independent Investigation process. Each witness to this Investigation felt that they had been appropriately supported by the Trust and had access to the lessons learned resulting from the Internal Investigation process.

15.5. Trust Internal Investigation Recommendations

1. *“The Trust reviews its processes for recording next of kin and carer details to ensure that:*
 - *Missing information is chased up*
 - *Where patients are unable or unwilling to give details this is specifically stated on the record rather than leaving blank*
2. *The Trust completes its work on the provision of a standardised record of care for those not receiving CPA, and ensures that this written summary includes details of how to get help in a crisis*
3. *The Trust reviews its use of the risk assessment tool for patients seen only in Clinic settings*
4. *The Trust reviews the arrangements for recording historical risk where patient contact pre-dates the use of the risk assessment tool*
5. *The Trust reviews the procedure for summarising and communicating management plans to GPs and other, when patients seen in an emergency, to ensure a standardised approach*
6. *The Trust ensures that all junior doctors, including locums, receive appropriate training in the use of AMIGOS and the Trust risk assessment tool*
7. *The Trust reviews its strategy in relation to the provision of psychiatric out-patient Clinics to ensure a more targeted recovery focused approach”.*²¹⁰

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15.6. Progress against the Trust Internal Investigation Action Plan
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Serious Untoward Incident Trust/Commissioner Action Plan

<i>No.</i>	<i>Recommendation</i>	<i>Key Actions</i>	<i>Date to be Completed</i>	<i>Nov 2011 Update</i>
1	<i>The Trust reviews its processes for recording next of kin and carer details to ensure that missing information is chased up and that where patients are unable or unwilling to give details this is specifically stated on the record rather than leaving blank.</i>	<i>Recommendation to be considered in context of outpatients review recommendations and incorporated as appropriate Embedding of this recommendation within day-to-day practice of Clinic reception function by appropriate staff.</i>	<i>August 2011</i>	<i>Pilot undertaken in Central Outpatients as part of the Outpatients Review Recommendations (IMP4) Roll-out across all outpatient/Clinic settings to commence on 1st August 2011 – on target Briefing sessions to all Clinic reception staff taking place in week commencing 25th July 2011. AMIGOS changes to be made to enable electronic capture of ‘unwillingness’ to give details Menu option “other” to be used for patients who prefer not to give NoK details.</i>
2	<i>The Trust completes its work on the provision of a standardised record of care for those not receiving CPA, and ensures that this written summary includes details of how to get help in a crisis.</i>	<i>Out-patient review group is preparing information leaflets for all Clinic attenders with details of service offered and how to get help in a crisis.</i>	<i>October 2011</i>	<i>Draft leaflets including contact details for out of hours services now in second draft Implementation being overseen by out-patient services review group as part of 3D Clinical strategy. For psychological services, standard letter confirming place on waiting list now includes details of crisis services.</i>

3	<i>The Trust reviews the use of the risk assessment tool for patients seen only in Clinic settings.</i>	<i>Recent review of risk assessment tool and presentation to Trust risk committee.</i>	<i>December 2011</i>	<i>Need agreement on use of out-patient Clinic template as main record of history for new Clinic patients, with risk only sections of full document completed. Review of risk assessment tool out for consultation via professional groups. Proposed change to use of risk scores and link between out-patient letters and AMIGOS risk record.</i>
4	<i>The Trust reviews the arrangements for recording historical risk where patient contact pre-dates the use of the risk assessment tool.</i>	<i>Care co-ordinators to add historical risk at point of care reviews where not previously complete.</i>	<i>August 2011</i>	<i>Assurance given, to be evidenced via repeat audits.</i>
5	<i>The Trust reviews the procedure for summarising and communicating management plans to GPs and others, when patients are seen in an emergency, to ensure a standardised approach.</i>	<i>A and E liaison teams directed to ensure that all Clinical contacts and letters to GPs to be available on AMIGOS.</i>	<i>March 2011</i>	<i>Assurance has been provided that this is now in place. Random audit to monitor.</i>
6	<i>The Trust ensures that all junior doctors, including locums, receive appropriate training in the use of AMIGOS and the Trust risk assessment tool.</i>	<i>Standardise and simplify information given to locums Confirmation of receipt Assurance re AMIGOS and risk assessment training for regular doctors.</i>	<i>March 2011</i>	<i>Locum doctors now instructed to report directly to A and E liaison staff. Laminated instructions given on each occasion and signed to ensure handover of information AMIGOS training and risk assessment provided to all regular doctors. Evidence from training records and basic skills training programme. Information governance obstacles to providing locum junior doctors with passwords for AMIGOS.</i>

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7	<i>The Trust reviews its strategy in relation to the provision of psychiatric out-patient Clinics to ensure a more targeted recovery focused approach.</i>	<i>Review of outpatient function being undertaken as cornerstone task in 3D community group.</i>	<i>August 2011</i>	<i>Draft paper completed for discussion at community services group Aug 2011. Timeline established to take via medical staff committee and Trust management board. Practical implementation to commence late 2011.</i>
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17. Notable Practice

1. SUI Process

The Trust has continued to review, update and improve its Serious Untoward Incident process. All SUI's are subject to an agreed timescale as part of the contractual arrangements with commissioners. SUI panel chairs are drawn from an approved list of senior managers and clinicians who have undertaken additional training in the SUI procedures, use of Root Cause Analysis techniques, report writing skills, and attending Coroner Inquests.

The Trust has developed a template report to ensure that investigations are thorough and key learning is captured. The procedures include working with families and carers as part of the overall process.

To further improve the quality of investigations, and learning from serious incidents the Trust has introduced a High Level Investigation Panel that meets to consider a final draft of the review report before it is signed off by the organisation. This meeting is chaired by a Non Executive Director and attended by a minimum of two Executive Directors, the General Manager responsible for the care group where the incident occurred and representatives from commissioners. The report is presented by the Panel Chair who is then available to answer questions. The recommendations are reviewed and agreed.

2. Working with families

Manchester Mental Health and Social Care Trust have managed communication with the family of Mr. Y well. They established communication with the family immediately after the incident, met with them face to face and maintained open lines of communication with regular updates throughout the internal review process and the subsequent court proceedings.

The Trust continued to work with the family despite difficulties in relation to information sharing and specifically sought the consent of Mr. Z to share confidential clinical information that had originally not been available to the family due to confidentiality.

The Trust has demonstrated through the management of this case that the family of the victim was of primary concern; they wished to work in the spirit of openness and were not defensive of their practice.

The Trust ensured that; contact with the family was direct and timely; and that senior Trust staff took the lead in working with the family showing a commitment to meeting their needs. Communication was open and sustained even through difficult and testing periods and the internal review and recommendations were shared in full with the consent of Mr. Z in relation to clinical confidential information.

The Trust has demonstrated an honest, open and forward thinking approach when working with families who are coping with a tragic incident. Despite the obvious difficulties they have consistently made timely contact, kept communication channels open and shared their report findings even when this has presented challenges.

3. Leadership Programme

The Trust has provided a range of management development and leadership development programmes. From 2008 – 2011 the Key Skills management development programme was an accredited 10-day programme delivered to six cohorts over a three-year period to approximately 90 managers who were defined as being staff that had a managerial or supervisory role regardless of band.

The leadership development programme which ran over the same time period (2008 – 2011) was delivered by an external training provider to four cohorts of managers who were identified as leaders by their managers. A total of 66 staff undertook the programme and delivered a number of Trust projects as part of their programme participation. Furthermore, a number of managers, termed 'Leadership Activists' and led by the Chief Executive, met and were facilitated to deliver a number of projects across the Trust over a specific period of time. In view of the need to update the programmes and more specifically address the leadership and management skills and competencies required in the context of the Trust's ambitious change agenda and Foundation Trust aspirations, a consolidated approach to management and leadership development was taken. This resulted in 'Leading for Success' being commissioned in 2011 which acknowledged the need for a revised programme to:

- be performance and accountability orientated;

- embrace a continuous improvement ethos;
- support stress reduction, well-being and resilience efforts;
- be supplemented by coaching and mentoring opportunities;
- be practically and Key Performance Indicator focused;
- harness previous leadership graduates and activists to initially support and eventually deliver the programme;
- identify and develop ‘champions’ from across the organisation to support organisational cultural change.

Four cohorts were commissioned and delivered to a total of 63 managers and the programme is currently being evaluated. Further to this, recommendations for programme amendments will be proposed to ensure alignment with organisational expectations regarding Trust leadership. In addition, a Partnership Development programme focusing on partnership within the Trust in the context of managers and joint unions was commissioned and is currently still in progress.

4. Commissioner provider relationship

The Trust and its commissioners strive to work in partnership with each other. A Mental Health Clinical Board was established in September 2011 this brings together the mental health trust, commissioners, local authority and acute trust representatives. There is a developing relationship with the newly formed Clinical Commissioning Group (CCG) leads with regular meetings between the lead for joint commissioning, the chair of the lead CCG, and Trust representatives including CEO and Medical Director. There is an extended invitation for CCG leads to attend the newly developed High Level Investigation Panels as part of the SUI process and for leads to be part of SUI panel investigations.

