

Independent Investigation

into the

Care and Treatment Provided to Ms A

by the

Dorset Healthcare University NHS Foundation Trust

Bournemouth Local Authority Social Services

and

Knightstone Housing Association

Executive Summary

Commissioned by

NHS South West and the Bournemouth and Poole Adults Safeguarding Board

Investigation Managed by: the Health and Social Care Advisory Service

Report Authored by: Mr Jonathan Allen

Contents

1. Preface	Page 3
2. Condolences	Page 4
3. Incident Description and Consequences	Page 4
4. Background and Context to the Investigation	Page 6
5. Terms of Reference for the Independent Investigation	Page 8
6. The Independent Investigation Team	Page 9
7. Summary of Findings and Conclusions	Page 10
8. Notable Practice	Page 26
9. Lessons Learned	Page 26
10. Recommendations	Page 29

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Ms A was commissioned jointly by NHS South West and Bournemouth and Poole Adult Safeguarding Board. The Investigation is pursuant to *HSG (94)27*¹ and the Bournemouth and Poole Adult Safeguarding Serious Case Review Policy and Procedure.² This Investigation was asked to examine the care and treatment received by Ms A in the years and months prior to the killing her mother, Ms B, on 25 of August 2010.

Ms A received care and treatment for her mental health condition from the Dorset Healthcare University NHS Foundation Trust in partnership with Bournemouth Local Authority Social Services from October 2001 through to the death of her mother in August 2010. She was also in receipt of supported accommodation from Knightstone Housing Association from December 2009 through to the killing of her mother in August 2010.

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, the Local Authority and Knightstone Senior Management Teams who have granted access to facilities and individuals throughout this process. The Senior Management Teams of all three organisations have acted in an exceptionally professional manner during the course of this inquiry process and have engaged fully with the root cause analysis ethos of this Investigation.

¹ Health Service Guidance (94) 27

² Bournemouth, Dorset and Poole Multi Agency Adult Safeguarding Policy and Procedure

2. Condolences to the Family and Friends of Ms B

The Independent Investigation Team would like to extend its condolences to the family and friends of Ms B. It is hoped that this report will provide a narrative to the events that occurred and address any of the outstanding questions that the family may still have. The Independent Investigation Team thanks the family for their involvement with this process and the assistance that they were able to provide.

3. Incident Description and Consequences

Background Information for Ms A

This background is predominantly drawn from a Psychiatric Court report on Ms A and a detailed history provided in an Independent Psychiatrist's report for a Mental Health Review Tribunal in 2007.^{3 4}

Ms A was born in Salisbury, Wiltshire, on 10 August 1971. Her mother and father separated when she was nine-years old. This was a few years after her younger sister had died from a brain tumour. She did well at school and went to University and gained a degree in art and ceramics. She first showed signs of mental health problems in 1995, when she was living in London. This led her to move back to her mother's home, where over the next few years her mental health problems started to materialise as a serious mental health disorder, and she commenced treatment under the care of local secondary mental health services. Over the next 15 years she received care and treatment from teams in London and more substantially in Dorset following a move back to the area to be close to her father.

Her illness developed into a serious and frequently remitting mental illness. Ms A did not sustain a significant period of stable mental health until 2008. This followed a two-year period of receiving inpatient rehabilitation. Following this she progressed over the next 18 months. She moved into her own supported flat, regained her driving licence and

³ Confidential Psychiatric Court Report

⁴ Independent Psychiatrists Report for Mental Health Review Tribunal 9 May 2005 – records EH132 Vol 43 pp 2120 2123

found some part-time paid work. This continued through to August 2010, when her mental health relapsed with tragic consequences.

Incident Description and Consequences

On 23 August Ms A's Housing Support Worker from Knightstone Housing called the Community Mental Health Team (CMHT) Duty Service to inform them that Ms A appeared unwell, and requested an assessment. The CMHT Team Leader, who took the duty call, asked the Housing Support Worker if Ms A was showing signs of relapse. The Housing Support Worker said she had not seen her unwell before so could not be sure, but advised that she had never seen Ms A like this before. The CMHT Team Leader stated the team was about to go off duty, and advised he would discuss the concerns with a member of staff who knew Ms A, and arrange for her to be seen if necessary the next day.

The following morning there was further discussion within the team. The CMHT Team Leader discussed the call from the Housing Support Worker with a Community Psychiatric Nurse who had seen Ms A in the last five days. She advised that she had given Ms A her depot antipsychotic medication, and at that time she appeared well. The Housing Support Worker called the CMHT again to ask what progress had been made and was told that a plan was being put into place.

On 25 August a further call was made by the Knightstone Housing staff who continued to express concerns about Ms A's mental state. It was agreed that a CPN would go and assess Ms A later in the afternoon.

Later that afternoon a call was received by the CMHT from Ms A's mother expressing concerns about her daughter. When the Duty Worker tried to call Ms B back there was no reply. By this time Ms A had already killed Ms B.