The Trust and commissioners work collaboratively to identify their CQUIN measures drawing heavily from themes and learning that have emerged from SUI's.

5. Comprehensive Psychological Therapy Service

The current structure for Psychological Services within Manchester Mental Health and Social care Trust reflects the recommendations laid out in “*Organising and Delivering Psychological Therapies*” (DOH, July 2004). Within this structure effective leadership and

management is provided through the Psychological Services Management Group (PSMG), which oversees a wide range of psychological therapies and services and undertakes to identify and resolve significant gaps in psychological service provision and provide advice on the implementation of psychological therapies outlined in National Institute of Health and Clinical Excellence (NICE) and related guidelines.

PSMG includes representation from managers of all the key specialist areas within Psychological Services, managed by the Clinical Director of Psychological Services and is accountable to the Chief Operating Officer of MMHSCT.

In addition the Psychological Therapies Quality Group (PTQG), has responsibility for advising the Trust on all quality and governance issues relating to psychological therapy.

Psychological services work across Community Mental Health Teams, Primary Care Mental Health teams, Later Life Services and Physical Health Services offering a range of specialist, evidence-based psychological therapies to clients experiencing a range of complex emotional adjustment disorders, psychosis and personality difficulties and also work with people with dementia and their carers.

PSCG also comprises a specialist psychotherapy service, a city wide eating disorders service and city wide psychosexual service.

In addition to direct clinical work, activity within the care group includes:

- clinical supervision and training to providers both within and outside the Trust;
- specialist consultation;
- specialist training;
- service development initiatives;
- audit, research and service evaluation supporting the setting, measuring, & monitoring of standards in relation to psychological interventions;
- service governance activities;
- liaison with other service providers and commissioners of services.

18. Lessons Learned

There are five key areas of learning resulting from this Investigation.

First: Care Coordination and CPA. Care Coordination and the Care Programme Approach provide an essential safety net of care. For those service users who are not considered eligible for the Care Programme Approach involved health and social care professionals need to remain vigilant and should consider re-classification when the service user's health and social care situation is subject to change. In the case of Mr. Z his presentation became complex and his social situation was chaotic. He probably continued to drink alcohol and made several attempts upon his own life. Mr. Z required a comprehensive review of his care and treatment. Clear protocols should be in place that can facilitate the transition of a service user from one level of care to another when this is clinically indicated.

Second: Professional Communication. Since the inception of the HSG (94) 27 professional communication issues have been identified as a key underlying factor when things go wrong in secondary care mental health service provision. Levels of professional communication were variable in this case. It was evident that information was not shared in either a comprehensive or timely manner. All health and social care professionals, in both primary and secondary care settings, need to be mindful of the information that they have in their possession about a service user and should ensure, where relevant, that this information is passed on to all members of the treating team. This is of particular importance if the treating team, as was the case for Mr. Z, is a disparate team comprising individuals from a wide variety of Trusts and services. The responsibility of all involved health and social care professionals for ensuring communication flow takes place is made more pertinent in the absence of a Care Coordinator for those service users classified as not requiring CPA.

Third: Risk Assessment and Management. Risk was occasionally assessed but no management strategy was prepared, it is fair to say that Trust risk management policies were not adhered to in the full spirit of the documentation. Mr. Z presented with a significant level of risk to both himself and to others. It would appear that the levels of personal safety felt by health care professionals when in Mr. Z's presence was a key determining factor in deciding whether or not he was truly a risk to other people. This was not good practice. A key lesson

to be noted here is that all identified risk needs to be managed actively and not simply identified and recorded. It must also be noted that risk presentation is dynamic and can be influenced by a multitude of factors. It is essential that risk is assessed at each transition in a service user's care pathway and following any worsening of their mental state.

Fourth: Evidence-based Practice. The Independent Investigation Team concluded that whilst the services provided to Mr. Z were of benefit to him practice was not always evidence-based and this could have placed the integrity of what was provided in jeopardy. National Institute of Health and Clinical Excellence (NICE) guidance should be embedded into all clinical policies and care pathways. All practicing health care professional should deliver their practice in keeping with the requirements of national best practice guidelines. When it is indicated clinically that an alternative approach to NICE guidance needs to be taken then the rational for doing so should be recorded and a risk assessment undertaken.

Fifth: Safety of Carer's and Third Parties. It is often the case that health and social care practitioners find it difficult to know when to breach patient confidently in the interests of a carer's or other third party's, safety. Trusts need to make explicit when confidentiality should be breached and when carers or other third parties should be contacted when their safety may be compromised by a service user. This is a problem that is flagged up on a regular basis with Investigations and Inquiries of this kind across the country.

19. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Manchester Mental Health and Social Care NHS Trust and NHS Manchester to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

19.1. Recommendations for Manchester Mental Health and Social Care NHS Trust

It should be noted that the findings of the Trust internal investigation and those of the Independent Investigation covered different topics. Whilst the Trust has finalised its own action plan the recommendations set out below address the additional areas for improvements and learning identified by this independent process.

Recommendation 1: Diagnosis.

- *Contributory Factor 1. The limited diagnostic formulation meant that Mr. Z was not understood in the full context of his mental health issues and his continued reliance upon alcohol.*

Recommendation 1. That in all cases where multiple factors are identified which may be contributing to a person's mental health problems a diagnostic formulation must be prepared

and reviewed in subsequent clinical contacts. This will be subject to review as a part of the ongoing medical appraisal and patient review process.

Recommendations 2-3: Medication and Treatment.

- *Contributory Factor 2. The approach taken to the psychological therapy that Mr. Z received did not run in accordance with national best practice guidance relating to PTSD treatment management. This potentially placed Mr. Z and those around him at risk.*
- *Contributory Factor 3. The failure to achieve the necessary levels of professional communication and disclosure of information placed Mr. Y in an unacceptable position of risk. This failure also prevented Consultant Psychiatrist 2 accessing significant facts that could have led to a more in-depth formulation of Mr. Z's case.*

Recommendation 2. That guidance on best practice should be disseminated when available to staff and an implementation plan should be developed by the Trust for all new guidance. Clinical staff must record where such guidance is not followed. All NICE guidance pertinent to the management of risk should be:

- referenced in Trust risk policy and procedure documentation;
- part of Trust clinical risk training processes;
- a focus of clinical supervision where appropriate and clinically indicated.

Recommendation 3. The Trust should review how it monitors and audits fitness to practice for those engaged in Psychological and Psychotherapy Services in relation to:

- safeguarding;
- abuse;
- PTSD treatment and risk methodologies.

Recommendation 4: CPA.

- *Contributory Factor 4. Mr. Z met the criteria for 'Enhanced' CPA at the point of his referral to secondary care mental health services in June 2005, and at certain other stages during his five-year period with the Trust. Mr. Z did not receive a Care Programme Approach and consequently had no overarching Care Coordination to ensure that he received holistic assessment and that his care and treatment was managed effectively.*

Recommendation 4. That the Trust ensures all staff are informed of the need to adhere to the revised CPA process which has been reviewed in light of all available guidance. The Trust must ensure that:

- Trust CPA training events make explicit the criteria for those eligible for CPA;
- the needs of all Trust service users are reviewed on a regular basis to ensure that they are placed appropriately as either CPA or Non CPA;
- clear protocols should be in place that can facilitate the timely transition of a service user from one level of care to another when this is clinically indicated;
- where a service user is *not* considered eligible for CPA clear protocols are developed when holistic and comprehensive assessment is required prior to the delivery of psychological therapy work as set out in NICE guidance.

Recommendation 5: Risk.

- *Contributory Factor 5. Mr. Z's risk profile was understood poorly despite opportunities existing for a more accurate understanding to be gained. Mr. Z's needs were complex in nature and he retained a latent potential for both self harm and violence to others. This potential was exacerbated by alcohol and Post-Traumatic Stress Disorder symptoms. A more structured approach may have ensured that the problems he had were acknowledged and identified and could have been managed more effectively.*

- *Service Issue 1. The clinicians involved in Mr. Z's care and treatment did not appear to understand the risks associated with the concurrent presence of alcohol usage, depression, Post-Traumatic Stress Disorder and intensive therapy. No appropriate level of risk assessment was conducted prior to therapeutic interventions counter to extant NICE guidance.*

Recommendation 5. That the Trust's risk assessment guidance will be updated to include an assessment of risk in light of complex interactions between intrinsic and extrinsic factors and the need to recognise risks that arise as a result of the proposed therapeutic interventions. These revisions need to be made in accordance with:

- National Institute of Health and Clinical Excellence best practice treatment guidelines;
- extant Trust clinical care pathways for service users with complex diagnoses and drug and alcohol problems.

These revisions to be completed within six months of the publication of this report.

The Trust must also audit current practice to identify risk policy compliance in order to ensure that:

- all identified significant risks have a realistic management plan developed;
- risk assessments occur when service users transition between services or when their mental state requires this to be done (e.g. after a self-harming event).

Recommendation 6: Referral, Transfer and Discharge.

- *Contributory Factor 6. Referral decisions about Mr. Z served to divert him away from services which may have been able to provide a holistic range of support. The referral decisions regarding Psychotherapy input were clinically indicated but could not provide a timely response to Mr. Z's needs following episodes of crisis.*

Recommendation 6. That the Trust issues guidance to ensure that high risk and complex patients can access care coordination when they are receiving treatment in areas of service that cannot offer urgent support in a crisis. The Trust must ensure:

- inter-department protocols are developed that ensure all known information about service users, relating to either risk of harm to others or self, is communicated with immediate effect;
- lead professionals responsible for communication are clarified in the absence of a Care Coordinator being involved in the service user's care.

Recommendation 7: Carer Communication.

- *Contributory Factor 7. Mr. Z had a turbulent relationship with Mr. Y which was both supportive and problematic at the same time. Both men, by virtue of a mix of physical and mental health problems, found it difficult to live their lives to the full and this created tension within the home that both shared. The kind of secondary care service that Mr. Z received precluded home visits and a holistic assessment approach and this was ultimately to the detriment of the wellbeing of both Mr. Z and his friend Mr. Y.*

Recommendation 7. The Trust should make a revision to both its risk and CPA policies to ensure that:

- when it is recognised that an holistic assessment is required for a person who is NonCPA this is undertaken with the support of the Community Mental Health Team;
- all assessors should be mindful of the service user's social/living arrangements and that home visits should be made when cases appear to be of a complex nature;
- carers/next of kin should be notified whenever a service user makes a threat of violence against them to a health or social professional within the Trust; the necessary support and advice should be provided with immediate effect;
- CPA and risk policies should make explicit when patient confidentiality should be breached in the interests of the safety of a third party and a protocol of required actions should be developed.

Service User Involvement.

- *Contributory Factor 8. Mr. Z received sensitive and person-centered care. However he was not understood in the full context of either his psychiatric history or his current alcohol consumption and social care needs. This meant that the care plan put into place for Mr. Z could not provide the range and depth of service that Mr. Z needed in order to be able to affect the problems that he had.*

No recommendations are required for this contributory factor as the issues are addressed in the recommendations set out above.

Recommendations 8-9: Professional Communication.

- *Contributory Factor 9. Professional communication practice was poor. An over reliance was placed upon the information that Mr. Z gave about himself and corroboration was seldom sought. Consequently the clinical picture was not based upon all of the information that was held by disparate members of the treating team and this meant that the care and treatment approach taken was not based upon the best evidence available.*

Recommendation 8. That the Trust ensures all clinical staff share information that will support the management of clinical risk and the development of the diagnostic formulation. This will include the development of a protocol for the recording and sharing of information relating to psychotherapeutic treatments. This protocol will;

- be embedded in all relevant clinical care pathways;
- be embedded into the Trust CPA and risk policy documentation.

Recommendation 9. Protocols should be established in order to ensure that relevant clinical communication takes place between primary and secondary care in a timely manner. Clear requirements should be set out for General Practitioners; Accident and Emergency staff; and Liaison Psychiatry.

Recommendation 10: Policy Adherence.

- ***Contributory Factor 10. The care and treatment delivered to Mr. Z fell broadly into local and national policy best practice guidance. However there were examples of clinical practice not adhering to NICE guidelines coupled with local policy adherence inconsistencies.***

Recommendation 10. The Trust must revise all policy documentation in keeping with the findings of this Investigation report and as set out in recommendations 1-9 above. All policy documentation should be subject to review and audit for both compliance and effectiveness as part of the Trust audit cycle.

Glossary

Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Case Management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against Clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Chlorpromazine	Chlorpromazine is classified as a low-potency typical antipsychotic and in the past was used in the treatment of both acute and chronic psychoses. The use of Chlorpromazine and other typical antipsychotics has been largely replaced by newer generation of atypical antipsychotics which are generally better tolerated.
Cognitive Analytic Therapy	CAT is a time-limited therapy which focuses on repeating patterns that were set up in childhood as a way of coping with emotional difficulties and deprivations. The CAT therapist and the patient, work together to recognise their maladaptive patterns and then to revise and change the patterns. CAT is particularly helpful for helping patients recognise relationship patterns that continue throughout life and are difficult to change without help.
DNA'd	This means literally 'did not attend' and is used in Clinical

records to denote an appointment where the service user failed to turn up.

Electrocardiography (ECG)	Electrocardiography is a test that measures the electrical activity of the heart.
Enhanced CPA	This was the highest level of CPA that person could be placed on prior to October 2008. This level requires a robust level of supervision and support.
Escitalopram	Escitalopram is primarily used for the treatment of major depressive disorder and general anxiety disorder in adults.
Euthymic	Euthymia is a word used for indicating a normal non-depressed, reasonably positive mood.
Haematemesis	Haematemesis is the vomiting of blood. This condition occurs when there is bleeding in the oesophagus, stomach or duodenum. This can be a complication for individuals who abuse alcohol.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983, amended in 2007, covers the assessment, treatment and rights of people with a mental health condition.
Mirtazapine	This is a drug used to treat moderate to severe depression.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others..
Risperidone	Risperidone is an atypical antipsychotic drug often prescribed for treatment of schizophrenia and the psychotic features of bipolar disorder.
Service User	The term of choice of individuals who receive mental health services when describing themselves.

Sodium Valproate

Sodium Valproate is commonly used for epilepsy and manic depression. It is also used when people have challenging behaviours and/or feel tense or angry.

Appendix One

Timeline Mr. Z

Date	Event
12 April 1970	Mr. Z was born.
1980-1981	<i>"Behaviour Disorder"</i> written in the GP record. On the 5 November 1980 it was written that Mr. Z had behaviour problems at home, lying and stealing. A psychiatry referral was made. It was decided that an admission was not necessary and that Mr. Z would do best at home.
June 1992	It was noted in the GP record that Mr. Z had been under psychological treatment for abuse as a child. He was half way through the treatment when he moved to Barrow. The GP sought a new referral so that the treatment could continue.
1994	Mr. Z was referred by his GP for counselling. Mr. Z failed to attend his appointments.
13 June 1996	<p>A Forensic Psychiatrist prepared a forensic psychiatry report. Mr. Z had told him about the abuse he had experienced as a child. Mr. Z appeared to have a close relationship with his mother and got on alright with his present stepfather.</p> <p>Mr. Z had been living with the plaintiff for about seven months. The attack occurred because Mr. Z did not want to have sex with the plaintiff. Mr. Z expressed genuine remorse and regret for what he had done. It was the opinion of the Forensic Psychiatrist that Mr. Z was fit to appear in Court although he was suffering from a mild depressive episode. It was thought that the attack had been perpetrated by a young man with a history of abuse who had acted impulsively under the influence of alcohol. It was thought highly unlikely that Mr. Z would commit another similar offence in the future. A non-custodial sentence was suggested with Outpatient follow-up.</p>
25 July 1996	The GP asked for a psychiatric referral for Mr. Z due to his history of multiple overdoses. It was recorded that Mr. Z had a history of abuse and that he was currently under the care of a Forensic Psychiatrist. He had attempted to overdose a week previously. Prior to this he had overdosed with more than 100 Paracetamol tablets for which had been an inpatient at Rotherham for some time.
3 August 1996	The word <i>"Overdose"</i> was written in the GP record.
2 December 1996	A Probation Officer wrote to Mr. Z's GP in Beaumont Street Nottingham. He explained that Mr. Z was being supervised by his Office. When he was sentenced at Nottingham Crown Court in the July the Court had two

	copies of a psychiatric report prepared by a Consultant Forensic Psychiatrist from Rotherham General Hospital. The report recommended Outpatient treatment. Mr. Z had requested a referral to a local psychiatrist. The Probation Officer was seeking advice as to the waiting times for such services.
22 April 1997	The GP made a referral for Mr. Z to have a psychiatric referral. The referral mentioned that he had been admitted to “ <i>Queens</i> ” in August 1996. He was then living in Rotherham under the care of a Forensic Psychiatrist. The problem appeared to have stemmed from his being abused between the age of ten and sixteen years of age. At this time he was on Prozac 40 mg a day. Advice and input was sought.
22 February 2001	“ <i>Overdose</i> ” was written in the GP record. Mr. Z took 8 x 500mg of Paracetamol and may have consumed up to six litres of strong cider. He said that he did not feel depressed unless he was drunk. It was noted that in spite of a “ <i>history of serious assaults</i> ” he had no current plans or intent to harm anyone.
29 June 2001	“ <i>Overdose</i> ” was written in the GP record.
18 June 2003	Mr. Z took 30 Paracetamol, six shots of vodka, six shots of whiskey and half a bottle of wine. His mother returned home early and called an ambulance. The GP said Mr. Z was of no fixed abode and had made some 12-13 previous attempts. Apparently Mr. Z had been living in Manchester, but had returned to Nottingham to be closer to his family. He was currently living with his mother. Mr. Z said that he had previously been a heavy drinker but that he had stopped six months ago. Mr. Z said he had stabbed someone because they had been trying to rape him. He was given 12 months of Probation following this.
28 June 2003	“ <i>Overdose</i> ” was written in the GP record.
	Care in Manchester-based Mental Health Services
21 June 2005	Mr. Z was now living back in Manchester. A Manchester-based GP referred Mr. Z to see a Consultant in the Psychiatric Clinic due to his history of depression which had been getting worse over the past two months. The referral also mentioned a history of overdoes and anxiety which had been present for some ten years.
5 July 2005 14.00 hours	<p>The GP referred Mr. Z to the Accident and Emergency Department where he was seen by a Staff Grade Psychiatrist. Mr. Z was living in a flat that he shared with a male friend. He had been referred for depression and suicidality.</p> <p>Mr. Z had said that he had suffered from depression following the prolonged abuse he experienced as a child. Mr. Z had been experiencing thoughts of self harm and had been low for several weeks. He was very irritable and had thoughts of knifing his flatmate. His sleep had been poor and he described visual hallucinations. He described obsessive compulsive behaviour of some two years standing.</p> <p>Three weeks ago he took a rock from the garden and Stanley knife. “<i>His thoughts were to smash his friend’s head</i></p>