It is reported by a colleague and friend of Ms A (who was an eye witness to the homicide) that Ms B had arrived at Ms A's flat in the early afternoon. She had not heard from her daughter for a couple of days as Ms A was not answering her telephone. Ms A's friend told Ms B that she could see Ms A in the flat and that she was pacing up and down, but would not answer the door. Ms B is reported to have knocked on the

door in an insistent manner. When she did not get an answer she went downstairs and outside of the block of flats to telephone the Community Mental Health Team. Ms A came out of her flat with a knife and attacked her mother, stabbing her over 22 times. Following the attack she proceeded to walk through the streets of Boscombe, until she was apprehended by the Police.

Ms A was arrested and placed into medium secure psychiatric care under the powers of recall of her Section 17a Community Treatment Order. At her trial she was found guilty of manslaughter on the grounds of diminished responsibility, and placed on Section 37 of the Mental Health Act (1983 & 2007) with Section 41 Home Office Restrictions.

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

The Health and Social Care Advisory Service was commissioned by NHS South West (the Strategic Health Authority, now NHS South of England) and the Bournemouth and Poole Adult Safeguarding Board to conduct this Investigation under the auspices of Department of Health Guidance *EL (94)27*, *LASSL (94)4*, and the Bournemouth and Poole Local Authority Adult Safeguarding Serious Case Review Protocol.

The HSG was 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.

Ms A Independent Investigation Executive Summary

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

- iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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

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

5. Terms of Reference

Terms of Reference for an Independent Investigation regarding the care and treatment of Ms A

“To review

- 1. The quality of health care commissioned and/or provided by the Trust, Local Authority, Housing Association and General Practitioner to include whether it complied with statutory guidance, statutory obligations, relevant department of health guidance, internal policies and adult safeguarding procedures.*
- 2. Whether the Care Programme Approach had been followed.*
- 3. Appropriateness of treatment and compliance with medication.*
- 4. Communication with the family including support to them as well as information that was available from them.*
- 5. Communication between the agencies involved in the support of Ms A.*
- 6. The quality of risk assessments, to include the frequency of such.*
- 7. Documentation, including recording of clear plans and risk assessments, decisions on frequency of contact and visits, actions taken and action taken to consider the appropriateness of a Community Treatment Order made in January 2009. In August 2010, whether the circumstances could or should have given rise to recall.*
- 8. The internal investigation (which was a local joint agency review), its recommendations and remedial action taken upon action plans.*
- 9. The learning points for improving systems of all relevant services, with practical recommendations for implementation.*
- 10. To report findings and recommendations to NHS Southwest and Chair of the Bournemouth and Poole Safeguarding Adults Board”.*

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Dorset Healthcare University NHS Foundation Trust, Dorset, Bournemouth or Poole Local Authorities, or Knightstone Housing Association. 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.

Independent Investigation Team Leader

Mr Jonathan Allen	Associate of the Health and Social Care Advisory Service. Chair and Report Author. Previous Director of Nursing and Director of Mental Health.
-------------------	--

Investigation Team Members

Dr Androulla Johnstone	CEO of the Health and Social Care Advisory Service. Nurse Team Member
Dr Liz Gethins	Locum Consultant Psychiatrist. Medical Team Member
Ms Jane Duncan	Local Authority Safeguarding Lead. Hampshire County Council. Safeguarding Team Member

Support to the Investigation Team

Mr Greg Britton	Administration
Mrs Fiona Shipley	Stenography Services

Independent Advice to the Investigation Team

Mr Ashley Irons	Solicitor. Capsticks
-----------------	----------------------

7. Findings and Conclusions Regarding the Care and Treatment Ms A Received

7.1. Findings

7.1.1. Diagnosis

From 2000 to 2007 Ms A's primary diagnosis was Paranoid Schizophrenia. In 2007 while she was being treated in Nightingale House the Rehabilitation Consultant Psychiatrist (Consultant 5) altered her diagnosis to Schizoaffective Disorder. The change in diagnosis followed a relapse of her illness when Consultant Psychiatrist 5 observed a number of symptoms and signs that were consistent with this diagnosis.

On discharge to the Community Mental Health Team in July 2008 the working diagnosis of the Associate Specialist and the Care Coordinators working with Ms A reverted to Paranoid Schizophrenia. They stated they were not aware Ms A's diagnosis had been changed to Schizoaffective Disorder whilst in the Rehabilitation Service. However the Community Consultant Psychiatrist (her Responsible Clinician and Consultant 4) stated his differential diagnosis had always been Schizoaffective Disorder. The Independent Investigation Team found no specific issues in relation to Ms A's diagnostic formulation.

7.1.2. Medication and Treatment

The Independent Investigation Team found that the medication Ms A was prescribed was appropriate for her diagnoses and within recommended therapeutic ranges. The Investigation Team understood Ms A was always reluctant to take medication, and frequently wanted to either cease or reduce her dosage and she experienced significant extrapyramidal side effects from her antipsychotic medication. The treating teams tried hard over time to establish a medication regimen that would keep her well and also minimise the side effects she experienced. They worked collaboratively with Ms A to try and establish her optimal level of medication. However the investigation did not find evidence of intervention which explored and worked on her attitudes and understanding of the importance of adhering to her medication plans.