	<p><i>in, and afterwards cut his throat</i>". He changed his mind. He expressed variable concern about having these thoughts.</p> <p>Mr. Z's past psychiatric history was noted as including a period of psychotherapy at the age of sixteen. In 1998 he apparently attacked a man for no reason, stabbing him with a fork 22 times. The man suffered from a collapsed lung. Mr. Z received a suspended sentence and spent three months in a psychiatric unit in Rotherham Yorkshire. Mr. Z was prescribed Fluoxetine; he took it for one to two years and then stopped as he did not think it helped him.</p> <p>Mr. Z said that he had made a number of suicide attempts. He had been on Amitriptyline 25mg <i>nocte</i> for one month with no effect. He had a previous history of heavy drinking, which he had reduced, but gave up when prescribed the Amitriptyline.</p> <p>The issues were described as being psychodynamic related to unresolved experiences of abuse. He was referred to the CMHT. The Amitriptyline was ceased and Sodium Valproate 200mg twice daily for one week, then increased to 400mg twice daily, was commenced. It was suggested that at a later date Paroxetine should be considered.</p> <p>Hand-written notes record that Mr. Z experienced seeing spiders and flies. He also reported thoughts of hitting and knifing a friend with whom he had been living. Mr. Z also explained that he had taken a rock and a Stanley knife to "<i>smash his friend's head and afterwards slit his throat but couldn't do it</i>".</p> <p>Mr. Z reported that he had been abused between the ages of six and 16 years.</p>
6 July 2005	A " <i>medical urgent</i> " referral was made by the Accident and Emergency Department to the Community Mental Health Team (CMHT) for a Multi Disciplinary Team assessment.
7 July 2005 13.00 Hours	A CMHT assessment took place by a Community Psychiatric Nurse (CPN). It was noted on the 'Violence Risk Assessment Tool' that Mr. Z had attacked a male partner in 1989 with a fork stabbing him 20 times and that the victim suffered a collapsed lung. It was noted that this attack was the only one that was known. It was uncertain whether or not a pattern could be ascertained from previous behaviour. It was recorded that Mr. Z had difficulty in forming close relationships with others and that he argued with his current partner often losing control, throwing and smashing things. Mr. Z said during the interview that he had thoughts of throwing the television at his partner but that if he hit him he might not be able to stop " <i>query fatal consequences</i> ".

	<p>The risk assessment indicated that Mr. Z had a depressive illness and that he did not feel he himself was at risk from others. There were no indications that Mr. Z thought his mind was dominated by forces beyond his control, or that he had thoughts that were not his own. He did not have any paranoid thoughts and claimed not to have any hallucinations. Mr. Z claimed to think about violence “<i>sometimes</i>” but that he never carried a weapon.</p> <p>Observations over the past 24 hours were that Mr. Z was very evidentially angry, verbally abusive and had glaring eye contact. It was recorded that Mr. Z did not drink alcohol, but a “?” was placed by illicit substances.</p> <p>Mr. Z was currently living in a house owned by his current partner. It was noted that healthcare professionals were currently involved in his support and supervision.</p> <p>The risk summary recorded that Mr. Z was easily aroused leading to arguments. There were issues around impulse control as Mr. Z frequently threw things when he lost his temper. Mr. Z said that he had never had any feelings of guilt or remorse following the assault on his ex partner in 1989. Mr. Z agreed that he ought to inform his current partner about the gravity of his feelings towards him but seemed vague and indecisive about this.</p> <p>The plan was to:</p> <ol style="list-style-type: none"> 1. monitor well being by maintaining regular telephone contact; 2. give Mr. Z the telephone numbers of the out of hours services; 3. set up initial outpatient consultant appointment; 4. discuss areas for service provision and CPN allocation at next team referral review meeting; 5. consider breaching patient confidentiality on a need to know basis due to the high risk to his partner. <p>The risk judgement was that Mr. Z was high risk. As well as the points set out above the plan included to “<i>raise anger management awareness</i>”.</p>
<p>8 July 2005</p>	<p>The CPN identified with the CMHT the risks to the partner and arranged for daily contact to be made by telephone. Consultant Psychiatrist 1 was present at this discussion. It was recorded that Mr. Z was seen and assessed by “<i>self and colleagues from the CMHT</i>”. The decision to accept the referral was to be deferred until the Team referral due to be held on the 11 July 2005.</p> <p>In the meantime the CPN raised concerns about interpersonal conflict between Mr. Z and his partner. The CPN raised the concerns as being high on the risk assessment in relation to harm to others from violence. An</p>

	appointment had been set up with Consultant Psychiatrist 1 for the 8 August 2005.
9 July 2005	A telephone call was made to Mr. Z who reported feeling tired and “ <i>groggy</i> ” since commencing on the Sodium Valproate. His thoughts of harming other remained although they were less intense than on assessment. It was planned to telephone him again the following day.
12 July 2005	Mr. Z was discharged from the CMHT on standard CPA.
4 August 2005	Consultant Psychiatrist 1 wrote to the GP to say that Mr. Z had been discussed on this day. The decision was made to trial Mr. Z on antidepressants prior to accepting him into secondary care services. Paroxetine was recommended due its anti-anxiety effects. The GP was advised that the medication could take between two-to-eight weeks to be effective and Mr. Z could be referred again if it was thought necessary.
8 August 2005	<p>Mr. Z was assessed by Consultant Psychiatrist 1 (a locum consultant). Mr. Z had been referred to him by Liaison Psychiatry. The Mental State Examination noted that Mr. Z was clean and had good eye contact. He appeared to have normal mood and levels of anxiety. There was no evidence of any disorder of thought or perception. His cognitive skills appeared to be intact.</p> <p>Mr. Z reported feeling a “<i>little anxious</i>” and “<i>a bit down</i>”. He was living with his ex partner. He denied having any suicidal ideation or any intrusive thoughts about killing his flatmate. Mr. Z reported that he had felt well for the past two to three weeks and that the Sodium Valproate appeared to suit him. His main concern was his anxiety and bad temper. Mr. Z said that he had been admitted as a psychiatric inpatient in 2000, 2001, 2002 (Salford) and 2004 (Nottingham) following suicide attempts induced by his alcohol intake. Mr. Z also mentioned his admission to Rotherham following the stabbing of a man, he was not sent to a forensic unit.</p> <p>The opinion was that Mr. Z suffered from a recurrent depressive disorder with obsessive traits, poor anger control and alcohol abuse until recently. The Sodium Valproate 800mg twice daily appeared to be controlling his anxiety and anger outbursts. Mirtazapine 15mg at night had been prescribed to help with underlying depressive symptoms and insomnia. It was suggested that he stop the Diazepam 20 mg at night.</p> <p>Another appointment was arranged for three-months time. Mr. Z was told that in crisis he could contact the CMHT.</p>
9 August 2005	<p>Consultant Psychiatrist 1 referred Mr. Z to the Psychotherapy Department. He sent to them a copy of the assessment that he made recently [see directly above]. He felt there were good grounds for psychotherapy.</p> <p>Consultant Psychiatrist 1 also wrote to the GP. He explained that Mr. Z had been referred to him by Accident and</p>