Ms A had a number of episodes of psychological therapy and she appeared to find these periods of treatment helpful. Whilst with the Rehabilitation Service the psychological elements of Ms A's treatment were based on developing her insight into her illness, developing her coping mechanisms and working with her to develop a relapse management plan. When Ms A returned to live in the community she had a period of receiving weekly sessions with a Counselling Psychologist for several months. This gave her the chance to explore her feelings about her illness and its impact upon her life.

The Independent Investigation Team found that psychological treatment helped develop Ms A's insight into her illness and understanding of her relapse signature. There was no evidence of structured, formal family interventions as recommended within NICE guidelines. This Investigation concluded this was an important gap in her treatment.

- *Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicine's management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.*
- *Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.*

7.1.3. Mental Health Act (1983 and 2007)

The Independent Investigation Team found that the Mental Health Act in its broadest terms was used in an appropriate manner and at the right times in Ms A's care. This Investigation found no evidence that the formal legal and administrative requirements of the Mental Health Act were not completed to the standards required by the law or Mental Health Act Code of Practice. However we found that in a number of areas the clinical practices involved in

supporting Ms A when she was subject to the Act were not as robust as they should or could have been.

Section 136

Section 136 was used in 2005 to bring Ms A into hospital after she was found swimming in the sea naked, and behaving in a bizarre way on Boscombe beach. She was subsequently admitted informally. One month later she left the ward and did not return. She was found by the Police several days' later living on Weymouth Beach. She was not thought by the Police to meet the criteria for Section 136. Eventually staff went from the ward and convinced her to come back informally. This Investigation concluded that in this situation it would have been clinically safer and more legally sound to have sent a doctor and social worker out, who could have assessed her for emergency admission under the Mental Health Act if required.

Section 117

It was found that three Section 117 meetings were held throughout the 10 years Ms A was cared for by the Trust. The first was in 2006 when being discharged, the other two both occurred in Nightingale Court in 2007 and 2008. It would appear that the first Section 117 discharge meeting met the minimum standards for an effective discharge meeting in that the Consultant and Care Coordinator were present; however the absence of the involvement of Ms A or her family was not good practice. The second and third meetings involved more people and demonstrated evidence of careful and thoughtful multiagency planning. Again the absence of direct input from Ms A or her family was not in line with either local or national policy expectation at that time.

This Investigation concluded that the service should have called a Section 117 discharge planning meeting when Ms A's discharge from Leven House was being planned in November 2009. That this did not happen was an omission on the part of the Trust and its staff, while the Investigation Team viewed this as predominantly a service issue, they took the view that it was symptomatic of the generally poor coordination and planning of care that is identified in other sections relating to this period of time in Ms A's care.

Section 17

Section 17 was used twice to facilitate discharge from hospital. The Independent Investigation Team considered that in the first instance in 2006 Section 17 leave could have been used for

longer to maintain a more robust legal hold on Ms A in the early stages of her discharge from what had been a very long admission, and her first detention on Section 3 of the Mental Health Act following an episode of assaultive behaviour.

In the second instance this Investigation concluded it was appropriate to use Section 17 leave prior to conversion to Section 17a Supervised Community Treatment Order.

Section 17a

Ms A met the criteria for Supervised Community Treatment and therefore use of the Community Treatment Order was appropriate. However members of the treating team did not make the link between this and the expected need to respond accordingly in the event of signs of relapse. This failure meant that Ms A being on a Community Treatment Order did not provide the safety net that it was intended to. Had clinicians responded in accordance with expected practice when Ms A's mental state was first reported as deteriorating, she would have been reviewed within 24 hours of concerns being expressed about her mental state. It is probable that she would have been recalled to hospital. That this did not happen was a serious omission, which will be considered as part of the overall management of care.

7.1.4. Care Programme Approach (CPA)

The Care Programme Approach did not assume the central position that both national guidance and Trust policy expected of it in the care and treatment of Ms A. This meant that clinical assessment (including risk assessment), care planning and decision making often occurred in isolation one from the other. The Care Programme Approach documentation appears to have been subject to the 'Boiling Frog' [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Ms A both her Care Programme Approach and risk assessment documentation remained largely unaltered over a nine-year period. It is a fact that changes to either Ms A's presentation or circumstances largely failed to alter the content of the CPA documentation between 2001 and 2010. Whilst it can be said that Ms A's risk factors and relapse indicators changed little over time the Independent Investigation Team made two observations.

Ms A Independent Investigation Executive Summary

First: whilst Ms A's underlying presentation and problems remained the same over a nine-year period her circumstances did not. She transitioned between both health and social care facilities several times and both risk and clinical assessment and subsequent care planning should have been undertaken at these pivotal points on her care pathway in order to reflect her changing needs. This did not happen in either a timely or coordinated manner. Issues were often identified but it was not possible to see demonstrated a systematic and coordinated response. Instead documentation appears to have been subject to a 'cut and paste' approach which relegated the function of CPA to that of a basic commentary rather than being the cornerstone of care and treatment.