	Emergency services which assessed him on the 5 July 2005.
18 August 2005	Mr. Z received a letter from the Psychotherapy Service at McCartney House explaining that he had been referred to them. He was asked to contact them within three weeks to make an appointment.
22 August 2005	Mr. Z was written to confirming his appointment with an Adult Psychotherapist for the 10 October 2005.
10 October 2005	<p>Mr. Z met with the Adult Psychotherapist. Mr. Z felt that he was always depressed expect for brief periods. He had recently planned to harm his flat mate and explained that he had begun preparing. He had got a sharp knife from the kitchen and a boulder from the garden. He had hidden these under his bed and had planned to wait until his flat mate was asleep. There were no apparent triggers other than feelings of being angry. Mr. Z mentioned that he had stabbed a friend seven-years previously after drinking a row had broken out and he had stabbed this friend repeatedly with a carving fork. He did not feel bad about this attack and that worried him. Following this attack he had a twelve-month suspended sentence and had a forensic psychiatry assessment which led to a hospital admission for 3-to-4 months. Following his discharge he described moving from city to city.</p> <p>In the Assessment Notes it was recorded that Mr. Z had been abused as a child. The Psychotherapist wrote <i>“my anxieties were raised in the counter-transference by his description of violence but simultaneously felt optimistic about being open and honest”</i>. It was recorded that the risks relating to Mr, X were alcohol and drug miscues, however these risks were considered to be low. The main risk was that of violence which would need to be monitored closely throughout the therapy.</p>
31 October 2005	Mr. Z met with the Psychotherapist. He described feeling <i>“drained”</i> following the previous session. He continued to have been <i>“up and down”</i> since then. He described himself as always feeling on the edge.
7 November 2005	Consultant Psychiatrist 1 saw Mr. Z in the Outpatient Clinic. He appeared to be free of psychiatric symptoms. He reported feeling a lot better and with fewer mood swings. He was still living with his flatmate. He recently attended McCartney House and said it had been very helpful. The care plan was to increase the Mirtazapine from 15mg to 30mg at night. It was arranged to follow him up again in three months time.
23 November 2005	<p>The Psychotherapist wrote to Consultant Psychiatrist 1. The psychotherapy assessment had taken place over three sessions. Mr. Z had been able to detail his history and described experiencing violent feelings towards his flatmate, but so far not having acted on them. She wrote <i>“this clearly raises a great deal of anxiety in him especially when he found himself organising the implements for an attack although he did not see it through”</i>.</p> <p>The Psychotherapist also wrote that Mr. Z had been admitted as an inpatient following his stabbing an acquaintance/friend. He was assessed by a forensic psychiatrist at this time which led to a three-month hospital stay. It seemed that there was no follow up on discharge.</p>

	<p>Mr. Z described a long history of childhood abuse. Mr. Z experienced “<i>a lot of emotional and physical pain</i>” when describing this abuse. Mr. Z was described as feeling curious enough to want to understand his feelings. He was cautioned that if therapy was too distressing he needed to tell his therapist. It was agreed to place him on the waiting list for psychodynamic counselling.</p>
6 February 2006	<p>Consultant Psychiatrist 2 took over the case and reviewed Mr. Z in the Outpatient Clinic. The diagnosis was recurrent depressive disorder with obsessive traits. The clinical issues were identified as being a poor control of anger outbursts, and alcohol abuse until recently.</p> <p>Mr. Z said that he had been well and that his mood was stable. He had been attending for psychotherapy. He said that he could better control his feelings of violence against his ex partner.</p> <p>Mr. Z avoided crowds, but had a decrease in his checking rituals. He was not sleeping well. The care plan was:</p> <ol style="list-style-type: none"> 1. increase the Mirtazapine to 45mg at night. Chlorpromazine 100mg at night was added to assist his sleep. Mr. Z was to continue his psychotherapy; 2. Mr. Z was to be reviewed again in three-months time. <p>The medical hand-written notes recorded that Mr. Z had attended psychotherapy sessions and that he felt better and had no violent feelings towards his ex-partner. Mr. Z still did not want to go out in crowded places but reported a decrease in his checking behaviours. Mr. Z was still having difficulty in sleeping.</p>
9 March 2006	<p>A Counsellor wrote to Mr. Z to offer him a meeting to discuss counselling sessions. An appointment was set for the 5 April 2006.</p>
5 April 2006	<p>The Counsellor met with Mr. Z for a contracting interview. Mr. Z gave a concise summary of his previous abuse.</p>
6 April 2006	<p>The Counsellor wrote to a Consultant Psychiatrist (not Consultant Psychiatrist 2) to say that Mr. Z was due to start 15 sessions of weekly counselling on the 27 April 2006 and that he would write to him again when the sessions were complete.</p>
27 April 2006	<p>The Counsellor met with Mr. Z who was reluctant to talk about his abuse. However Mr. Z did go on to do this.</p>
4 May 2006	<p>The Counsellor met with Mr. Z who was not sure what to talk about. Mr. Z talked about the close relationship he had with his grandmother. He described a history of alcohol, skunk and cannabis misuse which had increased his feelings of paranoia. Mr. Z described being left with feelings of anxiety about men, despite being gay.</p>
11 May 2006	<p>Mr. Z telephoned the counselling service to say he could not attend on this day as “<i>something had cropped up</i>”.</p>
18 May 2006	<p>The Counsellor met with Mr. Z. It was noted that he had missed the previous week’s appointment. This was</p>

	because his flatmate had gone into a diabetic coma. Mr. Z continued to talk about his previous abuse. He said that he was finding it easier to discuss his past abuse. Mr. Z said that he had been assaulted by two previous male partners and that he did not want another partner.
23 May 2006	Consultant Psychiatrist 2 wrote to the GP to say that Mr. Z had not attended his Outpatient appointment on the 8 May. Another appointment had been arranged for three-months time. It was noted that Mr. Z had appeared improved at the last review and that he continued with psychotherapy.
25 May 2006	The Counsellor met with Mr. Z who had experienced a difficult week.
1 June 2006	The Counsellor met with Mr. Z. He had dreamt about his mother and sister. Mr. Z was sad that his fear of men would prevent him having a loving relationship. Mr. Z also spoke about the rows he was having with his flatmate, these were described as frightening, but that they were both each others " <i>rocks</i> ".
15 June 2006	The Counsellor met with Mr. Z who was shocked that his mother had written to his flatmate, after not hearing from her for two-three years, to ask where he was. Mr. Z decided that he wanted nothing to do with her, this made him sad. Mr. Z said he felt safe at home in his own room.
22 June 2006	The Counsellor met with Mr. Z. Mr. Z had experienced a disturbing dream and four nights of poor sleep. Mr. Z said that after his counselling sessions he felt unsettled and went straight home.
29 June 2006	Mr. Z telephoned to cancel his counselling appointment due on this day because he had a stomach upset. The Counsellor wrote to Mr. Z saying that he hoped he felt better and to rearrange his appointment for the 27 July 2006.
27 July 2006	The Counsellor met with Mr. Z. Mr. Z had also been to the City Centre for the first time, he felt that he wanted " <i>energy and space</i> ".
3 August 2006	The Counsellor met with Mr. Z, he was tense. Mr. Z continued to talk about his stepfather and his abuse. Mr. Z mentioned getting the all clear for a melanoma from Christies Hospital (it is not clear when this was). It was noted that Mr. Z was going to talk to his Consultant about a reduction in his antidepressant medication.
10 August 2006	The Counsellor met with Mr. Z. Mr who had experienced a " <i>terrible week</i> ". During the week he had repeated arguments with his flatmate about the tidiness of the flat. The solicitors had told him he could change his name, this was something that he planning to consider in the New Year.
17 August 2006	The Counsellor met with Mr. Z. Mr. Z had experienced " <i>an awful week</i> ". The previous evening Mr. Z had felt down and drank three quarters of a bottle of whiskey. Drinking made his depression worse. He made a serious suicide plan to cut an artery in his arm with a Stanley knife. He then telephoned the emergency services at park House and spoke to a psychiatrist. This helped and he put the knife away. Mr. Z had also " <i>had his first bad argument with his friend for some time</i> ". These arguments have the potential to result in " <i>fisticuffs</i> " and have done so in the past. However on this occasion Mr. Z managed to walk away to his room.

	Mr. Z talked about his anxieties about the counselling coming to an end. He knew he could be referred again if he needed it.
24 August 2006	The Counsellor met with Mr. Z. Mr. Z. This was the penultimate session. Mr. Z said that he felt generally better than he did since he started counselling. He still felt suicidal at times, but could sometimes enjoy himself.
30 August 2006	Mr. Z telephoned to say he had a stomach upset and was going on holiday and that he would have to cancel his appointment with the Counsellor.
31 August 2006	The Counsellor wrote to Mr. Z saying that he hoped he felt better and had enjoyed his holiday. It was arranged that they would meet on the 21 September 2006.
19 September 2006	<p>Consultant Psychiatrist 2 reviewed Mr. Z in the Outpatient clinic. The diagnosis was given as being the same as previously with the additional “<i>revised impression of ? psychosis NOS</i>”. The medication was listed as being:</p> <ul style="list-style-type: none"> • Tablets Sodium Valproate 800mg at night; • Tablets Mirtazapine 45mg at night. <p>Mr. Z described a decrease in his anxiety and obsessions. He did however report nightmares regarding his stepfather’s abuse of him. He had been discussing this in psychotherapy. Mr. Z reported that he felt his thoughts were known by other people and that he tended to avoid being in open spaces and with other people.</p> <p>He continued to sleep poorly and to live with his ex partner.</p> <p>The care plan stated:</p> <ul style="list-style-type: none"> • <i>“I have added tablet Risperidone 2mg nocte</i> • <i>I have stopped tablet Chlorpromazine</i> • <i>I confirm Sodium Valproate 800mg at night and Mirtazapine 45mg nocte</i> • <i>He is to be reviewed for psychotherapy or psychology input over next follow up</i> • <i>I have arranged for the next Outpatient review in 3 months time”.</i>
21 September 2006	The Counsellor met with Mr. Z. Mr. Z had experienced a nightmare whilst on holiday. He still believed that people knew about the abuse when he left his flat and felt safe when in his home. He had talked about this with his Psychiatrist who was due to commence antipsychotic medication. This apart, however, he was feeling better. A CORE assessment was conducted and Mr. Z had a “0” score for risk.
12 October 2006	The Counsellor wrote to Consultant Psychiatrist 2 to say that Mr. Z had completed his 15 sessions of counselling.