Second: it is a fact that Ms A's underlying problems remained unchanged over a long period of time. This is well documented. A consistent feature is Ms A's relapse indicators, her risk factors and her very low deterioration threshold. Every assessment made over a nine-year period alludes to the fact that Ms A, when well, presented with no risk (or low risk), but when unwell could be a significant risk to herself, to others and from others. It was also recognised that once she was in the community these risk factors would increase and that she would need a consistent level of monitoring and supervision. The Community Treatment Order was put into place in January 2009 for this very reason. The behaviour of Ms A was both known and predictable. This then makes it less acceptable that a more robust crisis and contingency plan was not developed as part of the Care Programme Approach process which was widely communicated to all members of the care and treatment team. Due to the fact that so much was known about Ms A it is of particular concern that no plan was in place to guide the actions of health and housing workers between 23 and 25 August 2010.

The Independent Investigation Team concluded that the Care Programme Approach was not delivered in accordance with Trust policy and procedure expectation. Communication and care coordination levels were of a poor general standard and assessment and care planning did not take place based upon either Mr. A's presentation or circumstances.

The absence of effective Care Programme Approach processes was contributory to the poor levels of clinical management Ms A received in August 2010. The days and hours before Ms B died provided a clear window into the observation that the family, the housing support staff and the clinical team, had not established a common understanding of Ms A's needs and risks, or a coherent plan of how deal with her in relapse. In addition it demonstrated to the

Independent Investigation Team that those involved in Ms A's care and treatment had not established a level of professional relationship that enabled them to work together effectively as a single multiagency team looking after Ms A's best interests.

- *Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.*
- *Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.*

7.1.5. Risk Assessment and Management

The risk assessment and risk management processes that Ms A was subject to were not in keeping with either local or national policy expectation. Assessment was rudimentary and few attempts were made to develop a formulation which would have ensured Ms A continued to be managed in a robust manner.

The Consultant Psychiatrist who was Ms A's Responsible Clinician at the time she killed her mother had a sound understanding of Ms A's psychiatric condition and of her latent risk. On the basis of this knowledge he placed Ms A on a Community Treatment Order. The expectation was that any deterioration of her mental state would be monitored and an instant recall into hospital would be made if her mental health relapsed. This plan was not, however, implemented.

Unfortunately the culture of risk assessment and risk management was weak. Risk assessments appeared to be ‘tick box’ processes which did not always engage actively with either Ms A’s current presentation or social circumstances. The risk assessment process was neither multidisciplinary nor multiagency. Communication between the disparate members of the care and treating team appeared to be weak. The main problem was that Ms A did not have a comprehensive crisis and contingency plan in place which was known and understood by everyone working with her. Despite all of the care and treatment activity that was taking place around Ms A when her mental health deteriorated it was evident that the safety net put in place around her was largely illusory and when tested failed to operate in a timely manner. This was to the ultimate detriment of Ms A’s health safety and wellbeing and that of her mother.

- ***Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.***

7.1.6. Safeguarding of Vulnerable Adults

This Investigation found that vulnerable adult safeguarding procedures were not used in the care and treatment of Ms A. However this Investigation identified that for a significant proportion of the time Ms A was under the care of the Trust she met the criteria, set out in the local Adult Safeguarding policy, to be regarded as a vulnerable adult.

On occasions she was inadequately protected from harm. This was particularly manifest on the 23 August 2010. At this time Ms A was displaying symptoms of a relapse in her serious mental illness and fluctuating levels of capacity. However despite this Ms A was unable to access the mental health services that should have been available to her. In the context of the safeguarding policy this constitutes neglect.

Several other concerns regarding other vulnerable adults were identified. Firstly Ms A’s boyfriend had been identified as someone who might be regarded as a vulnerable adult. He was a service user, who had become dependent on Ms A. Ms A reported thoughts about stabbing her boyfriend in his sleep. The presence of these intrusive thoughts was taken seriously by the clinical team caring for Ms A and her Consultant Psychiatrist indicated that

she should be on a low threshold for recall to hospital. However no safeguarding referral was made or formal plan put in place on behalf of her boyfriend.

Ms A parents, especially her mother, have been identified by this review as potentially vulnerable adults in their role as carers. However many of the normal safeguards that should have been in place such as carers' assessments, which would have reduced their overall vulnerability to emotional or physical harm, were not put in place.

Finally: at the time Ms A was reported to be becoming unwell, her level of vulnerability had increased in that she clearly met the definition of a vulnerable adult. This Investigation concluded that not sending out someone to assess Ms A for 36 hours constituted neglect as defined in the local safeguarding policy, as services did not provide the required health and social care services to meet her needs at that time, given her known risks and vulnerabilities and the concerns raised by the Housing Support Worker. This Investigation speculated that it may have been beneficial for the Housing Support Worker or her superiors to have raised a safeguarding concern as soon as they had concerns that the Trust's duty team or crisis team were not going to provide Ms A with the healthcare services they thought she required to keep her safe.

7.1.7. Referral, Admission and Discharge Planning

Ms A had a relatively large number of admissions, transfers and discharges in the years under consideration. When Ms A moved around the country practitioners across the different Trusts worked hard to keep each other informed of her whereabouts, and ensured that local services picked her up. This was good practice and in keeping with the Care Programme Approach policy requirements.