	<p>The childhood abuse that Mr. Z had experienced had been the central issue. Mr. Z had wanted the counselling to replace some of his bad memories with better thoughts. He felt this had been achieved. When the bad memories return Mr. Z found it difficult to control his feelings of anger and he then found it difficult not to argue with the friend he shares his house with. Counselling has not helped the anger that he feels. Mr. Z had said that he felt “<i>all talked out</i>”.</p> <p>The Counsellor also explained that Mr. Z felt people in crowds somehow knew about his abuse. This at times was a firm belief. This was a longstanding problem and continued to trouble him. It had been decided that a follow up appointment would be offered in the new year after which the plan was to discharge Mr. Z.</p>
11 November 2006	The Counsellor wrote to Mr. Z to arrange a review of counselling on the 21 December 2006.
5 December 2006	Mr. Z telephoned to say that he could not make his appointment on the 21 December as he was going away on holiday. The Counsellor wrote to rearrange the review of counselling for the 11 January 2007.
11 January 2007	The Counsellor wrote to Mr. Z to arrange a review of counselling for the 31 January 2007.
1 February 2007	The Counsellor wrote to Mr. Z arranging a meeting for the 15 February 2007. Mr. Z telephoned on the 31 January 2007 to cancel his appointment as he had not been feeling very well physically.
5 February 2007	The GP wrote on the incapacity benefit form that Mr. Z had a long history of presenting with multiple somatic complaints, which following “ <i>exhaustive</i> ” investigation failed to yield a diagnosis. The GP wrote that he thought Mr. Z was suffering from kind of psychotic illness. This diagnosis had been made by Consultant Psychiatrist 2.
15 February 2007	Mr. Z had a follow-up session with the Counsellor. It was noted that Mr. Z had missed several appointments. Mr. Z believed that his condition would not change in the future. He still had bad days. However sometimes he was able to replace bad thoughts with good ones. He was rarely arguing with his friend and did not have such “ <i>black and white</i> ” thoughts of suicide. Mr. Z was anxious at only having three-monthly appointments with his psychiatrist. However he believed that he had “ <i>plateaued</i> ” now and would not change in the future.
21 February 2007	The Counsellor wrote to Consultant Psychiatrist 2. Mr. Z had attended for his follow up appointment. Mr. Z had maintained his progress and expected that his condition would remain stable in the future. He said he could manage his agoraphobia and that although he still had bad days they were only once a week or so. Mr. Z had always had bad dreams, but now they were explicitly about his childhood abuse. He believed that he could replace bad thoughts with good ones and his mood from bad to good in a few hours. Mr. Z still had suicidal thoughts, but the thought of the consequences stop him. He reported that he had not had an argument with his flatmate for several months. Mr. Z was happy to end counselling and he was discharged from the service.
26 June 2007	Consultant Psychiatrist 2 reviewed Mr. Z in the Outpatient Clinic. His diagnosis and medication remained the same. Mr. Z reported improvement in his ideas of reference both in frequency and intensity. However he reported

	<p>that his mood had become worse over the past few weeks. He was having nightmares and flashbacks. He had felt suicidal and had thoughts of slashing his wrists or taking an overdose. It was noted that Mr. Z had made suicide attempts in the past. Mr. Z's agoraphobic symptoms persisted.</p> <p>The care plan was to add a small SSRI to the Mirtazapine to help with the residual PTSD symptoms. A referral to Psychotherapy Services was discussed and Mr. Z was amenable to this.</p>
3 July 2007	Consultant Psychiatrist 2 wrote to the Consultant Clinical Psychologist to refer Mr. Z to his service. Mr. Z was referred for an expert opinion and advice.
9 July 2007	The Consultant Clinical Psychologist wrote to Mr. Z explaining that he had been referred for psychological treatment. Mr. Z was asked to confirm that he wanted to be seen.
16 August 2007	Mr. Z was written to by the screening clinic. The letter explained the reasons for the screening process. An appointment was set for the 31 October 2007.
19 August 2007	Mr. Z had been admitted into the Pennine Acute Hospital with haematemesis. The diagnosis was " <i>?Upper GI bleed. Alcohol withdrawal</i> ". He was in hospital until the 23 August.
25 September 2007	Mr. Z was due to be followed-up in Outpatients by Consultant Psychiatrist 2 but cancelled the appointment. The Consultant wrote to the GP to notify him of this. The appointment was rescheduled.
27 September 2007 15.15 hours	<p>A nurse conducted a two-hour long assessment was conducted on a medical ward at North Manchester General Hospital. A full mental state examination was conducted on the "<i>CHORES form</i>". Mr. Z was described as being a 37-year old man who had taken an impulsive overdose of mixed medication and a bottle of whiskey in reaction to feelings of stress when acting as a confidante to his neighbour which triggered long-standing issues regarding his own history of abuse. Mr. Z took the overdose to relieve his feelings of stress; he called a friend stating what he had done this immediately.</p> <p>Mr. Z expressed feelings of hope and said that he wanted to access help to address his psychological difficulties stemming from his childhood abuse. He expressed a one-week history of anxiety and low mood. His risk of suicide was considered to be low. His current self harm was considered to be low, but moderate in the long term due to his history of using self harm as a coping mechanism since the age of 16. There were no indicators of psychotic phenomena. Mr. Z was not abusing illegal substances or alcohol at this time although it was noted he had in the past. The nurse telephoned Consultant Psychiatrist 2 to inform him of Mr. Z's behaviour. Mr. Z was currently waiting for a clinical psychology appointment. A letter was written to his GP and liaison was made with the "<i>team in crisis</i>".</p>
31 October 2007	A Screening Clinic Assessment Pro-forma was completed by Psychotherapy Services (no signature on form). It

	<p>was stated that he had been “<i>sent</i>” by the psychiatrist. Mr. Z was not sleeping and was having vivid nightmares from which he would a day to recover. When experiencing nightmares Mr. Z’s mood would go “<i>right down</i>”. It was recorded that Mr. Z had taken an overdose four months previously. It was also recorded that Mr. Z was paranoid about strangers as he believed that they could tell he had been abused. It was noted that he lived with a friend and was currently “<i>on sick</i>”.</p> <p>It was recorded that he had attended Accident and Emergency after self harming due to traumatic memories. Mr. Z was to be referred for “<i>CAT</i>” at the McCartney Centre.</p>
<p>1 November 2007</p>	<p>A Principal Cognitive Behaviour Psychotherapist wrote to Consultant Psychiatrist 2. She had seen Mr. Z at the screening clinic on the 31 October 2007 and described him as a “<i>very troubled gentleman</i>”. Mr. Z had described symptoms associated with Post Traumatic Stress Syndrome. Mr. Z had said that he was extremely depressed and had difficulties in sleeping due to nightmares and flashbacks about his abuse as a child. Mr. Z said that in the past he had dealt with his resulting feelings of anxiety by drinking and taking illicit drugs, however this was a past behaviour and he now ready to begin psychological intervention for these problems.</p> <p>It was thought that Mr. Z should receive Cognitive Analytical Therapy (CAT). A referral had been sent to McCartney House to expedite the treatment. The Principal Cognitive Behaviour Psychotherapist was happy to meet with Mr. Z again once his treatment had been completed.</p> <p>The Principal Cognitive Behaviour Psychotherapist wrote to Mr. Z to say that she had referred his case on to McCartney House.</p> <p>The Principal Cognitive Behaviour Psychotherapist wrote to a colleague to ask for an assessment for Mr. Z. She referred to Mr. Z as “<i>a troubled gentleman</i>”. She wrote that she had seen him on the 31 October 2007 and that Mr. Z had presented with symptoms associated with Post Traumatic Stress Disorder. He had told her that he had difficulties sleeping with vivid nightmares and flashbacks during the day It had been suggested that he would benefit from Cognitive Analytic Therapy (CAT). Because there was a risk for Mr. Z regarding suicide she requested an early appointment.</p>
<p>13 November 2007</p>	<p>Consultant Psychiatrist 2 wrote to the GP to say that Mr. Z had been seen at Outpatients on the 13 November. The diagnosis was recurrent “<i>depressive disorder with obsessive traits? Psychosis NOS alcohol abuse in the past</i>”.</p> <p>The medication was listed as being:</p>