The Independent Investigation Team found that Ms A's assessments for admission to hospital typically occurred in a timely manner and were in keeping with the urgent referral criteria set out in the Trust's CMHT operational policies. This Investigation also found that practitioners were willing to give Ms A the benefit of the doubt, and did not admit her immediately if she promised she would take her medication. However even with quite close monitoring Ms A would often not keep to her promises to take medication and would relapse further. On occasions this led to her presenting a risk to herself and others. The Independent Investigation Team acknowledges that this presented a challenge to the clinicians as they had to take into

consideration Ms A's preferences, ensure that she was treated in the least restrictive environment, and uphold her rights to liberty.

Finally the Independent Investigation Team found that appropriate decisions were made about the level of care and support required to meet Ms A's needs. However there is no evidence in the clinical records available to the Independent Investigation that these decisions were based on the comprehensive assessment of needs and risk required by the Care Programme Approach. Both national guidance and local policy indicated that it is good practice to hold a CPA review at key transition points. Failing to do this consistently in Ms A's case meant that her risks were not comprehensively assessed, and her family and carers from other agencies were not fully apprised or engaged in supporting Ms A to effectively maintain her mental health.

7.1.8. Service User Involvement in Care Planning and Treatment

This Investigation concluded that whilst there was evidence of Ms A's day-to-day involvement in decisions, this was often reactive rather than proactive. When Ms A was well staff would respond to her wishes and aspirations and supported her as she pursued her interests. When she was unwell staff reacted to Ms A's behaviour and level of illness.

Ms A appeared to be more proactively engaged with her team in planning her care than may have been the case. The teams working with her appeared to mistake reacting to her behaviours as service user involvement. However this was not service user involvement and engagement in which the service user and the professional staff were in open and transparent dialogue about how to best work together to meet the service user's needs.

This conclusion is evidenced by the lack of involvement and sharing of CPA care plan documentation. The CPA care plans should have been used as a vehicle to encourage conversations about care and treatment, and help shape changes in the care plans to meet the service user's needs in a more acceptable as well as more effective way. That these documents were not used in this way demonstrated a lack of proactive service user involvement. A more proactive approach to service user involvement in care planning, may or may not have made a difference to the outcomes of Ms A's treatment and care. However it is a learning point for the Trust that service user involvement in decision about treatment and care requires more than reacting to the circumstance the service user presents with. It requires the active engagement

of a service user in proactively considering the plans of care and treatment being put in place for them.

7.1.9. Carer Assessment and Involvement

The joint agency investigation concluded that Ms A's family, although involved in supporting Ms A throughout her illness, had very little proactive interaction with the professionals involved in Ms A's care.

There was no evidence that Ms A's parents were involved in assessing their daughter's needs or developing her care plans as the Best Practice guidance recommends. Care plans and clinicians' views of risks were not regularly shared with the family, nor did clinicians spend adequate time understanding Ms A's parents' views of her illness.

The family were not provided with the education or support recommended within NICE guidelines, although on one occasion Ms A's mother was offered a family intervention. There was no evidence, however, that this was followed through. Ms B may have also benefited from a carer's assessment as she was carrying a great deal of responsibility as the named nearest relative.

- ***Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.***

7.1.10. Housing

The Independent Investigation Team saw evidence that the Trust and Local Authority tried hard to meet Ms A's needs, preferences and safeguarding issues when trying to identify suitable accommodation for Ms A. The level of care taken in this area, and the careful steps taken to move Ms A through to increasing levels of independence was good practice.

However when Ms A was discharged to Leven House, the team could have taken more time to explore the alternatives to discharging her to a flat with a two-year tenancy and housing support provided *via* Supporting People funding. This may have been assisted by a

multiagency review to ensure that a longer-term tenancy and viable support programme could be put in place prior to her next move.

Ms A's own statements to this Investigation made it clear that the pressure to move on from her flat within a two-year period was causing her concern. It cannot be known how this concern impacted upon her mental health. Finding long-term tenancies for people who are eligible for Section 117 aftercare is a service issue the Trust and Local Authority partners should seek to remedy.

- *Service Issue Two. The lack of availability of long term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.*

7.1.11. Documentation and Professional Communication

The most significant issue identified within this report regarding multiagency and professional communication was the absence of a recognisable Care Programme Approach process. This severely impacted effective multiagency communication.

This Investigation found that there was an absence of information-sharing protocols between the various third sector organisations involved in Ms A's care. As a result the third sector organisations were unclear as to what information they could reasonably expect to be shared with them.

The Independent Investigation Team noted that there was an absence of a regularly updated case summary, or a reliable record of key information, which people could use to orientate themselves to the case in an urgent or crisis situation. It was concluded that the absence of this information was not helpful to the duty team who tried to make decisions about how to manage Ms A's case when they were contacted by the Housing Support Worker on 23 August 2010.