	<p><i>“Tab Sodium Valproate 88mg nocte Tab Mirtazapine 45mg nocte Tab Escitalopram 5mg mane Tab Risperidone 2mg nocte”.</i></p> <p>Mr. Z had reported overdoses with painkillers in September 2007, coupled with alcohol and precipitated by the worsening of his “PTSA” symptoms. He had subsequently improved and reported that he now felt better. He had been referred to psychology. He currently reported no persistent mood features. The Post Traumatic Stress Disorder had persisted with ideas of reference and persecution; however these feelings were only prominent in crowded places. Mr. Z denied any ideas of self harm or suicide. Mr. Z had also been referred to McCartney House for Cognitive Behaviour Therapy and was looking forward to it.</p> <p>The GP was asked to raise the Risperidone to 3mg <i>nocte</i> (at night). The plan was to review Mr. Z again in three-months time.</p>
31 January 2008	<p>Mr. Z met with a member of the Psychological Therapy Service. Mr. Z repeated his history of abuse. He was still experiencing nightmares and flashbacks. Mr. Z was staying in bed until midday watching television. He was not exercising. He had found counselling helpful as it had been good to talk and not be judged. It was noted that he had taken an overdose in September 2007 which had resulted in three days in hospital. It was also noted that Mr. Z usually did not drink, but that this had precipitated his overdose. Mr. Z said that he had only had two-three rows with his ex-partner in seven years and was good friends with his ex-partner’s two sisters. He mentioned that he had stabbed a friend ten years ago.</p> <p>The psychotherapy assessment notes recorded that he had been referred for CAT. Four years ago he had talked to his mother about his experiences of abuse. This resulted in major conflict and accusations within his family. Mr. Z had been referred to a psychologist between the ages of six and seven after writing a story of burning his sister alive because she was a witch. It was noted that he had received counselling in 2006.</p> <p>It was recorded that Mr. Z had allegedly experienced abuse between the ages of six and 16. Mr. Z had a history of moving from city to city until four years ago when he moved to Manchester with his then partner. He continued to live in a flat with his ex-partner. He felt safe in his flat but this meant he lived a very restricted life.</p>
11 February 2008	Mr. Z cancelled his appointment with the Psychological Therapy Service because of a broken boiler.
19 February 2008	Mr. Z did not attend his Outpatient appointment with Consultant Psychiatrist 2. The next follow up was planned

	<p>for three-months time.</p> <p>Mr. Z did however attend his appointment with a member of the Psychological Therapy Service. Mr. Z said that he had been “<i>drained</i>” following the previous session. He said that this had also occurred after counselling, but that this was harder. Mr. Z said that he had not been drinking for four years except for the time leading up to his recent overdose. Mr. Z described spending a lot of time in his bed. His mood seemed to vary. He wanted to be able to understand himself better. Mr. Z also went back into his history of abuse and poor family relationships. He said that he had always been angry when young but had “<i>kept it in</i>”. He described himself as having acquaintances but not friends and that he did not feel safe outside of his flat.</p>
<p>4 March 2008</p>	<p>Some kind of risk assessment was completed by a member of the Psychological Therapy Service [documentation incomplete]. It was noted that Mr. Z had been convicted of violence in the past and that he suicidal ideation and had conducted acts of self harm in the past. Most of the form was left blank.</p> <p>The risk assessment included the information that he had cut his arms some ten years ago for which he was admitted for three-four months. His medication was listed. It was also mentioned that he had stabbed someone repeatedly some 10 years ago for which he received a three-month hospital admission. Mr. Z said he could not remember what he did, but that there had been no violence since then. It was noted that he used to drink heavily, but did not do so now. No formulation was made regarding his risk to others.</p>
<p>13 March 2008</p>	<p>A member of the Psychological Therapy Service wrote to Consultant Psychiatrist 2 and copied the GP into the correspondence. A member of the Psychological Therapy Service met with Mr. Z for two assessments. It was stated that Mr. Z was seeking therapy to understand himself better, to stabilise his moods and to reduce his symptoms of anxiety and intrusive imagery associated with Post Traumatic Stress Disorder.</p> <p>It was noted that Mr. Z had strong feelings of hurt and anger due to his abuse as a child and of being ignored. He had flashbacks and nightmares. Mr. Z also withdrew from others to the safety of his own home.</p> <p>It was noted that it appeared that Mr. Z’s symptoms had grown worse over recent years. He felt this was triggered by talking to his mother four years ago which had led to family conflict and recrimination. He found medication useful in controlling his mood swings. Facing his feeling was painful for Mr. Z however he had found counselling with the Counsellor useful.</p> <p>Consequently Mr. Z was placed on the waiting list for Cognitive Analytic Therapy.</p>

24 March 2008	<p>Mr. Z was assessed on a medical ward at North Manchester General Hospital by a Specialist Nurse Practitioner. Mr. Z had been admitted the previous day following an overdose of Tramadol tablets. Mr. Z could not really explain his actions. He had felt low the previous day and decided to get drunk. Whilst intoxicated he had impulsive thoughts about taking an overdose.</p> <p>Mr. Z thought that a friend had called the ambulance. Mr. Z regretted his actions and said he had further thoughts of self harm. There was no evidence of mental illness; however psychological difficulties were noted for which he was receiving treatment. There was no plan for further psychiatric intervention or follow up resulting from this incident. The GP was written to. A Mental State Examination and assessment were entered in the general case notes.</p>
20 April 2008	Psychological Services arranged a telephone discussion with Consultant Psychiatrist 2. However Consultant Psychiatrist 2 was unavailable. The record does not state what this was about in any depth.
1 May 2008	Psychological Services tried to call Consultant Psychiatrist 2, left a message and recorded that no one returned her call. A discussion took place within Psychological Services and it was ascertained that Mr. Z had mentioned a previous stabbing incident. However a previous therapist noted that she had felt safe in the room with Mr. Z and recalled that he had required coping skills.
7 May 2008	Mr. Z met with a Clinical Psychologist. The meeting lasted for 50 minutes during which time they discussed confidentiality and risk, particularly around his previous overdose. The aims of the therapy were that he would have a better understanding of himself and to reduce the impact of the past upon his present. At the time he discussed experiencing flashbacks and nightmares. He wanted to be able to make friends and engage in a meaningful activity, e.g. work. It was recorded that he lived with his ex partner and that he saw Consultant Psychiatrist 2 every three months. He appeared motivated to start therapy.
14 May 2008	It was recorded in the psychotherapy session with the Clinical Psychologist and that Mr. Z had experienced a good week. The session focused on Mr. Z talking about his childhood.
21 May 2008	The Clinical Psychologist recorded that Mr. Z was thinking about his grandmother and that he had written to an aunt requesting a photograph which she duly sent to Mr. Z.
25 May 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z had filled the Psychotherapy File documentation.
4 June 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z was able to talk about his past abuse.
10 June 2008	Consultant Psychiatrist 2 saw Mr. Z in the Outpatient Clinic. The diagnosis remained largely unaltered; however Post Traumatic Stress Disorder was added. Mr. Z's medication was:

	<p>“<i>Tab Sodium Valproate 800mg nocte</i> <i>Tab Mirtazapine 45mg nocte</i> <i>Tab Escitalopram 5mg mane</i> <i>Tab Risperidone 3mg nocte</i>”.</p> <p>Mr. Z informed the Doctor that he had been admitted with an overdose in March. He stated it had been an impulsive act. Mr. Z had been overwhelmed with flashbacks about his former abuse. However Mr. Z had changed his mind about killing himself and called an ambulance.</p> <p>Mr. Z thought people could read his thoughts. Mr. Z denied any further thoughts of wanting to commit suicide. He was under the care of psychotherapy and had only had three sessions so far.</p> <p>The care plan was: to increase the Risperidone to 4mg at night to increase the Escitalopram to 10mg in the morning to decrease the Mirtazapine to 30mg after a week of Escitalopram to take Mr. Z’s blood for Valproate levels to review Mr. Z in Outpatients in two months time.</p>
11 June 2008	It was recorded in the psychotherapy session with The Clinical Psychologist that Mr. Z was experiencing flashbacks which were overwhelming. In the past he had undertaken cottaging in order to meet people and had also experienced violence when drinking which had resulted in broken cheek bones and nose [not clear whether the violence was to Mr. Z or perpetrated by him]. There were issues regarding separating violence from sex. Mr. Z stated that there had never been violence between him and his ex partner, Mr. Y with whom he was living.
17 June 2008	Mr. Z telephoned to cancel his appointment with the Clinical Psychologist due to feeling unwell.
25 June 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z was “ <i>feeling good today</i> ”.
28 June 2008	The Clinical Psychologist wrote to Mr. Z as part of his therapy. The letter detailed Mr. Z’s history and what he had hoped to achieved from his psychotherapy sessions. The letter also set out what Mr. Z could do to cope.
2 July 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z had experienced nightmares for three nights.
9 July 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z was angry and sad.
16 July 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z was sleeping better but still experiencing flashbacks.