- *Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented 'joined up' working both in ongoing care, and crisis situations.*

7.1.12. Policy Adherence

This Investigation concluded that a number of key and interrelated policies and guidance documents were not well complied with. This was because of the way in which CPA and the care coordinator role operated in the Southbourne Community Mental Health Team. It appeared there was a strong Outpatient-based model of care and treatment, which was inconsistent with managing care through the Care Programme Approach. It was also clear that the role of the Care Coordinator had not been fully developed in line with the 2008 guidance in relation to Carer and Family Involvement and coordination of multiagency input into care planning and risk assessment.

Local policy lacked clear and concise direction on the minimum expectations of care coordination, care planning and risk management. It was also noted that care coordinators were not regularly updated on the core skills they required to fulfil the requirements of the Trust's policies.

Other elements of national policy and guidance were not complied with because of resource availability or unintended consequences of decisions to restrict access to service. The former meant family interventions were not available, and the latter meant Ms A did not get access to mental health services 24 hours a day, seven days a week when she required them.

- *Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.*

7.1.13. Overall Management of the Case

Ms A was in receipt of a comprehensive programme of care and support which was assisting her to move forward in terms of independent living and a fulfilled and meaningful life. However underpinning this should have been a robust safety net of care and treatment coordinated using the Care Programme Approach. This Investigation found this safety net was compromised which led to some significant gaps. The key weakness in the underpinning safety net of care was in the poor application of the Care Programme Approach. There was not an effective multi-agency/disciplinary approach to planning and reviewing care. Ms A's care and treatment was delivered by mental health professionals and agencies working predominantly in isolation. This lack of care coordination, sharing of information and joint

Ms A Independent Investigation Executive Summary

working, played a contributory role in the service's failure to respond to Ms A in a timely way. This was because people outside and within the team did not have a shared plan or knowledge of what to do if Ms A's mental health started to deteriorate. It may be further speculated that this also meant that the sort of trusting relationships between individuals working for different agencies which facilitate good care giving were also absent.

While the underpinning safety net of care was weakened by the absence of an effective Care Programme Approach, the failure of the protective barriers put in place to respond quickly and effectively to relapse, were most pertinent to Ms A not getting timely care when she relapsed. This Investigation saw that in principle there were a set of mechanisms in place to intervene in the event of relapse. However in the event of the relapse in August 2010 none of them worked. The duty team did not recognise that Ms A was relapsing from the information provided. The Care Coordinator when she was consulted did not alert the team to Ms A's risks. This meant she was not prioritised for assessment. The Responsible Clinician had not produced an operational plan which told staff what to do if Ms A relapsed. Therefore the Community Treatment Order did not flag the need to involve the Responsible Clinician and initiate an emergency assessment. The duty team did not make use of the Crisis and Home Treatment Team. These were serious omissions in her care and treatment

This Investigation found that the decision not to instruct an assessment within 36 hours had a causal relationship to the failure to intervene in Ms A's deteriorating mental health and the consequent attack on her mother on 25 August. The case for causality is set out below.

Knowledge. The CMHT Team Leader knew Ms A was on a CTO and understood that this meant she had particular risks if she relapsed. While it was not predictable that she would kill her mother or anyone else, it was known she could be a risk to herself and others when she relapsed. There was information both available and documented about her relapse signature. The information given to the CMHT Duty Worker was a close enough match to Ms A's relapse signature to have identified that her mental health was deteriorating. As a senior and experienced mental health practitioner, responsible for the management of a Community Mental Health Team and the supervision of other practitioners the CMHT Team Leader should have known that his first duty with a relapsing CTO client was to consult with the patient's Responsible Clinician.

Opportunity. 36 hours elapsed between the CMHT duty team being informed of Ms A's deteriorating mental health and the death of Ms B. The Trust's own policy on emergency assessments is to see a patient within four hours of referral. Even if the team had been busy at the time of referral, there was ample opportunity within the 36 hours to have instructed an assessment and intervention.

Means. The Community Treatment Order provided the means to intervene rapidly and have Ms A recalled to hospital. There should have been access to the Crisis and Home Treatment Team if required. These means were available to effect rapid assessment and support for Ms A but they were not utilised.

Consequently the Independent Investigation Team concluded that whilst the killing of Ms B could not have been predicted, a serious untoward incident of some kind was foreseeable based upon Ms A's previous behaviour when experiencing a psychotic episode. It was the conclusion of this Investigation that the killing of Ms B was preventable and that had a rapid response (as indicated to be required in her clinical record) for Ms A been forthcoming then this tragic incident would probably not have occurred.

- *Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or not getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.*
- *Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours.*
- *Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the*

case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.

- *Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.*

7.1.14. Clinical Governance and Performance

The Trust described a robust system of clinical governance, which appeared to be compliant with national standards. However to be effective clinical governance systems need to provide what is referred to in the National Audit Office report on NHS Governance – *Taking it on Trust* as the second line of defence. This second line of defence provides systems for detecting and closing gaps in service delivery that practitioners and local service managers (the first line of defence) have missed. Evidence from our investigation found that the clinical governance system extant at that time may not have provided an adequate or robust second line of defence. The Trust did not appear to be aware that:

- supervision arrangements for practitioners were patchy and informal;
- audits and quality assurance systems, whilst evaluating compliance in practice against national standards and expectations, did not appear to detect issues relating to Ms A's care and treatment;
- findings from internal investigations were not being addressed within reasonable timescales;
- there was inadequate monitoring or follow up of whether staff had attended core areas of training, such as the Care Programme Approach and risk management. However the Trust asserts that 'Did not Attend' notifications were always sent to managers on a monthly basis from 2010.