23 July 2008	It was recorded in the psychotherapy session with the Clinical Psychologist that Mr. Z said he had “ <i>nearly committed suicide</i> ” the previous Thursday. He felt he had <i>Had enough</i> ” and described an overwhelming sadness which he wanted to stop.
6 August 2008	Mr. Z was noted in his psychotherapy session as “ <i>still not well</i> ”. He was sleeping well, his flashbacks were decreasing and his mood was “ <i>pretty good</i> ”.
19 August 2008	Mr. Z cancelled his psychotherapy appointment because he had a hospital appointment.
27 August 2008	Mr. Z cancelled his psychotherapy appointment because he had not been well. He stated he was not cancelling because of the sessions.
7 October 2008	<p>Mr. Z attended the Outpatient Clinic. In the letter written to the GP following this event Consultant Psychiatrist 2 wrote that the diagnosis was <i>recurrent depressive disorder with obsessive traits and possible psychosis NOS. Alcohol abuse in the past. Post Traumatic Stress Disorder</i>”.</p> <p>The medication was listed as being: <i>“Risperidone 4mg nocte Escitalopram 10 mg mane Mirtazapine 30mg nocte Sodium Valproate 800mg nocte”</i>.</p> <p>Mr. Z had reported flashbacks and nightmares along with poor sleep. This occurred every two-three days and were primarily about being abused. However Mr. Z did say that his anxiety had lessened following cognitive therapy. Mr. Z reported improvement in psychotic phenomena; ideas of reference remained but his conviction was decreased. He still said that people could read his mind but that these beliefs were less intense that his insight was increasing. Handwritten notes say he was finding it difficult to apply the strategies for managing his flashbacks.</p> <p>Mr. Z reported that his mood was more or less stable most of the time. His self care was still poor. Mr. Z still had occasional thoughts of suicide but had no intent.</p> <p>Risk assessment: Mr. Z was reported to have shown an improvement in his symptomology. The risk of self harm remained but it was low. Although Mr. Z “<i>reported abstinence</i>” his GGT had been elevated. It was also noted that his serum Valproate level were low, less than the therapeutic range.</p>

	<p>The plan was to ask the GP to raise the Escitalopram to 15mg <i>mane</i> (morning) and to decrease the Mirtazapine to 15mg <i>nocte</i> (night). The Sodium Valproate was to be increased to 1000mg <i>nocte</i>. The Risperidone was to remain the same. Mr. Z was to be reviewed again in three-months time.</p> <p>Hand-written medical notes also recorded that the flashbacks lasted between two-three minutes and would leave Mr. Z scared and frightened for a couple of hours. Mr. Z had stated that he felt guilt about not staying in contact with his family. It was noted that there was an improvement in psychotic symptoms although Mr. Z still believed that people could read his mind. Mr. Z was still experiencing some suicidal ideation.</p>
22 October 2008	<p>A Clinical Outcomes in Routine Evaluation outcome measure was completed. There were no present indications of violence of self harm.</p> <p>22.10.2008 CORE outcome measures indicated an improvement since Jan 2008.</p>
29 October 2008	Mr. Z attended an appointment with the Clinical Psychologist.
4 November 2008	A status update recorded that Mr. Z was not on CPA but was receiving care.
13 January 2009	Mr. Z had flu and could not attend his psychology appointment with the Clinical Psychologist.
11 February 2009	A follow-up session with the Clinical Psychologist took place. It was recorded that things were “ <i>pretty much the same</i> ”. Mr. Z was still experiencing flashbacks and was not sleeping. He was going to visit his GP for this.
12 May 2009	<p>Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained unaltered. It was decided to increase the Escitalopram to 20mg once daily and to reduce the Mirtazapine to 7.5mg <i>nocte</i>.</p> <p>Mr. Z reported that he was stable overall; however he still experienced some lows. His flashbacks persisted and had become more frequent, some 4-5 times each day. These flashbacks only lasted a minute or so. Mr. Z’s psychotherapy at McCartney House had been completed in January. He found it difficult on occasion to apply the coping strategies. He was living with a friend. Mr. Z still had ideas of persecution, his self care was “<i>erratic</i>” and he remained socially isolated. It was noted that he had gained 2.5 stones in weight. The plan was to review him in three-months time. The GP was written to. Mr. Z was given Zopiclone 7.5mg for two weeks to help him sleep.</p>
17 August 2009	<p>Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis and medication remained unaltered. Mr. Z reported that his mood was “<i>maintaining well</i>” and was not drinking. There was an improvement in the ideas of reference that he experienced. He was still having nightmares about what had happened in the past “<i>suggestive of first residual symptoms of post traumatic stress disorder</i>”.</p> <p>Otherwise Mr. Z’s social activities had increased and he denied depressive symptoms. His personal hygiene was</p>

	<p>still noted to be poor as he only took a bath every few weeks. On mental state examination his affect was euthymic and no ideas of reference were reported. His insight was preserved and he was compliant with his medication. The plan was to continue with the same treatment to increase the Risperidone if the ideas of reference persisted. Mr. Z was to be reviewed again in three-months time.</p>
23 September 2009	<p>The Clinical Psychologist wrote to Consultant Psychiatrist 2. Mr. Z had been offered 16 sessions of Cognitive Analytic Therapy between June 2008 and December 2008. He had been seen for follow up earlier in 2009. Mr. Z had engaged well, however he had cancelled a number of appointments due to poor physical health. He acknowledged that at the time he was overwhelmed by the sessions. Mr. Z's flashbacks were reduced but did not disappear. He was able to use the methods of distraction that he was learning. He had now been discharged from the service</p>
4 December 2009	<p>Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained unaltered; however it was decided to stop the Mirtazapine. Mr. Z reported that he had been doing well since the last follow up. He still found it difficult to sleep and was still experiencing flashbacks, but was coping with this better.</p> <p>The medication was listed as being: Escitalopram 20mg in the morning; Mirtazapine 7.5mg at night; Sodium Valproate 1000mg at night.</p> <p>When Mr. Z went out on his own he still experienced ideas of reference, but he had insight into this. He was not drinking alcohol. Mr. Z was being active and was enjoying gardening. He was living with his ex-partner who was now his friend. His self care remained poor. The mental state examination recorded that his mood was euthymic, speech relevant and coherent with no formal thought disorder. There were no ideas of reference or persecution noted. No significant risks were identified. The care plan was to cease the Mirtazapine. Follow up was arranged for four-months time.</p>
10 June 2010	<p>Mr. Z was reviewed in the Accident and Emergency Department by a Locum Senior House Officer on call. The previous day Mr. Z had taken an overdose. Mr. Z had experienced a good day, but suddenly had thoughts of taking an overdose. He denied any further thoughts of self harm or suicide or of wanting to harm others. It was noted that Mr. Z saw Consultant Psychiatrist 2 as an Outpatient.</p> <p>The mental state examination reported that Mr. Z had paranoid ideation but also had good insight. It was thought that Mr. Z presented a low risk of both self harm and harm to others. Mr. Z was discharged home and advised to</p>

	keep his appointment with Consultant Psychiatrist 2 on the 28 June 2010. Mr. Z was advised to attend Accident and Emergency in the future when in a state of crisis.
28 June 2010	Mr. Z cancelled his appointment with Consultant Psychiatrist 2 who wrote to the GP to inform him of this and that Mr. Z had been booked into the next available clinic.
26 October 2010	<p>Mr. Z was seen at the Outpatient Clinic by Consultant Psychiatrist 2. The diagnosis remained the same. The changes to the medication were to increase the Risperidone to 5mg <i>nocte</i>, and to prescribe Zopiclone 7.5mg at night for a couple of weeks. Procylidine was also to be given PRN if required.</p> <p>It was noted that Mr. Z was not on CPA. Mr. Z had reported feeling “<i>up and down</i>” since the last follow up. Since June his flashbacks had increased to some 3-4 times a day. He also thought people could read his mind and reported persecutory ideas. The mental state examination noted that Mr. Z was well dressed and well kempt. He had good eye contact and a rapport was established easily. The plan was to refer Mr. Z to the Cognitive Therapy Team for booster sessions with regards to his PTSD.</p> <p>Informed by Mr. Z that he went to Accident and Emergency in June after increase in flashbacks and suicidality.</p>
19 November 2010	Consultant Psychiatrist 2 referred Mr. Z to the Counsellor. It was explained that Mr. Z had an exacerbation of his PTSD symptomology following a seemingly innocuous remark made by a person at a pub in June about Mr. Z’s family. It was also explained that Mr. Z had been using the strategies formally taught but that he could benefit from some booster sessions. The referral was for advice and opinion.
22 November 2010	<p>It was reported that Mr. Z had been arrested the preceding evening on suspicion of murder of the person with whom he lived. The Police had been called after Mr. Z had told a neighbour that he had stabbed and killed his partner. Mr. Z had reported hearing voices before the act. The Police Surgeon asked Consultant Psychiatrist 2 if an assessment would be required [under the Mental Health Act]. He was told that he would and that he would liaise with an Approved Mental Health Practitioner (AMHP) for the same.</p> <p>A duty AMHP, received a call from the Police Surgeon who requested a Mental Health Act assessment. Mr. Z had been in Police custody since the preceding day. A discussion took place with Consultant Psychiatrist 2 regarding referral Mr. Z to Edenfield for forensic support. Mr. Z was described as calm and relaxed in manner. The Police Surgeon from Edenfield made the assessment with Consultant Psychiatrist 2 and it was thought that Mr. Z was fit to be interviewed.</p>
31 December 2010	The GP wrote to the Trust to say that Mr. Z had been a regular, if not frequent attendant at the GP surgery. At no time had he “ <i>complained of suicidal thoughts, ideation or express any feelings of aggression towards others</i> ”. Mr

	<p>X had a previous history of abuse, however he had never presented in any way to give cause for concern. Mr. Z had always appeared to be a placid individual. The GP expressed satisfaction with the care and treatment Mr. Z had received from Consultant Psychiatrist 2. The GP added that he had received reports from Mr. Z's neighbours to say that he had been drinking heavily prior to the homicide and that when he went to his neighbour's house for assistance following the incident he was drunk and unable to recall what had happened.</p>
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