Whilst the staff interviewed commented clearly on their clinical supervision experiences these did not fully reflect the overall Trust framework for clinical supervision. The Trust has a central list of clinical supervisors which staff can access via the intranet to identify a suitable supervisor. This list comprises in-house staff who have completed the Trust's approved Clinical Supervision for Supervisors course. As part of the Trust's Appraisal/Personal Development Review process managers should confirm that staff are in receipt of clinical supervision and discuss any development needs that have arisen during clinical supervision. This information also forms part of the PDR form which managers complete to confirm supervision is being received by clinicians as per Trust policy. The supervision policy requires the supervisor and supervisee to complete a supervision contract/agreement and then maintain supervision record sheets for each session. These should be filed in the individual's professional portfolio.

7.2. Conclusions

This Investigation concluded that Ms A was in receipt of a comprehensive package of care, which was supporting her to achieve recovery and independence. The recovery support services and supported housing available to Ms A were impressive, and they together with statutory mental health teams were working towards Ms A's recovery.

Unfortunately this Investigation found that despite these strengths there were some serious underlying weaknesses in the underpinning safety net of care. Significant omissions existed in relation to risk assessment and management and the limited way in which the Care Programme Approach and Care Coordination was put into practice. The test of a good package of care and treatment cannot depend solely upon the quality of provision when things are going well and a service user is in a state of recovery. The test also has to apply when a service user relapses and enters a state of crisis. In the case of Ms A the care and treatment package that worked well when she was in recovery, failed to provide for her continued health, safety and wellbeing when in relapse.

8. Notable Practice

At the time of the incident Ms A was receiving a comprehensive care package. This included regular support from the Care Coordinator, individual psychological therapy; a regular (quarterly) Outpatient review by medical staff; regular depot medication and ongoing review of medication; floating housing support from a Housing Association; support to assist with finding and maintaining voluntary work provided by the Vocational Rehabilitation Centre and ongoing support from her befriender.

Ms A's care was appropriately provided under a Community Treatment Order. The team had worked with Ms A so that she was accepting of this and recognised the value of the Order. Although there were a number of changes of Care Coordinator and it is acknowledged that there were some differing views about her, Ms A's care was provided by a multi-disciplinary team, many of whom had known her for several years. This meant that Ms A had received a continuity of care. The team were able to engage with Ms A and work with her in a positive way.

Following the incident the Trust proactively worked with the Primary Care Trust, Local Authority and Safeguarding Board to carry out a joint review.

9. Lessons Learned

Clinical Policy and Process

Ms A received a good general quality of care and treatment from treating teams who over the years were sensitive to her needs. However this care and treatment did not always follow national good practice guidance or local policy expectation. When Ms X was in a stage of recovery the approach taken by the multidisciplinary team was on the whole appropriate. However it did not take into account adequately enough the fact that Ms A had a severe and enduring mental illness which would predispose her to the possibility of future relapse. It was known that when Ms A was in a state of relapse she would become a risk to both self and others. The essential safety nets of care, such as the Care Programme Approach, Safeguarding, risk assessment and crisis and contingency planning were not in place in a

manner robust enough to support Ms A when unwell. The real test of policy, process and system is not so much when a person is well and at their least challenging, but when a person is unwell and often difficult to engage. In the case of Ms A these essential safety nets of care failed to operate sufficiently well when she reached a state of crisis. The lesson for learning is that evidence-based practice provides the basis for safe and effective care and treatment. When clinical teams depart from this practice the ongoing health, safety and wellbeing of service users is compromised.

Professional Communication

In keeping with the findings of most other *HSG (94) 27* Investigations since 1994 this Investigation also found that the failure to provide appropriate and consistent levels of professional communication impacted negatively upon the quality of the care and treatment Ms A received. It was apparent that communication was often poor at the multidisciplinary team level and also at the interagency level. The relatively poor application of the Care Programme Approach made a distinct contribution to this aspect of care in that there was no formally constructed forum where decisions could be both made and shared. The lesson for learning is that professional communication is not simply a matter of maintaining the clinical record but is an active part of professional life which must be pursued with diligence. Additional responsibilities are placed upon Care Coordinators and senior members of clinical teams to ensure that communication opportunities are taken full advantage of and that additional care and attention is paid to the interfaces between primary and secondary care and the third sector.

Carer Involvement and Support

Ms A was fortunate in having two loving and supportive parents who remained actively involved with her. However neither her mother nor her father were incorporated into her care and treatment plans by her clinical teams. No considerations were given to the following:

- education;
- family focused therapy;
- assessment and support;
- risk assessment;

Ms A Independent Investigation Executive Summary

- information sharing;
- care planning.

This was poor practice as the family were an ever-present protective factor in Ms A's life which was seemingly overlooked by each clinical team over the years. This was a serious omission and represents a lack of carer focus. The lesson for learning is that carers and families must be worked with in a collaborative manner especially when they are identified as being a keystone for a service user's recovery. Families can be placed at risk, both emotionally and physically, when caring for loved ones with mental illness and their needs should be both identified and managed as a matter of priority.

Medicines Management

Service users with known histories of medication non compliance should always have a medicines management care plan in place when living in the community. Clinical staff should always be aware of the difference between the concepts of medication non-compliance and medication non-adherence and seek to develop a medicines management plan that will be effective and that ensures that the service user, and any preferences or concerns that they may have, are central to any plan and long-term treatment strategy.

10. 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 Dorset Healthcare University NHS Foundation Trust and Bournemouth Local Authority Social Services 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 investigation process.

10.1. Recommendations

Recommendations 1 and 2: Medication and Treatment

- *Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicines management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.*
- *Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.*

Recommendation 1. The Trust will provide training to Community Mental Health Team staff on Medicines Management Planning; this will cover compliance and non-adherence and will incorporate motivational interviewing skills. The Trust will instruct clinicians of the importance of documenting the reason behind decisions to change treatment, either medication or psychological and social intervention, so that not only is the decision recorded but the reasons underpinning the decision are recorded.

Recommendation 2. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 3: The Care Programme Approach

- *Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.*
- *Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.*

Recommendation 3. The Trust will review the Care Programme Approach Policy including the specific requirements for Patients on Community Treatment Orders. The Trust will provide training to all staff of Community Mental Health Teams on the revised policy. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- holistic needs assessments are conducted;
- care plans are developed, monitored and reviewed;
- carers and service users are involved fully (where appropriate) in the process;
- primary care practitioners are sent copies of all relevant documentation;
- specific management plans are in place when a person is placed on a Community Treatment Order.

Recommendation 4: Clinical Risk Assessment and Management

- *Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her*

latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.

Recommendation 4. All staff from Community Mental Health Teams will be trained in the revised Clinical Risk Policy. The Trust will review and ensure that clear guidance and protocols are in place with partner agencies to ensure that information pertaining to increased risk and significant change is communicated in a robust manner and documented in the RiO record. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- risks are assessed at a frequency in accordance with Trust risk and CPA policy documentation;
- all identified risks are managed by comprehensive risk plans;
- relapse and crisis and contingency plans are updated in accordance with service user need and are communicated widely to all members of secondary and primary care-based care and treating teams.

Recommendation 5: Carer Assessment and Involvement

- *Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.*

Recommendation 5. The Trust will ensure that each Community Mental Health Team has a Carer's Lead to champion the needs of Carers and their families. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 6: Housing

- *Service Issue Two. The lack of availability of long-term supported tenancies can cause a degree of uncertainty for vulnerable people. This ‘move on’ culture is not always in the interests of their health, safety and wellbeing.*

Recommendation 6: The Trust will work with the Local Authority to participate in a scoping exercise of housing need, reviewing need against current provision. The Trust will work with the Local Authority to use this information to develop a Mental Health Housing Strategy to include a strong focus on individuals with severe and ensuring mental health needs.

Recommendation 7: Documentation and Professional Communication

- *Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented ‘joined up’ working both in ongoing care, and crisis situations.*

Recommendation 7. The Trust will develop new Information Sharing Protocols for each Third Sector Organisation that jointly provides care with the Trust. These protocols to be audited for effectiveness as part of an ongoing audit process.

Recommendation 8: Policy Adherence

- *Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.*

Recommendation 8. The Trust will review its systems for informing teams of new/revised Policies and Procedures. The Trust will develop a revised management and clinical supervision policy that takes account of adherence to new Policies and Procedures.

Recommendations 9, 10, 11, 12: Overall Management of the Case

- *Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and*

relationship building was managed poorly. This laid the foundations for people not knowing what to do, or getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.

- *Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours or sooner.*
- *Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.*
- *Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.*

Recommendation 9. The Trust will ensure that all Community Mental Health Teams are instructed of the referral routes to the Crisis and Home Treatment Team and of the role that Duty Workers have in managing patients who require urgent assessment or intervention. The Trust will ensure that all Service Users on Community Treatment Orders are discussed as a minimum on a monthly basis within Team Meetings and that a record of the discussion is recorded in the RiO system. The Trust will also review all Operational Policies and care pathways to ensure that referral and access to Crisis Team is made explicit to:

- primary care workers;
- secondary care workers;

Ms A Independent Investigation Executive Summary

- third sector workers;
- services users;
- carers and families.

Recommendations 10 and 11 set by the Local Authority

Recommendation 10. The Safeguarding Adult Board (SAB) and the Trust at Board/leadership level to understand and define the relationship between adults at risk by reason of their mental health issues and those at risk within the broader definition and therefore oversight of adult safeguarding. The SAB to communicate and train relevant staff when that understanding has been reached and agreed.

Recommendation 11. The SAB to debate and agree the extent to which adult safeguarding protocols and procedures are/should be the backstop for service failures elsewhere in the system.